



# COMPENDIUM OF PUBLIC HEALTH STRATEGIES

VOLUME 1

*Adopted by*  
WHO Regional Committees (1998 – 2011)



World Health  
Organization

REGIONAL OFFICE FOR

Africa

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# Foreword

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The review of past and recent challenges in health development in the African Region showed that tangible achievements and significant progress cannot be made without the development and implementation of sound policies and strategies. The strategies of the WHO in the African Region are drafted by the WHO Secretariat, peer-reviewed by Representatives of countries during the Programme sub-committee meeting and endorsed by the Ministers of Health during the annual session of the WHO Regional Committee for Africa.

These strategies provide guidance to countries and serve as reference tools for governments, as well as technical and financial partners in health in their effort to address major issues and challenges in order to improve health outcomes. Their structure has evolved over time and reflects the change of our thinking on various issues.

Most of the public health strategies approved by the Regional Committee so far remain valid and could enhance the way governments and partners design specific national health programmes, interventions and services. We hope that having all the strategies in an easily retrievable form can facilitate wider access and use.

This was the justification for the preparation of a compendium of strategies approved by the Regional Committee. This first volume of the compendium contains strategies approved by the Regional Committee between 1998 and 2011. We have also included in the annex, documents from the Regional Committee that address current priority public health issues, which were not reflected in the strategies.

For ease of reference, the Strategic Directions (SD) of WHO in the African Region (2010-2015), which were developed taking into account the 11th General Programme of Work also known as “A New Global Health Agenda” and the Medium-term Strategic Plan (2008-2013), are used as a matrix to relate each strategy to the current work of WHO in the Region.

The section related to SD 1 contains the strategic health research plan for the African Region. Research for health is instrumental in informing

the decision-making process by health managers and policy leaders at various levels. The Strategic Health Research Plan is an important tool to enhance national capacity to carry out relevant research for health to narrow the knowledge gap and accelerate the attainment of national and international health goals.

Section SD2 relates to the health workforce, health financing, medical products and medicines, including blood and technologies, and knowledge management. These strategies contain the key ingredients required to bolster local and national health systems and improve health outcomes. To this end, they provide sound policy and technical guidance.

Section SD3 contains orientations for scaling up proven and cost-effective interventions such as newborn care, infant and young child feeding, micronutrient supplementation, integrated management of childhood illness, and immunization among others, which is key in reducing infant and child mortality. In addition, promoting women’s health and accelerating the attainment of relevant milestones that are spelt out in several strategies, roadmaps and commitments will further contribute to the reduction of maternal mortality, which remains very high in the African region.

The strategies in section SD4 show that despite some progress over the past decade, the burden of HIV/AIDS, Malaria and Tuberculosis, including the multidrug-resistant and extensively resistant tuberculosis cases, is still gloomy and requires special attention. Reversing the current trends will require the following: enhanced country ownership and leadership for comprehensive scaling up of cost effective interventions for the prevention and control of HIV/AIDS, malaria and tuberculosis. Furthermore, the driving forces will be identified by generating reliable data through research.

Section SD 5 presents strategies that address the scourge of communicable (63% of total deaths in the African Region) and noncommunicable diseases (NCDs). In fact, NCDs constitute the biggest challenge to the under-performing national health systems in the African Region. The morbidity and mortality burden attributable to noncommunicable



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diseases such as cardiovascular diseases, cancer and diabetes is on increase; some of these diseases are associated with the following risk factors: tobacco use, abuse of alcohol, physical inactivity and unhealthy diets. The strategies contain innovative interventions for the prevention and control of communicable and noncommunicable diseases, including mental health, violence and injuries, which are central in the current efforts to curb the plight of these diseases in the Region.

Section SD6 contains strategies related to determinants of health. The determinants, most of which are intertwined, constitute the root causes of the double burden of communicable and noncommunicable diseases in the African Region.

Despite the progress made to date, especially in controlling communicable diseases, there has been an alarming increase of noncommunicable diseases over the past few years and their burden is projected to become the leading cause of death in less than two decades. The success factors in addressing this emerging situation lie on social and economic development (not just growth!) that results in betterment of environment, housing, food, provision of water, hygiene and sanitation.

It is our hope that this compendium will serve as a reference book for governments, public and private health institutions, academia, professional associations, partners and health workers.

**Dr L G Sambo**  
Regional Director

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The assistance of Mrs Assamala Amoi-Seminet and her team in retrieving the strategies, and organizing the editors is gratefully acknowledged.

# Acronyms and Abbreviations

AACHRD	African Advisory Committee for Health Research and Development	IEC	Information, Education and Communication
ACHR	Advisory Committee on Health Research	IDF	International Diabetes Federation
ACT	Artemisinin-based Combination Therapy	IDPCD	Integrated Disease Prevention and Control Division
ADB	Asian Development Bank	IM	Intervention Measures
AfDB	African Development Bank	IMAI	Integrated Management of Adolescent and Adult Illness
AFR	WHO African Region	IMCI	Integrated Management of Childhood Illness
AFR/RC	Regional Committee for Africa	IPCS	International Programme on Chemical Safety
AFRO	WHO Regional Office for Africa	IPT	Intermittent Preventive Treatment
AIDS	Acquired Immune Deficiency Syndrome	IPTP	Intermittent Preventive Treatment in Pregnancy
AIM	African Initiative for Malaria	IRS	Indoor Residual Spraying
AMFM	Affordable Medicines Facility for Malaria	ITN	Insecticide-Treated Nets
ANUG	Acute Necrotizing Ulcerative Gingivitis	LLIN	Long-Lasting Insecticide-Treated Nets
APOC	African Programme for Onchocerciasis Control	MAP	Multisectoral AIDS Programme
ARI	Acute Respiratory Infections	MCV	Measles-Containing Vaccine
ART	Anti-retroviral therapy	MDG	Millennium Development Goals
CBO	Community Based Organization	MDR TB	Multidrug-Resistant Tuberculosis
CCM	Country Coordination Mechanism	MOH	Ministry of Health
CHCM	Comprehensive Health Care Management	MTEF	Medium-Term Expenditure Framework
CMH	Commission for Macroeconomics and Health	NEPAD	New Partnership for Africa's Development
COPD	Chronic Obstructive Pulmonary Diseases	NGO	Non-Governmental Organization
CSDH	Commission on Social Determinants of Health	NORAD	Norwegian Agency for Development Cooperation
CVD	Cardiovascular Diseases	OAU	Organization of African Unity
DALY	Disability Adjusted Life Years	ODA	Official Development Assistance
DG	Director General	PHC	Primary Health Care
DGIS	Dutch Ministry of Foreign Affairs	PLWHA	People Living with HIV/AIDS
DHMT	District Health Management Teams	PMTCT	Prevention of Mother-to-Child Transmission
DHO	District Health Office	PRSP	Poverty Reduction Strategy Papers
DOTS	Directly Observed Treatment, Short-course	RBM	Roll Back Malaria
EOC	Emergency Obstetric Care	RDT	Rapid Diagnostic Tests
EPI	Expanded Programme on Immunization	SCD	Sickle-Cell Disease
FAO	Food and Agriculture Organization	SD	Strategic Direction
FGM	Female Genital Mutilation	SDH	Social Determinants of Health
GDF	Global Drug Facility	STI	Sexually Transmitted Infections
GDP	Gross Domestic Product	SWAp	Sector-Wide Approaches
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria	TAG	Technical Advisory Group
GMO	Genetically-Modified Organisms	TB	Tuberculosis
GTZ	Gesellschaft für Technische Zusammenarbeit	TDR	Special Programme for Research and Training in Tropical Diseases
HA CCP	Hazard Analysis and Critical Control Points	UN	United Nations
HAT	Human African Trypanosomiasis	UNAIDS	Joint United Nations Programme on HIV/AIDS
HbS	Haemoglobin S	UNDP	United Nations Development Programme
HIPC	Heavily Indebted Poor Countries	UNEP	United Nations Environment Programme
HIV	Human Immunodeficiency Virus	UNGASS	United Nations General Assembly
HIV/AIDS/STI	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome/Sexually Transmitted Infections	UNICEF	United Nations Children's Fund
HRD	Human Resource Development	UNIDO	United Nations Industrial Development Organization
HPV	Human papillomavirus	USAID	United States Agency for International Development
HRP	Special Programme of Research, Development and Research Training in Human Reproduction	VCT	Voluntary Counselling and Testing
HSR	Health Sector Reform	WHA	World Health Assembly
HSR	Health Systems Research	WHO	World Health Organization
HTC	HIV Testing and Counselling	XDR TB	Extensively Drug-Resistant Tuberculosis
HTP	Harmful Traditional Practices		
IAPB	International Agency for the Prevention of Blindness		

# **STRATEGIES ADOPTED BY THE REGIONAL COMMITTEE FOR THE AFRICAN REGION (48th to 61st SESSIONS<sup>1</sup>) CLASSIFIED BY STRATEGIC DIRECTION (2010–2015)**

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<sup>1</sup>RC48 (Harare, Zimbabwe, 31 August–4 September 1998); RC 49 (Windhoek, Namibia, 30 August–3 September); RC50 (Ouagadougou, Burkina Faso, 28 August–2 September 2000); RC51 (Brazzaville, Congo, 27 August–1 September 2001); RC52 (Harare, Zimbabwe, 8–12 October 2002); RC53 (Johannesburg, South Africa, 1–5 September 2003); RC54 (Brazzaville, Congo, 30 August–3 September 2004); RC55 (Maputo, Mozambique, 22–26 August 2005); RC56 (Addis Ababa, Ethiopia, 28 August–1 September 2006); RC57 (Brazzaville, Congo, 27–31 August 2007); RC58 (Yaounde, Cameroon, 1–5 September 2008); RC59 (Kigali, Rwanda, 31 August–4 September 2009); RC60 (Malabo, Equatorial Guinea, 30 August–3 September 2010); RC61 (Yamoussoukro, Côte d'Ivoire, 29 August–2 September 2010).



# Strategic Direction 1

*Continued focus on WHO's leadership role in the provision of normative and policy guidance as well as strengthening partnerships and harmonization*





# 1.1 Strategic health research plan for the WHO African Region: 1999–2003

(AFR/RC48/11)

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## EXECUTIVE SUMMARY

1. *Health managers and policy-makers need evidence-based information for decision-making in programme and policy matters. Such information should emanate from health research. Unfortunately, research has not been accorded the priority that it deserves in this Region.*
2. *Inadequate resources coupled with a feeling of rivalry and competition rather than cooperation between policy-makers and managers on the one hand and the researchers on the other explain in part the inadequate use of research to guide managers and policy-makers.*
3. *Countries, particularly developing countries in the African Region of WHO, no matter how poor they are, should use research to promote knowledge, guide policy, strengthen health action and maximize the use of limited resources in order to improve human health.*
4. *The WHO Regional Committee, at its forty-seventh session, requested the Regional Office “to formulate and propagate a regional strategy that would help strengthen national capacity in health research”.*
5. *This strategic plan is intended to strengthen national capacity to carry out relevant health research; develop necessary mechanisms for ensuring adequate funding, effective coordination and efficient management of research; and promote the use of research results to address major health issues and problems.*

## INTRODUCTION

1. Health and health-related issues have recently moved very high on the political agenda worldwide and have thus gained greater international visibility. Governments are being increasingly requested by their constituencies and other partners to develop a broad array of policies and programmes to deal with a wide spectrum of health problems and health management matters, the aim being to reduce the disease burden in order to enhance socioeconomic development.

2. In order to promote rational decision-making in programme and policy matters, health managers and policy-makers need evidence-based information. Such information has to emanate, among others, from health research. In this strategy document, the term health research includes clinical and biomedical research, health systems research, operational re-

search, behavioural research, health economics research and epidemiological research.

3. In many cases where information is available, public health practitioners, especially high-level decision-makers, are still somewhat sceptical about the value of research. At the same time, the research establishment tends to operate as a separate entity with its own objectives and agenda. The scepticism of public health practitioners about research is partly due to the belief that “we do not need more research; what is required is for us to apply what we already know”. Added to such a feeling has been the controversy between policy-makers and managers regarding the role of research. This often culminates in competition with health care for the limited resources available in the health sector.

4. Yet research has led to tangible improvements in two ways: by providing knowledge that people use



daily in their homes to maintain their health and by producing direct technical interventions such as vaccine development, new drugs and many other public health measures, which have had a major impact on diseases such as smallpox, onchocerciasis and leprosy. Research has also led to the introduction of insecticide-treated mosquito bed nets, to mention just a few.

5. This regional strategic health research plan has been developed following the request of the African health ministers “to formulate and propagate a regional strategy that would help strengthen national capacity in health systems research”.

## **JUSTIFICATION FOR HEALTH RESEARCH**

### **Policy basis**

6. There are several resolutions of the World Health Assembly and the WHO Regional Committee for Africa, which provide policy justification for health research. Resolutions WHA4.26 (1951) and WHA33.25 (1980) both focus on the need for health research; the latter specifically called for an effective WHO role in the coordination and promotion of research in order to achieve better health. The resolutions of the Regional Committee all point to the need for research for overall national health development.

### **Technical justification**

7. Despite the progress made, there remains an overwhelming burden of infectious diseases that can be addressed with the cost-effective interventions available. Addressing this unfinished agenda is mostly a matter of political will and commitment of adequate resources. But research and development can help through operational and behavioural research (often by developing and evaluating linked packages of care, such as the proposed Mother-Baby Package) and by selective development of new tools and technologies.

8. A more global class of challenges is emerging from the continually changing nature of microbial agents. New pathogens – such as HIV – and the evolution of drug-resistant variants of familiar ones (e.g. those causing tuberculosis and malaria) are creating the need for new biomedical knowledge and for an understanding of the systemic determinants of the spread of resistance to new drugs and vaccines.

9. Member States in the African Region are increasingly facing major (and hitherto neglected) epidemics of injury and non-communicable diseases.

Selected psychiatric conditions, heart disease, stroke and road-traffic accidents dominate the disease profile projected for countries of the Region by the year 2020. Research and development is required to ascertain ways of preventing and managing these conditions under budgetary constraints.

10. All countries, particularly developing countries in the African Region, no matter how poor they are, should use research to promote knowledge, guide policy, strengthen health action and maximize the use of limited resources in order to improve human health. Each country should have a health research base which will enable it to address its health problems. National health agenda must be selectively targeted at the cross-sectional approaches of biomedical, clinical, epidemiological, behavioural and health systems research. It must utilize all available expertise in the biomedical and social sciences and should serve as the starting point for inter-country and regional research efforts.

11. Twenty-two African countries met in 1995 to discuss “Achieving evidence-based health sector reforms in sub-Saharan Africa”. Focusing on the role of research in health sector reforms, the following conclusion was drawn: Reforms especially require specific data and objective information for rational decision-making, and every health sector reform programme should have a research component as its integral part to provide reliable information.

## **SITUATION ANALYSIS**

### **Research capacity**

12. Health research plays a pivotal role in enhancing the effectiveness and efficiency of the provision and financing of health services in any country. Therefore, adequate institutional capacity for research is a necessary condition for improving the health status of the people. Although some efforts have been made to build or strengthen capacity in the countries of the Region, institutional capacity for health research remains generally weak.

13. The Special Programme for Research and Training in Tropical Diseases (TDR) has played a pivotal role in the Region by strengthening research capability. It has trained researchers at graduate level, introduced sandwich doctorate courses to motivate and support qualified researchers working in their countries and provided programme-based research grants and grants for institutional research capacity development.

14. The Joint WHO/AFRO Health Systems Research (HSR) Project for Eastern and Southern

Africa has provided training to a considerable number of health personnel and has developed various training materials. Since January 1998, the WHO Regional Office for Africa has absorbed the project into its Health Systems Research programme, which has expanded to cover all Member States.

15. Also worthy of mention here is the Special Programme of Research, Development and Research Training in Human Reproduction (HRP). Among other things, the Programme has provided technical and financial support to strengthen the capacity of countries in the Region to undertake research in reproductive health.

16. WHO collaborating centres are expected to serve as a valuable mechanism for securing scientific and technical advice. They are, therefore, expected to play a leading role as well as act as catalysts in stimulating research and in organizing, planning and coordinating training activities in different areas of research. In recent times, there has been a lot of debate on the extent to which collaborating centres have been able to play these roles successfully.

17. Most countries of the Region have at least a national research council, with a committee for health research. The role of these councils in providing direction and coordination in health research in support of national health problems and needs has not been critically assessed.

18. There are many national medical research institutes in the Region. Their research capacity has also been limited in recent times as a result of the brain drain and the financial squeeze.

19. Academic training institutions, particularly universities, had potential research capacity, but this has been weakened by the brain drain in many countries of the Region and by budgetary cuts.

### **Research activities and funding**

20. Within the limited research capacity that exists in the Region, research activities have been and are still being undertaken. Subjects addressed include disease-specific problems, operational problems and health sector reform issues (including health care financing).

21. A large proportion of the health research undertaken in the Region is externally funded from sources which include TDR, HRD, the World Bank, the Rockefeller Foundation, Ford Foundation, Carnegie Foundation, Kellogg Foundation as well as bilateral agencies such as USAID, ODA, NORAD, GTZ and DGIS.

22. The WHO Regional Office supports some research at country level. Most of the research funded by various regional programmes is geared towards operational research and health systems research.

23. Funding for research by national authorities and institutions still remains relatively low as compared with external funding. This is, no doubt, a worrisome situation.

24. Funding for national health research from the private sector is still at a low level. The high potential of this source is still untapped. However, before research funding from the private sector could be used, a code of conduct needs to be developed.

### **Constraints**

25. Some of the constraints on health research in the Region have already been alluded to above. Specifically, they include: weak to fragile institutional research capacity; lack of trained personnel capable of generating, implementing and managing research (a problem compounded by the brain drain); inadequate political commitment to health research; lack of well-articulated national research policies and priorities in Member States; and inadequate use of research results due to lack of communication and collaboration between researchers and potential users of research results.

### **Challenges**

26. The problems enumerated above highlight some of the challenges of health research facing countries in the Region, namely, how to increase political awareness about the importance of health research and get countries to define their national health research priorities and policies within the context of their health needs and problems and to allocate adequate resources; strengthen national health research capacity and set up appropriate coordination mechanisms to avoid duplication of health research efforts; arrest the current trend of donor-driven health research priority-setting; and ensure that health research results are used for health policy-making, improving the organization and management of health services, and tackling the various diseases that are taking a heavy death toll on the people of the Region.

## **THE REGIONAL STRATEGIC HEALTH RESEARCH PLAN**

### **Goal**

27. The overall goal of the regional strategic health research plan is to strengthen research capacity at both institutional and individual health worker levels in

Member States in order to conduct priority research that could be optimally used to improve the provision, financing and management of health services.

### Principles

28. In order to achieve the above overall goal, the following basic principles must underpin the health research to be promoted or for which health research capacity strengthening would be provided:

- (a) it must be as holistic, integrated and multidisciplinary as possible;
- (b) it must attempt to provide information that would enhance the integration of health considerations into decision-making at the individual, family, community, national and regional levels;
- (c) it must be relevant to the different health needs and problems of each of the Member States;
- (d) it must contribute to the definition and implementation of policies that will support health development;
- (e) it must enhance both human resource development processes and actions that are necessary to influence the values and behaviours of individuals and communities in a positive way; and
- (f) it must contribute to the integration of health determinants into the context of an overall strategy to achieve sustainable development.

### Objectives

29. The major objectives of the strategic health research plan are to:

- (a) support Member States to develop a national health research strategy and the mechanisms needed to ensure adequate funding, effective co-ordination and efficient management of research; and
- (b) support Member States to develop their national capacity (at institutional and health worker levels) to carry out health research relevant to major health needs and problems;
- (c) promote the use of research results to address major health issues and problems.

### Targets

30. Related to the above objectives, the following targets must be met by the end of the strategic plan period (2003):

- (a) All countries of the Region will have clearly spelt out their health research policies and defined their health research priorities.
- (b) At least 50% of the countries will have formulated strategies and set up mechanisms for mobi-

lizing adequate funds for implementing their priority research agendas.

- (c) At least 50% of the countries will have established mechanisms that will facilitate the utilization of research results.
- (d) At least 50% of the research institutions will have been adequately strengthened to undertake research in defined priority areas.
- (e) At least 10% of health workers at different levels of the health system will have been adequately trained to undertake research in defined priority areas.
- (f) The Regional Office will have set up appropriate mechanisms for facilitating intercountry collaboration and networking in order to strengthen the organization and management of health research in the countries of the Region.

### Strategic thrusts

31. In order to overcome the current problems of and constraints on health research in Member States and achieve the objectives and targets defined above, the major strategic thrusts will be advocacy; national capacity-building; strengthening of mechanisms and processes that support research; technical support; regional linkages and networking; strengthening of the capacity of the Regional Office; and resource mobilization.

32. **Advocacy:** This is indispensable for obtaining and sustaining political will in support of health research. It helps to explain to the countries the relevance and necessity of evidence-based decision-making processes. Such commitment will enhance resource mobilization for research as long as the research to be carried out is focused on priority health problems.

33. **Capacity-building:** Successful research will require the availability of a critical mass of nationals trained in the various disciplines (the epidemiological, biomedical, clinical and social sciences and health systems research) and working in an appropriate institutional framework. Training should be in-country and directories and inventories of existing trained persons must be readily available to managers, policy-makers and donors. Research career profiles need to be created in order to attract and retain professionals. There is a need to organize specialized training in research management and leadership and in informatics and data management.

34. **Strengthening of mechanisms and processes that support research:** Such mechanisms as health research advisory committees, institutional review panels, ethics committees and planned meetings for the

dissemination of research results are critical for sustaining the research culture.

35. **Technical support:** Adequate technical support should be provided to enable countries to draw up their priority research agendas and to formulate research policies and strategies based on national health plans and on-going reforms in the health sector.

36. **Regional linkages and networking:** Existing regional initiatives on health research must be used to complement Regional Office efforts. Where necessary, those initiatives should be actively pursued to enhance national research efforts and promote multi-centre studies on regionally identified priority research issues.

37. **Strengthening of the Regional Office:** It is important to advocate, promote, fund, coordinate, facilitate and evaluate health research in the Region through individual task forces in the various programmes, using a multidisciplinary and multisectoral approach. Research coordination at the Regional Office is facilitated by the Research Policy and Strategy programme (RPC).

38. **Resource mobilization:** This should be carried out at the national level through support of WHO country offices and at the regional and international levels.

## Implementation framework

### Priority Interventions

#### *At country level*

39. Research activity should be promoted by Ministry of Health through the prioritization of essential national health research and identification, recruitment and remuneration of national professional staff to coordinate all research at national level and to involve all stakeholders. Ministry of Health should mobilize resources for research activities from both national and external sources.

40. Ministry of Health research officers, in collaboration with the WHO research staff, should organize national research workshops involving policy-makers, managers, researchers and donors. Such workshops should be the forums for presentation of research results and planning of how they will be used. Such meetings could focus on single topics or discuss multiple issues.

41. The Ministry of Health should:

- (a) develop research policies and long-term research plans, with the participation of all interested partners;

- (b) determine existing national research capacity and indicate the additional number of people to be trained. It should also create an appropriate climate for retaining such staff;
- (c) carry out, in conjunction with all interested parties, a participatory and transparent exercise on the prioritization of research issues at national level.

42. The WHO country office should play a leading role in promoting and supporting health research and in mobilizing resources for it. It should also identify a national officer among its national staff to support the Ministry's research staff and promote research coordination with other external partners.

#### *At Regional Office level*

43. The Regional Office should:

- (a) provide research training and award training grants;
- (b) support research projects developed within national health research priorities and submitted by researchers from Member States;
- (c) encourage various programmes at the regional level to commission research in priority areas defined by it;
- (d) develop and update the regional health research information system;
- (e) develop a new mechanism or approach for effectively supporting and utilizing WHO collaborating centres for various research activities;
- (f) support Member States to establish or strengthen any existing mechanisms for coordinating and managing health research activities;
- (g) promote the exchange of individuals with skills and experience between countries;
- (h) provide expertise and financial and technological resources for collaborative research partnerships between countries;
- (i) organize subregional conferences and workshops on health research issues or for sharing research results.

#### **Partnerships for plan implementation**

44. In order to effectively implement the strategic health research plan, many 'partners' or 'actors' will be involved. These can be broadly divided into three categories: actors at the country level, WHO research supporting structures (particularly at the Regional Office), and other partners.

#### *Country level*

45. National research policies must be based on existing national health policies and ongoing health

reforms. There is need for wide participation in the formulation of research policies. There should be constant reviews in order to capture and anticipate changing health situations.

46. It will also be necessary to involve universities, policy-makers, managers, WHO collaborating centres, the private sector and health-related NGOs.

47. Institutional review panels will be needed to assess research projects and proposals before submission for funding.

48. A functional research coordination unit in Ministry of Health or a research institute with clear terms of reference, a multidisciplinary core staff of epidemiologists, health economists, social scientists and support staff will be expected to play a pivotal role.

49. WHO country offices should spearhead support and promote research at country level through advocacy with ministries of health, other UN agencies, external partners, NGOs, universities and private institutions.

#### ***Regional Office research support structures***

50. The African Regional Advisory Committee on Health Research and Development (AACHRD) is a body that advises the Regional Director on research issues. The Research Policy and Strategy Programme, which is responsible for the overall coordination of health research, acts as the secretariat for the AACHRD. It is located in the Programme Management and Development Unit under the charge of Director, Programme Management.

51. The Research and Development Committee is a managerial organ that makes recommendations to the Regional Director with respect to the Research Policy and Strategy Programme. It identifies mechanisms for strengthening relations with research programmes at the three levels of WHO and is responsible for the evaluation of nominations for research prizes and awards.

52. There are task forces for each priority programme in the Regional Office. Each task force carries out research in its own area. What is needed is to maximize the use of such research for the benefit of all, including the sharing of methodologies, co-funding and provision of support for multi-centre studies.

#### ***WHO collaborating centres***

53. Before designating new ones, existing collaborating centres should be strengthened and provided with adequate resources so that they can be maximally involved in conducting and promoting health research.

#### ***Global Advisory Committee on Health Research***

54. The Global Advisory Committee on Health Research (ACHR) will provide global input to the African Advisory Committee on Health Research and Development (AACHRD) and the Regional Office Research Development Committee.

#### **Other agencies promoting health research**

55. A strong political, technical and financial commitment is required from international agencies to implement an integrated and long-term programme for strengthening health research in Africa. These include multilateral and bilateral agencies, international scientific research institutions, professional organizations and other public and private centres. In order to support Member States in health research, WHO would provide guidance to, and collaborate with these bodies in order to:

- (a) mobilize resources and equitably distribute them with respect to geographical location and type of research to be conducted (operational vs. basic; clinical vs. community-based; disease vs. public health-oriented research, etc.);
- (b) train researchers wishing to apply their research skills but hampered by financial difficulties (local vs. foreign training; type and level of training);
- (c) determine relevant research topics and facilitate the dissemination and use of findings; and
- (d) support national health research plans where they exist or promote the preparation of such plans.

### **MONITORING AND EVALUATION**

56. Monitoring and evaluation must provide feedback through planned information that is collected periodically to guide decision-making. It serves as a control mechanism and a basis for accountability; it also shows whether resources are being used efficiently.

#### **Structures and mechanisms for monitoring and evaluation at country level**

57. Health advisory committees should be asked to carry out or commission regular monitoring and evaluation of research in order to demonstrate its advantages and disadvantages in various programmes.

#### **Structures and mechanisms for monitoring and evaluation at regional level**

58. Each programme should have an in-built mechanism for periodically monitoring and evaluating its

research component, with special emphasis on country research activities.

### **Monitoring and evaluation tools**

59. In collaboration with Member States, the Regional Office should spearhead the development of tools for the evaluation of research.

### **Role of WHO in support for Member States**

60. WHO's regional structure is ideally suited to provide specific technical or managerial support for health research activities and training at the local, country and sub-regional levels. Following the managerial and research cycles, this would focus on technical support to Member States in:

- (a) completing the situation analysis of countries, determining the existence and functioning of structures, institutions, coordinating mechanisms, manpower and other resources for research; identifying research priorities and activities; utilizing research results; and overcoming constraints;
- (b) developing and disseminating an inventory of research topics in health and related areas and preparing an inventory of priority research issues;
- (c) designing protocols and guidelines for preparing and executing research projects;
- (d) training a critical mass of trainers for research, who will train other health workers to develop the analytical capacity to design and carry out operational and epidemiological research;
- (e) facilitating the exchange of experience and dissemination and application of research findings; and
- (f) mobilizing financial and technical resources and creating networks.

61. WHO should facilitate the organization of regional and country consultations, involving health policy-makers, administrators, researchers, universities and related research institutions and potential donors in order to review the situation of health research in the Region and develop a strategy for strengthening not only health research capability but also coordination mechanisms and research management. Such consultations would also help identify priority health research issues and how results therefrom could be disseminated and applied.

## **CONCLUSION**

62. The implementation of the strategic research plan for the African Region is an evolutionary process. Realization of the plan will require the commitment of Member States and the international

community. The development of this strategic plan bears testimony to the importance the Regional Office attaches to health research as a means of contributing to the health and socioeconomic development of all the people of the Region.

### **Resolution AFR/RC48/R/4**

#### **Strategic health research plan for the WHO African Region**

The forty-eight session of the Regional Committee for Africa,

Having examined the Regional Director's report on health research in the Region;

Recalling World Health Assembly resolutions WHA4.26 and WHA33.25 relating to health research;

Bearing in mind the importance accorded by the Regional Committee to health research policies during the different sessions of the Technical Discussions, particularly during the 42nd (ref. Doc; AFR/RC42/TD/1) and the 47th (AFR/RC47/TD/1) sessions; and

Considering that health research was one of the means for obtaining reliable information to guide decision-making and improve the management and quality of the services of health systems;

1. APPROVES the strategic health research plan for the African Region
2. REQUESTS the Member States;
  - (i) to determine, together with all parties concerned, priority research areas at the national level;
  - (ii) to draw up medium- and long-term research policies and strategies consistent with national health development policies;
  - (iii) to create an enabling environment for researchers to function effectively;
  - (iv) to build national research capacities, particularly through resource allocation, training of senior officials, strengthening of research institutions and establishment of coordination mechanisms;
  - (v) to put in place a national health research plan, in collaboration with health development partners; and
  - (vi) to establish a national committee to formulate and ensure compliance with ethics, especially regarding the conduct of clinical trials on humans; and
3. URGES the Regional Director:
  - (i) to draw up and disseminate an inventory of health research institutions in the Region;

## COMPENDIUM OF RC STRATEGIES

- (ii) to draw up and disseminate an inventory of research work on health and health-related areas;
- (iii) to strengthen the health research programmes of the Regional Office as well as the effectiveness of the African Advisory Committee for Health Research and Development;
- (iv) to take stock of WHO collaborating centres aiming at optimizing their role in the conduct and promotion of health research;
- (v) to promote the training of trainers in research methodology in the Member States;
- (vi) to encourage the exchange of experiences, the dissemination and application of research findings;
- (vii) to sensitize partners (NGOs, multilateral and bilateral cooperation agencies, etc.), and mobilize financial and technical resources to support the Member States in the implementation of their priority research programmes;
- (viii) to put in place mechanisms for monitoring and evaluating the progress made in the Region; and
- (ix) to inform the Regional Committee every two years on the progress made in the implementation of the strategic plan.

*Tenth meeting, 2 September 1998*

## Strategic Direction 2

*Supporting the strengthening of health systems based on the primary health care approach*







## 2.1 Regional strategy for the development of human resources for health (AFR/RC48/10)

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### EXECUTIVE SUMMARY

1. *Health for all, through primary health care, proclaimed twenty years ago at the Alma-Ata Conference, will remain a major objective for the years and century to come.*
2. *Among the many resources to be mobilized to this end, human resources constitute the most precious. Unfortunately, they have not always received the attention they deserve, hence the persisting significant gaps between ongoing reforms in the health sector and the management of human resources for health. It is, therefore, crucial that the changes taking place in the organization, functioning and financing of health care systems be accompanied by appropriate measures for developing both human resources for health and supporting institutions.*
3. *The strategy proposed in this document aims to strengthen the capacity of Member States to optimize the utilization of their human resources for health with a view to achieving the health objectives of the Region.*
4. *This strategy is essentially based on the following: harmonization of global and national health policies with the development of human resources for health, including in the private sector; strengthening of institutional capacity; reorientation of medical training and practice; coverage of the whole country by competent and motivated health teams; research on the development of human resources for health; and regulation of professional practice.*

### INTRODUCTION

1. In all countries of the world, human resources constitute the most valuable asset because, in addition to their economic impact, they enhance the value of all the other resources by converting them into socially useful products.

2. Thus, in the health sector, efforts have been made for many years to better integrate human resources development into the health for all objectives.

3. Further, for the last five years, at least, programmes for enhancing and developing human resources have been proposed and implemented in many African countries, within the framework of bilateral and multilateral cooperation activities, in order to cope with the chronic problems affecting the development of human resources for health. These problems include lack of integration between human resources

development and development of the sector; poor numerical, spatial and qualitative distribution of personnel in the public and private sectors; the mismatch between training on the one hand, and needs and job profiles on the other; non-identification of the health team appropriate to each health care delivery level; inability to retain and optimally utilize existing staff in a manner as to guarantee stability, which is required for achieving medium- and long-term objectives, such as health for all.

4. Investments in training at the national level and within disease control programmes have rarely produced the expected results, probably due to compartmentalized, isolated and uncoordinated implementation approaches to all aspects of the development of human resources for health.

5. Indeed, developing human resources for health means attempting to provide: the health personnel

we need, in sufficient numbers, with the right competence, motivation and experience, in the desired institutions, and at appropriate posts, at the right time, and at an affordable cost, so that users may have quality health care adapted to the state of health of the individual and the community.

6. Human resources development is therefore directly associated with planning, training and managerial capacities of health personnel at all levels of the health system, especially at the policy and strategic levels, on the one hand and on the other, with guaranteeing career prospects to health personnel.

## JUSTIFICATION

### Situation analysis

7. The development of human resources for health depends on a number of factors, some of which relate to the overall national situation, while others relate to the health sector. The targeting of one or the other of these factors instead of a systematic approach is the source of the many problems compromising the optimal utilization of health resources and the implementation of health policies.

#### *Factors related to the overall national situation*

8. Reforms are ongoing in all the sectors of national life in the majority of African countries. These reforms are being encouraged and supported by the international community. Despite this favourable environment, the rhythm of reforms remains slow due to a number of social, economic and political reasons. For example:

- (i) The population, by its demographic characteristics, behaviour in the face of disease and death and the epidemiological profile, exerts some influence on the demand for and utilization of health services, including the type of personnel.
- (ii) The socioeconomic crises of the 80s and 90s, in arresting economic growth and social progress, had serious repercussions on the health services, particularly on personnel, whose training and recruitment were suspended in many African countries.
- (iii) The political situation certainly impacts on the organization, functioning and management of the health sector. Nonetheless, the following facts must be mentioned:
  - Poor understanding by policy-makers and health officials of the importance of human resources in the implementation of their

health policy rarely led to the inclusion of human resources development for health on the priority policy agenda of these countries or to the allocation thereto of the resources needed.

- The “medical model” as the dominant health model continued to influence to a large extent, the health and development policies related to human resources, despite the movement begun almost two decades ago in favour of community health and despite the adoption of primary health care as the strategy for achieving the social objective of health for all.

#### *Factors related to the health sector*

9. The capacity to plan, produce and manage health personnel and guarantee them career prospects is a determinant factor in human resources development for health. Yet, not much importance is always accorded to this. The result, in the majority of the countries of the Region, has been ill-suited structural, technical and regulatory arrangements. For example:

- (a) The department responsible for human resources for health is hardly ever structured or given the tools with which to carry out the principal functions of modern day human resource management, namely, planning (qualitative and quantitative determination of staffing needs, identification, projection and programming of those needs); production (training related to needs and job profiles); management (routine, forward-looking and performance evaluation). The activities of these departments are limited essentially to routine personnel management.
- (b) Some laxity and politically-oriented measures characterising health personnel planning exclude the private sector and neglect its planning and personnel training needs.
- (c) Initial and specialist training in the health sciences is still elitist and focused on hospitals, despite the recognized reform needs or the re-orientation of medical training and practice. Continuing training, virtually inexistent in the private sector, is carried out almost exclusively within specific disease control programmes or for the purpose of promoting specific drugs. These training efforts must necessarily be accompanied by an organizational change of the health system in order to have any chance of success. Conversely, isolated reforms without changes in the knowledge base of the personnel will stand little chance of success.

- (d) Training in human resource management, in the institutions where this is a training discipline, seems to have rarely received privileged treatment; the expertise needed for such training, especially for training permanent trainers adept in human resource management, are often lacking; there is no inventory or needs assessment and partnerships between the authorities concerned; training institutions are also practically non-existent.
- (e) The tools to help act on the behaviour of staff or to influence their retention are generally few or non-existent, and not adapted to the sector or to ongoing reforms, be they in the area of legislation or existing regulations, including the legislation applicable to professional practices, living conditions, incentives or to the professional environment.

## Guiding principles

### Policy basis

10. The Alma Ata Declaration attaches special importance to the role of health personnel in the implementation of the primary health care strategy, and requires that the personnel adopt a more holistic approach, in conformity with WHO's Constitution and the definition of health.

11. In 1995, the report of the working group on WHO's response to global changes called for a revision of the health for all strategy, specially emphasizing the development of health care systems based on the principles of human dignity, equity, solidarity and professional ethics.

12. The same year, in its resolution WHA48.8, the World Health Assembly urged Member States to undertake coordinated health system reforms, in other words, reforms in training and the practice of the health professions. The importance of the role of the other categories, particularly nursing and midwifery, was reaffirmed and addressed in a specific resolution in 1996 (WHA49.1) and in a special report in 1997.

### Social justification

13. Health costs to the society, especially those relating to health personnel (70% of the operational budget of the health sector in many countries), associated with the scarcity of resources, brain drain both within countries and the continent and outside them, are additional arguments for improving the efficiency of health care services and, hence the competence and motivation of health personnel at all levels of the health system.

### Programmatic justification

14. The ongoing changes and reforms in the countries and at the level of WHO offer both an opportunity and an obligation to tie in the issue of human resources development for health with the expected changes in the organization, functioning, financing and management of the health system on the one hand, and on the other hand, with technical cooperation with countries of the Region.

## THE REGIONAL STRATEGY

15. Reforming the health system means setting a number of objectives, namely, guaranteeing equity of access to health services and care to all citizens; improving the quality and effectiveness of health services; controlling health expenditure increases and ensuring efficient management of available resources; increasing the degree of satisfaction of users and health personnel. Faced with such objectives, the insufficiency of staff, their poor distribution, the absence of continuing training and of quality assurance mechanisms, and the low productivity and morale of the personnel are urgent problems requiring solutions.

### Aims and objectives

16. This strategy aims to contribute to the achievement of the health objectives of the Region by strengthening the capacity of the countries to optimize the use of their human resources for health.

### Strategic objectives

17. The strategy aims to ensure that each Member State:

- (i) defines a human resources development policy, supportive of the implementation of its health policy.
- (ii) possesses the required capacities for diagnosing the problems of human resources development for health, formulating relevant policies, mobilizing actors and implementing, monitoring and evaluating the policies.

### Targets

18. The targets for the period 1999–2008 are as follows:

- (i) By the year 2004, the 46 countries of the Region will have developed a policy for human resources development for health.
- (ii) By the year 2007, the 46 countries of the Region will have acquired the capacity to

implement their policy on human resources development for health.

### Principal thrusts

19. This strategy comprises six principal thrusts. They are:

- a policy framework, in other words, the commitment of decision-makers and health officials to consider the development of human resources for health as a necessary condition for achieving the objectives of the national health policy;
- planning of human resources development for health based on three elements: the environment and its trends, the needs and aspirations of the population, and employees' expectations;
- training-education of quality personnel, based on needs, the absorption capacity of the sector and job profiles;
- administration-management or creation of working and living conditions that enhance the satisfaction of both the users and personnel;
- research in key fields of human resources development for health, with a view to clarifying the choices of policy-makers and health officials;
- regulation of the medical profession in order to protect the sick and the communities against risks and professional malpractice.

### Priority interventions

20. The formulation and adoption of a policy for the development of human resources for health, in accordance with health objectives, is a first step that is both difficult and delicate but indispensable, due to the nature of the resource concerned and its impact on the preparation of strategies and sectoral plans.

21. In the countries, advocacy before policy makers and health officials will be required to bring them to include human resources development for health on the list of national policy priorities, and to identify, mobilize and support institutional actors. This political will should be reflected in restructuring and strengthening of the institutional capacity of ministries of health, in the establishment of coordination mechanisms, in the adoption of appropriate human resources development tools, and in the allocation of additional resources for the implementation, monitoring and evaluation of the human resources development policy.

22. At the regional level, the measures to be taken will focus on the following: adoption of a resolution on the development of human resources for health; leadership to support the inclusion of human resources development for health among the priority

policies; coordination of the programmes concerned; and mobilization of resources.

### Planning the development of human resources for health

23. Human resources planning consists of analysing the factors that influence the supply of and demand for health personnel, with a view to improving performance. The essential role of such planning will be to:

- (i) make operational the strategy or strategies by clarifying them, identifying implications and the actions to be taken to achieve the set objective;
- (ii) facilitate coordination;
- (iii) orient all actors to the desired direction;
- (iv) stimulate the creativity of the officials in valid data analysis and heighten awareness regarding the acceptability and feasibility of envisaged solutions.

24. Environmental uncertainty, the nature of the resources to be planned and the necessity to take cognizance of the values and motivations of the personnel in realizing the selected plan make the task both complex and difficult.

25. In the countries, the measures to be taken are as follows:

- (i) Preparation of a realistic plan for the development of human resources for health. This plan must be compatible with the health objectives and in harmony with changes in the organization, functioning, financing and management of the health system. It must take cognizance of the values and motivations of the personnel and include the role and place of the private sector. The plan must also: (a) define qualitative and quantitative criteria for the production and distribution of health personnel, such as to correct inequity in access to health services; ensure efficient utilization of personnel; assure the effectiveness of health care and services; as well as ensure users' satisfaction; (b) adopt strategies to be implemented to achieve set objectives in the following areas: production and distribution of personnel, education or training, performance evaluation, working and living conditions; (c) identify the necessary resources; (d) indicate the schedule of implementation; (e) define the mechanisms for monitoring, evaluating and adjusting objectives and strategies.
- (ii) Acquisition of requisite capacities for diagnosing problems relating to human resources development for health, formulation of a relevant

policy and plan, mobilization of the institutional actors, and implementation, monitoring and evaluation of the plan.

26. At the regional level, the envisaged arrangements will aim at:

- (i) designing activities that will strengthen the capacity of countries to reach the levels indicated above;
- (ii) making an inventory of lessons learnt and innovative experiences in the field of human resources development for health and disseminating such information.

### **Education and training and skills development**

27. To ensure the success of current health sector reform, comprehensive efforts must be made to reorient training and update the knowledge base of the staff. It is necessary, therefore, to redefine the roles of these staff and the missions of health institutions in which they work. It is also necessary to adapt basic training programmes, both for specialists and continuing training, to the spirit of the Cape Town Declaration and to global recommendations and strategies aimed at this reform.

28. In the countries, it will be necessary to:

- (i) undertake advocacy action vis-à-vis policy-makers and training institutions;
- (ii) define the job profile of each professional category to be trained;
- (iii) define the missions and functions of health care facilities;
- (iv) evaluate the training given in faculties of medicine and health schools in order to bring about the necessary changes in training, research, services offered to the community, and in cooperation with other institutions;
- (v) put in place structures to guide the reform at the national level and within the training institutions;
- (vi) train the personnel in the teaching of health sciences and research;
- (vii) train the personnel in the management of human resources for health;
- (viii) combine training by example and the teaching of professional ethics and deontology in health; and
- (ix) programme fellowships in accordance with the objectives of the plan relating to human resources development for health.

29. At the regional level, it will be necessary to:

- (i) make available to the countries guides on and methods for the evaluation and revision of training programmes;
- (ii) organize evaluations and revisions of programmes and disseminate their results;
- (iii) select, every two years, two countries for assistance in their implementation of a co-ordinated reform of health practice and training.

### **Administration and management**

30. To improve health personnel productivity and performance, personnel managers must have relevant legal and regulatory texts:

- texts relating to health personnel functions;
- texts regulating the geographic distribution of health workers;
- texts relating to training and supervision of health personnel;
- texts relating to working conditions;
- texts relating to initial and continuing training and maintenance of skills;
- texts relating to the procedures, mechanisms and modes of financing;
- texts relating to career plans; and
- texts relating to professional ethics and deontology in health.

31. In responding, therefore, to multiple objectives, the application of policies relating to the efficient distribution and utilization of health personnel can be facilitated through legislation.

32. In the countries, actions to be implemented will aim at:

- (i) restructuring and strengthening functions for the development of human resources for health;
- (ii) training and recruiting competent managers;
- (iii) preparing appropriate legislative and regulatory instruments;
- (iv) setting up an information system and a system for managing human resources for health;
- (v) distributing, equitably, the available staff based on population distribution, health care levels, health services models or types of institution;
- (vi) evaluating the performance of health workers in relation to job profiles and posts;
- (vii) adopting rules and regulations governing the profession and drawing up progressive career plans;
- (viii) conducting studies and analysing the evaluation of jobs, requisite qualifications, organizational modalities, the professional environment and staff remunerations;

- (ix) creating merit-based systems of incentives and rewards;
- (x) putting in place at all levels quality assurance programmes; and
- (xi) estimating costs (salaries and employer expenses) and financial capacities.

33. At the regional level, it is necessary to study and evaluate country experiences, disseminate the results thereof and provide support to national programmes.

### **Research**

34. Issues such as policy formulation, planning of the health professions and the training and utilization of health personnel deserve in-depth studies.

35. For the countries, this signifies:

- introducing research on human resources development for health as a component in national health systems research programmes;
- conducting studies and research on priority themes;
- giving feedback to policy-makers and health officials regarding research results and encouraging them to use these results to improve the health system and the health situation.

36. For the regional level, this signifies:

- promoting research on the development of human resources for health;
- defining priority themes in the above-mentioned areas;
- encouraging institutions, groups and individual researchers to draw up research protocols;
- identifying sources of funding and encouraging policy-makers and health officials to utilize research results to develop human resources for health;
- promoting exchanges of information and data on experiences in the field of human resources development for health;
- creating a databank for collecting and disseminating information and knowledge on strategies and methods in human resources development for health.

37. An inventory of the regional institutions for training and research in public health and in management, especially health management, could be made, from which some institutions could be selected and supported with a view to making them real collaborating centres for the development of human resources for health, to the benefit of the Region.

### **Regulation of the health professions**

38. Respect for professional ethics and deontology in health will guarantee provision to the population

(patients, communities) of quality care by qualified health personnel who comply with professional rules.

39. In the countries, and for each health profession, a legal status, compulsory registration and a control system governed by corresponding professional boards or bodies should be established, a national ethics committee created and made functional, and a patient charter promulgated.

40. At the regional level, an awareness drive for good health care practices and the drafting of a Charter for the African Patient will be necessary.

### **Mobilization of resources**

#### *(a) Actors in the countries*

41. A number of actors are involved. These are so-called institutional actors, and are grouped as follows:

- the State and national institutions and agencies responsible for health issues
- employers who pay salaries or national public or private health insurers
- health sciences training and research institutions
- the health professions
- bodies that regulate the health professions
- professional associations
- users of health care services
- external partners and donors.

42. The identification, definition and recognition of their respective roles, their mobilization and coordination will be determinant factors in the implementation and success of the national strategy for the development of human resources for health.

#### *(b) Actors at the regional level*

43. The aim of WHO and the other partners (bilateral and multilateral) will be to support the efforts of the country in the formulation, adoption and implementation of the coordinated reform of training and practice in the health professions.

44. This support, considered an asset, should promote overall assistance to meet the needs of the health sector. It should also stimulate the allocation of sufficient funds to the health sector, and enhance the equitable distribution and efficient use of these public funds, thereby, guaranteeing their sustainability, while avoiding dependence on assistance.

#### *(c) The period covered*

45. The period concerned (2000–2012) sits astride that of the Tenth and Eleventh General Programmes of Work of WHO.

*(d) Financing*

46. Funding will be principally by the countries.

47. WHO will work with other health development partners and other institutions to mobilize additional resources at the international level and to support the efforts of the countries of the Region.

**Managerial framework**

48. The viability and effectiveness of the proposed strategy will depend heavily on the importance given to political will and support of policy-makers and health officials; ownership of the concept; orientation and implementation of country-specific strategies at the different levels of the health pyramid; effective partnerships among institutional actors; the quality of training and of health services and care; the judicious use of available resources and of research results; and formation of real health teams.

**MONITORING AND EVALUATION**

*(a) In the countries*

49. A national advisory committee of all institutional actors will assist ministries of health to guide this coordinated reform of the system of health care and human resources development for health.

50. Every year, it will examine the state of progress of the following six components:

- Policy: legislation and regulatory instruments, resource allocation and coordination of actions;
- Planning: formulation of a plan; level of implementation annually; adjustments;
- Education or training: analysis of annual results, quality of training administered, number of graduates, educationists, researchers and managers trained,
- Administration or management: user and health personnel satisfaction,
- Research: publication, feedback and utilization of results,
- Regulation of the professions: creation of regulatory bodies, much discussed in the media.

*(b) At the regional level*

51. WHO will coordinate the implementation of this strategy.

52. A regional multidisciplinary group of experts in health policy, health planning, and human resources development for health will be created with a view to assisting the Regional Office in this strategy.

53. Partnerships and collaboration arrangements with other institutions involved in the development of human resources for health will be sought.

54. A follow-up report will be submitted every year by the regional programme concerned.

55. Principal monitoring indicators are the number of support missions organized for the formulation of policies and plans, the number of fellowships granted for training in human resources management and the number of managers trained.

**Evaluation**

56. In the countries, evaluation will be conducted every two years by the orientation committee and will analyse the reports relating to the different components.

57. At the regional level, evaluation will be done every two years with the collaboration of the multi-disciplinary groups created; the indicators to be used will be: percentage of countries that have a realistic policy and plan on human resources development congruent with their health objectives; percentage of countries that have put in place coordinated reform of the health system and of training in health sciences; percentage of countries that regulate the health professions.

**Success and failure factors**

58. The necessity for long-term political commitment, the duration of this programme on the national priority agenda, its orientation to assure internalization of the process within the countries (health care system and institutional actors, ministries and departments responsible for human resources, national institutions for training and research in administration or management, especially of health), scarcity or lack of resources, are all major problem areas.

59. The commitment of Member States and other partners to the health sector, and hence, to the development of human resources for health, demonstrated by the proportion of national budgets allocated to the social sectors such as education or training and health, will need to be encouraged and sustained.

**CONCLUSION**

60. Health personnel constitute the most important resource in health, on account of its cost and the value it gives to the other resources.

61. Attaching value to and developing this resource is a challenge that the countries of the Region,



WHO and other partners must face. The achievement of health for all depends on it.

**Resolution AFR/RC48/R3**

**Regional strategy for the development of human resources for health**

The Regional Committee,

Having reviewed the Regional Director's report on the development of human resources for health;

Recalling World Health Assembly resolutions WHA42.27, WHA47.9, WHA48.8 and WHA49.1 and Regional Committee resolutions AFR/RC37/R13 and AFR/RC38/R15 on the role of health personnel in the implementation of national health development policies and plans;

Seeking to apply the spirit of the 1993 World Conference and the 1995 Regional Conference on Medical Education;

Mindful of the need to make optimal use of the available human resources as part of the ongoing health sector reform in the countries of the African Region;

Recognizing the increasing burden of the problem of brain drain on the Member States;

Recognizing the increasing attrition of health personnel in Member States due to HIV/AIDS epidemic;

Aware that health sector reform and reorientation of professional practice and training should be coordinated, pertinent and acceptable;

Recognizing the need for an integrated approach to the development of health services and human resources for health;

Aware also that this approach to the development of human resources should be adapted to the needs and means of the countries and be based on active participation of the entire health personnel at all levels of the health system just as for beneficiaries of health care, policy-makers and officials of the private and public sectors, representatives of professional associations and teaching institutions, and all persons in charge of economic and social development; and

Considering WHO's special role in health matters, which can facilitate working relations between health authorities, professional associations and schools of health in the African Region;

1. ENDORSES the regional strategy for the development of human resources for health contained in document AFR/RC48/10;

2. URGES Member States:

- (i) to harmonize national health policy and the plan for the development of human resources for health;
- (ii) to collaborate with all the institutional sectors of health development in the formulation and implementation of policies and plans for the development of human resources for health in order to better meet the needs and improve the health status of the population;
- (iii) to promote and support health systems research with a view to determining the standard health team for each of the various levels of the health care system, the optimal numerical strength, the mix and deployment of health personnel and the technologies and working conditions most likely to improve their performance in the provision of quality health care; and
- (iv) to support efforts to improve education, training, utilization of health personnel and regulation of health professions; and

3. REQUESTS the Regional Director:

- (i) to encourage health authorities, professional associations and schools of health to study and establish, in a coordinated manner, new models of care and new working conditions that will enable health personnel to play their specific roles in order to better meet the needs of beneficiaries of health care;
- (ii) to support the development of guidelines and models that will enable the countries to strengthen their capacity to plan, train, utilize and regulate health professions;
- (iii) to ensure continuity in the work of the regional multidisciplinary advisory group on the development of human resources for health;
- (iv) to reorganize and strengthen the unit responsible for human resources for health programme in order to ensure easier coordination of regional and national efforts for optimal use of health personnel;
- (v) to sensitize partners to and mobilize resources for the implementation of this strategy; and
- (vi) to keep the Regional Committee informed of the progress made in the implementation of this resolution and to report to the Committee every other year.

## 2.2 Promoting the role of traditional medicine in health systems: A strategy for the WHO African Region (AFR/RC50/9)

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### EXECUTIVE SUMMARY

1. *In the Alma-Ata Declaration of 1978, recognition was given to the role of traditional medicine and its practitioners in achieving health for all. The WHO Regional Committee for Africa, by its resolution AFR/RC34/R8 of 1984, urged Member States to prepare specific legislation to govern the practice of traditional medicine as part of national health legislation and ensure an adequate budget allocation that will make for effective development of traditional medicine.*
2. *The forty-ninth session of the Regional Committee invited WHO to develop a comprehensive regional strategy on traditional medicine and, by its resolution AFR/RC49/R5, requested the Regional Director to support countries in carrying out research on medicinal plants and promoting their use in health care delivery systems. In order to implement these orientations, the countries will need to articulate policies that would enhance the development and use of traditional medicine. Furthermore, research leading to improved access to essential traditional medicine and appropriate utilization of medicinal plants in health systems should be pursued.*
3. *The proposed strategy aims at assisting the countries to optimize the use of traditional medicine in order to contribute to the achievement of health for all. The principles on which the strategy is based are advocacy, recognition by governments of the importance of traditional medicine for the health of the people, institutionalization of traditional medicine and partnerships. The priority interventions are policy formulation, capacity building, promotion of research and development of local production.*
4. *The Regional Committee examined this strategy document and gave orientations for its implementation, consistent with national health policies.*

### INTRODUCTION

1. The World Health Organization estimates that 80% of the population living in rural areas in developing countries depend on traditional medicine for their health care needs<sup>1</sup>. WHO defines traditional medicine as “the total combination of knowledge and practices, whether explicable or not, used in diagnosing, preventing or eliminating physical, mental or social diseases and which may rely exclusively on past experience and observation handed down from generation to generation, verbally or in writing”. This Strategy promotes the integration into health systems of traditional medicine practices and medicines for which evidence on safety, efficacy

and quality is available, and the generation of such evidence, when it is lacking. In this context, “integration” means increase of health care coverage through collaboration, communication, harmonization and partnership building between conventional and traditional systems of medicine, while ensuring intellectual property rights and protection of indigenous knowledge.

2. The Alma-Ata Declaration of 1978, the relevant recommendations of WHO governing bodies and the orientations of the Regional Health-for-All Policy for the 21st century underscore the importance of traditional medicine and its practitioners in primary health care. They also address the strategic

options that are expected to help achieve health for all. Other partner agencies of the United Nations and the Organization of African Unity have also been stressing the importance of traditional medicine.

3. Despite these policy orientations, few countries have developed national policies, legal frameworks and codes of conduct for the practice of traditional medicine. Several countries have created associations of traditional medicine practitioners and developed programmes for the training and continuing education of traditional health (medicine) practitioners, including traditional birth attendants, and for their inclusion in undergraduate courses in the health sciences.

4. The situation of traditional medicine remains weak in some Member States. Major weaknesses include inadequate policies and legal frameworks, insufficient evidence on safety and efficacy, lack of knowledge of attitudes, practices and behaviours in traditional medicine, lack of coordination among institutions, inadequate documentation and lack of protection of intellectual property rights and endangered medicinal plant species, e.g. mass destruction, inadequate protection of endangered medicinal plant species and bad harvesting practices. To address these weaknesses, there is need to strengthen and develop traditional medicine and integrate it into the national health systems of Member States and to protect the genetic rights of the indigenous locale where the materials come from.

5. This document responds to the recommendation of the 49th session of the Regional Committee for Africa requesting WHO to develop a comprehensive strategy on traditional medicine.

## SITUATION ANALYSIS AND JUSTIFICATION

6. Trends in the use of traditional and complementary medicine are on the increase in many developed and developing countries. In Australia in 1998, about 60% of the population used complementary medicine, 17 000 herbal products had already been registered and a total of US\$ 650 million was spent on complementary medicine. In 1992, 20 million patients in Germany used homeopathy, acupuncture as well as chiropractic and herbal medicine as the most popular forms of complementary medicine. In Malaysia, it is estimated that about US\$ 500 million are spent every year on traditional medicine, compared to only about US\$ 300 million on modern medicine. In Sri Lanka, 50–60% of the population

rely on traditional medicine and traditional birth attendants.

7. The herbal medicine market has expanded tremendously in the last 15 years and the total annual sale of herbal medicines is still growing. In 1996, the total annual sale of herbal medicines reached US\$ 14 billion worldwide. In China, traditional medicines account for 30–50% of total medicinal consumption<sup>2</sup>.

8. Some countries in the African Region are producing locally, on a pilot-scale, various plant-based preparations for chronic diarrhoea, liver disorders, amoebic dysentery, constipation, cough, eczema, ulcers, hypertension, diabetes, malaria, mental health and HIV/AIDS. Some of these medicines have been registered and included in the national essential drug lists. Some research institutions, including WHO collaborating centres, are carrying out research on traditional medicine.

9. The African Region is facing difficulties in ensuring equitable access to health care and only about half of the population in the Region have access to formal health services. Traditional medicine, however, maintains its popularity for historic and cultural reasons. In Benin and Sudan, for example, 70% of the population rely on traditional medicine while, in Uganda, users of traditional medicine make up 30% of the population. In Ghana, Mali, Nigeria and Zambia, 60% of children with fever were treated with herbal medicines at home in 1998.

10. A survey, using a questionnaire, was carried out in 1998 on the situation of traditional medicine in countries of the African Region. The results of the survey showed that many countries are yet to develop and implement national policies on traditional medicine as part of their overall national health policy, enact legislation, set up structures and develop codes of ethics and conduct for the practice of traditional medicine. The organizational aspects of traditional medicine have to be strengthened. National bodies for the management of traditional medicine should be established, associations of traditional medicine practitioners should be created, while forging closer collaboration between practitioners of traditional medicine and those of conventional medicine. Moreover, the survey indicated that needs in traditional medicine had to be assessed and training programmes established and strengthened. There is also need to improve the regulatory environment, the protection of intellectual property rights and the development of small-scale local production into large-scale manufacturing; to document best practices; to curtail charlatans; and to take into account cultural and religious dimensions.

## THE REGIONAL STRATEGY

### Aim and objectives

#### *Aim*

11. The aim of this strategy is to contribute to the achievement of health for all in the Region by optimizing the use of traditional medicine.

#### *Objectives*

12. The objectives are:

- (a) to develop a framework for integration of the positive aspects of traditional medicine into health systems and services;
- (b) to establish mechanisms for the protection of cultural and intellectual property rights;
- (c) to develop viable local industries to improve access to traditional medicines;
- (d) to strengthen national capacity to mobilize stakeholders and formulate and implement relevant policies;
- (e) to promote the cultivation and maintenance of medicinal plants.

### Principles

#### *Advocacy*

13. Countries should embark on advocacy for community orientation, dissemination of appropriate information, promotion of positive attitudes and practices and discontinuation of bad practices.

#### *Government recognition of traditional medicine*

14. The recognition by governments of the importance of traditional medicine for the health of the people in the Region and the creation of an enabling environment are the basis for optimizing the use of traditional medicine. There is need to rally the sustainable political commitment and support of policy-makers, traditional medicine practitioners, nongovernmental organizations, professional associations, the community, teaching and training institutions and other stakeholders, through advocacy and utilization of social marketing and participatory methods and development of a legal framework, which will, *inter alia*, address the issue of charlatans.

#### *Institutionalization of traditional medicine*

15. The setting up or strengthening of structures for traditional medicine is essential for optimizing the use of traditional medicine and should be based on a thorough analysis of the prevailing systems, with the involvement of traditional practitioners themselves

and the communities. Some of the organizational arrangements required are:

- (a) The establishment of a multidisciplinary national body responsible for the coordination of traditional medicine; the formulation of a policy and legal framework; the allocation of adequate resources; the development of strategies and plans for improving the regulatory environment for the local production and rational use of traditional medicines; and greater protection of intellectual property rights.
- (b) The setting up of professional traditional medicine bodies to enhance the discipline in areas such as the drawing up of a code of conduct and ethics; the development of norms and standards; the establishment of mechanisms for the official recognition of traditional medicine, including the identification, registration and accreditation of qualified practitioners.
- (c) Mechanisms of collaboration between conventional and traditional medicine practitioners in areas such as referral of patients and information exchange at local level.

#### *Partnerships*

16. The ministry of health should collaborate and promote contact with other ministries, professional associations, consumer groups, nongovernmental organizations, associations of traditional medicine practitioners, regional and interregional working groups on traditional medicine and training institutions in both the public and private sectors to optimize the use of traditional medicine. The ministry of health should also facilitate effective collaboration between traditional and conventional health practitioners.

### Priority interventions

#### *Policy formulation*

17. The countries should formulate a national policy on traditional medicine as part of their overall national health policy. This should be followed by legislation, spelling out the rights and responsibilities of traditional medicine practitioners and addressing legal issues related to the cultivation, conservation and exploitation of medicinal plants and their rational use. Existing legislation should be reviewed to conform to national policies.

18. WHO will develop guidelines and organize regional and intercountry workshops to stimulate the development of national policies on traditional medicine. WHO will also advise the countries on relevant legislation for the practice of traditional medicine.

### ***Capacity building***

19. The countries should assess their needs with regard to traditional medicine practice, develop regulations on traditional medicine practice and draw up a code of ethics to guarantee the provision of safe and quality services.

20. Integration of traditional medicine into health systems at country level requires a better understanding of the specific role of traditional medicine. Therefore, health science institutions should incorporate aspects of traditional medicine into the training curricula of health professionals and embark on continuing education and skills development programmes. The development of information, education and communication approach on traditional medicine for traditional health practitioners, consumers and the general public should be encouraged.

21. WHO will promote the acquisition of knowledge and skills by facilitating the exchange of experiences and supporting the development of training programmes and training materials.

### ***Research promotion***

22. At the country level, research and training institutions, including WHO collaborating centres for traditional medicine, should be supported to carry out research on traditional medicine. Resources should be mobilized to support participatory research particularly on knowledge, attitudes, practices and behaviours and on safety, efficacy and quality to enhance the role of traditional medicine in health systems. Intercountry, regional and international collaboration in medicinal plant research, cultivation and use should be fostered.

23. WHO will identify and strengthen institutions carrying out research on traditional medicine. WHO collaborating centres will be strengthened to carry out research and disseminate the results. Medicinal plant research that could promote self-reliance and reduce costs will be supported, as will the documentation of inventories of effective traditional medicine practices and development of national formularies on traditional medicines.

### ***Development of local production***

24. At the country level, mechanisms for developing and improving the local production of traditional medicines should be put in place. Such mechanisms should include encouraging local industry to invest in the cultivation of medicinal plants; exchanging information about ongoing research; and learning from experiences existing outside the Region.

Governments should play the key role of creating an enabling political, economic and regulatory environment for local production. Access to traditional pharmaceutical products should be improved. A list of traditional medicines could be agreed upon and mechanisms worked out towards introducing medicines with evidence-based efficacy and safety in the essential drugs list. Large-scale cultivation and conservation of medicinal plants should be carried out with the involvement of traditional medicine practitioners and the communities.

25. WHO will undertake advocacy and encourage the countries to develop local production and include medicines with proven safety and efficacy into their national essential drug lists.

## **Implementation framework**

### ***The role of ministries of health***

26. At the country level, governments should recognize the importance of traditional medicine to their health systems. They must be instrumental in creating an enabling environment for promoting traditional medicine. Their role should include allocating adequate resources to traditional medicine, and mobilizing additional resources to support the institutionalization of traditional medicine and facilitating the training of health personnel in traditional medicine.

### ***The role of other sectors***

27. Sectors such as education, information and communication should be involved in the development and promotion of culture and traditional practices and in educating the population to empower them to make the right choices as regards the use of traditional medicine. The natural resources, agriculture and industry sectors will have an important role to play in the conservation of medicinal plants and the local production of traditional medicines.

### ***The role of partners***

28. Communities, nongovernmental organizations and other partners will have major roles to play in optimizing the use of traditional medicine in Member States. Several international partners are particularly well placed to facilitate specific aspects of the implementation of the regional strategy. They include the ADB, UNEP and UNIDO in matters related to the conservation of medicinal plants and the development of local production.

29. WHO will advocate for political commitment, support from stakeholders and the creation of an

enabling environment for traditional medicine and will facilitate the mobilization of resources to assist the countries in the implementation, monitoring and evaluation of this strategy. Guidelines and tools to assist the countries in developing policies and regulations, strengthening national traditional medicine programmes and developing local production, among others will be prepared and made available to the countries. WHO will encourage the involvement of all interested partners in the Region in the implementation of the strategy.

## **MONITORING AND EVALUATION**

30. WHO will collaborate with the countries in monitoring and evaluating the implementation of the strategy.

### **Determinants of success**

31. Critical determinants of success of the implementation of this strategy are political commitment, ownership of the strategy, development of country-specific strategies, mobilization and judicious use of available resources, utilization of research results for decision making, effective partnerships and establishment of management bodies, availability of traditional medicinal products from traditional health practitioners and sharing of information. The human and financial resources of the Regional Programme on Traditional Medicine will be strengthened to facilitate the implementation of the strategy.

## **CONCLUSION**

32. The development of the present strategy reflects the importance Member States and WHO attach to the role that traditional medicine and its practitioners play in health development in Africa. Integration of traditional medicine in health systems will result in increased coverage of, and access to, health care. The promotion of positive traditional medicine practices and the use of traditional medicines of proven efficacy and safety will supplement other efforts to achieve health for all.

33 The implementation of this strategy requires concerted collaboration among all the partners and effective and rational mobilization of all resources available at the country and regional levels. In that context, the promotion of the role of traditional medicine in the African Region is critical to, if not decisive in, assisting Member States to integrate traditional medicine into their national health systems.

34. The Regional Committee examined this strategy document and gave orientations for its implementation, consistent with national health policies.

### **Resolution AFR/RC48/R3**

#### **Promoting the role of traditional medicine in health systems: A Strategy for the African Region**

The Regional Committee,

Recalling World Health Assembly resolutions WHA30.49, WHA31.33, WHA41.19, WHA42.43

WHA44.33, WHA44.33, on the potential medical and economic value of medicinal plants, health human resources development and research on traditional medicine;

Recalling World Health Assembly resolutions AFR/RC36/59, AFR/R34/R8, AFR/RC40/R8, and AFR/RC49/R5 on the use of traditional medicines, legislations governing the practice of traditional medicine, promotion of traditional medicine, development of the traditional medicine system and its role in health systems in Africa and research on medicinal plants;

Aware of the fact that about 80% of the population living in the African Region depend on traditional medicine for their health care needs;

Recognizing the importance and potential of traditional medicine for the achievement of health for all in the African Region and that development of local production of traditional medicines should be accelerated in order to improve access;

Noting that some countries in the Region have established national bodies for the management of activities in traditional medicine, formulated national policies on traditional medicine, enacted legislations and codes of ethics and conduct for the practice of traditional medicine, and created associations of traditional health practitioners;

Further noting that research on traditional medicine is being carried out in some countries in the Region and that aspects of traditional medicine have been incorporated into the curricula of some training institutions;

1. APPROVES the report of the Regional Director on promoting the Role of Traditional Medicine in Health Systems: Strategy for the African Region;

2. URGES Member States:

(i) to translate the regional strategy into realistic national policies on traditional medicine,

followed by appropriate legislation and plans for specific interventions at national and local levels and to actively collaborate with all partners in their implementation and evaluation;

- (ii) to consider the development of mechanisms and establishment of institutions for enhancing the positive aspects of traditional medicine into health systems in order to improve collaboration between conventional and traditional health practitioners;
- (iii) to produce inventories of effective practices as well as evidence on safety, efficacy and quality of traditional medicines and undertake relevant research;
- (iv) to actively promote, in collaboration with all other partners, the conservation of medicinal plants, development of local production of traditional medicines and protection of intellectual property rights and indigenous knowledge in the field of traditional medicine;
- (v) to establish a multidisciplinary and multisectoral mechanism to support the development and implementation of policies, strategies and plans;
- (v) to foster strong regional and subregional collaboration in information exchange.

### 3. REQUESTS the Regional Director:

- (i) to advocate for support from stakeholders for creation of an enabling environment for traditional medicine, and to facilitate the mobilization of additional resources to assist countries in the implementation, monitoring and evaluation of this strategy;
- (ii) to propose to Member States the institution of an African Traditional Medicine Day for Advocacy;

- (iii) to develop guidelines for formulation and evaluation of national policies on traditional medicine, advise countries on the relevant legislation for the practice of traditional medicine and the documentation of practices and medicines of proven safety, efficacy and quality and facilitate the exchange and utilization of this information by countries;
- (iv) to advocate for the development of mechanisms for improving the economic and regulatory environments for local production of traditional medicines and nurturing of medicinal plants, strengthening WHO collaborating centres and other research institutes developing monographs of medicinal plants and disseminating results on safety and efficacy of traditional medicines;
- (v) to establish a regional mechanism to support Member States to effectively monitor and evaluate the progress made in the implementation of the Regional Strategy on Promoting the Role of Traditional Medicine in Health Systems;
- (vi) to submit to the fifty-second session of The Regional Committee a report on progress made and challenges encountered in the implementation of the Regional Strategy on Promoting the Role of Traditional Medicine in Health Systems.

*Seventh meeting, 31 August 2000*

### REFERENCES

1. Bannerman RB, Buton J and Wen-Chieh C (1983). Traditional medicine and health care coverage. World Health Organization, 9–13.
2. WHO (1998) Background information for reviewing the Traditional Medicine Cabinet Paper, WHO/EDM/HQ.

## 2.3 Blood safety: A strategy for the WHO African Region (AFR/RC51/9 rev.1)

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### EXECUTIVE SUMMARY

1. *Blood safety is still a major concern of countries in the African Region in view of the high prevalence of HIV/AIDS and other transfusion-transmissible infections.*
2. *In 1994, the forty-fourth session of the WHO Regional Committee for Africa, by its resolution AFR/RC44/R12, invited Member States to take urgent measures to formulate and implement a policy on blood transfusion safety, mobilize resources for developing the infrastructure of the blood transfusion services of central and district hospitals and set the objectives for the transfusion, in hospital settings, of blood uninfected by HIV.*
3. *Today, very few countries have acquired the structures and resources needed to promote the development of blood transfusion services.*
4. *The present strategy aims to propose concrete actions and a framework that will help the countries to have reliable and sustainable transfusion facilities.*
5. *The success of this strategy will depend primarily on the mobilization of adequate financial and material resources and the preparation and implementation of a realistic plan, based on an objective analysis of the situation prevailing in each country.*
6. *The priority interventions are the formulation and implementation of national blood transfusion policies, quality assurance, mobilization of funds and development of human resources.*
7. *The Regional Committee examined this strategy, enriched it, adopted it and gave guidance for its implementation.*

### INTRODUCTION

1. Transfusion therapy is a form of treatment based on the use of blood and blood products of humans. Although this therapy helps to save human lives in some circumstances, blood can nonetheless be a dreadful vector of some infectious and parasitic diseases or can trigger serious and, sometimes, fatal reactions of rejection if the rules governing its prescription and use are not properly followed.

2. The safety of blood and blood products is of serious concern to the countries, all officials in charge of blood transfusion services and the clinicians who prescribe blood. This concern is even greater in the African Region, where there is a heavy burden of HIV/AIDS, a high prevalence of

other transfusion-transmissible infections and a high frequency of malaria anaemia, deficiency anaemia and severe haemorrhages which, sometimes, require massive transfusion.

3. The safety of blood transfusion depends on three main factors:

- (a) the availability of blood, which is contingent upon the adequacy of storage facilities and the existence of a sound policy of recruitment and retention of voluntary and benevolent donors;
- (b) the safety of blood, taking into account all the immuno-haematological and serological aspects;
- (c) the appropriate use of blood transfusion as a mode of treatment, which requires smooth collaboration between blood transfusion centres



and clinicians as well as adherence to the rules of prescription.

4. In May 1975, the Twenty-eighth World Health Assembly, by its resolution WHA28.72, called on Member States to promote national blood transfusion services, based on voluntary and benevolent donations, and to promulgate laws to govern their operation. In spite of that recommendation, very few African countries have a reliable and well-organized transfusion system, today.

5. In 1994, the Regional Committee for Africa, in its resolution AFR/RC44/R12, noted with great concern that only 10 out of the 46 Member States of the African Region could guarantee the safety of blood transfusion in health care settings and, consequently, urged Member States to take urgent steps to enact blood safety policies and mobilize resources for the development of the infrastructure of blood services in central and district hospitals.

6. Twenty-six years after the World Health Assembly resolution and seven years after the Regional Committee resolution, there is still a lot to be done to improve the safety of blood transfusion in countries in the Region. The present strategy, therefore, proposes interventions and a framework that will enable Member States to improve blood transfusion safety.

## SITUATION ANALYSIS AND JUSTIFICATION

### Situation analysis

7. Of the 46 Member States in the African Region, only 30% have drawn up their national blood transfusion policy. Even so, the recommendations of the policy are not always implemented, with the result that coordination has been lacking at field level. This has led to non-standardization of practices, and, indeed, to exposure of patients to complications that are sometimes fatal, and exposure of health personnel to avoidable risks of contamination.

8. Less than 15% of countries in the Region have implemented effective strategies for the recruitment of regular and benevolent blood donors. About 60% of the blood collected is from family replacement donors even though it is firmly established that the prevalence of transfusion-transmissible infections among that category of donors is higher than among voluntary, regular and non-remunerated donors.

9. It is estimated that over 25% of the units of blood transfused in Africa, today, are not tested for HIV, and that 5% to 10% of cases of HIV infection

in Africa are transmitted via blood. Furthermore, less than 50% of the units of blood are actually tested for hepatitis B in most of the countries, while barely 19% of the countries test blood units for hepatitis C. This situation exposes transfused patients to the risk of infection by the viruses that cause hepatitis or liver cancer.<sup>1</sup>

10. Inadequate supply of reagents still poses a major obstacle to the determination of the serological status of donated blood. Red tape in centralized systems, coupled with inadequate funding, often creates stockouts. Lack of national reagent procurement strategies and of reference centres that can validate the testing of blood for transfusion-transmissible infections has led to the introduction, on national markets, of products whose quality is, sometimes, dubious.

11. The cold chain is an essential link in any blood transfusion system. In the African Region, the irregular supply of electricity, lack of equipment suited to field conditions or the absence of an effective equipment maintenance programme adversely affect the storage of reagents and blood products. In some Member States, this situation hampers the establishment of functional blood transfusion services at all levels of the health pyramid and, more particularly, in district hospitals.

12. The shortage of qualified staff in the African Region puts a major limitation on health services in general and blood transfusion services in particular. In addition, lack of career prospects for the staff of blood transfusion centres often leads to staff demotivation and consequent departure for other areas deemed to be more rewarding and more fulfilling. This instability of the staff of transfusion services is prejudicial to the development of the skills needed to establish sustainable and reliable blood transfusion services.

13. In most cases, blood transfusion services are administratively answerable to, and physically located within, hospital laboratories. They, therefore, have no fixed staff or specific budgets of their own, a situation which adversely affects their smooth functioning. The fact that transfusion services are not hierarchically structured is yet another impediment to their effective supervision and the quality of the services they provide.

14. Very few countries have built quality assurance programmes into their blood transfusion services or into the facilities serving such a purpose. Consequently, the blood products made available to prescribing physicians do not always meet the required safety standards. Although in January 2000,

WHO started a project on the provision of quality management training for blood transfusion centres, the lessons learnt from the project have yet to be translated into deeds.

15. Few African countries have assigned a budget line to activities related to blood transfusion safety. Since blood transfusion is often not an independent entity on its own, its funding in many countries is assured by bilateral or multilateral cooperation agencies. Given the lack of national blood transfusion policies in most of the countries, the cooperation agencies limit their funding to only the procurement of reagents. Unfortunately, the countries are unable to purchase the reagents for themselves after the co-operation programme is ended.

16. Bilateral and multilateral cooperation has played, and continues to play, an important role in the development of blood transfusion systems in Africa and, more particularly, in the prevention of HIV transmission by blood. However, since there is no national coordination, each donor agency pursues its own blood transfusion policy within the geographical area specifically assigned to it. The result is that, within a given country, the blood transfusion policy may vary from province to province or from region to region.

17. In 1999, the annual blood needs of countries in the Region were estimated at 12 million units, but blood collection in that year totalled just 30% of that quantity, thus leaving a substantial deficit.

18. Very few countries in Africa have laid down stringent rules to govern the use of blood and blood products. In most cases, transfusion involves whole blood, and some of the accidents that occur in the process are due to either inadequate staff training or non-adherence to the rules of sound professional practice and ethics. Although the techniques of auto-transfusion have undisputed advantages in regard to safety, they are not practised on a widespread scale.

### **Justification**

19. Despite the recommendation of the World Health Assembly in 1975, and of the Regional Committee in 1994, a situation analysis clearly shows that the blood transfusion systems of countries in the Region are still fraught with weaknesses.

20. WHO has made blood transfusion safety one of its priorities since the year 2000 when the main theme of World Health Day was blood safety. Furthermore, the year 2000 saw the birth of many initiatives aimed at mobilizing energies to promote the safety of blood and blood products. These initia-

tives include the WHO quality management training project.

21. In the year 2000, WHO classified all countries of the world according to the level of safety of their blood transfusion services. More than 85% of countries in the African Region were thus classified among the countries in which blood transfusion is least safe.

22. In the implementation of the present strategy by the countries, blood transfusion should be made a health priority and the related services must be re-organized so that blood transfusion safety in the Region can be improved.

## **THE REGIONAL STRATEGY**

### **Aim**

23. The aim of the regional strategy is to improve blood transfusion safety and bridge the gap between blood needs and blood availability in health services.

### **Objectives**

24. The main objectives are:

- (a) to assist the countries to set up an effective system of recruitment of low-risk, voluntary and regular donors;
- (b) to improve the safety of blood and blood products by implementing quality assurance programmes and mapping out effective strategies for the screening of blood for all transfusion-transmissible infections;
- (c) to promote the appropriate use of blood and blood products by clinicians.

### **Targets**

25. By the end of 2012:

- (a) all the Member States will have carried out a situation analysis of blood transfusion safety;
- (b) at least 75% of the countries will have drawn up, adopted or implemented their national blood transfusion policy;
- (c) one hundred per cent of the blood units transfused will be screened, beforehand, for HIV and other transfusion-transmissible infections;
- (d) at least 80% of blood donors in all countries of the Region will be voluntary and regular donors.

### **Guiding principles**

26. The principles that will guide the implementation of the strategy will be the following:

- (a) formulation, adoption and implementation of national blood transfusion policies;
- (b) establishment of universally applicable norms for avoiding discrimination in the distribution and use of blood products;
- (c) creation of an enabling environment for the development of effective, reliable and sustainable blood transfusion services at all levels, especially in the districts.

### **Priority interventions**

27. The first intervention will consist in carrying out a situation analysis of blood transfusion safety in all countries in the Region in order that the prevailing problems and needs can be well identified. The information thus gathered will help improve the planning of future activities.

28. The second intervention will involve drawing up and/or implementing national blood transfusion policies and action plans whose main thrusts will be: the formulation of a strategy for the recruitment and retention of regular and benevolent donors; the definition of norms to be followed in the screening and processing of blood donations; the development of guidelines for the prescription of blood and blood products; review of ethical and regulatory issues; financing and cost recovery.

29. The third intervention will involve addressing the special challenge faced by countries with high HIV prevalence, in terms of attracting and retaining a pool of low-risk blood donors.

30. The Member States must assess their staffing needs, judiciously select persons to be trained and create an environment conducive to the advancement of the staff of blood transfusion services and, thereby, dissuade them from deserting, or resigning from, their posts.

31. In addition, each country must pursue a true policy of education, sensitization and retention of low-risk donors.

32. Health authorities must ensure that safety standards are met in the screening of blood for transfusion-transmissible infections, in the context of clearly established national blood transfusion policies.

33. Participation in the WHO project on the training of staff of blood transfusion centres in quality management techniques and procedures will be the bedrock of future actions and should foster concrete action at field level.

34. Blood transfusion research, which generates information indispensable for the planning of activi-

ties, must be encouraged and supported by the countries. There is need for research into the optimal use of blood products, including HIV-positive blood.

35. Particular attention must be given to the training of blood prescribers and care providers. Guidelines for the prescription and use of blood and blood products, including for research on the technique of auto-transfusion must be produced and made available to them. In each health facility, a committee must be set up to enforce the rules of good practice and, thereby, foster appropriate use of blood.

### **Implementation framework**

#### **Role of Member States**

36. As proof of their commitment, Member States must include blood transfusion safety in the priorities of their health programmes, assign a budget specifically to it and draw up programmes and plans of action for its development. That will lead to a more rational and more proactive approach to the resolution of blood transfusion problems.

37. The ministry of health will, as a matter of duty, prepare texts on the organization of blood transfusion services, propose a plan of action, implement the national policy and coordinate this activity nationwide. Furthermore, it will play a normative role, ensure adherence to the set rules in the private and public sectors and undertake the development of human resources. In addition, it will collaborate with all national and international structures that are in a position to promote blood transfusion safety.

#### **Role of partners**

38. In the context of the national blood transfusion policy, and under the coordination of the ministry of health, the various bilateral and multilateral international cooperation agencies as well as non-governmental organizations will be called upon to provide technical and financial support for the implementation of strategies leading to effective and reliable blood transfusion services.

#### **Role of WHO**

39. WHO will play a vital role in ensuring the success of this strategy by supporting the countries to formulate and implement national blood transfusion policies; establish a consultation framework for all stakeholders in the area of blood transfusion safety; design and provide to Member States the tools needed to assess the blood transfusion situation and; determine the blood transfusion profile of each

country. In collaboration with the other partners, WHO, will produce procedures handbooks and guidelines and provide technical or financial support for staff training. Furthermore, WHO, in collaboration with Member States, will develop a database on blood safety and make it available to them.

## **MONITORING AND EVALUATION**

40. It will be important to establish a mechanism for the monitoring and evaluation of this strategy. The monitoring should be undertaken, each year, in the countries to enable the necessary adjustments to be made on time. At the regional level, a mid-term review will be conducted after five years of implementation of the strategy and progress reports submitted to the Regional Committee every two years.

41. WHO will develop evaluation indicators and each country will, based on its specific situation, define monitoring indicators that will be used to assess its own progress.

## **CONCLUSION**

42. Today, at the dawn of the 21st century, blood transfusion safety poses a real challenge to the African continent. The present strategy, mapped out as a consequence, examines the weaknesses of the blood transfusion system in Africa and proposes a framework and actions to expand the pool of low-risk blood donors, ensure adequate screening of blood for transfusion-transmissible infections and promote research as well as the judicious use of blood in order to foster progress.

43. The Regional Committee examined this strategy, made the necessary amendments for its improvement, adopted it and gave guidance for its implementation.

### ***Resolution AFR/RC48/R2***

#### **Blood safety: A strategy for the WHO African Region**

The Regional Committee,

Having considered the report of the Regional Director on the strategy for blood transfusion safety in the African Region;

Considering World Health Assembly resolution WHA 28.72 recommending that Member States promote the development of national blood transfusion services based on voluntary non-remunerated blood donations and enact legislation governing them;

Recalling resolution AFR/RC44/R12 on HIV/AIDS control, which urges Member States to take urgent steps to enact blood safety policies, mobilize resources for blood service infrastructure development at central and district hospitals and set goals and targets for the attainment of HIV-free blood transfusion in health-care settings;

Noting with concern that only 30% of the countries in the Region have so far formulated a blood transfusion policy, and the need in all countries for systematic screening of blood for the main transmissible infections, especially for blood transfusion;

Recalling also that the transmission of HIV, hepatitis B, hepatitis C, syphilis, malaria and other parasitic infections through the blood can be effectively prevented by adopting a sound blood transfusion policy and carrying out systematic screening for such infections in all units of donated blood;

Concerned by the fact that, since the adoption of resolution AFR/RC44/R12 in 1994, the changes that have taken place in most of the Member States in this area are hardly perceptible and that the current economic situation has contributed to a worsening of the health situation in the countries of the Region;

Convinced that Member States in the African Region can achieve blood safety;

1. APPROVES the regional strategy for blood transfusion safety as proposed in document AFR/RC51/9:

2. COMMENDS the Regional Director for actions already taken to improve blood transfusion safety in the Region;

3. URGES Member States:

(a) to formulate, adopt and implement a national blood transfusion policy consistent with national needs and HO technical recommendations, especially for:

(i) the establishment of safety norms and standards and a quality assurance programme in order to provide all patients, who so require, with blood that is safe;

(ii) the formulation of human resource policies which ensure the training, promotion and retention of the staff of blood transfusion centres and the training of prescribers in the judicious use of blood;

(iii) the promotion of research in the area of blood transfusion safety, including the use of blood and blood products;

(b) to allocate adequate funds for developing the infrastructure of blood transfusion services and

- creating an enabling environment for the establishment of a reliable blood transfusion system, including the cold chain;
- (c) to promote voluntary and non-remunerated blood donation on a regular and permanent basis;
  - (d) to mobilize bilateral and multilateral partners as well as nongovernmental organizations (NGOs) to provide technical and financial support for the establishment of reliable and sustainable blood transfusion services;

4. REQUESTS the Regional Director:

- (a) to play a leadership role in instituting blood transfusion and AIDS control programmes in the WHO African Region;
- (b) to support Member States in drawing up and implementing national blood transfusion policies;
- (c) to promote and support training programmes for the staff of blood transfusion services and prescribing physicians;
- (d) to facilitate the use of reference centres in blood transfusion in the Region for the training of appropriate staff from Member States;

- (e) to mobilize resources from international partners to finance blood transfusion safety in the Region;
- (f) to strengthen technical cooperation and collaboration between Member States and WHO so as to improve the management of blood transfusion centres and the quality of blood and blood products;
- (g) to ensure the follow-up and implementation of this strategy and report to the fifty-fourth session of the Regional Committee.

*Fifth meeting, 29 August 2001*

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## 2.4 Health financing: A strategy for the WHO African Region (AFR/RC56/10)

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### EXECUTIVE SUMMARY

1. *The manner in which a health system is financed affects its stewardship, input creation, service provision and achievement of goals such as good health, responsiveness to people's non-medical expectations (short waiting times, respect for dignity, cleanliness of physical facilities, quality meals) and fair financial contributions, so that individuals are not exposed to great financial risk of impoverishment.*
2. *Countries of the Region are confronted with a number of key challenges, including low investment in health; low economic growth rates; dearth of comprehensive health financing policies and strategic plans; extensive out-of-pocket payments; limited financial access to health services; limited coverage by health insurance; lack of social safety nets to protect the poor; inefficient resource use; ineffective aid; and weak mechanisms for coordinating partner support in the health sector.*
3. *In order to reach the health-related Millennium Development Goals (MDGs) and achieve national health development objectives, national health systems in the African Region urgently need more money; greater equity in health services financing and accessibility; efficient use of health resources; and expanded coverage of health services, especially those targeting the poor. Countries are urged to institutionalize national health accounts to facilitate financial planning, monitoring and evaluation.*
4. *The aim of this strategy is to foster development of equitable, efficient and sustainable national health financing to achieve the health-related MDGs and other national health goals.*
5. *The Regional Committee considered this strategy and the attached resolution and adopted the recommended actions.*

### INTRODUCTION

1. Health financing is one of the four functions of health systems. Health financing refers to the collection of funds from various sources (e.g. government, households, businesses, donors), pooling them to share financial risks across larger population groups, and using them to pay for services from public and private health-care providers.<sup>1</sup> The objectives of health financing are to make funding available, ensure choice and purchase of cost-effective interventions, give appropriate financial incentives to providers, and ensure that all individuals have access to effective health services.<sup>2</sup>

2. The performance of a health financing system depends among others on its capacity for equitable and efficient revenue generation; the extent to which financial risk is spread between the healthy and the sick, and the rich and the poor; extent to which the poor are subsidized; efficient purchasing of health inputs and services; and the prevailing macroeconomic situation, e.g. economic growth, unemployment, size of the informal sector compared to the formal sector, governance, etc.

3. There is ample evidence that the manner in which a health system is financed affects both the performance of its functions and the achievement of

its goals.<sup>3</sup> The magnitude, efficiency and equity in health financing determine the pace at which individual countries are able to achieve national health development objectives and the Millennium Development Goals (MDGs).

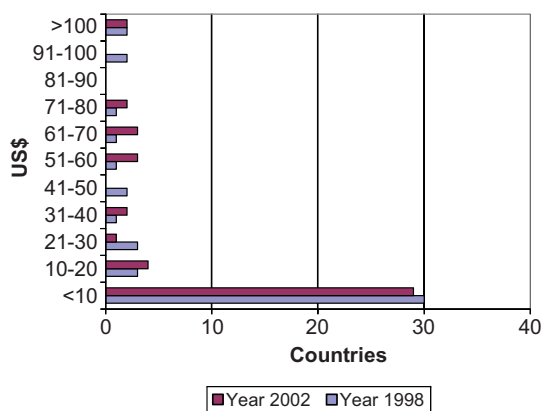
4. Cognizant of the important role of financing in health development, African Heads of State, in 2001, committed themselves to taking all necessary measures to ensure that resources are made available and are efficiently utilized. In addition, they agreed to allocate at least 15% of their national annual budgets to improving the health sector;<sup>4</sup> this commitment was reaffirmed in the Maputo Declaration.<sup>5</sup> Recent resolutions<sup>6</sup> of the WHO Regional Committee for Africa urge Member States to honour the pledge made by Heads of State in Abuja.

5. In May 2005, the Fifty-eighth World Health Assembly adopted a resolution<sup>7</sup> that urges Member States to ensure that health financing systems include a method for prepayment of financial contributions for health care. This is aimed at sharing risk among the population and avoiding catastrophic health-care expenditure and impoverishment of care-seeking individuals. The resolution also encourages planned transition to universal coverage and ensured, managed and organized external funds for specific health programmes or activities which contribute to the development of sustainable financing mechanisms for the health system as a whole.

6. This document briefly reviews the state of health financing in the Region; proposes priority interventions that could be implemented to strengthen national health financing systems; outlines roles and responsibilities for countries WHO and partners; and proposes a brief monitoring and evaluation framework. The proposed interventions should be urgently implemented to ensure the achievement of MDGs and other national health goals. This strategy document is consistent with the spirit of the Health-for-all Policy for the 21st Century in the African Region.<sup>8</sup>

## SITUATION ANALYSIS

7. As of 2002, out of 46 countries in the WHO African Region, 15 countries spent less than 4.5% of their gross domestic product on health; in 29 countries, government expenditure per person per year was less than US\$ 10 (see *Figure 1*); and 43 countries spent less than 15% of their national annual budget on health (see *Figure 2*). Thus, most countries are far from reaching the 15% target set by African Heads of State in 2001. In addition, 31 countries failed to meet the WHO Commission for Macroeconomics



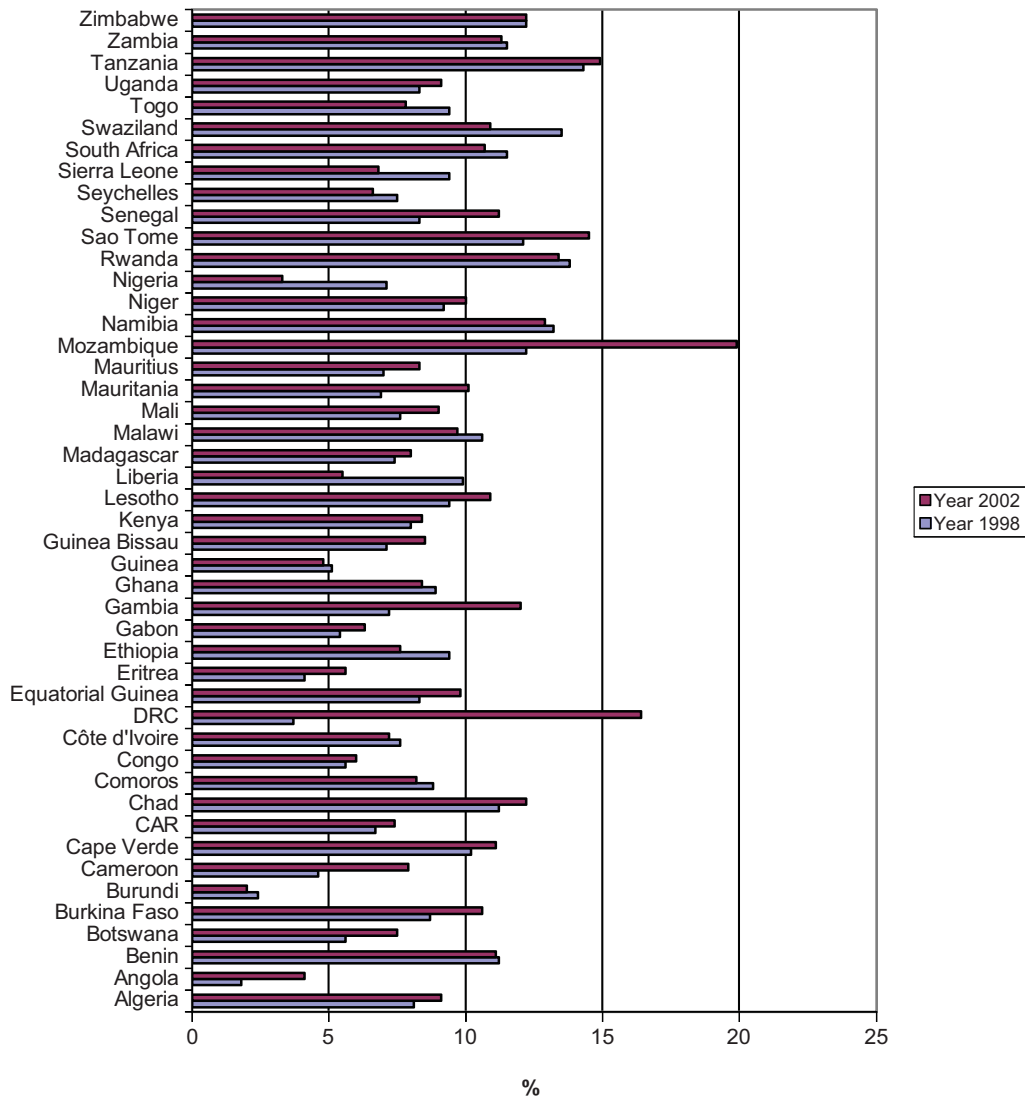
**Figure 1:** Per capita government expenditure on health at average exchange rate (US\$), WHO African. Source: Compiled from data in WHO, *The world health report 2005: Making every mother and child count*, Geneva, World Health Organization, 2005, Annex Table 5

and Health (CMH) recommendation<sup>9</sup> of US\$ 34 per capita expenditure for health (see *Figure 3*) needed to buy an essential package of health services. Indeed, estimates based on 2002 data show that even if all countries met the Abuja target, more than half of them would not have made much progress towards attaining the CMH and MDG targets.<sup>10</sup>

8. In 24 countries, 50% of the total health expenditure came from government sources; in 17 countries, 25% of total health expenditure came from external sources. Thus, the international community makes an important contribution to health financing in the Region. However, the recurrent cost implications of donor-supported capital investments are often not taken into account, which impacts negatively on their sustainability.

9. Private spending from households and businesses constituted over 40% of the total health expenditure in 31 countries. The bulk of private spending is from direct out-of-pocket household expenditures (see *Figure 4*), i.e. including the Bamako Initiative cost recovery schemes.<sup>11,12</sup> Prepaid health financing mechanisms (including mutual health insurance schemes and community-based health insurance schemes<sup>13</sup>) cover only a small proportion of populations in the Region. Prepaid financing mechanisms account for more than 72% of the private health expenditure in two countries. However, even in those countries, the proportion of the population that is covered in prepaid health schemes is relatively small.

10. Health personnel employed by governments and NGOs are often paid fixed salaries unrelated to workload. Financing of public services in most



**Figure 2:** General government expenditure on health as % of total government expenditure, WHO African Region. Source: Compiled from data in WHO, *The world health report 2005: Making every mother and child count*, Geneva, World Health Organization, 2005, Annex Table 5.

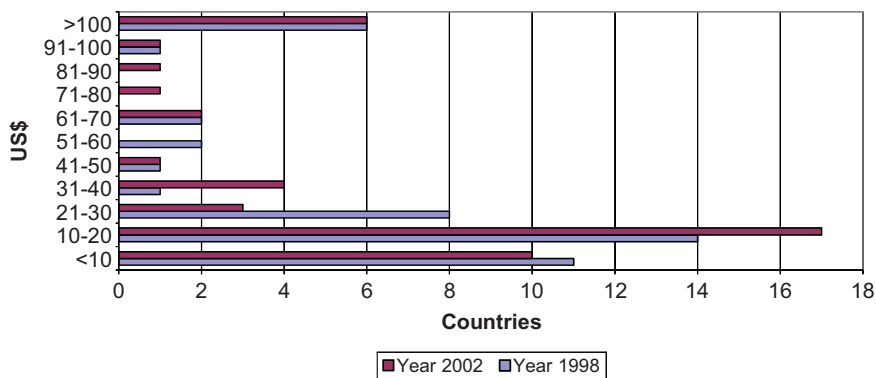
countries is done through inflation-adjusted historical budgets and transfer of funds from one government department to another with little strategy behind allocation decisions.<sup>14</sup>

11. Some progress has been made during the past few years in mobilizing more money for the health sector and addressing a number of equity and efficiency issues, including revenue pooling and risk management. There is also some understanding of the key issues related to resource allocation and purchasing of health services.

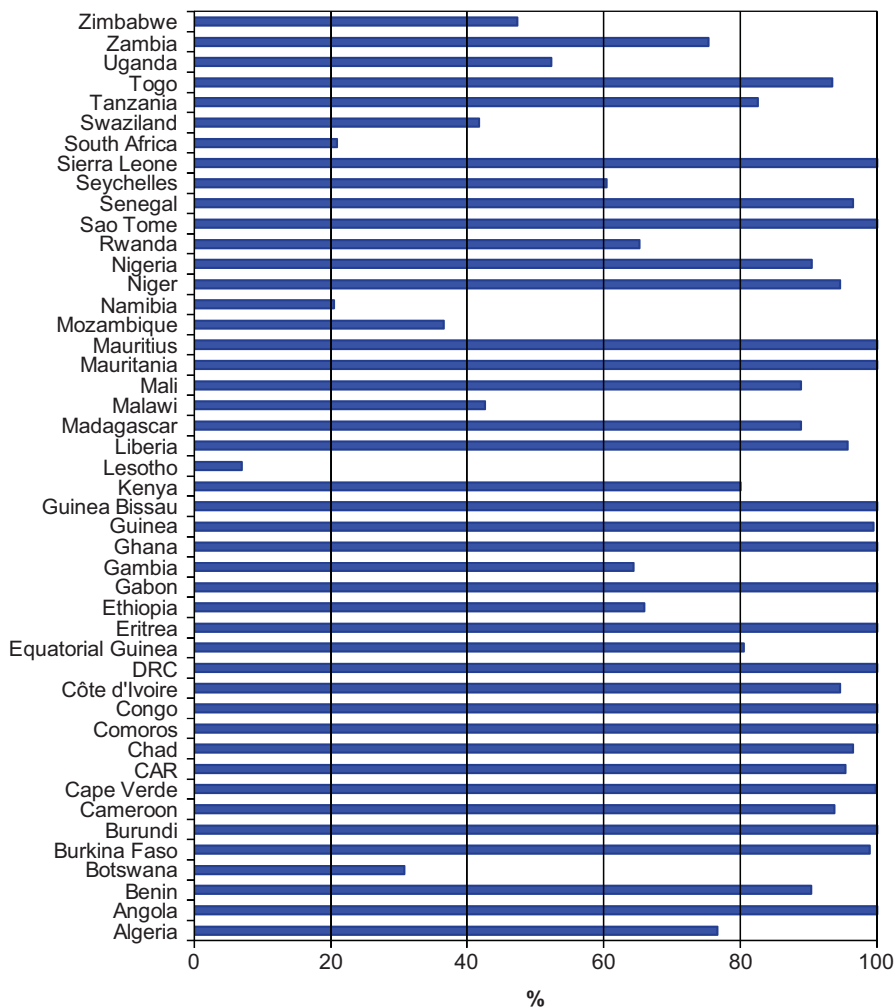
### Challenges

12. The challenges related to efficient and equitable revenue collection include low investment in health; heavy reliance on out-of-pocket expenditures; low household capacity to pay due to widespread poverty; high unemployment; low economic growth; limited fiscal (budgetary) space; double burden of communicable and non-communicable diseases; high but declining population growth rates; erratic disbursement of donor funds; weak mechanisms for coordinating health partnerships.





**Figure 3:** Per capita total expenditure on health at average exchange rate (US\$), WHO African Region. Source: Compiled from data in WHO, *The world health report 2005: Making every mother and child count*, Geneva, World Health Organization, 2005, Annex Table 5.



**Figure 4:** Out-of-pocket expenditure as % of private expenditure on health, 2002, WHO African Region. Source: Compiled from data in WHO, *The world health report 2005: Making every mother and child count*, Geneva, World Health Organization, 2005, Annex Table 5.

13. Challenges in revenue pooling and risk management persist. For example, direct out-of-pocket household spending does not go through pooling mechanisms. Countries tend to rely only on one or two of the four risk management mechanisms (i.e. state-funded health care systems, social health insurance, community-based health insurance, and voluntary health insurance), which may not be adequate to meet all the health financing objectives. Limited re-insurance options make insurance schemes vulnerable to bankruptcy.<sup>15</sup> Risk management is also adversely affected by weak management capacities in the public sector, low quality of public health services, restrictive public benefit packages, weak cross-subsidization, and underpaid public health-care workers.

14. There are a number of challenges related to resource allocation and purchasing of health services. Many governments still provide all their health services through the public sector, despite the presence and popularity of NGO and private sector facilities. Donor funds are often earmarked for priority diseases and thus cannot be used to strengthen health systems. Some subsidies to health-care providers are benefiting the rich rather than the poor. Current salaries in the health-care sector in most countries in the Region do not create performance incentives, and payment mechanisms in public health institutions discourage maximum output and cost containment. Health facilities continue to make inefficient use of resources.<sup>16</sup>

### Opportunities

15. Countries could take advantage of various opportunities. These include the impetus provided by the MDGs; commitment by African Heads of State to significantly increase health spending; commitment by the donor community (e.g. International Financing Facility, G8, European Union, Organization for Economic Co-operation and Development) to significantly expand aid instruments (e.g. Global Fund to Fight AIDS, Tuberculosis and Malaria; Global Alliance for Vaccines and Immunization; Highly Indebted Poor Countries Initiative) and increase aid effectiveness;<sup>17</sup> increased willingness of partners in countries to participate in sector-wide approaches (SWAPs). Other opportunities are the increased determination of the African Union, in the context of the New Partnership for Africa's Development, to promote governance, transparency and accountability in the Region; the increased evidence and awareness of the pivotal role of health in development; inclusion of a health component in national poverty reduction strategies (including Poverty Reduction Strategy Papers [PRSPs]) and the Medium-Term Expenditure Frameworks (MTEFs); existence

of potential for increasing availability of resources through efficiency improvements; and increased knowledge-sharing in health financing.<sup>18</sup>

## THE REGIONAL STRATEGY

### Objectives

16. The general objective of this strategy is to foster development of equitable, efficient and sustainable national health financing to achieve the health MDGs and other national health goals.

17. The specific objectives of this strategy are:

- (a) to secure a level of funding needed to achieve desired health goals and objectives in a sustainable manner;
- (b) to ensure equitable financial access to quality health services;
- (c) to ensure that people are protected from financial catastrophe and impoverishment as a result of using health services;
- (d) to ensure efficiency in the allocation and use of health sector resources.

### Guiding principles

18. The choice and implementation of priority health financing interventions will be guided by the following principles:

- (a) **Country ownership** must ensure that all health financing processes are led and owned by countries.
- (b) Provision of health-care services should aim at fostering **equity in access** among all population groups, with special attention to vulnerable groups (e.g. the poor, women and children). **Equity in financing** must ensure that contributions to the funding of the health system are made according to ability to pay and long before health care is needed in order to protect families from impoverishment.
- (c) **Efficiency** must ensure that maximum health benefits are derived from scarce available resources, with particular attention to both immediate operating expenditures and the long-term recurrent cost implications of major human resources and capital investments.
- (d) **Transparency** in a high degree must be seen in all financial procedures and mechanisms and in actual spending.
- (e) **Risk sharing** mechanisms must be expanded to increase the proportion of the health budget that is pooled and reduce the proportion that comes as out-of-pocket payments.

- (f) **Evidence-based decision-making** should be practised on a day-to-day basis, align with health financing reforms, rely on best practices, and be economically viable.
- (g) **Partnerships** should involve all health-related sectors, various levels of government, the private sector, international development organizations, communities and civil society.

### **Priority interventions**

19. The proposed priority interventions are centred around **strengthening** the three functions of health financing: revenue collection; revenue pooling and risk management; and resource allocation and purchasing.

20. This strengthening of functions may require training and hiring new categories of staff with skills in actuarial analysis; health economics; financial and asset management; information technology; insurance management and prepayment programmes; and planning, monitoring and evaluation.

### **Revenue collection**

21. *Strengthening of financing mechanisms.* In the long term, the aim should be to develop prepaid mechanisms such as social health insurance, tax-based financing (including earmarked taxes on alcohol and tobacco) of health care, or some mix of prepayment mechanisms (with maximum community participation) to achieve the universal coverage goal. During the transition to universal coverage, countries are likely to use a combination of mechanisms to effectively manage financial risk. These include subsidies (taxes and donations), compulsory insurance (e.g. social health insurance coverage for specific groups), voluntary insurance (community-, cooperative- and enterprise-based), reinsurance, savings and limited direct spending.

22. *Honouring of past regional commitments.* Political action is now needed to ensure that African Heads of State honour their commitment to allocate 15% of their national budgets to health. This requires ambitious but realistic increases in allocations to the health sector under each country's Medium-Term Expenditure Framework. In addition, budgets approved through appropriate government processes should be fully executed.

23. *Monitoring multi-donor budgetary support.* There is a need to closely monitor multi-donor budgetary support to ensure that the shift from sectoral to general budgetary support does not decrease donor contribution to the health sector.

24. *Removing or reducing out-of-pocket payments.* Countries that choose to remove or reduce out-of-pocket payments must ensure that an alternative source of financing is available to continue providing high quality services.<sup>19</sup>

25. *Improving efficiency in revenue collection.* Revenue collection mechanisms should avoid wasting scarce resources through high administrative costs and maximize resources from both the formal and informal sectors.

### **Revenue pooling**

26. *Developing prepayment systems.* Countries should introduce or expand prepayment systems, where funds are collected through taxes and/or insurance contributions. Such systems allow people to access services when in need and protect the poor from financial catastrophe by reducing out-of-pocket spending. When designing such systems, policy-makers will need to involve all other stakeholders.<sup>20</sup>

27. *Establishing new health financing agencies.* Because of the complex links between risk management and both revenue collection and purchasing of health services, many countries may choose to establish new health financing agencies to ensure proper coordination of the three health financing functions. The governance arrangements of the new health financing agencies should include representation from all relevant stakeholders. Whatever institutional arrangements are made, issues relating to quality of care, range of benefits, provider payment mechanisms and staff remuneration should be addressed in a manner that supports revenue pooling and risk management.

28. *Strengthening safety nets to protect the poor.* The effectiveness of exemption mechanisms could be enhanced through increased community awareness of the exemption policy; issuance of exemption cards to poor people long before the need for health care arises; decreased direct (including transport) and indirect costs to poor people; strengthened administrative capacity for monitoring, supervising, interpreting and applying exemptions; compensation to health facilities for revenue lost through granting of exemptions; increased funding to health facilities where the poor are concentrated; and strengthened political support for exemptions<sup>21</sup>. In addition, when almost entire communities are living under the poverty line, governments will need to provide subsidized services; where community-based health insurance exists, government involvement will still be needed in terms of subsidies and re-insurance mechanisms.

### **Resource allocation and purchasing**

29. *Financing the strengthening of health systems.* Existing and additional funding from both national and international sources for the health sector needs to focus on both overall systems strengthening as well as specific disease programmes.

30. *Using priority disease resources to strengthen health systems.* In order to ensure that priority disease programmes are implemented effectively, there is an urgent need to strengthen the underlying health system, including management capacity and integrated care (e.g. primary care and Integrated Management of Childhood Illness).

31. *Contracting the private sector and nongovernmental organizations.* Significant resources exist through NGOs and the private sector in the African Region. These resources can be harnessed to meet public policy objectives through contracts with the public sector, but many countries need to create the necessary enabling environment with suitable policy and legislative frameworks. Governments should be encouraged to contract services to nongovernmental and private providers, especially in areas where they have a comparative advantage, and ensure mechanisms are in place to provide access to high-quality health services to the poor.

32. *Incorporating demand-side targeting mechanisms.* Some countries have tried demand-side targeting mechanisms such as conditional cash transfers, vouchers and subsidized insurance premiums. Where relevant and feasible, these mechanisms should be complementary to underlying broader financing mechanisms. These demand-side mechanisms could be used more widely throughout the Region to lower the financial barriers to health-care service access.

33. *Reforming provider payment mechanisms.* Provider payment mechanisms can be used to create incentives for greater productivity, efficiency and equity.<sup>22</sup> Countries need to ensure that remunerations, promotions and contracts for health personnel are directly linked to performance. Significant payment reforms often require parallel civil service reforms in order to achieve the desired policy goal of maximizing health benefits from available resources.<sup>23</sup>

34. *Other interventions exist for reducing resource wastage.* They include allocating resources on the basis of assessed need for health services; improving input procurement (e.g. through competitive tendering), distribution systems and prescribing practices; perfecting financial management systems; and strengthening the costing, budgeting, planning, monitoring and evaluation capacities at all levels of the health sys-

tem. Equally beneficial are improved referral systems, institutionalized equity and efficiency monitoring, health sector coordination mechanisms (e.g. SWAPs) and an essential service package based on priority setting and choice of interventions agreed by society.

### **Roles and responsibilities**

35. Securing increased financial resources at the country level in an equitable and efficient manner will be critical to meeting the regional objectives of accelerating progress towards reaching the MDGs and protecting populations from the impoverishing effects of illness. Because the health financing strategy will play a critical role in meeting these objectives, adequate human and financial resources are necessary for its successful implementation.

### **Countries**

36. National political will, commitment and support are crucial for successful implementation of this strategy. In addition, the technical leadership of the ministry of health is essential for its implementation. Therefore, each country will:

- (a) strengthen the leadership capacity of the ministry of health and its collaboration with the ministry of finance, ministry of labour and other relevant ministries and stakeholders;
- (b) strengthen or develop a comprehensive health financing policy and a strategic plan, which become essential parts of the national health policy and health development plan; in addition, the strategic health financing plan should have a clear roadmap for achieving the MDG targets and eventually universal coverage;
- (c) incorporate its health financing strategic plan into national development frameworks such as PRSP and MTEF;
- (d) secure statutory protection for minimum health financing allocations to the health sector;
- (e) fulfil the commitment made by African Heads of State to allocate at least 15% of the national budget for health development;
- (f) mobilize additional resources and utilize existing opportunities for funding to reach internationally agreed targets (e.g. MDGs);
- (g) strengthen health sector stewardship, oversight, transparency, accountability and mechanisms for preventing wastage of health resources;
- (h) strengthen financial management skills, including competencies in accounting, auditing, actuarial science, health economics, budgeting, planning, monitoring and evaluation;
- (i) strengthen the national health financing system, including financing structures, processes and

- management systems as well as building or strengthening prepayment systems (including health insurance) with community participation;
- (j) institutionalize efficiency and equity monitoring and national and district health accounts within health information management systems;
  - (k) reinforce capacities for health financing (including cost) evidence generation, dissemination and utilization in decision-making.

### **WHO and partners**

37. WHO, in close partnership with the World Bank, International Monetary Fund, International Labour Organization, African Development Bank, regional economic communities, European Union, bilateral donors, other relevant UN agencies (e.g. UNICEF), and other public and private donors, will provide technical and financial support to countries of the Region to implement this strategy. There will be need to tailor technical and financial support to the special needs of countries. In addition, WHO and partners will:

- (a) prepare regional guidelines for developing comprehensive health financing policies and strategic plans, and for monitoring and evaluating their implementation;
- (b) provide technical support to Member States, as appropriate, for developing tools and methods for evaluating different practices in health financing, including collection of revenue, pooling and purchasing (or provision) of services as they move towards universal coverage;
- (c) create networking and mechanisms to facilitate the continuous sharing of health financing experiences and lessons learnt;
- (d) support health financing research, disseminate the research findings and use them in decision-making;
- (e) ensure that the key recommendations in this regional strategy become a central part of the health contents of all relevant action plans.

38. Furthermore, WHO and partners will work with Member States to ensure that:

- (a) an increasing share of national budgets is allocated to the health sector and other critical sectors in order to accelerate progress towards the health MDGs, in line with the commitments reaffirmed by African Heads of State in Maputo in 2003;
- (b) the funds allocated to the health and health-related sectors from international donors and other development partners should be additional to, and not a substitute for, national resources

- and should remain consistent with macro-economic and growth objectives;
- (c) the donation commitments made at various international forums<sup>24</sup> are fulfilled, including the commitments made in the Paris Declaration on aid effectiveness.<sup>25</sup>

## **MONITORING AND EVALUATION**

39. The overall objective of monitoring and evaluation for the financing strategy is to assess progress towards achieving the objectives of the strategy and to aid informed decision-making.

40. Member States, with support from WHO and other development partners, should conduct regular national health accounts exercises and develop a monitoring and evaluation framework based on:

- (a) sources of financing: level, distribution and execution rates
- (b) pooling: population coverage through pooling mechanisms
- (c) spending: expenditure tracking; benefit incidence of spending.

41. WHO will propose a set of global indicators for intercountry comparability. In addition, countries will agree on a set of indicators to be used for monitoring the implementation of the strategy's objectives and priority interventions. With support from WHO and other partners, countries will collect information on the implementation of the strategy continuously, and carry out intercountry evaluation of health financing performance every three years.

## **CONCLUSION**

42. In order to achieve the health-related Millennium Development Goals, national health development objectives and expanded coverage of health services, especially those targeting the poor, countries in the African Region urgently need increased funding; greater equity in financing and access to health services; and improved efficiency in the use of health resources.

43. The WHO Regional Committee for Africa considered this strategy and adopted the proposed attached resolution.

### **Resolution AFR/RC56/R10**

#### **Health financing: A strategy for the African Region**

The Regional Committee,

Cognizant of the finding of the Commission on Macroeconomics and Health that poor health contributes significantly to poverty and low economic growth;

Aware that investments in health yield substantial returns in terms of poverty reduction and economic development;

Recalling resolutions AFR/RC52/R4 on poverty and health, AFR/RC53/R1 on macroeconomics and health, and the World Health Assembly resolution WHA58.30 on accelerating achievement of the internationally-agreed health-related development goals;

Recalling the pledge made by Heads of State in Abuja in 2001 to allocate at least 15% of their national budgets to health;

Recalling World Health Assembly resolution WHA58.33 urging Member States to ensure sustainable financing mechanisms;

Recalling the resolution of ministers of health of the African Union (Sp/Assembly/ATM (1) Rev.3) on health financing in Africa that renews their commitment to accelerate progress towards achieving the Abuja and Millennium Development Goal targets;

Appreciating the support being provided under international initiatives such as the Highly-Indebted Poor Countries; the Global Fund to Fight AIDS, Tuberculosis and Malaria; the Global Health Research Fund; the Global Alliance for Vaccines and Immunization; Roll Back Malaria; Stop TB; and the Bill and Melinda Gates Foundation;

1. ENDORSES the document entitled “Health financing: a strategy for the African Region”;
2. URGES Member States:
  - (a) to strengthen leadership capacities of ministries of health and re-enforce their collaboration with ministries of finance and labour as well as other relevant ministries and stakeholders;
  - (b) to strengthen or develop comprehensive health financing policies and strategic plans and incorporate them into national development frameworks such as Poverty Reduction Strategy Papers and Medium-Term Expenditure Frameworks;
  - (c) to fulfill the commitment made by African Heads of State to allocate at least 15% of their national budgets to health;
  - (d) to strengthen the national prepaid health financing systems, including financing structures, processes and management systems;

- (e) to strengthen capacities for generating, disseminating and using evidence from health financing in decision-making;

3. REQUESTS the Regional Director, in collaboration with the World Bank, other multilateral and bilateral funding agencies, and public and private funding bodies:

- (a) to make available regional guidelines for developing comprehensive health financing policies and strategic plans, and for monitoring and evaluating their implementation;

- (b) to provide technical support to Member States, as appropriate, for developing tools for and methods of evaluating different practices in health financing;

- (c) to create networks and mechanisms to facilitate the continuous sharing of health financing experiences and lessons learnt;

- (d) to support health financing research, the dissemination of findings there from and their use in decision-making;

- (e) to report on implementation of the strategy every two years.

- (f) to strengthen or develop comprehensive health financing policies and strategic plans and incorporate them into national development frameworks such as Poverty Reduction Strategy Papers and Medium-Term Expenditure Frameworks;(c) to fulfil the commitment made by African Heads of State to allocate at least 15% of their national budgets to health;(d) to strengthen the national prepaid health financing systems, including financing structures, processes and management systems;

- (g) to strengthen capacities for generating, disseminating and using evidence from health financing in decision-making;

3. REQUESTS the Regional Director, in collaboration with the World Bank, other multilateral and bilateral funding agencies, and public and private funding bodies:

- (a) to make available regional guidelines for developing comprehensive health financing policies and strategic plans, and for monitoring and evaluating their implementation;

- (b) to provide technical support to Member States, as appropriate, for developing tools for and methods of evaluating different practices in health financing;

- (c) to create networks and mechanisms to facilitate the continuous sharing of health financing experiences and lessons learnt;

- (d) to support health financing research, the dissemination of the findings and their use in decision-making;
- (e) to report on implementation of the strategy every two years.

*Fifth meeting, 30 August 2006*

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## 2.5 Knowledge management in the WHO African Region: Strategic directions (AFR/RC56/16)

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### EXECUTIVE SUMMARY

1. *Efficient Knowledge Management is now considered a key factor in organizational performance and competitiveness. New Knowledge Management approaches, including those using information and communication technology, can improve efficiency through better time management, quality service, innovation and cost reduction.*
2. *The WHO Knowledge Management Strategy, the WHO Regional Office for Africa strategic orientations for 2005–2009, strategies of the African Union and the New Partnership for Africa's Development, and the World Summit on the Information Society stress efficient information and knowledge management as an important contribution to the achievement of the Millennium Development Goals and other internationally-agreed development goals, including those related to health.*
3. *The weak Knowledge Management culture and limited information and communication technology (ICT) skills and infrastructure represent serious impediments to knowledge access, sharing and application. The new Knowledge Management approaches and the current ICT revolution represent, for the WHO African Region, a historic opportunity to foster a culture of Knowledge Management and overcome the digital divide in order to strengthen health systems, improve health outcomes and provide equity in health.*
4. *Countries would benefit from making Knowledge Management a priority component of their national health development policies and plans, and this emphasis requires allocation of adequate resources as well as the support of relevant partners.*
5. *The Regional Committee reviewed these strategic directions and adopted them along with the proposed resolution.*

### INTRODUCTION

1. Efficient Knowledge Management (KM) is now considered a key factor in organizational performance and competitiveness. New KM approaches, including those using information and communication technology (ICT), can improve efficiency through better time management, quality service, innovation and cost reduction. The growing inequities in access to information and knowledge and in the transformation of knowledge into policy and action (the know-do gaps) as well as the digital divide<sup>1</sup> (or electronic diversity) between and within countries present serious impediments to the achievement of the health-related Millennium Development Goals and other internationally-agreed health development goals.

2. The World Summit on the Information Society (WSIS), held in Geneva (2003) and Tunis (2005), adopted a plan of action that emphasizes the importance of Knowledge Management and the efficient use of information and communication technology (ICT) for the international development agenda, including health. The African Union and New Partnership for Africa's Development have also addressed the digital divide and e-Health<sup>2</sup> as high priority issues in the continental development agenda.

3. WHO has defined Knowledge Management as: "a set of principles, tools and practices that enable people to create knowledge, and to share, translate and apply what they know to create value and improve effectiveness."<sup>3</sup> The *WHO Knowledge*



*Management strategy and Strategic orientations for WHO action in the African Region 2005–2009* implicitly suggest Knowledge Management for health as a key strategic priority.<sup>4</sup> In addition, Resolution WHA58.28 of the Fifty-eighth World Health Assembly<sup>5</sup> urged Member States and requested the Director-General to actively promote and support e-Health initiatives.

4. This document proposes strategic directions for more efficient knowledge generation, sharing and application, and discusses the subsequent and respective roles and responsibilities of countries, WHO and partners.

## SITUATION ANALYSIS

5. The work of ministries of health, WHO and other stakeholders already comprises Knowledge Management components such as the generation, sharing and application of scientific, technical, explicit and implicit knowledge. Concrete examples of KM in health include health research; medical education and other elements of human resources development; health situation analyses; programme monitoring and evaluation; and development of strategies, norms, standards and guidelines. Publications, library services, documentation centres, meetings, workshops and seminars are typical examples of KM tools and methods.

6. It is nevertheless widely acknowledged that Knowledge Management for health is generally weak and that there is a need for serious improvement in this crucial area. Knowledge Management should deal not only with formal and explicit knowledge deriving from health research and systematically-documented health issues but also with tacit knowledge residing in people's minds and linked to valuable individual and collective experiences.

7. New technological advances are rapidly changing communications, widening possibilities and making new KM tools available. The most important are electronic mail, electronic databases, internet web sites, intranets, search engines, video- and tele-conferencing, virtual libraries, electronic collaborative tools and expertise locators.

8. The digital divide, which separates those who are part of the electronic revolution in digital communications and those who have no access to the benefits of the new technology, represents a major obstacle to effective use of ICT solutions in KM. At present, the 942 million people in developed countries enjoy five times better access to fixed and mobile phone services, have nine times better access to

Internet services, and own 13 times more personal computers than the 5.6 billion people living in low-income and lower middle-income countries. There are currently 800 000 villages worldwide that lack access to even basic telephone services.<sup>6</sup> As recognized by the WSIS, sub-Saharan Africa is the world's most digitally-disadvantaged region.

9. Policy-makers, health practitioners and communities often lack relevant information and knowledge when and where they actually need it. Conversely, there is an information overload which results in time wastage, confusion and inappropriate decision-making and problem-solving.

10. E-Health and telemedicine are playing increasingly important roles in public health, clinical knowledge and medical practice. They provide a wide range of solutions for health situation assessment; alert systems and responses to epidemics; management of health institutions, services and programmes; health promotion; provision of health care; training; and continuing education through e-learning.

11. There is a proliferation of Communities of Practice, stakeholders interested in common specific issues who exchange their information and knowledge directly or through electronic tools. This approach is a powerful instrument for knowledge sharing and application.

12. The most important strengths and opportunities for Knowledge Management in the African Region are the increasing awareness and commitment of policy-makers and professionals; the growing number of partners willing to support KM programmes such as e-Health and telemedicine; the progress (albeit limited) in ICT infrastructure; and the conducive environment created by the World Summit on the Information Society. Several e-Health projects are being implemented, and others are being developed, such as the pan-African e-Network coordinated by the African Union.

13. Weaknesses and threats in Knowledge Management area include lack of formal policies, norms, standards and strategies; managerial and leadership styles that hinder learning, or knowledge sharing and application; poor ICT infrastructure and the subsequent digital divide; and limited human and financial resources.

14. The main challenges for countries, WHO and partners are the limited access to relevant knowledge (knowledge gap) and limited transformation of knowledge into action (know-do gap); weak learning and knowledge-sharing behaviour; irrelevant managerial processes and mechanisms for efficient

KM; and lack of coordination of the various approaches and initiatives in KM.

## REGIONAL AGENDA

### Objectives

15. The overall objective of this document is to contribute to the improvement of health system performance and outcomes through effective Knowledge Management in health.

16. The specific objectives are:

- (a) to improve access to and sharing of health information and knowledge;
- (b) to maximize the impact of explicit and tacit knowledge, including health research and experiential knowledge, through effective knowledge sharing and application;
- (c) to foster e-Health as a powerful means of strengthening health systems and improving health service delivery, including quality of care.

### Priority interventions

17. *Advocacy.* Knowledge Management for health should be promoted by policy-makers at the highest level of government and by international and regional development partners.

18. *Data and evidence generation.* A situation analysis of KM at regional and country levels through surveys and special studies should be performed and regularly updated. Such analyses should generate evidence; identify best practices; consider explicit, tacit, community-based and traditional knowledge; and locate available expertise.

19. *Development of policies and plans.* Country-specific policies and plans should be developed for further progress in KM and to ensure that KM is embedded across the health system, including all programmes and projects. They should agree with overall national development policies and plans, ICT plans, and health policies and plans. They should also consider the strategies of the African Union, New Partnership for Africa's Development, World Summit on the Information Society and World Health Organization. KM policies and plans should explicitly support national capacity building, human resource development and equity in health services provision and health outcomes.

20. *Setting of standards and norms.* Appropriate norms, standards and regulations are the key for sustainable progress in KM, especially in e-Health and tele-medicine. They should be based on the best international practices and adapted to the national context.

21. *Capacity-building.* Capacity concerns three main components of KM: people's skills and behaviour, managerial processes and technologies. The key approaches to be implemented include training and continuing education, staff incentives, institutional mechanisms and effective use of ICT infrastructure.

22. *Fostering partnerships and mobilizing appropriate resources.* The global momentum in favour of Knowledge Management and Information Technology development created by the WSIS and other international and regional initiatives should be actively used for building strong partnerships at country and regional levels, and for mobilizing adequate resources for KM.

23. *Effective knowledge generation, sharing and application.* Countries and all stakeholders should foster Knowledge Management across health systems for health development and equitable health outcomes. KM, including learning, sharing and application, should be an integral part of the managerial culture in health sectors and systems. Special attention should be given to health and health-related tacit, traditional and oral knowledge, particularly in rural areas. This includes extensive use of mechanisms such as communities of practice and ICT-assisted tools. KM should be strongly associated with health information systems, health research and human resources development.

### Roles and responsibilities

24. **Countries** should develop Knowledge Management programmes as part of their national health development policies and plans. Relevant strategies of the African Union and the New Partnership for Africa's Development, the WSIS Plan of Action, the WHO Eleventh General Programme of Work, and the strategic orientations of the WHO Regional Office for Africa should inform national policies, strategies and plans for Knowledge Management. Countries should also actively foster partnerships and mobilize resources for the implementation, monitoring and evaluation of KM and ICT programmes, in close collaboration with all stakeholders, especially training and research institutions.

25. **WHO** will provide support to countries for developing and implementing policies, plans and programmes; setting norms and standards; monitoring and evaluating programmes; and coordinating partnerships, advocacy and resource mobilization.

26. **All partners**, including academic and corporate institutions, are invited to strongly support countries in their efforts to foster information and knowledge management for health. They should actively

contribute to effective coordination and consensus-building and allocate appropriate financial resources to support KM for health.

## MONITORING AND EVALUATION

27. Countries should integrate appropriate Knowledge Management indicators in their health development plans; they should ensure that the monitoring and evaluation of the health development plan includes a KM component. KM should be an integral part of any important public health programme and evaluated as such.

28. Progress reports about Knowledge Management at country and regional levels will be presented to the Regional Committee every two years.

## CONCLUSION

29. In view of the paramount importance of Knowledge Management for health development, Member States are encouraged to take full advantage of the current revolutions in KM and ICT. These phenomena present extraordinary opportunities to advance health development; achieve the health-related Millennium Development Goals and other internationally-agreed health goals; and avoid marginalization at global, regional and country levels. KM for health, including appropriate use of ICT, deserves to be put very high on the agendas in all Member States and the Region as a whole.

30. The Regional Committee reviewed these strategic directions and adopted them along with the proposed resolution.

### **Resolution AFR/RC48/R8**

#### **Knowledge management in the WHO African Region: Strategic directions**

The Regional Committee,

Recalling resolution WHA58.28 on e-Health;

Aware of the importance of knowledge management for improvement of national health system performance;

Recalling the WHO *Eleventh General Programme of Work and the Strategic orientations for WHO action in the African Region 2005–2009*;

Considering the Plan of Action and Declaration of the World Summit on the Information Society, as well as the orientations of the African Union and the New Partnership for Africa's Development

(NEPAD) on the development of information and communication technology;

Cognizant of the opportunities provided by the efficient use of information and communication technology in all health development areas;

Noting the many national or regional initiatives in the areas of knowledge management and e-Health;

Having examined the document presented by the Regional Director on knowledge management;

1. APPROVES the strategic directions proposed by the Regional Director for health knowledge management;

2. URGES Member States:

(a) to prepare national strategic directions for knowledge management, including e-Health, ensuring that they are integrated as a priority into their national health policies and plans;

(b) to establish norms and standards, including ethical ones, taking into account new technology and approaches to knowledge management;

(c) to strengthen national capacity in knowledge management;

(d) to include the health sector in national information and communication technology development plans;

(e) to build sustainable partnerships, and allocate and mobilize the resources needed to improve knowledge management at all levels of the health sector;

3. REQUESTS the Regional Director:

(a) to continue advocacy for knowledge management as a key approach to strengthening health systems;

(b) to make available generic guidelines, norms and standards for knowledge management;

(c) to provide technical support to Member States for the development and implementation of national policies and plans;

(d) to strengthen partnerships at the regional level, in particular with the African Union, NEPAD and regional economic communities;

(e) to report every other year to the Regional Committee on progress in the implementation of this resolution.

*Seventh meeting, 30 August 2006*

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- NEVA A/9(Rev.1)-E 18 February 2004, Annex 2, Geneva, World Summit on the Information Society, 2003.
2. The term e-Health encompasses all of the information and communications technology necessary to make the health system work; see <http://www.itu.int/itu-news/issur/2003/06/standardization.html-15/03/2006> (last accessed 23-03-2006).
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## Strategic Direction 3

*Putting the health of mothers and children first*





# 3.1 Integrated management of childhood illness (IMCI): Strategic plan for 2000–2005 (AFR/RC49/10)

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## EXECUTIVE SUMMARY

1. *In countries in sub-Saharan Africa, about 1.2 million children under five years of age die every year of acute respiratory infections (ARI), especially pneumonia. An estimated 800 000 people die of diarrhoeal diseases, about 500 000 of measles and some 600 000 of malaria. Each of these diseases is also associated with malnutrition in more than 50% of the ensuing deaths. Projections based on an analysis of the global burden of disease, completed in 1996, indicate that these conditions will continue to be major contributors to morbidity and mortality up to the year 2020 unless significantly more serious efforts are made to control them.*
2. *The need for a global response to this situation calls for the anchoring of health in a broad setting, which provides opportunities for the implementation of preventive, promotional, curative and developmental interventions. Achieving sustained improvement in child health requires integration of these efforts as well as long-term partnerships to support nationally-defined and evidence-based policies and strategies.*
3. *In response to the challenge of childhood illnesses, the WHO Regional Office for Africa has, since 1995, intensified its support to Member States by adopting the Integrated Management of Childhood Illness (IMCI) programme, which is a cost-effective strategy for the reduction of morbidity and mortality in this vulnerable group. As at December 1998, the strategy was being implemented in 22 of the 46 countries in the Region.*
4. *In spite of the potential gains of IMCI, a number of constraints exist at the regional, national and subnational levels, which require attention in order to accelerate implementation. These constraints are: limited human and financial resources and weakness of health systems in many countries of the Region.*
5. *The purpose of this document is to provide a strategic plan for the acceleration of IMCI implementation during the next five years in order to assist Member States in the reduction of childhood morbidity and mortality through the implementation of interventions at various levels of the health system, especially at the district and community levels.*
6. *The major thrusts of the proposed strategic plan are: strengthening of capacity at national, district and regional levels; strengthening of health systems; and promotion of sustainable IMCI implementation by introducing it into the curricula of medical and paramedical institutions.*
7. *The Regional Committee reviewed and adopted the IMCI strategic plan.*



## INTRODUCTION

1. About 11 million children under five years of age die annually of common preventable diseases such as acute respiratory infections, diarrhoea, malaria, measles, and malnutrition. Many of these deaths occur in countries in sub-Saharan Africa. Every year, some 1.2 million children under five years of age die of acute respiratory infections (ARI), mainly pneumonia; 800 000 of diarrhoeal diseases, 500 000 of measles, and about 600 000 die of malaria. Each of these conditions is also associated with malnutrition in more than 50% of the ensuing deaths.

2. Projections based on an analysis, completed in 1996, of the global burden of disease indicate that these conditions will continue to be major causes of morbidity and mortality up to the year 2020 unless significantly more efforts are made to control them.

3. The late 1980s and early 1990s witnessed growing global concern about child health and the prospect of controlling illnesses and health problems. Despite the fact that adequate tools are available for effective control, childhood diseases are claiming the lives of millions of children worldwide.

4. The need for a global response to this problem calls for the anchoring of health in a broad setting which provides opportunities for implementing preventive, promotive, curative and developmental interventions. The Integrated Management of Childhood Illness (IMCI) strategy, prepared by WHO and UNICEF in 1995, is intended to meet this challenge.

5. IMCI offers a set of interventions that promote rapid recognition and effective treatment of major killers of children under five years of age. It promotes the prevention of illness through improved nutrition (including breast-feeding), vaccination, and the promotion of insecticide-treated materials. It also promotes the use of micronutrients such as vitamin A and iron therapy, and deworming of the most vulnerable. Lastly, IMCI reinforces family practices that are important for child health. These can be achieved through the implementation of the three components of IMCI:

- (i) improvement in the case management skills of health staff
- (ii) improvement in health systems
- (iii) improvement in family and community practices.

6. The implementation of IMCI started in 1995 in the African Region and, as at 1998, the strategy was being implemented in 22 of the 46 countries, with six countries already implementing it at the district level,

and two incorporating improvements in family and community practices. Other countries of the Region are planning to begin implementation in 1999.

7. The purpose of this document is to provide a framework for the implementation of the IMCI strategy during the next five years.

## JUSTIFICATION

### Policy background

8. International events such as the Alma-Ata conference of 1978, the adoption, in 1989, of the Convention on the Rights of the Child now ratified by a record 191 countries, the World Summit for Children in September 1990, during which government leaders committed themselves to Goals for Children by the Year 2000, the International Conference on Nutrition in 1992, the 1994 International Conference on Population and Development in Cairo, and the Fourth World Conference on Women in Beijing in 1995, have resulted in the implementation by countries of interventions towards improving child survival, development and protection. The adoption of these goals was extremely important in that it committed the countries to obtaining concrete results with respect to reducing mortality and morbidity and providing health care for children.

9. WHO and UNICEF, in collaboration with other partners, have provided leadership in galvanizing the international community towards coordinated actions for children and have supported efforts to reduce child morbidity and mortality. To this end, the following specific steps have been taken:

- (i) In 1990, there was a joint meeting of WHO and UNICEF to consider the possibility of developing the Integrated Management of Childhood Illness (IMCI).
- (ii) The WHO Ninth General Programme of Work (1996–2001) adopted the integrated approach for the implementation of disease control programmes.
- (iii) In May 1995, the World Health Assembly adopted IMCI as a more cost-effective approach for the survival and development of the child.
- (iv) In August 1995, the WHO/AFRO Policy Framework for Technical Cooperation with Member States confirmed IMCI as an appropriate and effective approach for implementation in the Region.

10. In the past decade, there has been a global re-awakening to equity and social justice. Children are

the key in the pursuit of a future of equity and social justice, hence, the need to include child health at the top of the political agenda.

### **Technical justification**

11. Since the early 1980s, WHO and its partners have provided support to countries for the development of disease-specific control programmes. Effective though these control programmes were, they did not generally establish clear ties with other components of health care. Instead, they helped to focus the attention of health workers on specific signs and symptoms of illnesses, which usually constituted the reasons why mothers sought care for their children. They did not establish a systematic assessment of other aspects of children's health. Generally, there was no clear link between preventive and promotional care within the overall approach to child health care. Consequently, there was a general case of missed opportunities for immunization and management of other conditions, duplication of efforts, and wastage of scarce resources. Based on the lessons learnt from the implementation of disease-specific control programmes, the need for an integrated strategy to link individual strategies emerged, and has constituted a major challenge for this decade.

12. The IMCI strategy is unique in that it is conceived in a generic form, which can be adapted to the epidemiological and cultural realities of the countries as well as to the operational conditions for implementing activities that exist in each country. Thus, some components of the control programmes of the prevalent illnesses in some countries can be added to the IMCI strategy. On the other hand, other non-prevalent components (such as malaria) can be eliminated, depending on the characteristics of the area in question.

### **Situation analysis**

13. In spite of the potential gains of IMCI, a number of constraints exist at the regional, national and sub-national levels, which require attention so that IMCI implementation can be accelerated:

- (i) There is limited capacity at regional and national levels in terms of competent and available consultants and the number of staff to respond to the increasing demands of IMCI.
- (ii) Available funds to provide technical assistance to countries and districts are limited. Many countries are yet to allocate funds for IMCI implementation.
- (iii) The health systems in most countries in the Region are too weak at both national and dis-

trict levels to meet the needs of IMCI, especially with respect to the availability of drugs and vaccines.

- (iv) Networks for the exchange of information, experiences and expertise are limited.
- (v) Different partners have different priorities at country level. In addition, there are inconsistencies in the approaches to child health. This makes coordination difficult and may lead to a duplication of effort.

14. A review of the three years of IMCI implementation in the African Region was conducted in 1998. This revealed the following challenges, among others:

- (i) providing adequate technical support in response to increased country demands;
- (ii) ensuring continuous collaboration with programmes such as malaria, essential drugs EPI, child health, and nutrition, considering activities to be implemented in an integrated manner and those where only coordination is needed;
- (iii) bringing IMCI to families and communities with their active participation and ownership in order to prevent or reduce the high rate of deaths of children under five years of age before they reach the health facilities;
- (iv) ensuring sustainable implementation of the strategy, considering the currently low level of allocations from countries and the international community;
- (v) including and implementing IMCI in the decentralized health system and meeting the attendant needs;
- (vi) ensuring continuing collaboration with partners in order to have a common aim and understanding of the IMCI strategy.

## **THE REGIONAL STRATEGIC PLAN**

### **Aim**

15. The strategic plan aims to contribute to the reduction of childhood mortality in the African Region by improving the case management skills of health staff and the support provided for health systems and family and community practices.

### **Guiding principles**

16. Eleven countries, which account for more than 80% of childhood mortality in the Region, will receive intensive technical and financial support in an effort to make a difference.

17. In implementing the IMCI strategy appropriate effort should be made to ensure:

- (i) country ownership and commitment at policy and operational levels
- (ii) institutionalization of IMCI in national health services
- (iii) district-based response to the expressed needs of the population
- (iv) contribution to the prevention and early diagnosis and treatment of childhood illness.

### General objectives

18. The overall objectives of the regional strategic plan are to ensure that each Member State:

- (i) improves the quality of care provided to children under five years of age at health facility and household levels; and
- (ii) strengthens the health system in order to sustain IMCI implementation.

### Specific objectives

19. To achieve the above, the Regional Office will collaborate with Member States and partners:

- (i) to strengthen capacity at the regional, national and district levels for sustainable implementation of IMCI; this will be achieved through training in structured apprenticeships of national experts to ensure ownership of the strategy and reduce costs;
- (ii) to promote sustainable IMCI implementation by introducing it into the curricula of medical and paramedical institutions; building partnerships with technical programmes and partners in the Region; ensuring the availability of essential drugs, an effective referral system, support supervision, programme monitoring and a health information system, which are essential to improve the quality of care;
- (iii) to build partnerships with parties interested in health at the regional, national and community levels for more effective support to and coordination of country-level activities, including resource mobilization inside and outside the countries, in order to increase the capacity to respond to country demands and needs, support country-level implementation, promote co-funding with partners, and conduct operational research;
- (iv) to promote operational research to provide evidence-based answers to implementation issues which arise at the regional, national and subnational levels, including cost-benefit analyses, and in the process, build the capacity of institutions in the Region for research.

### Expected outcomes

20. The expected outcomes are:

- (i) Capacity for sustainable IMCI implementation at the regional, national and subregional levels is increased.
- (ii) IMCI implementation is achieved in a sustainable way in each Member State.
- (iii) Partnerships for the effective implementation of IMCI at the regional, national and sub-national levels are built.
- (iv) Results of operational research activities are used to strengthen IMCI implementation at all levels.

### Priority interventions

21. Capacity-building will include training in IMCI at national, district, community and regional levels for improved quality of care.

*National level:* National experts will be identified to provide support to their countries as well as to other countries for planning, training, adaptation, evaluation and monitoring. The use of IMCI focal points will be encouraged. WHO and partners will provide initial financial support, but arrangements will be made for devolution to countries for sustainable development purposes.

*District level:* District health management teams (DHMTs) will be trained on IMCI in order to provide the needed support to the implementation of IMCI at the health facility. The strategy will be part of the district plan of action.

*Community level:* Based on the documented experiences of ongoing activities in the countries, the capacity of the non-formal health care providers and family members will be improved through appropriate training, monitoring and supervision of their activities. Key family practices such as exclusive breast-feeding, adequate complementary feeding, adequate micronutrient intake or supplementation, safe disposal of faeces, complete immunization, use of insecticide-treated materials, appropriate care-seeking, and correct treatment of infections will be strengthened.

*Regional level:* The regional and subregional staffing of WHO will be strengthened to help provide prompt technical support to the countries. The intercountry teams for western, southern and central Africa and the Horn of Africa will be strengthened. A pool of consultants will be trained to supplement the efforts of staff.

### **Promotion of sustainable activities**

22. This intervention will target areas that are crucial for the sustainability of IMCI at country level, including:

*The strengthening of pre-service training:* Current experiences on pre-service training as a sustainable method of improving health worker skills will be extended to medical and paramedical institutions in countries of the Region. This will include training, evaluation through structured examination of students, and monitoring of the performance of trained health workers.

*The availability of drugs:* The Bamako Initiative or “Bamako-like” initiatives such as the promotion of cost-sharing in order to ensure drug availability for mothers and children, with community ownership, will be used as an entry point for IMCI in selected districts. Improvement of drug procurement, storage and distribution mechanisms and mobilization of resources to procure and supply seed stocks of drugs for implementation in countries will be carried out in collaboration with national pharmacists and pharmaceutical boards. Involvement of the private sector and the non-formal drug distribution system will be promoted.

### **Building partnerships**

23 Implementation of IMCI will be carried out in close collaboration with partners at regional, national and subregional levels. The comparative advantage of partners in specific areas such as research, drug management, communication and community orientation will be used. Joint planning, implementation and evaluation will be encouraged.

### **Promotion of research**

24 The capacity of experts in countries will be strengthened through the priority operational research areas identified during the first meeting of the Regional IMCI Task Force in June 1998. These are: drug supply management, pre-service training, referral systems, caretaker compliance, and organization of work in health facilities. The Regional IMCI research committee will develop appropriate protocols and conduct studies linking with the African Advisory Committee on Research and the Research Development Committee in the Regional Office. Collaboration will be maintained with universities and research institutions.

### **Implementation framework**

#### **The role of Member States**

25. At the country level, advocacy will be promoted to encourage inclusion of the IMCI strategy in the national health policy and plan of action. Implementation will be carried out using a step-wise approach. During the expansion phase, specific attention will be paid to the quality of implementation.

#### **The role of WHO**

26. WHO will provide strategic direction for more effective action to tackle child health problems in Member States through the implementation of IMCI. Innovative designs, broad ownership, full private sector and community participation, flexible implementation, and clear emphasis on outcomes will be promoted. WHO will play the leadership role to promote adequate preparation and involvement of a wide range of stakeholders in IMCI implementation.

#### **Resource mobilization**

27. National and district plans of action will be used as tools for the mobilization of funds through country health budgets and additional resources from relevant internal and external stakeholders. In order to maximize the contributions of multilateral and bilateral agencies as well as nongovernmental organizations (national and international), efforts will be made to involve them at every stage of implementation. Co-funding will be explored for activities of common interest. Health sector reforms (HSR) will be used to foster resource mobilization.

### **MONITORING AND EVALUATION**

28. A continuous monitoring process will be ensured at country and regional levels through reports of activities, documentation of the progress of implementation, and review and publication of research results. At national level, periodic evaluation will be undertaken at two-year intervals to assess the impact of IMCI. WHO will collaborate with partners in the development, design and implementation of impact assessment studies.

29. **Networking for information sharing**, using the IMCI Newsletter, global, regional and country-level meetings and conferences, electronic communication systems and other mechanisms, will be established.

30. The indicators to be used for monitoring are:

- (i) the percentage of countries in the Region implementing IMCI;
- (ii) the percentage of countries where IMCI is implemented in all districts;
- (iii) the percentage of countries where IMCI is implemented in at least one medical school;
- (iv) the percentage of countries where IMCI is implemented in at least one paramedical training institution.

31. At country level, the following indicators will be used to monitor the quality of IMCI implementation at the district level:

- (i) percentage of children who need an oral antibiotic and who are prescribed the drug correctly;
- (ii) percentage of children who need an oral antimalarial and who are prescribed the drug correctly;
- (iii) percentage of children who need an oral antibiotic and an antimalarial who are prescribed the drugs correctly;
- (iv) percentage of children needing referral who are effectively referred;
- (v) number of operational research results used for improving the implementation of IMCI.

### Critical factors for success

32. The implementation of IMCI is a long-term process, considering the three components of the strategy. It will be necessary that countries develop their ownership of the strategy by expressing their commitment, institutionalizing IMCI in the existing structures, empowering districts and providing human and financial resources.

33. The promotion of collaboration with all partners interested in the implementation of IMCI as a way to maximize their additional contributions will need to be encouraged.

34. Capacity-building at national, district and regional levels is critical for sustained development of the strategy.

### CONCLUSION

35. Children have rights – the right to health and the right to health care. The Convention on the Rights of the Child ‘Article 24’ calls on states to implement interventions to reduce infant and childhood mortality, ensure medical assistance and health care to ALL children, and combat disease and malnutrition. The Integrated Management of Child-

hood Illness has the potential to achieve the above. Its implementation is taking place within structures existing at country and community levels, and it has been used as a major tool for fostering collaboration among programmes and partners.

36. This document will, serve as a guide to countries for IMCI implementation. Individual country decisions will help promote collective action to ensure that the African child is not born just to die but to live a long and healthy life.

### *Resolution AFR/RC49/R3*

#### **Integrated management of childhood illness (IMCI): Strategic plan for 2000–2005**

The Regional Committee,

Recalling World Health Assembly resolution WHA48.12 which adopted IMCI in May 1995 as a cost-effective strategy for child survival and development;

Recalling the regional *Policy Framework for Technical Cooperation with Member States*, in which IMCI was confirmed as an appropriate and effective strategy that should be implemented in the Region;

Considering that 70% of childhood deaths are due to acute respiratory infections, diarrhoeal diseases, measles, malaria and malnutrition and that IMCI is an appropriate strategy for controlling these childhood killer diseases;

Bearing in mind the spirit of international events such as the 1978 Alma-Ata conference on primary health care, the adoption of the Convention on the Rights of the Child in 1989, and the 1990 World Summit for Children during which government leaders committed themselves to giving the child a better future;

Aware of the high infant and child mortality rates in the countries of the Region and the need to support health sector development in a broad setting which provides opportunities for implementing preventive, promotive, curative and rehabilitative interventions;

Acknowledging that the integrated strategy to childhood illness will help reduce under-five morbidity and mortality and that the strategy is capable of enhancing cost effectiveness;

Considering the present status of implementation of IMCI in the African Region and the need to give more intensive support for the implementation of this strategic plan;

Recognizing the invaluable support that multi-lateral and bilateral cooperation partners have given to the countries to date for IMCI implementation,

1. APPROVES the regional strategic plan for the integrated management of childhood illness (IMCI) as presented in document AFR/RC49/10.

2. CALLS UPON Member States:

- (i) to include the IMCI strategy in national health policies and plans of action;
- (ii) to accelerate IMCI implementation, maintaining a step-wise approach and paying attention to quality, particularly during the expansion phase;
- (iii) to take the necessary steps to ensure greater availability of human and financial resources, and to strengthen district health systems, for sustainable implementation of the IMCI;
- (iv) to revise their essential drug list in order to facilitate the implementation of the IMCI strategy;
- (v) to strengthen the nutritional rehabilitation of sick children ;

3. REQUESTS the Regional Director:

- (i) to provide support to Member States to strengthen and accelerate the implementation of the strategic plan;
- (ii) to develop human resources and mobilize regular budget and extrabudgetary resources to support the implementation of the strategic plan;
- (iii) to monitor the implementation of the strategic plan in the countries and facilitate the sharing of experiences and lessons learned among the Member States;
- (iv) to report to the fifty-first session of the Regional Committee on the progress made in the implementation of the strategic plan;

4. REQUESTS international and other partners concerned with the implementation of IMCI in the African Region to intensify their support to the countries for the implementation of the IMCI strategic plan.

*Fifth meeting, 1 September 1999*

## 3.2 Adolescent health: A strategy for the WHO African Region (AFR/RC51/10 Rev.1)

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### EXECUTIVE SUMMARY

1. *The health of adolescents is a component of public health, which is of major concern globally and in the African Region in particular.*
2. *Adolescence is characterized by physiologic, psychosocial, especially emotional, intellectual and spiritual development and maturation processes. Adolescent health is in part determined by the family environment that provides for basic needs for shelter, food, education, health care, and moral and spiritual values necessary for character building. Behaviour acquired in adolescence impacts health outcomes and lasts a lifetime.*
3. *The heterogeneous nature of adolescents, their difficulty to access and fully utilize available health services and their vulnerability to morbidity and mortality are recognized. Their health and development problems include those related to reproductive health, risk-taking behaviour and accidents, mental illness and communicable diseases such as STI and HIV/AIDS. These are often interrelated and linked to behaviour.*
4. *Global concern for the health and well-being of young people has been expressed in various instruments, including the 1985 International Year of the Youth (UN General Assembly), the 1990 Convention on the Rights of the Child, the OAU African Charter on the Rights and Welfare of the Child and the Reproductive Health Strategy for the African Region.*
5. *The strategy aims at providing guidance to Member States and partners in the formulation of policies, programmes and interventions that address adolescent health and development. It draws attention to the health sector response, the role of parents, families, communities and other sectors and the active involvement of young people.*
6. *Effective and successful implementation of the strategy in Member countries will depend on its adaptation, with the full involvement and participation of health professionals, young people, families, communities and key partners in policy and programme development, and backed up by research, to make it culture and value sensitive.*

### INTRODUCTION

1. The health of adolescents is a component of public health, which is of major concern globally and in the African Region in particular.
2. Adolescence, a period of transition from childhood to adulthood, is characterized by rapid and objective physiologic changes, such as rapid growth, maturation of the reproductive system and changes in physical appearance. Significant psychosocial

development, especially emotional, intellectual and spiritual aspects occurs through a progressive maturation process from childhood dependence to adult interdependence.

3. The perception of adolescents as generally healthy has changed due to a better understanding of the adaptation processes that they undergo. It is evident that adolescents are vulnerable and at risk of morbidity and mortality. Ill-health in adolescents is

often caused by unhealthy environments, inadequate support systems for promoting healthy lifestyles, lack of accurate information and inadequate or inappropriate health services. Many behaviour patterns acquired and health conditions encountered during adolescence will last a lifetime.

4. Young people's health has a significant impact on national development, and national development, in turn, is central to addressing problems like poverty that undermine young people's health. Development in the context of adolescents refers to total human development. Youth are a valuable resource for socio-economic and cultural development. Their energy and resourcefulness are not yet fully appreciated and reflected in national development policies. The family has primary responsibility for the healthy development of adolescents, supported by the community and the wider multisectoral environment. The age-old values of respect for truth and human dignity as epitomized within the family or by societal role models in general enable most adolescents to emerge as well-adjusted members of society.

5. Common adolescent health problems include sexually transmitted infections, parasitic and water-borne diseases, malnutrition, injuries and disability as a result of risk-taking activity, and mental illness such as depression and psychosis, which can lead to suicide and violence. Adolescents' sexuality and reproductive health are generally not well addressed to protect them from unwanted pregnancies, complications of unsafe abortion and HIV/AIDS.

6. Data on alcohol, tobacco and psychotropic drug usage among adolescents are fragmented. However, use by young people in the Region is evident. Some cultural and traditional practices associated with initiation and early marriage have health consequences and violate the rights of adolescents.<sup>1</sup>

7. Whereas the general public is also susceptible to similar health threats, adolescents are particularly vulnerable due to several factors. They are not economically independent to access health services; they lack the level of maturity required to make responsible decisions when they are sick; health services are not oriented to meet the health and development needs of adolescents. These combined factors contribute to under-utilization of available services by adolescents.

8. The health of adolescents is to a large extent determined by family environments that provide the immediate basic needs for shelter, food, education, health care and moral and spiritual values necessary for character building as well as by schools and the work environment. The influence of their peers and

the wider community can promote health and well-being in the adolescents by providing an environment that is conducive to healthy development. Conversely, they can create unsafe and hostile conditions detrimental to health and development. Adolescents can either be victims or perpetrators of violence, for example, rape and assaults.

9. Preventive health interventions and actions to promote adolescent development can build the adolescents' capacity to develop individual social and life skills and competencies to offset negative social influences. This is particularly true of interventions that help them to feel appreciated, have belief in their own worth and a sense of belonging as well as hope in the future, including knowledge of their rights and responsibilities.<sup>2</sup>

10. There are also examples in Member countries of how resourceful adolescents can be if their energy and enthusiasm are directed towards the improvement of their own health and that of other young people in and out of school. Experience with the use of peer educators and health clubs (e.g. anti-AIDS, anti-alcohol and drug abuse clubs in schools) managed by young people with the support of teachers, parents and responsible adults has been positive.

## **SITUATION ANALYSIS AND JUSTIFICATION**

### **Situation analysis**

11. There are approximately 1700 million young people in the world, 86% of whom live in developing countries.<sup>3</sup> About 16% of those living in these countries are in Africa. In many countries of the Region, young people constitute approximately 33% of the population.<sup>4</sup> Adolescents contribute to the high maternal mortality in the Region, accounting for up to 40% of all maternal mortality in some countries.<sup>5</sup> Lack of access to reproductive health services, including counselling, contributes to the high incidence of post-abortion complications. In some countries of the Region, 25% to 27% of first births occur among adolescents.<sup>6</sup> On average, boys and girls initiate sexual activity during adolescence. Of all new cases of HIV infection in 1999, 65% were in young people living in Africa.<sup>7</sup>

12. The health problems of adolescents in Africa are associated with socio-economic conditions characteristic of the Region. Some parts of the Region are experiencing civil strife or armed conflicts resulting in mass displacements of people, disruption of family life, dislocation of social support systems, and increased poverty. In others, intergenerational conflicts



have weakened family structures and coherence, leaving adolescents exposed to negative environmental influences such as drug abuse and prostitution. Disparities existing between rural, peri-urban and urban living conditions, inadequate access to safe drinking water and sanitation, food, health services, formal and informal education, employment, recreation and housing, associated with increased rural-urban migration of children and young people in developing countries (70%), increase their vulnerability to poor health.<sup>8</sup>

13. Poverty, a cross-cutting factor, affects the majority of the Member States of the Region. It increases vulnerability of adolescents to poor health. It denies them optimal conditions and opportunities for education to acquire intellectual and vocational skills that would enable them to improve their employment options and potential. Poverty breeds environments where crime, drug abuse, violence, rape and commercial sex thrive. Experience with projects that integrate young people in sustainable development and poverty alleviation programmes to promote rural and urban development, coupled with life and vocational skills development, has shown the benefit of equipping them to become responsible individuals, parents and citizens. This approach has also increased young people's opportunities for productive formal and informal employment.

14. Adolescents are a heterogeneous group and are exposed to different degrees of vulnerability based on different parameters such as their age, gender, nutritional, marital and employment status, school enrolment and popular places where they hang out and spend most of their leisure time. Male adolescents are more vulnerable to disability and mortality as a result of risk taking leading to unintentional and intentional injuries from, for example, road traffic accidents, violence and suicide. Female adolescents carry the brunt of consequences of unwanted pregnancy. There are also adolescents living in difficult circumstances. These include those with disability, orphans, street children, those affected by HIV/AIDS, and those living as refugees or displaced persons.

15. Adolescents are not adequately accessing and adequately utilizing available health services due to lack of guidelines and orientations and they do not benefit from the advances made in health and medical technologies. They lack accurate information about available services, and the necessary economic and social means to empower them to make informed decisions to protect their health. The setting up of services that address adolescent reproductive health needs, and their endorsement by health

professionals, parents and communities, will increase the rate of use of those services by the young people.

16. In general, Member States of the Region have recognized the long-term benefits of investing in healthy development, including recreation and culture-promoting activities, of adolescents. Countries of the Region are at different stages of development and implementation of programmes for adolescent health and development. Approximately 50% have established ministries of youth and 60% of these have developed national policies on adolescent health. About 97% of ministries of health have focal points responsible for adolescent health, while approximately 60% of the countries have developed reproductive health and broad-based health policies for adolescents.<sup>9</sup>

17. Television, radio and other entertainment media reach a large proportion of adolescents in urban areas and have the potential to reach those in rural areas. Adolescents can also be reached through social structures such as families, peers, NGOs and the civil society, as this has been proven to be effective in situations where the reach of the media is limited. Non-formal means of communication in the form of entertainment such as drama and theatre have also been effective channels of communicating information and presenting sensitive issues to young people in general and to out-of-school youth in particular.

### Justification

18. Global concern for the health and well-being of adolescents and young people has been expressed in various fora. The United Nations General Assembly declared 1985 the International Year of the Youth. The 1990 Convention on the Rights of the Child recognizes the child as an individual in its own right entitled to life, health, protection and education. The 1994 International Conference on Population and Development advocates for the promotion of healthy sexual maturation from pre-adolescence, responsible and safe sex throughout lifetime and gender equality.

19. The 1990 Organization of African Unity Charter on the Rights and Welfare of the Child discourages customs, traditions and cultural or religious practices inconsistent with the rights, duties and obligations contained in the Charter. It draws attention to the right of every child to enjoy the best attainable state of physical, mental and spiritual health.

20. The *Reproductive Health Strategy for the African Region 1998–2007* includes reproductive health needs and problems of adolescents. Other regional strategies have specific components which address

adolescent problems. The *Regional Strategy for Mental Health* also addresses the prevention of substance abuse, especially among young people.

## THE REGIONAL STRATEGY

### Aim and objectives

21. The aim of this strategy is to identify and respond to the health needs of adolescents, as well as to promote their healthy development.

22. Its **objectives** are to support Member States to:

- (a) review, develop, implement and evaluate national policies and programmes on adolescent health and development in order to meet their needs and rights;
- (b) build the capacity of the health sector to provide basic services to meet the needs of adolescents through the active participation of young people, families, communities, religious and key partners;
- (c) mobilize the private sector and other public sector institutions to support programmes for the adolescent development, in particular, educational, vocational, cultural and life skills activities.
- (d) utilize research findings as a basis for policy and programme development, problem solving, service design and promotion of best practices;
- (e) establish national mechanisms for ensuring collaboration among key partners, young people, parents, community leaders, youth-serving organizations and others involved in programmes for adolescent health and development at different levels.

### Guiding principles

23. The success and sustainability of the implementation of the strategy will depend on the following principles:

- (a) adapting the generic strategy as a basis for developing culturally sensitive national programmes that are modulated by policy orientations;
- (b) a good understanding of the problems affecting the health and development of adolescents by health professionals, young people, parents, families and communities, and of issues and factors affecting the health and development of adolescents;
- (c) establishing and strengthening effective management information systems to monitor trends and evaluate the effectiveness of adolescent health programmes, based on carefully selected and sensitive indicators;

- (d) developing evidence-based policies and programmes;
- (e) strengthening partnerships in support of adolescent health and development in countries and at regional and global levels.

### Priority interventions

24. Member States will be encouraged to use strategic approaches to reach adolescents in different circumstances and settings. The key areas for interventions include but are not limited to:

- (a) creation, implementation and strengthening of essential conditions to **increase advocacy and awareness** about the needs and corresponding rights of adolescents, to orient national development policies and legislation and to place young people's issues in the broader context of social and economic development; the legal frameworks provided by the Convention on the Rights of the Child and the African Charter on the Rights and Welfare of the Child form the basis for the review of existing national instruments and formulation of new ones;
- (b) **the conduct by countries of a participatory situation analysis** of adolescent health needs and use of findings to formulate policies and design programmes that include promotive, preventive, curative and rehabilitative health services;
- (c) **a review of health promotion** interventions and their adaptation for adolescents, families, and communities. The interventions will be culture sensitive and based on local values that help make the environment safe, supportive and protective (reducing risks), and that stimulate young people's development;
- (d) **a re-orientation of health services** and their strengthening to be adolescent friendly so as to improve their utilization; in particular, health personnel will be oriented to enable them to recognize and deal with young people's holistic health care needs, provide accurate information, maintain confidentiality and attend to them without judgement and with understanding and respect; special approaches will be developed to provide health services for young people in difficult circumstances;
- (e) **the building of the capacity** of all categories of personnel who deal with and care for young people, including strengthening of the capacities of families and communities and of the health system; training will be conducted to fill identified gaps in competencies and skills of personnel; the capacity of communities to understand

adolescents' need for basic health services and to facilitate healthy development will be strengthened.

25. The development of the regional strategy has been enriched through **partnerships and collaboration** with Member States, United Nations agencies, international and national non-governmental organizations, professional associations, researchers, young people and youth-serving organizations. At country level, inter-agency collaboration and partnerships will be strengthened through the establishment of mechanisms that support country programmes at all levels.

26. Countries will **identify research priorities** to support programme development and implementation. Linking adolescent health with socio-economic activities will be achieved through the promotion and use of participatory action research involving young people. Research is also needed to differentiate between the information and health needs of male and female adolescents. An important area for operational research is that which links adolescents' health-seeking behaviour with psychosocial and sociocultural beliefs of young people, parents, teachers, health service providers, community and religious leaders, and others. Other areas for research will be selected in response to problems arising from implementation.

### Implementation framework

#### *At country level*

27. To achieve the objectives of the strategy within the context of its guiding principles, countries will implement interventions at different levels. Focus will be on the review of existing programmes and the assessment of needs; development of policies and legislation to protect and promote healthy development; and integration of adolescent health interventions into programmes in other sectors.

#### *Role of the health sector*

28. The health sector will:

- (a) take the leading role in advocacy and adaptation of the regional strategy to national strategies and programmes and obtain wider government and donor commitment;
- (b) ensure that the approach to adolescent health reflects the commitment and participation of other sectors, including those responsible for educa-

tion, community development, law enforcement, economic planning and technical and vocational skills development;

- (c) set norms and standards for basic package of health services, conduct training, define indicators, and monitor and evaluate the effectiveness of policies and programmes.

#### *Role of other sectors*

29. The strategy provides guidance for other sectors to advocate for and reform legislation and policies affecting education, child labour, human rights and rights relevant to the health and development of adolescents. Each sector will review its policies to support the national adolescent health strategy and policy.

#### *At regional and international levels*

30. WHO will provide technical support to Member States in policy and programme development, including advocacy and mobilization of resources. Collaboration with regional and international partners will be strengthened and coordinated to support national programmes and action plans.

## MONITORING AND EVALUATION

31. Monitoring and evaluation of country programmes, using appropriate indicators, will be built into national strategies. Evaluation results will be used to improve planning and implementation. Mechanisms for regional monitoring and periodic evaluation and reporting to the Regional Committee will be utilized.

## CONCLUSION

32. The strategy clearly recalls the importance of the problems of adolescent health and their determinants. It reflects the multisectoral and multidisciplinary nature of the issues and the solutions relating to adolescent health and development. It underscores the roles and the collective will of different levels in society (family, community and adolescents themselves) in the effort to change the situation for the better, using all feasible means and approaches. Coherent and coordinated actions are required now in order to achieve the aim of the strategy.

### **Resolution AFR/RC51/R3**

#### **Adolescent health: A Strategy for the African Region**

The Regional Committee,

Recalling the Regional Committee resolution AFR/RC45/R7 on “The health of youth and adolescents: A situation report and trends analysis”, and the concern for the health and well-being of adolescents expressed through various instruments, both globally and regionally;

Cognizant of adolescence as an important phase in human development, characterized by significant changes that typify the transition from childhood to adulthood;

Recognizing that common health problems of adolescents such as early and high-risk pregnancies, complications of abortion, sexually transmitted infections, HIV/AIDS, alcohol and drug abuse, non-communicable diseases, depression and suicides are linked to behaviour and are inter-related;

Aware of the critical roles that families, schools, communities, religious institutions, governments, nongovernmental organizations (NGOs) and work, leisure and recreational places play in contributing to the health and development of adolescents;

Conscious of the multisectoral and multidisciplinary approach to address adolescent health and development;

Appreciating the efforts of Member States and partners to improve the health and development of adolescents;

1. APPROVES the regional strategy on adolescent health as proposed in document AFR/RC51/10;
2. COMMENDS the Regional Director for promoting and supporting adolescent health and development in the Region;
3. URGES Member States:
  - (a) to accord adolescent health and development priority in their national social and economic development agenda;
  - (b) to review, develop, implement and evaluate national policies and programmes on adolescent health and development;

- (c) to reorient and build the capacity of the health sector to provide basic services to meet the special needs of adolescents, including those in difficult circumstances, through the active participation of young people, families, communities, religious leaders, local NGOs and other relevant partners;
  - (d) to build multisectoral partnership and strengthen collaboration to increase resources for adolescent health and development;
  - (e) to equip young people with the requisite skills to enable them to participate meaningfully in the development and implementation of adolescent health policies and programmes;
4. REQUESTS the Regional Director:
- (a) to continue to advocate for adolescent health programmes and to mobilize adequate resources for their implementation;
  - (b) to provide technical support to Member States for the development and implementation of national policies and programmes on adolescent health;
  - (c) to mobilize governments, agencies of the United Nations, NGOs and other stakeholders to organize youth seminars and conferences to discuss the problems and challenges of adolescents in order to improve their health and development;
  - (d) to support institutions and national experts to carry out research on the problems and needs of adolescent health;
  - (e) to report to the Regional Committee in 2003 on progress made in implementing adolescent health programmes at national and regional levels.

*Fifth meeting, 29 August 2001*

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### 3.3 Women's health: A strategy for the WHO African Region (AFR/RC53/11)

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#### EXECUTIVE SUMMARY

1. *Women's health is a state of complete physical, mental and social well-being of women throughout their lifespan and not only their reproductive health. Women's health is a result of the interaction of different factors: biological, psychological and sociocultural influences; environmental and occupational conditions; and economic development. The various stages in the life of a woman range from infancy, childhood, adolescence and adulthood to the post-reproductive years. Each stage has specific health problems that influence outcomes in subsequent years.*

2. *Women's biological vulnerability, low social status, limited access to health services, low level of literacy and lack of decision-making powers are major determinants of ill-health. Difficult geographical and financial access, poor quality of care, attitude of health care workers and long waiting hours in health facilities have limited women's utilization of services. All these factors require detailed studies in order to inform policies and promote effective planning and interventions.*

3. *The creation of an enabling environment for women at all levels is critical to the attainment by them of the highest possible level of health as reflected in the Health-for-All Policy for the 21st Century in the African Region: Agenda 2020. This consists of health system responsiveness to the needs of women, education of the girl-child, quality health care, elimination of gender discrimination and harmful traditional practices, and an appreciation of the role of women in sustaining human life.*

4. *The goal of the women's health strategy is to contribute to the attainment of the highest possible level of health for women throughout their lifespan in line with the Millennium Development targets. It addresses the health conditions that are specific to or more prevalent in women, have severe consequences and imply certain risk factors.*

5. *The proposed interventions focus on improving the responsiveness of health systems based on well researched information on the specific needs of women; developing appropriate evidence-based policies, advocacy and communication strategies; and strengthening capacity of various cadres of health providers at all levels.*

6. *The Regional Committee adopted the proposed strategy for implementation by Member States.*

#### INTRODUCTION

1. Women's health is a state of complete physical, mental and social well-being of women throughout their lifespan and not only their reproductive health.<sup>1</sup> Women's health is a result of the interaction of different factors: biological, psychological and socio-cultural influences; environmental and occupational

conditions; economic development.<sup>2</sup> The various stages in the life of a woman<sup>3</sup> range from infancy, childhood, adolescence and adulthood to the post-reproductive years. Each stage has specific health problems and subsequent health outcomes are influenced by the experience of previous stages.

2. Women's biological vulnerability to some health conditions (such as HIV/AIDS), low social status, limited access to health services, low level of literacy and lack of decision-making powers are major determinants of ill-health. In the African Region, many women are subjected to sociocultural discrimination as well as harmful traditional practices (HTPs) such as female genital mutilation<sup>4</sup> (FGM), food taboos, early and forced marriage and pregnancy. Various factors such as difficult geographical and financial access, poor quality of care, negative attitude of health care workers and long waiting hours in health facilities have limited women's utilization of services. These factors are more critical in rural population.

3. The collective effect of these factors determines the way a woman's health is perceived by her and others as well as the value placed on her well-being. The decision about when to seek health care is not always vested in the woman but rather in those who have power over her.

4. Numerous conferences, meetings and symposia have focused on aspects of women's health, and various resolutions<sup>5</sup> and guidelines for action have led to the disaggregation of data and the establishment of programmes for improving women's health worldwide. Despite global and regional calls for action, there are still information gaps on what is required to improve women's health and how to respond to the health risks and needs of poor women.

5. A few countries in the Region have improved access to quality health services for all in terms of both distribution and affordability. These countries have reduced maternal mortality rates. On average, there is a decline in total fertility rates in the majority of countries over the past ten years, as assessed in women's health profiles in selected countries.<sup>6</sup>

6. The women's health strategy addresses the health of women holistically and proposes interventions that will assist Member States to identify priorities and plan their programmes accordingly.

## **SITUATION ANALYSIS**

7. Deficiencies in early life affect women's health and reproductive performance and that of their daughters, creating intergenerational health effects. Newborn survival is intricately linked to maternal nutrition, health and care.<sup>7</sup> The common childhood diseases — diarrhoea, acute respiratory infections, measles and malnutrition — affect both female and male infants. The African girl-child suffers from a perpetual intergenerational cycle of under-nutrition, child labour, abuse, neglect and social discrimina-

tion, including FGM, all of which increase the risk of morbidity and mortality.

8. Early marriage, unwanted pregnancy and pregnancy complications coupled with sexual violence and substance abuse characterize the period of adolescence. In some countries, 25–27% of first births occur among adolescents, and this group accounts for up to 40% of total maternal deaths, a significant proportion of which results from unsafe abortions.<sup>8</sup>

9. WHO estimates that reproductive ill-health accounts for 33% of the total disease burden for women, as compared to 12.3% for men of the same age. Despite the availability of safe and affordable technologies, in developing countries, one woman in 14 dies of pregnancy and childbirth-related complications compared with one in 4000 or even one in 10000 in developed countries. This demonstrates a high level of inequity. Maternal mortality ratio in the African Region remains at an extremely high level of 1000 per 100000<sup>9</sup> live births, the world's highest. Major causes include antepartum and postpartum haemorrhage, sepsis, malaria and complications of abortion, and lack of antenatal care. While malaria occurs throughout the lifespan in both men and women, malaria in pregnancy presents an additional challenge to the woman and the baby. It results in maternal anaemia, antepartum haemorrhage, foetal anaemia and low birth weight or death.

10. For every woman who dies as a result of maternal causes, approximately 20 others will suffer short-term or long-term disabilities such as obstetric fistula, chronic depression, urinary incontinence, infertility, maternal exhaustion and chronic anaemia.<sup>10</sup> Case studies on maternal disabilities in a number of countries reveal an enormous but unaddressed problem shrouded in a "culture of silence and endurance" because of values that encourage women to give lower priority to their own health than that of other family members.<sup>11</sup>

11. Women account for the majority of the elderly population, and this trend is increasing. In Africa, the average life expectancy is 51 years for women and 48 years for men.<sup>12</sup> This fact masks a very different profile of morbidity and quality of life in women due to reproductive disabilities. Major causes of ill-health among elderly women include cervical and breast cancers, osteoporosis, post-menopausal syndrome and mental depression. Many of these problems are usually silent and unrecognized in the early stages, hence the fatality associated with them in the post-menopausal period.

12. HIV/AIDS occurs throughout the lifespan. Although it affects both women and men, women

are more vulnerable due to biological and epidemiological factors, sexual violence, low socioeconomic status and lack of negotiating powers with male partners. In sub-Saharan Africa, 55% of the 28.1 million HIV-infected adults are women; among the youth, there are four infected women for every HIV infected man.<sup>13</sup> Increasing numbers of women attending antenatal clinics are being diagnosed with HIV infection. HIV transmission rates from mother-to-child range from 25% to 40% in some countries.<sup>14</sup> In sub-Saharan Africa, there are 11 million children orphaned by HIV/AIDS. This large population of orphaned children has increased the burden of care provided by the poor and elderly women.

13. With the re-emergence of tuberculosis (TB), it has become the single leading infectious cause of death in women worldwide. It kills over one million women aged 15–44 years annually; 600 000 TB deaths occur in the African Region, mainly in women.<sup>15</sup> HIV, TB and malaria constitute a deadly triad in African women.

14. Violence against women<sup>16</sup> is recognized worldwide as a violation of women's human rights, although regional data are sparse. Globally, 16–50% of women have been victims of physical violence at some time in their lives. In some African countries, high levels of psychological abuse have been reported. Adolescent girls have become the main victims<sup>17</sup> of sexual assault and human trafficking. The health consequences of gender-based violence include post-traumatic stress disorders, substance abuse, sexually transmitted infections, HIV/AIDS, femicide, attempted suicide and suicide.

15. FGM and nutritional taboos are prevalent in many societies. In many cultural settings, FGM is viewed as a rite of passage from childhood to womanhood. The immediate and long-term consequences of FGM are numerous.<sup>18</sup> In the African Region, some form of FGM with its attendant immediate and long-term health consequences occurs in 27 of 46 Member States. The prevalence ranges from 5–98% in some countries.<sup>19</sup> While there are some good reasons for recognizing and respecting the initiation of girls into womanhood, eliminating the associated mutilation has many advantages. Some Member States that have adopted the 20-year Regional Plan of Action for the Acceleration of the Elimination of FGM in Africa are showing a reduction in prevalence of FGM.

16. In armed conflicts, 80% of the refugees or internally displaced persons are women and children<sup>20</sup> who have special health needs. Women with disabilities and in specialized institutions<sup>21</sup> live in difficult situations that require specific interventions.

These include access to reproductive health services, psychosocial support, care and rehabilitation services. A minimum package of public health services in emergency situations has been developed by WHO to address some of these problems.<sup>22</sup>

17. Over the years, fragmented approaches have been employed to address the health of women. The present women's health strategy focuses on the health conditions that are specific to women, have severe consequences and imply different risk factors for them. It also proposes interventions that will assist countries to contribute to the attainment of the millennium development goals (MDGs) related to women's health.

## THE REGIONAL STRATEGY

### Goal and objectives

18. The goal of the strategy is to contribute to the attainment of the highest possible level of health for women throughout their lifespan in line with the Millennium Development targets.

19. The specific objectives are to support Member States to:

- (a) advocate for women-sensitive health policies and programmes that respond to their needs and are in line with agreed international instruments and conventions;
- (b) accelerate the implementation of interventions aimed at improving the health of women, focusing on major causes of morbidity and mortality, in particular, maternal mortality;
- (c) improve access for all women to quality health services that are responsive to their specific needs, and ensured safe motherhood;
- (d) accelerate the elimination of all forms of violence and harmful traditional practices.

### Guiding principles

20. The success and sustainability of the implementation of the strategy will be guided by the following principles:

- (a) adopting a holistic approach to women's health, including their physical, mental, social and economic well-being throughout their lives;
- (b) promoting equity in health through women's access to quality health services, in particular, emergency obstetric care;
- (c) empowering women to participate in, benefit from and play a leadership role in health, in particular through the education of the girl-child;

- (d) advocating for the implementation of internationally agreed conventions and declarations in countries;
- (e) incorporating a gender perspective into health policies and programmes.

### **Priority interventions**

21. Interventions addressing the promotive, preventive, curative and rehabilitative aspects of women's health will be implemented.

22. Member States will be supported to formulate national women's health policies and programmes derived from the national women's health profile. The profile will enable countries to identify interventions needed to improve the health and survival of women, and reduce the disease burden in the context of existing health care delivery systems. National women's health policies should include appropriate health care financing mechanisms to enable the poorest of poor women to access the services. Countries may need to formulate or review laws to protect the health and rights of women.

23. Further support will re-orient health services to provide accessible quality care which is convenient, timely, affordable and responsive to women's specific health needs. These will include preventive sexual and reproductive health services; appropriate and timely management of cervical and breast cancers, TB and HIV/AIDS, including prevention of mother-to-child transmission of HIV; and early diagnosis and treatment of special conditions such as hypertension, diabetes and blindness that affect women's health. Management and rehabilitation of women with obstetric fistula, where this is a problem, will be addressed. Special approaches will be developed to provide responsive health care services for women in difficult circumstances.

24. Support will be provided to strengthen the capacity of health personnel to provide basic and comprehensive emergency obstetric care (EOC), psychosocial support and counselling and to adopt positive attitudes to women clients. Capacity of women and men, families and communities will also be strengthened to advance the cause of women's health, including the provision of information on appropriate care seeking for the reduction of maternal mortality and the elimination of all forms of social violence and health risks. Building the capacity of a multidisciplinary national collaborating group to conduct operations research on HTPs, gender-based violence and pre-service training of health personnel using WHO FGM training manuals will be supported.

25. Member States will be supported to strengthen mechanisms for the elimination of HTPs and all forms of violence by applying proven interventions (such as community involvement, alternative rites of passage, government commitment<sup>23</sup>) for prevention and timely case management.

26. Support will further develop and implement advocacy and communication strategies to promote the human rights approach to women's health at individual, family and community levels, in the broader context of social and economic development. Results of the national women's health profile and research findings will inform the development of appropriate advocacy and communication strategies.

27. Member States will be supported to identify and conduct priority research on issues related to women's health and apply the results to improve policy, programme planning and implementation. Areas for operational research include understanding women's health care seeking behaviour, sociocultural beliefs, psychosocial support and service providers' attitudes in women's health. Specific participatory research will be conducted in response to problems arising in the course of implementation.

### **Roles and responsibilities**

#### **Role of countries**

28. This strategy will be implemented in the context of national health policy or health sector reform, using the districts and communities as entry points, and putting emphasis on integration with relevant health-related programmes. This integration will be done with the recognition that the health of women is the foundation for sustainable human development.

29. Member States will develop or strengthen national frameworks for implementing the strategy in an integrated manner in partnership with women, men, opinion leaders, community-based organizations, NGOs, relevant government ministries, and public and private institutions. Countries will implement the Abuja Declaration so as to mobilize and allocate adequate resources for women's health.

30. The development or revision of country-specific legal frameworks to prevent gender-based violence and HTPs will contribute greatly to women's health.

31. The ministry of health will play a stewardship role in ensuring the collection and collation of disaggregated gender data as well as strengthening health systems to meet the promotive, preventive, curative and rehabilitative health needs of women.



The ministry of health will ensure the inclusion of gender perspectives in health sector reforms, poverty reduction strategy papers, quality of care and responsiveness of health systems. In addition, it will strengthen mechanisms for a national multidisciplinary and multisectoral coordination structure to monitor trends in women's health.

### **Role of WHO and partners**

32. WHO will provide technical assistance to countries for the implementation of this strategy, taking into consideration major causes of morbidity and mortality in countries, while ensuring equity and rights of women to access quality health service. Generic tools and guidelines for implementation, monitoring and evaluation will be provided for adaptation by countries.

33. Partnerships for education, capacity building and leadership roles for women will be fostered to ensure their active participation in health development. This will involve interested and relevant UN and bilateral agencies as well as international and national NGOs, private organizations, women's groups and communities.

### **MONITORING AND EVALUATION**

34. WHO will assist countries to select and apply appropriate indicators for monitoring and evaluation. These include disaggregated vital health statistics, percentage access to EOC, percentage access to cervical and breast cancer screening, contraceptive prevalence rate, female literacy rate and percentage of women in decision-making positions. Information will be collected on strategy implementation, and reports will be provided periodically to the Regional Committee. Evaluation results will be used for strengthening national programmes and action plans.

### **CONCLUSION**

35. Women deserve special attention because of the high burden of disease they endure and because of the health conditions related to their reproductive life. This calls for high-level commitment of families, communities, governments and international partners. Efforts to scale-up interventions aimed at improving women's health must be coordinated and involve all stakeholders. Strategic budgeting and effective monitoring and evaluation mechanisms will ensure implementation of proven interventions and demonstrate change.

36. The creation of an enabling environment for women at all levels is critical for the attainment of the highest possible level of health as reflected in the *Health-for-All Policy for the 21st Century in the African Region: Agenda 2020*. This enabling environment must be in the context of health sector reforms in countries. Major components are health system responsiveness to the needs of women, education of the girl-child, quality health care, elimination of gender discrimination and HTPs, and an appreciation of the role of women in sustaining human life.

37. The Regional Committee endorsed "Women's health: A strategy for the African Region" for implementation in Member States.

### **Resolution AFR/RC53/R4**

#### **Women's health: A strategy for the African Region**

The Regional Committee,

Recalling previous World Health Assembly resolutions WHA40.27, WHA42.42, WHA43.10 and WHA45.25 on women's health and development;

Bearing in mind the Regional Committee resolutions AFR/RC39/R9 on traditional practices affecting the health of women and children, AFR/RC43/R6 on women, health and development and AFR/RC47/R4 on promotion of the participation of women in health and development;

Adhering to the *Health-for-All Policy for the 21st Century in the African Region: Agenda 2020* that calls for the creation of conditions that will enable women to participate in, benefit from and play a leadership role in health development;

Mindful of the human rights instruments stated in international and regional conventions, declarations and charters;

Concerned about the extremely high level of morbidity and mortality in women, and the additional efforts that will be needed by Member States to achieve international goals for women's health, including maternal health;

Convinced of the need for sex-disaggregated data and the incorporation of a gender perspective in health programmes;

1. APPROVES the document "Women's health: A Strategy for the African Region", which focuses and emphasizes health conditions that are exclusive to or more prevalent in women as well as those that have more severe consequences and imply specific risk factors;

2. COMMENDS the Regional Director for advocating for, promoting and supporting women's health in the Region;

3. URGES Member States:

- (a) to accord greater priority to women's health in their national socioeconomic development agenda through strengthening and expanding efforts to meet international targets for improved women's health, particularly the education of the girl-child;
- (b) to make additional efforts to improve advocacy at the highest level for women sensitive health policies and programmes, resources, partnerships creation and sustained political commitment to the Abuja Declaration;
- (c) to promote access by all women to a full range of information and quality health services, focusing on the major causes of morbidity and mortality;
- (d) to accelerate the implementation of interventions aimed at eliminating all forms of violence and harmful traditional practices, based on existing international and regional strategies;
- (e) to equip health personnel, communities families and individuals, women and men, with the requisite skills to enable them develop, implement, monitor and evaluate women's health policies and programmes at all levels;

4. REQUESTS the Regional Director:

- (a) to provide technical support to Member States for the development of policies, and the implementation of agreed conventions and declarations towards the attainment of international goals on women's health;
- (b) to continue to advocate for a strategic approach to the reduction of morbidity and mortality in women, including the effective interventions in the Safe Motherhood Initiative, regional plans for the elimination of female genital mutilation and other harmful traditional practices, prevention of violence, and education of the girl-child;
- (c) to mobilize governments, UN agencies, NGOs and other stakeholders to organize symposia, conferences and workshops to refocus women's health in the national development goals;
- (d) to support public and private institutions and national experts to carry out research on identified priorities and document findings and best practices for use by Member States in full implementation of cost-effective approaches for improved women's health;
- (e) to maintain WHO commitment to incorporation of gender perspective in policies and programmes

(f) to report to the fifty-sixth session of regional Committee and every three years thereafter on the progress made in the implementation of the women's health strategy.

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## 3.4 Child survival: A strategy for the WHO African Region (AFR/RC56/13)

### EXECUTIVE SUMMARY

1. The past 20 years have witnessed improvements in child survival due to effective public health interventions and better economic and social performance worldwide. Nevertheless, about 10.6 million children die yearly, 4.6 million of these in the African Region. About one quarter of these deaths occur in the first month of life, over two thirds in the first seven days. The majority of under-five deaths are due to a small number of common, preventable and treatable conditions such as infections, malnutrition and neonatal conditions occurring singly or in combination.
2. The average decline in under-five mortality experienced globally over the years is mainly attributed to decline in rates in countries with rapid economic development. The African Region needs to increase its average annual mortality reduction rate to 8.2% per annum if Millennium Development Goal 4 is to be achieved by 2015. A number of affordable recommended interventions have been identified which could prevent 63% of current mortality.
3. The key to making progress towards attaining the goal by 2015 is reaching every newborn and child in every district with a limited set of priority interventions. New and serious commitments are necessary to prioritize and accelerate child survival efforts and allocate resources within countries.
4. Priority child survival interventions that will be implemented and scaled up include newborn care with a life-course approach and continuum of care; infant and young child feeding, including micronutrient supplementation and deworming; provision and promotion of maternal and childhood immunization and new vaccines; prevention of mother-to-child transmission of HIV; and using Integrated Management of Childhood Illness to manage common childhood illnesses and care for children exposed to or infected with HIV.
5. This document presents a strategy for optimal survival, growth and development of children 0–5 years of age and for reduction of neonatal and child mortality in the African Region in line with the Millennium Development Goals.
6. Governments will take the lead in ensuring an integrated and focused approach to programme planning and service delivery to scale up newborn and child health interventions. WHO and partners will support countries in this effort.
7. The Regional Committee reviewed the proposed WHO, UNICEF and World Bank strategy and adopted it along with the attached resolution for use by countries in the African Region.

## INTRODUCTION

1. Child survival, which refers to survival of children aged 0–5 years, is a major public health concern in most countries in Africa. The past 20 years have witnessed improvements in child survival due to effective public health interventions and better economic and social performance worldwide. Nevertheless, about 10.6 million children die yearly, 4.6 million of these in the African Region. About one quarter of these deaths occur in the first month of life, over two-thirds in the first seven days. The majority of under-five deaths are due to a small number of common, preventable and treatable conditions.

2. In 2000, the nations of the world met and agreed to the Millennium Development Goals (MDGs). One of the targets is to reduce by two-thirds between 1990 and 2015, the under-five mortality rate (MDG 4). A few countries have made progress, but overall, countries in sub-Saharan Africa are not on track to achieve MDG 4. The African Region needs to increase its average annual mortality reduction rate to 8.2% if MDG 4 is to be achieved by 2015.<sup>1</sup>

3. International treaties and conventions such as the Convention on the Rights of the Child (1990), the UN Special Session on Children (2002) and the WHO/UNICEF Global Consultation on Child and Adolescent Health and Development (2002) emphasize the inherent right to life and the urgency of reducing child mortality for future prosperity.

4. The Millennium Declaration and the MDGs provide a framework for addressing the high mortality rates in the Region. The pertinent goals call for reduction in hunger (MDG 1), reduction in under-five mortality rates (MDG 4) and improvement in maternal health (MDG 5) and combating HIV/AIDS, malaria and other diseases (MDG 6).

5. A number of affordable recommended interventions have been identified, which could prevent 63% of current mortality if implemented at very high levels of coverage.<sup>2</sup> New and increased commitments are necessary to prioritize and accelerate child survival efforts and allocate resources within countries.

6. Partnerships, resources and more effective programmes at all levels are increasingly needed to reach the MDGs. Only a focused, coordinated effort and appropriate action by the international community and Member States can bring newborns and children the health care they need in a more efficient way.

7. In Africa, the Organization of African Unity African Charter on the Rights and Welfare of the

Child (1990), the adoption of the Integrated Management of Childhood Illness strategy by the WHO Regional Committee for Africa (1999) and the African Union Declaration on Child Survival (2005) recognize the duty to accelerate action for child survival.

8. The African Union requested all Member States to mainstream child survival into their national health policies. Health and child survival have been prioritized by the New Partnership for Africa's Development. The Delhi Declaration (2005) on maternal, newborn and child health and the subsequent Fifty-eighth World Health Assembly resolution<sup>3</sup> call for the highest political commitment.

9. This document provides strategic direction for Member States of the African Region to address child survival and development, decrease the unacceptably high child mortality rates and attain Millennium Development Goal 4.

## SITUATION ANALYSIS AND JUSTIFICATION

10. The average decline in under-five mortality experienced globally over the years can be mainly attributed to the decline in rates in countries with rapid economic development.<sup>4</sup>

11. The situation of most African children remains critical and is exasperated by the serious poverty on the continent. A number of factors contribute to the slow reduction in the average annual mortality rate and the large disparities in child survival between and within developing countries. These include socioeconomic, cultural, traditional and developmental circumstances as well as natural disasters, armed conflict, exploitation and hunger. Poverty is the single most important factor accounting for low coverage of effective interventions.

12. In the African Region, infections are the main direct cause of child mortality. Although the relative importance of infections varies from country to country, on average, more than 70% of child deaths are attributed to just a few mainly preventable causes, namely, acute respiratory infections, diarrhoea, malaria, measles, malnutrition and neonatal conditions (asphyxia, prematurity, low birth weight and infections), singly or in combination. HIV/AIDS may account for up to 57% of under-five deaths in countries with the highest HIV prevalence.

13. The HIV pandemic has contributed to increased poverty, the erosion of the family and community support needed for child survival, and the human

resource crisis in the health and other sectors. Although it is known that HIV treatment for children can reduce mortality and improve quality of life, very few countries have comprehensive approaches to paediatric HIV care and support.

14. Indirect determinants of health may vary between countries; however, malnutrition is a critical risk factor in most countries, and food and nutrition security remain fundamental challenges to child survival.<sup>5</sup> Lack of water and sanitation, poor living conditions, and inadequate child spacing are associated with high mortality. In Africa, water, sanitation and hygiene are seldom linked to national child survival strategies.

15. There are a few cost-effective interventions that could significantly reduce mortality, and these interventions vary greatly between and within countries. In some countries, progress achieved in the early 1980s and 1990s has not been sustained, and coverage rates have actually regressed. For example, use of insecticide-treated nets can reduce child deaths from malaria by about 17%,<sup>6</sup> but coverage remains low at about 15%<sup>7</sup> in Africa. Interventions such as oral rehydration therapy and treatment of acute respiratory infections seem to have lost their momentum. Newer interventions such as those for improving newborn health have received little attention because of misconceptions about their complexity and cost.<sup>8</sup>

16. There are multiple constraints in health systems that hamper effective scaling up of interventions. Insufficient human, financial and material resources coupled with limited managerial capability, out-of-pocket payments and inadequate mechanisms for families to access health care are just some of the factors that lead to poor service delivery and low coverage of interventions. Insufficient availability of essential drugs and supplies, and inadequate supervision of health-care providers are among the persistent problems of the health systems in many countries.

17. Financial resources for child survival programmes are far from adequate for reaching every community in every district with low-cost interventions. Globally, US\$ 52.4 billion are needed to reach universal coverage in addition to current expenditures. This corresponds to US\$ 0.47 per individual initially, increasing to US\$ 1.48 in year 10 when 95% of the child population would be covered.<sup>9</sup>

18. In 1999, the WHO Regional Committee for Africa adopted Integrated Management of Childhood Illness (IMCI) as the major strategy for child survival and the reduction of the high child mortality rate in the Region.<sup>10</sup> IMCI has been found to be an effective delivery strategy for various child sur-

vival interventions and has contributed to a 13% mortality reduction over a two-year period in districts in Tanzania where it has been implemented.<sup>11</sup>

19. For greater impact, however, it is imperative to implement the IMCI strategy by applying the life-course approach and to coordinate its implementation with strategies for other relevant intervention areas. Growth and development during pregnancy is essential to ensure a healthy neonatal period. Reducing newborn morbidity, on the other hand, is essential to healthy growth and development during childhood, adolescence and adulthood. This requires a holistic approach, which combines a comprehensive child survival strategy with strategies for eradicating extreme poverty and hunger, improving maternal health, and combating HIV/AIDS, malaria and other diseases.

## THE REGIONAL STRATEGY

### Objective

20. The objective of the strategy is to accelerate the reduction of neonatal and child mortality in line with the Millennium Development Goals by achieving high coverage of a defined set of effective interventions.

### Guiding principles

21. The strategy is founded on the following principles:

- (a) *Life-course approach*: This strategy promotes optimal growth and development of the foetus and across the 0 to 5 age group to prepare each individual for a healthy, well-adjusted, productive adult life, through coordinated implementation with other strategies aimed at achieving the MDGs and promoting health.
- (b) *Equity*: Emphasis will be on ensuring equal access to child survival interventions for all children.
- (c) *Child rights*: Rights-based planning will be incorporated in child health interventions to ensure protection of the most vulnerable.
- (d) *Integration*: All efforts will be made to implement the proposed priority interventions at various levels of the health system in a coherent and effective manner that is responsive to the needs of the child.
- (e) *Multisectoral collaboration*: Considering that health issues are development issues, achieving health outcomes requires contributions from other sectors.

- (f) *Partnerships*: Emphasis will be put on developing new partnerships and strengthening existing ones to ensure that child survival interventions are fully integrated in national and district health systems in a sustainable way.

### Strategic approaches

22. The strategic approaches are:

- (a) *Advocating for harmonization of child survival goals and agendas* in order to promote, implement, scale up and allocate resources to achieve the internationally-agreed goals and targets;
- (b) *Strengthening health systems* by building capacity at all levels of the health sector and ensuring quality service delivery to achieve high population coverage of child survival interventions in an integrated manner;
- (c) *Empowering families and communities*, especially the poor and marginalized, to improve key child-care practices and to make the treatment of malaria, pneumonia, diarrhoea and HIV/AIDS available within the community;
- (d) *Forming operational partnerships* to implement promising interventions with government in the lead, and donors, NGOs, the private sector and other stakeholders engaged in joint programming and co-funding of activities and technical reviews;
- (e) *Mobilizing resources* at international, regional and government levels for child survival to scale up proven interventions.

### Essential package of services

23. **Integrated Management of Childhood Illness** will remain an important *delivery mechanism* for most of the priority interventions listed below. In addition, strong linkages with Road Map for accelerating the attainment of MDG 5 and Making Pregnancy Safer (MPS) services will be promoted, especially for newborn care and Prevention of Mother-to-Child Transmission of HIV (PMTCT).

24. **Newborn care**. Taking into consideration the life-course approach and continuum of care, neonatal interventions that need to be scaled up will include access to skilled care during pregnancy, childbirth and the immediate postnatal period at community and facility level. Capacity building of professional and non-professional staff will include optimal newborn care practices of newborn resuscitation, early and exclusive breastfeeding, warmth, hygienic cord and skin care as well as timely and appropriate care-seeking for infections and care of low-birth-weight infants. The Making Pregnancy Safer initiative through Integrated Management of

Pregnancy and Childbirth offers opportunities for addressing early newborn health. Integrated Management of Childhood Illness will also be expanded to include newborns in the first seven days of life.

25. **Infant and Young Child Feeding, including micronutrient supplementation and deworming**. Key interventions to be emphasized are exclusive breastfeeding for the first six months of life, including colostrum, timely and appropriate complementary feeding, and adequate micronutrient intake (particularly vitamin A, iron and iodine). Regular deworming throughout childhood and during pregnancy will be promoted for its functional and developmental benefit. Special emphasis will be given to prevention and treatment of malnutrition. Integration of Infant and Young Child Feeding in other child health services, such as Baby Friendly Hospital Initiative, IMCI, PMTCT, and Growth Monitoring Promotion and Referral, provides critical entry for scaling up these interventions.

26. **Prevention of malaria using insecticide-treated nets and intermittent preventive treatment of malaria**. Use of insecticide-treated nets (ITNs) for both under-fives and pregnant mothers and incorporating intermittent preventive treatment of malaria (IPT) during pregnancy in malaria-endemic areas are priority interventions for reducing low birth weight, child morbidity and child mortality. One mechanism to ensure universal access to ITNs is to provide free or subsidized ITNs on a regular basis or through campaigns. ITNs and IPT should be integrated with the Expanded Programme on Immunization (EPI), antenatal care and IMCI activities to increase coverage rapidly.

27. **Immunization of mothers and children**. Provision of tetanus toxoid to pregnant women in antenatal clinics and childhood immunizations, including new vaccines, at community and facility levels through outreach and fixed services will be promoted. Proven ways of improving access to and coverage of services include outreach campaigns to provide services to the remote and integration of EPI with other child survival interventions such as vitamin A, deworming and ITN distribution. The implementation of this child survival strategy will be closely coordinated with the implementation of the WHO/UNICEF Global Immunization Vision and Strategy.

28. **Prevention of Mother-to-Child Transmission of HIV**. The key to ensuring an HIV-free start in life is the prevention of HIV transmission to children by preventing HIV infection in mothers. Other interventions are family planning, antiretroviral therapy, counselling in infant feeding and

support for HIV-infected women and their infants in countries with high HIV prevalence. Integration of PMTCT interventions in antenatal care, nutrition programmes, IMCI and other HIV/AIDS services enhances opportunities for reducing paediatric HIV and the associated deaths.

**29. Management of common childhood illnesses and care of children exposed to or infected with HIV.** Interventions include oral rehydration therapy and zinc supplementation for the management of diarrhoea; effective and appropriate antibiotic treatment for pneumonia, dysentery and neonatal infections; and prompt and effective treatment of malaria at health facility and community levels. Care of HIV-exposed and HIV-infected children is the key to improved quality of life. Integrated Management of Childhood Illness provides an approach for addressing these common illnesses in an integrated manner.

### Implementation Framework

30. To achieve universal coverage with these interventions, this strategy proposes that countries base their health system and long-term plans on a suitable mix of delivery channels based on the following service delivery modes:

- (a) **Family-oriented, community-based services** that can be delivered on a daily basis by trained community health or nutrition promoters with periodic supervision from more skilled health staff;
- (b) **Population-oriented scheduled services** that require health staff with basic skills (e.g. auxiliary nurses, midwives and other para-medical staff) and can be delivered either by outreach or in health facilities in a scheduled way;
- (c) **Individually-oriented clinical services** that require health workers with advanced skills (such as registered nurses, midwives or physicians) available on a permanent basis.

31. Not all countries can currently ensure full coverage of the whole range of interventions. Obstacles to comprehensive implementation of the continuum-of-care concept across service delivery modes will need to be addressed in the medium and long term. To facilitate long-term planning, the strategy identifies a phased approach that allows each country to define and implement an essential package of service interventions that, over time and with increasing coverage, can then be expanded to arrive at an optimal (or maximum) package of interventions. The essential packages include:

- (a) A **minimum package** of high-impact, low-cost interventions that need to be implemented at scale

immediately. The minimum package may include ITNs for pregnant women and infants; antenatal care; promotion of early, exclusive and prolonged breastfeeding; neonatal care; routine immunization of mothers and children; vitamin A supplementation; deworming; complementary infant feeding; oral rehydration therapy and zinc supplementation for diarrhoea; malaria treatment, including artemisinin-based combined therapy; management of pneumonia in newborns and children; antiretroviral drugs for the management of paediatric AIDS; and birth spacing;

- (b) An **expanded package** equivalent to the minimum package plus additional evidence-based interventions such as expanded neonatal care, *Haemophilus influenzae* type B vaccine, and emergency obstetric care;
- (c) A **maximum package** equivalent to the expanded package plus new planned interventions such as rotavirus and pneumococcal vaccine, and intermittent preventive treatment of malaria in young children.

32. The total resources required to implement the strategy for each of the proposed packages through the various delivery modes is indicated in a separate document to be finalized.

### Roles and responsibilities

#### Countries

33. Governments will take the lead in ensuring an integrated and focused approach to programme planning and service delivery to scale up newborn and child health interventions. They will ensure certain priority interventions for universal access and high coverage among under-five children, including newborns. Specific roles of countries will be:

- (a) **Policy development:** To put in place the necessary policies that allow effective scaling up of interventions;
- (b) **Capacity building:** To strengthen national capacity to effectively plan, implement and monitor activities, including implementation of policies that address child survival and related health system constraints;
- (c) **Communication and social mobilization:** To ensure relevance and consistency of messages for priority child survival interventions, countries will develop a national communication strategy to support integrated health promotion activities with a focus on empowering families, households and communities, ensuring clear links with effective delivery of essential services by different sectors, institutions and players;



- (d) *Advocacy and partnership development*: To advocate and develop partnerships within the framework of the Maternal, Newborn and Child Health Partnership by ensuring consensus building, harmonization of interventions and resource mobilization from within and outside the country; this includes child survival interventions in the various global and national development initiatives such as Poverty Reduction Strategy Papers, sector-wide approaches and the Global Fund to Fight AIDS, Tuberculosis and Malaria as well as close collaboration with partners in the health sector and linkages with other programmes such as malaria control, HIV/AIDS, Maternal and Neonatal Health, EPI, Integrated Disease Surveillance and Response, and Health System Development;
- (e) *Operational research*: To conduct operational research in priority areas in order to improve policy, planning, implementation and scaling-up of cost-effective child survival interventions;
- (f) *Documentation*: To assess, document and share their experiences and programme efforts to achieve set goals and apply the lessons during the expansion phase and for advocacy purposes;
- (g) *Development of a framework for monitoring and evaluation*: To develop a framework for monitoring and evaluation that includes gathering baseline data, tracking progress, documenting and sharing experiences with countries and regions.

#### **WHO, UNICEF, World Bank and other partners**

34. WHO, UNICEF, World Bank and other partners will:

- (a) advocate for the priority interventions and mobilization of resources;
- (b) provide technical support to countries to scale up child survival interventions by strengthening country and intercountry capacity, monitoring and evaluation mechanisms, and health management information;
- (c) support countries to identify, document and disseminate best practices in implementing these interventions;
- (d) support countries to develop capacity for operational research;
- (e) facilitate coordination and collaboration.

#### **MONITORING AND EVALUATION**

35. A minimum set of process and impact indicators to track progress will be agreed upon with partners and stakeholders.

36. The monitoring process will conform to child rights principles. Information and results will be stratified by various groups so that comparisons can be made about the impact of different policy and programme measures. Evaluation will be conducted every two years.

#### **CONCLUSION**

37. Children represent the future of Africa. Hence, investing in children's health is imperative in ensuring healthier and more productive future generations who will guide the socioeconomic development of the continent.

38. This strategy reflects a life-course and comprehensive approach to child health issues and health-care service delivery. It underscores the need for implementing cost-effective maternal newborn and child health interventions for reducing newborn deaths by three fourths and child deaths by two thirds in the largest population possible.

39. The key to making progress towards attaining Millennium Development Goal 4 by 2015 is reaching every newborn and child in every district with a few priority interventions. The interventions described above are not new; however, this strategy calls for a strong commitment to prioritize interventions, allocate resources and accelerate a few known cost-effective child survival interventions for implementation at high levels of population coverage.

40. The Regional Committee reviewed the Regional Child Survival Strategy proposed by WHO, UNICEF and the World Bank, and adopted it along with the attached resolution for use by countries.

#### **Resolution AFR/RC56/R2**

#### **Child survival: A strategy for the African Region**

The Regional Committee,

Alarmed that of the 10.6 million children who die every year globally, 4.6 million are from the African Region, and that the majority of these under-five deaths are due to a small number of common, preventable and treatable conditions;

Taking due account of the fact that Millennium Development Goal number 4 aims to reduce under-five mortality by two-thirds by 2015 compared to 1990 levels;

Recognizing that international treaties and conventions, including the 1990 Convention on the

Rights of the Child, the United Nations Special Session on Children (2002) and the WHO/UNICEF Global Consultation on Child and Adolescent Health and Development (2002), emphasize the inherent right to quality life and the urgency to reduce child mortality;

Considering that children represent the future of Africa and that investing in their health is imperative to ensure a healthier and more productive generation for the socioeconomic development and prosperity of the Region;

Mindful of the fact that the OAU African Charter on the Rights and Welfare of the Child (1990), the strategy for Integrated Management of Childhood Illness (IMCI) adopted by the WHO Regional Committee for Africa in 1999, and the Tripoli Declaration on Child Survival adopted by the African Union Assembly in 2005, recognize the urgent need to accelerate action for child survival;

Having carefully examined the document entitled "Child survival: a strategy for the African Region", jointly developed by WHO, UNICEF and the World Bank, proposing a strategy on child survival for the African Region;

1. APPROVES the proposed strategy for child survival in the African Region;
2. URGES Member States:
  - (a) to put in place the policies needed for effective implementation of the child survival strategy;
  - (b) to strengthen national capacity to effectively plan, implement and monitor activities, including implementing policies that address the issue of child survival in the context of health-care delivery systems;
  - (c) to ensure the relevance and consistency of messages for priority child survival preventive interventions and develop national communication strategies to support integrated health promotion activities with a focus on empowering individuals, families and communities;
  - (d) to ensure consensus-building, harmonization of interventions and resource mobilization from within and outside the country, within the framework of maternal, newborn and child health partnerships;
  - (e) to conduct operational research in priority areas in order to improve policy, planning, implementation and scaling up of cost-effective child survival interventions;
  - (f) to assess, document and share experiences and programmatic efforts to achieve set goals so as to

- apply the lessons learnt during the expansion phase and for advocacy purposes;
  - (g) to develop a monitoring and evaluation framework, including gathering baseline data and tracking progress, documenting the data and sharing them among countries and regions;
3. REQUESTS the Regional Director:
    - (a) to stimulate partnerships and work with UNICEF, the World Bank and other relevant partners to support the implementation of this strategy;
    - (b) to advocate for the scaling up of priority interventions and mobilization of resources;
    - (c) to provide technical support to countries to scale up child survival interventions by strengthening country and intercountry capacities, monitoring and evaluation mechanisms, and health management information;
    - (d) to support countries to identify, document and widely disseminate best practices in implementing these interventions;
    - (d) to support countries to develop capacity for operational research;
    - (f) to facilitate coordination and collaboration with the African Union and regional economic communities;
    - (g) to report every other year on progress in the implementation of the child survival strategy for the African Region.

Fourth meeting, 29 August 2006

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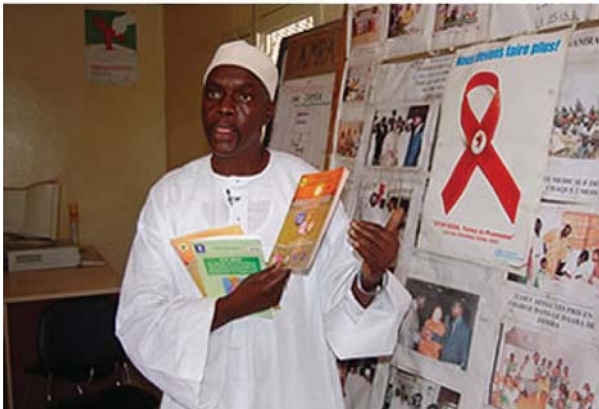
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## Strategic Direction 4

*Accelerated actions on HIV/AIDS, malaria and tuberculosis*





# 4.1 HIV prevention in the WHO African Region: A strategy for renewal and acceleration (AFR/RC56/8)

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## EXECUTIVE SUMMARY

1. Nearly two-thirds of the world's HIV-positive population live in sub-Saharan Africa. In 2005 alone, out of the 4.9 million new infections, 3.2 million occurred in the African Region, the majority of those affected aged between 15 and 49 years.
2. Countries in the African Region have made encouraging progress in implementing various elements of prevention and treatment interventions to control the HIV/AIDS epidemic. The main challenges include limited effective coverage of services in order to have the required impact, weak linkage between prevention and treatment interventions, weak health systems, lack of favourable policy environment for HIV prevention and inadequate resources at all levels.
3. Recognizing the alarming trend in HIV incidence in the Region and the need to increase measures to control further progress of the epidemic, the WHO Regional Committee for Africa, at its fifty-fifth session in August 2005, adopted Resolution AFR/RC55/R6, "Acceleration of HIV prevention efforts in the African Region". By that resolution, the Regional Committee declared 2006 the "Year for Acceleration of HIV Prevention in the African Region" and urged Member States to re-emphasize and re-invigorate HIV prevention efforts.
4. The main objective of this strategy is to contribute to the acceleration of HIV prevention and to the reduction of the impact of HIV/AIDS in the context of universal access to prevention, treatment, care and support. The strategic approaches proposed focus on scaling up access to prevention interventions and integrating prevention with treatment, care and support.
5. The Regional Committee reviewed and adopted this proposed strategy along with its resolution.

## INTRODUCTION

1. The regional HIV strategy adopted in 1996 during the forty-sixth session of the WHO Regional Committee for Africa reaffirmed the major role of the health sector in national response to the HIV/AIDS epidemic with a clear prevention component.<sup>1</sup> In spite of the resources and efforts invested, the epidemic has continued unabated, with high morbidity and mortality, undermining health gains and the improvement of health status in the Region.
2. HIV prevention efforts have been outpaced by the HIV/AIDS epidemic, with a rising trend of HIV incidence in most countries. Should the current trends continue, most countries in the African

Region are unlikely to achieve Millennium Development Goal No 6.<sup>2</sup> It is, therefore, imperative to reshape strategies of prevention, identify measures to quickly scale up successful interventions and highlight what should be done differently.

3. Recognizing the alarming trend in HIV incidence in the Region and the need to increase measures to control further spread of HIV, the WHO Regional Committee for Africa at its fifty-fifth session, held in Maputo in August 2005, adopted Resolution AFR/RC55/R6, "Acceleration of HIV prevention efforts in the African Region". By that resolution, the Regional Committee declared 2006 the "Year for Acceleration of HIV Prevention in

the African Region” and urged Member States to urgently re-emphasize and re-invigorate HIV prevention efforts, establish stronger partnerships and coordination mechanisms, and ensure effective leadership and coordination.

4. Current global initiatives and commitments provide an enabling environment to scale up prevention efforts in the Region, while ensuring linkages to treatment, care and support interventions. In June 2005, UNAIDS approved a policy position paper, “Intensifying HIV prevention”.<sup>3</sup> Similarly, the Gleneagles G8 Summit of July 2005 made a commitment to provide support to countries for achieving universal access to prevention, care and treatment for all those who need it by 2010.<sup>4</sup>

5. Recognizing that there were insufficient resources to protect and save children, UNICEF, with its partners, launched a global campaign under the theme: “Unite for children, unite against AIDS”. The campaign seeks to place children infected and affected by HIV/AIDS at the centre of the global response through focused efforts to scale up prevention and care interventions.<sup>5</sup>

6. In March 2006, representatives of 53 African countries adopted the “Brazzaville Commitment” calling on countries to take urgent and bold actions to address the bottlenecks that impede progress in the implementation of prevention, treatment, care and support services.

7. This document proposes key interventions and actions for accelerating HIV prevention interventions in the health sector and highlights the linkages to treatment, care and support interventions within the context of universal access. However, effective implementation of this strategy requires multi-sectoral involvement and coordination.

## SITUATION ANALYSIS

8. At the end of 2005, of the estimated 40 million people living with HIV/AIDS, 25.8 million were in sub-Saharan Africa.<sup>6</sup> According to the WHO-UNAIDS report of December 2005, of the 4.9 million new infections, worldwide, 3.2 million (65%) occurred in sub-Saharan Africa, with an overall prevalence of 7.2% (6.6%–8.0%). During the same year, an estimated 2.4 million adults and children died, and more than 12 million children were orphaned due to AIDS. Now the leading cause of death for both children and adults, AIDS has reduced average life expectancy from 62 years to 47 years<sup>7</sup> in the African Region.

9. Prevention, like treatment, remains concentrated in urban areas. Vulnerable groups are inadequately targeted, fuelling the epidemic. Prevention would be more effective if closely coordinated with treatment, care and support interventions. It has been shown that HIV prevention is cost-effective and that implementation of a comprehensive HIV prevention package (linked to treatment) could avert 29 million (63%) of the 45 million new infections expected to occur in the Region by 2010.<sup>8</sup>

10. In 2003, the proportion of adults receiving voluntary counselling and testing was 7%, while the proportion of pregnant women covered by prevention of mother-to-child transmission (PMTCT) services was 5% in sub-Saharan Africa.<sup>9</sup> Coverage of voluntary counselling and testing (VCT) and prevention of mother-to-child transmission services in the Region remains among the lowest in the world, estimated at 7% and 5%, respectively.<sup>10</sup> In 2004, condom use with non-cohabiting partners was reported as 19% in sub-Saharan Africa.<sup>11</sup> Of the estimated 4.7 million adults and children in need of antiretroviral drugs in the Region, only 17% received treatment by the end of 2005.<sup>12</sup>

11. Efforts to accelerate HIV prevention interventions and move towards the goal of Universal Access will face a number of challenges:

- (a) *Lack of favourable policy environment.* Prevention and care that improve utilization of services and address underlying factors of HIV transmission require an enabling policy environment.
- (b) *Low coverage of HIV prevention interventions.* In order to ensure comprehensive coverage at all levels of the health system, HIV prevention intervention will need to be expanded and integrated.
- (c) *Weak linkages.* HIV prevention, treatment, care and support interventions should be linked in the context of an “essential package”.
- (d) *Limited access for target populations.* Participation of the private sector, civil society groups, PLWHA and all target groups would be ensured by a national public health response to HIV/AIDS.
- (e) *Weak health systems.* In order to meet the increased demand for HIV/AIDS prevention, treatment, care and support services, health systems need to be strengthened.
- (f) *Inadequate financial resources.* There is a need to mobilize and ensure additional and sustainable financial resources that reach operational levels, while ensuring effective coordination and accountability of resources.

12. However, several opportunities exist to scale up comprehensive HIV services with a focus on prevention. They include:

- (a) increased commitment at global, regional and country levels for scaling up response to HIV;
- (b) existence of the “Three Ones” principle<sup>13</sup> with improved management, coordination, partnerships, monitoring and evaluation;
- (c) lessons learned from The “3 by 5” Initiative and sharing of experiences and best practices;
- (d) progress in operational and clinical research to inform programmes and generate new preventive and therapeutic alternatives.

### Objectives

13. The main objective is to contribute to the acceleration of HIV prevention and to the reduction of the impact of HIV/AIDS in the context of universal access to prevention, treatment, care and support.

### Targets

14. By the end of 2010:

- (a) all districts will provide counselling and testing services;
- (b) 100% safe blood and blood products will be ensured;
- (c) at least 80% of pregnant women attending antenatal care will access PMTCT services;
- (d) at least 80% of patients with sexually transmitted infections will access comprehensive STI management;
- (e) at least 80% of people living with HIV and AIDS will have access to comprehensive prevention, treatment and care services;
- (f) condom use will reach at least 60% in high-risk sexual encounters.

### Guiding principles

15. The following guiding principles will underpin the acceleration of HIV prevention in the African Region:

- (a) **Human rights approach.** Equitable access to quality services based on a human rights approach will ensure adequate attention to vulnerable populations, including women, children, particularly those affected by conflicts, the poor, and populations in underserved areas. Issues of sexual violence and deliberate transmission of HIV need to be given due attention.
- (b) **Adaptation of proven interventions.** Priority should be given to identification, adaptation and

scaling up of culturally- and socially-acceptable HIV preventions.

- (c) **Linkages.** HIV prevention and HIV care, treatment and support interventions should be implemented simultaneously. Every situation in which an individual seeks health care should be an opportunity for HIV prevention.
- (d) **Community participation.** Communities and civil societies should be promoted and supported as key components in scaling up intervention at all levels. Participation should be from all communities, including PLWHA.
- (e) **“Three Ones” principle.** Governments should take the lead and, with participation of all stakeholders, update or develop an overall strategic framework for national response, national HIV/AIDS coordination, and national monitoring and evaluation.
- (f) **Sustainability and accountability.** There is a need to advocate for additional resources, ensure proper disbursement and utilization of resources, and develop a system to monitor appropriate use of funds.

### Strategic approaches

16. Accelerating the implementation of HIV prevention services will require decentralized implementation of the strategic approaches set forth below.

### Creating an enabling policy environment

17. Specific policies and legislation that promote a human rights-based approach should be developed. Where these exist, they should be revised to ensure that approaches for the prevention of discrimination and for increasing access to services are incorporated. Specific issues that need to be addressed include stigmatization of people living with HIV; discrimination against them in employment, marriage, founding a family, access to health care and medicines; youth testing and counselling; sexual violence and deliberate transmission of HIV. Policies should take into account age and gender issues (including rape) and exposure of under-age persons to alcohol and drug consumption and other risky behaviours.

18. All channels of communication should be drawn upon to ensure that the general public and specific target groups are adequately informed about existing policies and legislation related to HIV/AIDS. Emphasis should be put on channels that facilitate interactive discussions with communities, families and individuals.



### **Expanding and intensifying effective HIV prevention interventions**

19. Prevention efforts and interventions that work best in the Region should be identified and tailored to specific cultural and social circumstances prevailing locally.

20. Behaviour change communication interventions should be strengthened using all opportunities of contact with various groups. These services should be youth-friendly and should also target commercial sex workers. Operational research should also be strengthened to guide behaviour change communication programmes, particularly among the most vulnerable populations.

21. It is necessary to strengthen management of sexually transmitted infections (STIs) by building the capacity of health-care workers to provide quality syndromic management, ensure availability of drugs, improve tracing and treatment of partners, promote correct and consistent use of condoms, and strengthen STI surveillance systems.

22. Routine testing at tuberculosis (TB) clinics, STI units, and other inpatient and outpatient departments can help to scale up HIV testing and counselling services. VCT services can be expanded to reach peripheral and remote health centres where there is also the possibility of using mobile and satellite units. The use of simple techniques such as rapid testing and working with lay providers for counselling and testing services has also proved successful.

23. Implementing innovative strategies and using all points of contact with pregnant women can expand coverage and uptake of PMTCT interventions. These include universal testing and counselling for pregnant mothers with an “opt out” option, rapid HIV testing during labour, routine offer of family planning services to women who have been through antenatal care and postnatal services and who want to avoid future pregnancies, and routine rapid HIV testing for newborns of untested high-risk mothers. Infant feeding policies and support mechanisms should be put in place to assist mothers in reducing the risk of HIV transmission through breastfeeding.

24. Development and implementation of appropriate national blood transfusion policies and expansion of services to the peripheral levels can strengthen blood and blood products safety programmes.

25. Infection prevention and control measures can be strengthened by ensuring development and implementation of policy guidelines and workplans on injection safety, post-exposure prophylaxis (to include services for the sexually-abused and health-

care providers), health care waste management, timely availability of safety equipment and supplies, and treatment.

26. Use of condoms, including female condoms, by both men and women should be promoted throughout the society. There should be a special focus on STI clients, TB patients, commercial sex workers and their clients, PLWHA and their partners.

### **Linking HIV/AIDS prevention, treatment, care and support in an “essential package”**

27. A Technical Working Group should be set up to define the “essential package” and develop operational mechanisms for all levels. The Technical Working Group should include as many stakeholders as possible and adopt a participatory approach to achieving national consensus on the essential package.

28. In order to effectively contribute to the implementation of interventions, the essential package for HIV/AIDS prevention, treatment, care and support should be defined as encompassing public health, education, legal and social service issues. The approach should be decentralized and integrated with emphasis on delegation of authority, collaborative activities between programmes, task shifts and capacity building at the district and community levels.

29. Existing technical policies and guidelines for the delivery of prevention, treatment, care and support policies will have to be revised to embrace the essential package. The revised technical policies and guidelines should reflect new approaches for increasing access to services, including task shifts.

### **Increasing access by scaling up implementation and adopting a national simplified public health approach**

30. It will be necessary to develop or update national plans for HIV/AIDS prevention, treatment and care with a view to universal access. The development of the plan should be based on consensus among all key stakeholders. The plan should quantify resource gaps; build on existing programmes, resources and capacities; and define the role of various stakeholders.

31. Simplified and evidence-based methods should be adopted for the implementation of interventions. This ensures that first-line health workers are able to use these approaches with Integrated Management of Childhood Illness (IMCI), Integrated Management of Adolescent and Adult Illness (IMAI), TB, malaria and PMTCT activities. For their part,

health-care workers should integrate such interventions with the interim WHO clinical staging of HIV/AIDS and HIV/AIDS case definition for surveillance,<sup>14</sup> HIV testing and counselling guidelines, simple and standardized antiretroviral therapy regimens and enrolment guidelines, monitoring of patients who are on treatment, prevention in HIV-positive and discordant couples, and syndromic management of STIs.

32. There is need to strengthen community participation as part of scaling up HIV interventions. Every effort must be made to encourage communities to talk about HIV/AIDS, its effect on their lives, and actions to be taken to deal with the epidemic. They should also be engaged in activities aimed at positive behaviour change, improving knowledge about treatment, and creating awareness regarding testing and counselling. Associations of PLWHA must be supported to play a leading role in facilitating community participation in prevention, treatment adherence and reduction of HIV-related stigma.

### **Strengthening health systems to meet increasing demand**

33. The leadership role of the Ministry of Health (MOH) should be strengthened to include coordination, regulation, implementation, monitoring and evaluation of activities. In accordance with the “Three Ones” principle, appropriate mechanisms for coordination of the activities of relevant MOH departments and other stakeholders need to be defined, including the specific and complementary roles of the MOH, national AIDS councils or commissions, other sectors of government, and the private and corporate sectors.

34. Revitalization of district structures and capacities is necessary because HIV prevention and care programmes are mainly implemented at district level. District health teams need to be strengthened in terms of staffing and skills to effectively plan, implement and monitor interventions. Linkages with community-based organizations and civil society groups should be established at district level.

35. It is imperative that knowledge and skills for key interventions are integrated into pre-service and in-service training curricula. Innovative ways for expanding training as well as retaining and motivating staff, especially at peripheral levels, need to be explored.

36. To ensure availability of quality diagnostics, medicines and commodities, countries will need to improve their procurement and supply management

systems, including estimation and projection of requirements, use of information on best prices and suppliers. Quality control systems for generic and proprietary diagnostics and medicines should be strengthened.

37. The laboratory plays a critical role in HIV/AIDS prevention and control. Countries should ensure that the needs for strengthening and decentralizing laboratory services are adequately addressed in the comprehensive implementation plan.

38. Strategic information collection and management are important to guide the implementation of scaling up HIV prevention, treatment, care and support programmes. Countries must develop systems for tracking progress of the epidemic, implementation and outcomes of interventions, and HIV drug resistance.

### **Increasing and sustaining financial resources**

39. Countries should continue to strive to achieve the Abuja Declaration target of allocating 15% of their budgets to the health sector. Additional resources need to be mobilized from donors and development partners for overall health system strengthening, including human resources for health and improvement of infrastructure. Innovative methods of mobilizing funds from the private, corporate sector and communities should be pursued. HIV/AIDS interventions should be integrated with the national agendas for development and poverty alleviation. Resource mobilization should consider appropriate utilization and reallocation of existing resources, while strengthening the country’s capacity to absorb additional resources.

40. Member States should increase their efforts to put in place sustainable pro-poor financing mechanisms for the provision of services.<sup>15</sup> Countries should strengthen mechanisms for reporting and tracking funds in order to ensure accountability and transparency. Particular attention should be given to mechanisms for rapid disbursement of funding to peripheral levels to improve access to services.

41. Existing partnerships should be strengthened and nurtured through the involvement of key stakeholders, including PLWHA, in programming as well as regular sharing of information on progress. The United Nations Theme Group, the International Donor Groups, Country Coordinating Mechanisms, the Technical Working Group on HIV/AIDS as well as other partnership forums should be utilized. The momentum generated by the “3 by 5” Initiative should be used to scale up HIV prevention interventions.

## Roles and responsibilities

### Countries

42. Governments should ensure stewardship and leadership as well as forge partnerships with civil society and PLWHA for developing plans and mobilizing both internal and external resources for accelerating HIV/AIDS prevention, treatment, care and support interventions. Governments should also ensure effective coordination of interventions; the health sector should provide technical guidance for the implementation of this health sector HIV prevention strategy, within the framework of intersectoral collaboration.

43. Countries should be responsible for implementing planned activities, monitoring and evaluating programmes, and coordinating all partners.

### World Health Organization and other partners

44. WHO will provide technical leadership and normative guidance for developing plans of action, implementing programmes, monitoring and evaluation.

45. WHO and other partners will provide support to countries in resource mobilization, planning (including estimation of costs) and strengthening government capacity to coordinate the activities within the framework of the “Three Ones” principle.

## MONITORING AND EVALUATION

46. Global consensus has been reached on a monitoring and evaluation framework for HIV/AIDS.<sup>16</sup> The indicators and approaches in the framework and other agreed interagency indicators will guide monitoring and evaluation of this regional strategy. Intensified efforts will be made to monitor the incidence of HIV infection in order to more effectively assess the impact of prevention interventions. Monitoring of progress in the implementation of the strategy will be carried out every two years and reported to the Regional Committee.

## CONCLUSION

47. The impact of the HIV/AIDS epidemic has seriously undermined progress made in human development in the past decades. It has contributed to high morbidity and mortality, resulting in reduction of life expectancy, with grave social and economic consequences. Despite the efforts undertaken at national, regional and international levels, HIV incidence remains very high, indicating that HIV pre-

vention efforts have not been adequate. It is imperative to renew and accelerate HIV prevention, linking it with treatment, care and support, and adopting clear and comprehensive strategies and actions as set out in this document.

48. The Regional Committee reviewed and adopted this proposed strategy along with the attached resolution.

### *Resolution AFR/RC56/R3*

#### **HIV prevention in the African Region: A strategy for renewal and acceleration**

The Regional Committee,

Considering that HIV/AIDS is a leading cause of mortality in the African Region, with a disproportionate burden on young people and women;

Alarmed that despite early signs of decline in HIV prevalence in some countries, more than 3 million new infections continue to occur annually in the African Region;

Bearing in mind the increasing political commitment and engagement by governments and the international community in the fight against HIV/AIDS in the African Region;

Encouraged by the progress made in scaling up antiretroviral treatment and convinced that treatment and care offer a good opportunity for accelerating HIV prevention;

Cognizant of the March 2006 Brazzaville Commitment on Universal Access to HIV Prevention, Treatment, Care and Support, and the May 2006 Abuja Call for Action by the Heads of State Special Summit on HIV/AIDS, Tuberculosis and Malaria;

Mindful of the progress made in implementing resolution AFR/RC55/R6: Acceleration of HIV prevention efforts in the African Region, adopted in Maputo in August 2005; the declaration of 2006 as the Year for Acceleration of HIV Prevention in the African Region under the leadership of the African Union; the mobilization of the UN family to support the acceleration of HIV prevention in the African Region; and the steps being taken by countries to accelerate HIV prevention;

1. APPROVES the document entitled “HIV prevention in the African Region: a strategy for renewal and acceleration”;
2. URGES Member States:
  - (a) to develop, adapt or revise national strategies for accelerating HIV prevention in the context of

- universal access to HIV prevention, treatment, care and support;
- (b) to develop operational plans for implementation of the strategy in the context of multisectoral collaboration, with targets for scaling up HIV prevention and based on those defined in the regional strategy;
  - (c) to ensure political leadership and coordination for implementation of the strategies and plans;
  - (d) to ensure operational research on behaviour change in order to guide behaviour change communication programmes;
  - (e) to commit long-term resources, with international support, to ensure scaling up of sustainable national HIV prevention efforts;
3. REQUESTS the Regional Director:
- (a) to provide technical support to Member States in the development and implementation of health-sector-based HIV prevention strategies;
  - (b) to advocate for more resources and help mobilize long-term international support for scaling up HIV prevention efforts;
  - (c) to monitor progress in the implementation of the strategy and report to the Regional Committee every other year.

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## 4.2 Tuberculosis and HIV/AIDS: A strategy for the control of a dual epidemic in the WHO African Region (AFR/RC57/10)

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### EXECUTIVE SUMMARY

1. *The tuberculosis epidemic in the WHO African Region has reached emergency proportions. Based on recent surveillance data, the Region accounts for 25% of the global notified tuberculosis cases but only 10% of the world population. During the past ten years, tuberculosis notification rates have more than doubled in most countries. While the increase is widespread, it is most noticeable where HIV prevalence is high. On average, 35% of tuberculosis patients in the Region are co-infected with HIV, and tuberculosis accounts for approximately 40% of deaths in people living with HIV/AIDS.*
2. *Several randomized trials have demonstrated the effectiveness of joint tuberculosis and HIV/AIDS interventions in reducing morbidity and mortality among the dually infected. Notwithstanding the recognized importance of co-infection in driving the TB epidemic as well as evidence of effective delivery of joint interventions, TB and HIV/AIDS control, programmes continue to implement control activities independent of each other. The result has been low coverage, limited access and inefficient use of scarce resources.*
3. *This strategy proposes interventions for strengthening mechanisms for collaboration; improving prevention, case-finding and treatment of TB among people living with HIV/AIDS; improving access to HIV testing and counselling among TB patients; infection control to reduce transmission; advocacy, communication and social mobilization; partnerships; resource mobilization; and research.*
4. *The Regional Committee reviewed and adopted the proposed strategy.*

### INTRODUCTION

1. Tuberculosis cases have more than trebled in many countries over the past 10 years,<sup>1</sup> especially where HIV prevalence is high. With approximately 35% of TB patients also infected with HIV, TB and HIV co-infection has become the most important factor driving the TB epidemic in the African Region.
2. Recognizing the public health importance of the two epidemics, the WHO Regional Committee for Africa passed two resolutions at its fifty-fifth session in 2005. Resolution AFR/RC55/R5 declared TB an emergency in the Region; it further called

upon Member States to implement urgent and extraordinary actions to bring the TB epidemic under control, including scaling up TB and HIV/AIDS interventions. Resolution AFR/RC55/R6 called for accelerating HIV prevention interventions in countries. Earlier, African ministers of health had committed to the goals of the “3 by 5” Initiative and universal access to antiretroviral therapy for people living with HIV/AIDS (PLWHA).

3. This strategy proposes priority interventions to promote and accelerate the implementation of joint activities against the two diseases, to reduce morbidity and mortality associated with TB and HIV

co-infection, and to improve the quality of life of people living with TB and HIV/AIDS. However, effective implementation of this strategy requires multisectoral involvement, coordination, and additional and sustainable resources.

## SITUATION ANALYSIS AND JUSTIFICATION

### Situation analysis

4. Over one million new TB cases were reported in 2005. With only 10% of the world population, the African Region accounts for at least 25% of notified TB cases every year.<sup>2</sup> Since the beginning of 2006, evidence of increasing incidence of TB cases resistant to first-line and second-line antituberculosis drugs have emerged in some countries in the Region. By the end of 2006, all Member States were implementing the recommended directly-observed treatment short-course for controlling TB.<sup>3</sup>

5. Sub-Saharan Africa carries the highest burden of HIV infections and HIV/AIDS-related mortality in the world, accounting for more than 60% of PLWHA. Approximately three quarters of women and nearly 90% of children living with HIV/AIDS are in this Region.

6. In HIV-infected persons, the virus promotes progression of active TB if there is latent or recently-acquired *Mycobacterium tuberculosis* infections. At a pathological level, TB accelerates the development of AIDS among people living with HIV and is a defining condition for AIDS. In some countries, especially in southern Africa, HIV prevalence among TB patients is as much as 70%, and TB is responsible for at least 40% of deaths of PLWHA in the Region.<sup>4</sup>

7. Coverage with key TB and HIV/AIDS interventions is still unacceptably low in the Region. In 2005, between 2% and 50% of TB cases were being tested for HIV, and less than 10% of eligible dually-infected TB patients were accessing antiretroviral treatment. Just over 50% of dually-infected HIV patients were accessing cotrimoxazole prophylactic therapy while less than 10% of PLWHA were screened for active TB. Overall, antiretroviral therapy coverage in sub-Saharan Africa is approximately 28% (24%–33%). By the end 2005, among the general population, the median percentages of men and women who had been tested for HIV and had received the results were 12% and 10%, respectively.<sup>5</sup>

8. Despite the known negative synergistic interaction between the two infections and evidence of reduced morbidity and mortality through the

provision of joint TB and HIV/AIDS interventions, programmes for the control of the two conditions have largely been implemented independent of each other. TB control programmes focus on implementing DOTS; HIV/AIDS control programmes tend to view TB only as one of the opportunistic infections, giving little attention to the special care needs of PLWHA co-infected with TB.

9. There is increased political commitment at both the regional and international levels for universal access to TB and HIV/AIDS control services, including joint TB and HIV/AIDS interventions. There is also increased funding from the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) and other partners to scale up such interventions.

### Justification

10. To date, several randomized trials have shown the effectiveness of joint interventions to reduce TB incidence and death among PLWHA. The use of cotrimoxazole and isoniazid preventive therapy and management of other opportunistic infections have reduced morbidity and mortality among PLWHA. In addition, antiretroviral therapy has reduced the incidence of tuberculosis by more than 80% in PLWHA.<sup>6</sup>

11. While the negative effect of dual TB-HIV infection is known, and the positive impact of joint interventions has been shown, TB and HIV/AIDS control programmes have largely been implemented independently. This has limited access to available effective interventions for the dually-infected and resulted in inefficient utilization of scarce resources.

12. Effective TB and HIV/AIDS control must necessarily include delivery of interventions to address the dual epidemic. TB patients must have ready access to HIV/AIDS prevention, care and support interventions; likewise, PLWHA must have access to TB prevention, care and support interventions.

13. This strategy emphasizes the importance of the dual TB and HIV/AIDS epidemic and will facilitate the scaling up of available effective interventions to improve the quality of life of the dually-infected.

## THE REGIONAL STRATEGY

### General objective

14. The aim of this strategy is to contribute to the reduction of morbidity and mortality associated with TB and HIV co-infection in the Region by ensuring universal access to TB and HIV/AIDS interventions as guided by the Stop TB strategy.

### Specific objectives

15. The specific objectives are:

- (a) to provide a framework for planning, organizing, implementing, monitoring and evaluating delivery of joint TB and HIV/AIDS interventions;
- (b) to promote the provision of TB and HIV/AIDS prevention, care and support services as an integral part of a comprehensive package of care for dually-infected persons;
- (c) to provide a platform for advocacy to control the TB and HIV dual epidemic;
- (d) to enhance intersectoral collaboration and partnerships for dual TB and HIV/AIDS control;
- (e) to promote universal access to TB and HIV services.

### Guiding principles

16. Implementation of the strategy will be guided by the following principles:

- (a) Equitable access to TB and HIV/AIDS interventions includes deliberate targeting and inclusion of all vulnerable groups.
- (b) National ownership and leadership of the strategy and implementation process should be country-owned and managed to ensure harmonization and sustainability.
- (c) Partnership and collaboration involve all sectors, including the civil society and communities at all stages of programme development and implementation to increase acceptability of interventions, expand access to services, and broker additional human and financial resources for programme implementation.

### Priority interventions

17. The key interventions are aimed at strengthening collaboration between the two control programmes; improving prevention, case-finding and treatment of TB among PLWHA and vulnerable populations such as prisoners; and improving access to HIV testing and counselling among TB patients. The proposed actions are recommended for all areas where HIV prevalence among TB patients exceeds 5%, and are to be carried out within the context of existing TB and HIV/AIDS control programmes.

### Strengthening mechanisms for collaboration

18. It is necessary to develop improved mechanisms for collaboration between TB and AIDS control programmes. This could be facilitated by setting up joint coordinating bodies at operational level as well

as developing joint TB and HIV plans of action. In order to establish the basis for collaboration, it is necessary to develop a comprehensive package of interventions as well as technical guidelines and tools to deal with co-infection. All stakeholders and care providers in the public and private sectors need to be sensitized and trained to support delivery of all collaborative interventions.

### Improving prevention, case-finding and treatment of TB among PLWHA

19. Reducing the burden of tuberculosis among PLWHA is one of the critical pillars of this strategy. This could be achieved through intensified tuberculosis case-finding among PLWHA to identify and treat those with active TB, while providing isoniazid preventive therapy and other methods for PLWHA without active TB.

### Improving access to HIV testing and counselling among TB patients

20. This strategy is for improving HIV testing and counselling among TB patients. This can be achieved by offering routine HIV testing and counselling as an entry point, with an opt-out option, for all TB patients and for continuum of HIV/AIDS care and support for dually-infected TB patients. Other services include interventions to prevent new HIV infections, reduce HIV transmission, offer prophylactic therapy for other opportunistic bacterial infections and provide antiretroviral drugs for eligible dually-infected TB patients to reduce viral load.

### Infection control to reduce transmission

21. Infection control measures must be implemented as an integral part of joint TB/HIV interventions. Special attention should be given to preventing cross transmission of multidrug resistant and extensively drug resistant TB to vulnerable PLWHA and other high-risk groups such as prisoners and refugees. This could be facilitated where possible by patient triage, physical separation (isolation and barrier nursing), environmental engineering of facilities, and improving patient compliance to TB treatment to prevent acquired drug resistance.

### Contributing to health systems strengthening

22. Health systems strengthening is a component of the Stop TB strategy. Strengthening of human resources for health, laboratory infrastructure and medicines supply and management are major

contributions of TB control programmes to health systems strengthening. The innovations in TB service delivery within general health services need to be documented and shared. The ongoing work by WHO on development of documents and tools to support active engagement of national tuberculosis programmes in health systems strengthening should be accelerated and guidance should be provided to Member States.

### **Advocacy, communication and social mobilization**

23. In order to promote popular support for implementation of the activities, there is need to create community and health care worker awareness and sensitization to the importance of TB and HIV co-infection. This could be facilitated through implementation of targeted advocacy, communication and social mobilization strategies for TB and HIV control.

### **Partnerships and resource mobilization**

24. Mobilization of additional financial and other resources is critical for meaningful scaling up of the proposed interventions. While donor funding is an option to increase the resource envelope, allocation of sufficient national resources and inclusion of TB/HIV interventions within national development plans are crucial to ensure sustainable resources. Support can be elicited by submitting grant applications to funding agencies such as the Global Fund to Fight AIDS, Tuberculosis and Malaria; the Bill and Melinda Gates Foundation; and other bilateral and multilateral donor partners.

25. It is equally important to enhance the capacity of collaborating partners to deliver joint interventions through decentralization of decision-making processes and delivery of services. This could be achieved through increased community and civil society participation as well as public-private partnerships in the delivery of identified services.

### **Research**

26. Ongoing clinical and other research for better understanding and evaluation of the impact of interventions is an important element of programme implementation. This could be done through promoting close collaboration with national research institutions and researchers to carry out operational research useful for TB and HIV/AIDS prevention and control.

## **Roles and responsibilities**

### **Countries**

27. Countries should allocate funding for priority interventions to promote universal access to TB and HIV/AIDS services. Specific roles and responsibilities for countries are: development and implementation of advocacy and social mobilization activities, and short- and medium-term action plans for controlling the dual TB and HIV epidemic; development and adaptation of tools and technical guidelines; mobilizing both internal and external resources for implementation of activities; monitoring and evaluation of programme implementation and impacts; coordination of collaborating partners; and development of national partnerships for the delivery of TB, HIV/AIDS and joint TB-HIV/AIDS activities.

### **WHO and other partners**

28. The strategy envisages the following roles and responsibilities for WHO and other partners: support of national programmes to promote effective control of TB, HIV/AIDS and dual TB-HIV infections; provision of technical support to countries to develop or adapt tools and national guidelines, programme implementation, monitoring and evaluation; and support to countries in resource mobilization and strengthening health delivery systems. WHO should identify and support centres of excellence, particularly for MDR and XDR TB, and develop a strategy for resistant TB strains.

### **Resource implications**

29. According to WHO and the International Union against Tuberculosis and Lung Disease, it costs about US\$ 5–10 to screen one case for TB, US\$ 17 to treat one uncomplicated TB case, and about US\$ 2000 to treat one case of multidrug resistant TB. UNAIDS estimates that one HIV test costs approximately US\$ 2, and antiretroviral therapy for one year costs US\$ 130–300 per patient. Thus a meaningful scaling up of interventions to control the TB-HIV/AIDS dual epidemic will require an increased level of financial resources on a sustainable basis.

30. Additional resources are required to cater for the increased numbers of people who will require testing and counselling for HIV, screening for TB and correct management of dual infections.

## **MONITORING AND EVALUATION**

31. In order to monitor and evaluate implementation of the proposed joint TB and HIV/AIDS



interventions, the following indicators will be monitored according to locality, age group and sex:

- (a) proportion of target population with defined geographical access to joint TB and HIV/AIDS services;
- (b) proportion of eligible HIV-positive TB patients accessing core HIV/AIDS services, including antiretroviral therapy;
- (c) HIV/AIDS-related mortality among TB patients, and TB-related mortality among AIDS patients;
- (d) proportion of PLWHA screened for active TB and proportion of PLWHA with active TB accessing effective TB treatment;
- (e) tracking of MDR and XDR TB.

## CONCLUSION

32. HIV co-infection is the most important risk factor for increased TB incidence in the African Region. At the same time, TB is the commonest cause of death among PLWHA. Interventions to reduce the impact of the dual epidemic exist but are currently delivered independently by separate control programmes. The result is limited access to services; missed opportunities for diagnosis, treatment and care; reduced effectiveness; and inefficient use of resources.

33. The strategy calls for joint delivery of services in order to accelerate the scaling up of interventions for TB and HIV/AIDS towards universal access and to maximize on scarce resources and health impacts.

34. The Regional Committee reviewed and adopted the proposed strategy.

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## Strategic Direction 5

*Intensifying the prevention and control of communicable and non-communicable diseases*



**UNITING AGAINST NCDs:  
THE TIME TO ACT IS NOW.**





# 5.1 Integrated disease surveillance in the WHO African Region: A regional strategy for communicable diseases (1999–2003)

(AFR/RC48/8)

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## EXECUTIVE SUMMARY

1. In September 1993, through resolution AFR/RC43/R7, the Regional Committee approved the proposed steps for strengthening epidemiological surveillance at various levels of the health system, including organization of training activities at district level. Furthermore, the Committee declared the next five years as a period for preventing and combatting epidemics of communicable diseases in Member States, through improved epidemiological surveillance at district level.

2. Despite the increasingly important role of disease surveillance in planning, resource allocation and mobilization, and for early detection of, and response to epidemic outbreaks as well as for quantifying the impact of disease prevention and control programmes, the existing system in many Member States is not producing the required relevant information.

3. Currently, the dysfunction in disease surveillance systems in most Member States is causing failure to detect epidemic outbreaks, resulting in diseases spreading, human suffering and loss of lives. Among other things, weaknesses in data collection, analysis, and use of information for action at all levels, lack of resources and lack of awareness on the usefulness of the system are some of the reasons for the weak surveillance system.

4. Consequently, the Regional Director proposes that each Member State should strengthen its disease surveillance system, following an integrated approach, the details of which are presented in this document.

5. The Regional Committee reviewed and adopted this strategy.

## INTRODUCTION

1. Communicable diseases remain the major health problem in Africa. The commonest causes of death and illness in the Region are acute respiratory infections, diarrhoeal diseases, malaria, tuberculosis, HIV/AIDS/STIs, and vaccine preventable infections. Epidemic-prone diseases such as meningococcal meningitis, cholera, yellow fever and viral haemorrhagic diseases, especially Lassa fever and Ebola virus fever, are also dominant health threats in the continent.

2. A functional disease surveillance system is useful for priority setting, planning, resource mobilization and allocation, prediction and early detection of

epidemics and monitoring and evaluation of disease prevention and control programmes. The current disease surveillance systems are neither working effectively to measure the health impact of dominant diseases nor adequately evaluating current disease control programmes, not to mention detecting outbreaks for early intervention.

3. Because of the above, the Regional Office proposes to strengthen national disease surveillance systems using an integrated approach. This approach aims to coordinate and streamline all surveillance activities and ensure timely provision of surveillance data to all disease prevention and control programmes. As part of the strengthening process, the

Regional Office plans to develop guidelines for a comprehensive, integrated surveillance system for the community level, health facility level, the district and national levels, and at the Regional Office itself.

4. This strategy describes the need for strengthening the disease surveillance system and suggests the approach that Member States may adopt in the strengthening process for the next five years (1999–2003).

## JUSTIFICATION AND POLICY BASIS

5. The policy basis for strengthening the surveillance system of communicable diseases emanated from the following resolutions of the World Health Assembly and Regional Committee meetings:

- (i) *Resolution WHA22.47*, July 1969, requesting the Director-General to assist Member States in utilizing their existing services to perform epidemiological surveillance as effectively as possible.
- (ii) *Resolution WHA41.28*, May 1988, declaring the commitment of WHO to the global eradication of poliomyelitis by the year 2000 and urging all Member States to intensify surveillance to ensure identification, investigation and accurate and timely case reporting at national and international levels.
- (iii) *Resolution WHA48.13*, 12 May 1995, urging Member States to strengthen national and local programmes of active surveillance for infectious diseases, ensuring that efforts are directed to early detection of outbreaks and prompt identification of new, emerging, and re-emerging infectious diseases. It also requested the Director-General to draw up plans for improved national, regional and international surveillance of infectious diseases and their causative agents as well as plans for accurate laboratory diagnosis and prompt dissemination of case definition and surveillance information, and to coordinate the implementation of these plans by Member States, agencies and other groups.
- (iv) *Resolution AFR/RC38/R9*, of September 1988, urging Member States to strengthen the epidemiological surveillance of HIV/AIDS and to report regularly to the Organization on the situation.
- (v) *Resolution AFR/RC38/R34*, of September 1988, requesting the Regional Director to collaborate with Member States in evaluating the potential capabilities of Member States for sur-

veillance, prevention and control of diseases in general and of epidemics in particular and to support Member States in the formulation of simple and effective measures for the surveillance and control of communicable diseases.

- (vi) *Resolution AFR/RC38/R13*, of September 1988, calling on all affected Member countries to intensify national surveillance of dracunculiasis and report regularly to WHO, and urging the Regional Director to intensify regional surveillance of trends.
- (vii) *Resolution AFR/RC43/R7*, of September 1993, approving the proposed steps for strengthening epidemiological surveillance at various levels of the national health systems, including the organization of training activities at district level and declaring the next five years as a period for preventing and combating epidemics of communicable diseases in Member States, through improved district-level epidemiological surveillance.

## Major problems

6. A review of national surveillance systems in selected Member States helped to identify the following problems:

- (i) Vertical surveillance systems established as a component of different disease control programmes have resulted in duplication of efforts and resources, with different programmes approaching the same agency for funding for surveillance activity.
- (ii) Health workers fail to report on time the first cases of epidemic-prone diseases that fit standard case definitions. This delay in reporting the earliest suspected cases significantly retards the identification of outbreaks and impedes the effectiveness of response.
- (iii) Collection, analysis and dissemination of surveillance data at the district level have been inadequate. For the most part, surveillance data are passed without adequate analysis from the district level to the national level. Feedback has also generally been inadequate at every level.
- (iv) Little attention has been given to seeking opportunities to integrate surveillance activities and increase efficiency. As a result, each programme organizes programme-specific training courses (including courses on surveillance) for the same health personnel, especially at the district and health facility levels.
- (v) The system does not include pneumonia and diarrhoeal diseases, which are the number one

and two causes of childhood death in Africa. Surveillance of malaria is also deficient. Information collected is inadequate for diseases with highly effective intervention or large outbreak potential and whose case load is relatively low.

- (vi) Inadequate attention has been given to evaluating programmes, using surveillance data. Large quantities of resources are being put into inadequately evaluated interventions.
- (vii) Laboratory involvement in the surveillance system is inadequate. Neither national nor inter-country laboratory networks have been established to carry out important public health functions, including the confirmation of cases and outbreaks when clinical diagnoses cannot be specific.
- (viii) Supervisory support, completeness and timeliness of reporting are generally inadequate.

#### **Strengthening disease surveillance systems: An integrated approach**

7. Currently, different intervention programmes have their own disease surveillance systems and are making efforts to strengthen them in order to get regular and timely surveillance data.

8. The WHO Regional Office for Africa proposes to all Member States to adopt the integrated approach for strengthening surveillance systems. This approach envisages integration of all surveillance activities (collection, analysis, interpretation and dissemination of surveillance data) at district level. All the support for implementing the integrated disease surveillance system, including training, supervision, resources (financial and material) from all programmes and donors, will be assigned to the districts.

9. At the central level, all support for the implementation of integrated disease surveillance systems will be coordinated by the surveillance unit. Data management for routine surveillance will also be performed by the same unit, while specialized analysis could be left to the concerned intervention programmes.

10. As part of the implementation of the strategy, the Regional Office is suggesting the following to Member States for consideration:

- (i) a list of priority diseases for the integrated disease surveillance system;
- (ii) minimum data (total case and death counts) for reporting to enable the monitoring of epidemiological trends and early detection of epi-

demics as well as the monitoring and evaluation of intervention programmes;

- (iii) introduction of two sets of case definitions to facilitate case detection by health facilities and the community respectively.

#### **Development of integrated disease surveillance systems**

11. The need to strengthen the surveillance system, using the integrated approach, stems from the following common actions, which should be undertaken in a coordinated manner:

- (i) building awareness among clinicians (physicians and nurses attending patients) regarding the use of case definitions and actions, specimen collection and timeliness of reporting;
- (ii) initiating case-based surveillance for selected diseases, including neonatal tetanus, haemorrhagic fever, yellow fever, and for diseases with highly effective intervention or large outbreak potential whose case load is relatively low;
- (iii) strengthening health personnel skills and practices regarding all components of surveillance (particularly analysis and dissemination of surveillance data) at the district, intermediate and national levels through integrated in-service training and supervisory support;
- (iv) establishing or strengthening feedback loops at all levels;
- (v) building the capacity of the laboratories and strengthening their involvement in supporting the disease surveillance system;
- (vi) monitoring of surveillance activities including timeliness and completeness of reporting.

### **THE REGIONAL STRATEGY FOR INTEGRATED DISEASE SURVEILLANCE**

#### **Long-term vision**

12. Within ten years, all Member States will have established a functional integrated disease surveillance system that ensures continuous and timely provision of information to all national programmes for disease prevention and control as well as to health services at all levels. With adequate surveillance data, there will be improved prediction and control of epidemics, enhanced quality of planning, rational allocation of resources and improvement in monitoring and evaluating the feedback loop. This will result in a reduction in disability, morbidity and mortality attributable to major communicable diseases.

### Guiding principles

13. The basis for the integrated disease surveillance system is “data collection for action”, implying that only data necessary for taking action is collected and processed. This will be achieved and sustained by complying with the overall guiding principles of **usefulness, simplicity and flexibility of the system; action-specific orientation and integration.**

- (i) **Usefulness** refers to the applicability of the data to programme management (monitoring disease trends, detecting or predicting epidemics, quantifying the impact of intervention programmes, etc.). The current system ensures that only data that aid public health decision-making and action will be collected.
- (ii) **Simplicity** is the ease of putting the system into operation. The watch words of integrated disease surveillance are “keep the system as simple as possible” (case definition, types of data to be reported, reporting tools and procedures, etc.). The simpler the system the more likely the compiling of the reporting forms by clinicians and health workers and their timely transmission to the next higher level.
- (iii) **Flexibility** of the system refers to adaptability to changes in information needs and operations (revision of lists of priority diseases, case definitions, and reporting) with little additional personnel, time and financial resources. The current approach is designed to be as flexible as possible.
- (iv) **Action-specific orientation** in the context of integrated disease surveillance refers to making information available to specific intervention programmes for action.
- (v) **Integration** refers to the coordination of all surveillance activities common to all control programmes (data collection, processing and dissemination, training, supervision, monitoring and evaluation of the surveillance system, etc.). Specific follow-up action is left to the different intervention programmes.

14. Other attributes of the surveillance system include **acceptability** and **reliability** of data, **timeliness** and **completeness** of reporting, **sensitivity** and **specificity**.

- (i) **Acceptability** reflects the willingness of individuals and organizations to participate in a surveillance system. **Reliability** of data refers to the accuracy and quality of data made available through the system.

- (ii) **Completeness** of reporting means that all reporting requirements have been met, including reporting on diseases selected for surveillance from all reporting units, while timeliness refers to the receipt of data on or before the due date. Indeed, failure to make information available on time retards public health action.
- (iii) **Specificity** refers to the ability of the system to be specific in detecting those cases without obvious symptoms. It refers to the proportion of persons without visible disease conditions who are correctly identified through a case definition as having the disease.
- (iv) **Sensitivity** refers to the ability of the system to detect a disease or an outbreak, be it epidemic or other changes in disease occurrence. It refers to the proportion of persons with disease correctly identified through case definition as having the disease.

### Strategic framework

#### Strategic objectives

15. The strategic objectives of the integrated disease surveillance system are:

- (i) to design an integrated disease surveillance system that includes: (a) an index of the principal causes of disability, morbidity and mortality in Africa, (b) case-based reporting on selected diseases; and (c) the enhanced use of standard case definitions for notification.
- (ii) to integrate all surveillance activities, including transportation of specimens, training of health personnel on surveillance and provision of supervisory support to the districts and health facilities.
- (iii) to strengthen surveillance data management (collection, analysis, interpretation and dissemination) and the use of surveillance data and outcomes for decision-making and the monitoring and evaluation of intervention programmes.
- (iv) to strengthen the capacity and involvement of laboratories in surveillance activities.

#### Targets

16. The country targets for the integrated disease surveillance system are:

- (i) By the end of 1999:
  - (a) 80% of the Member States will have assessed their national surveillance system as part of the implementation of the regional strategy;

- (b) 80% of the Member States will have formed a central body to coordinate all surveillance activities;
  - (a) a surveillance unit will have developed at the WHO Regional Office level to coordinate all disease surveillance activities.
- (ii) By the end of 2003:
  - (a) all Member States will have assessed their national surveillance systems as part of the implementation of the regional strategy;
  - (b) all Member States will have formed central bodies to coordinate all surveillance activities;
  - (c) all Member States will have had functional and integrated disease surveillance systems.

### **Major thrusts**

#### **Priority diseases or syndromes for integrated disease surveillance**

17. The Regional Office has suggested 18 (eighteen) communicable diseases or syndromes for integrated disease surveillance. Member States are expected to adapt the list to suit their local epidemiological profiles, taking into consideration national, regional and international perspectives.

18. The suggested list of diseases or syndromes and their grouping includes:

##### **(i) Epidemic-prone diseases**

Cholera, Bacillary dysentery, Plague, Measles, Yellow fever, Meningococcal meningitis, Viral haemorrhagic fever

##### **(ii) Diseases targeted for eradication**

Dracunculiasis, Poliomyelitis

##### **(iii) Diseases targeted for elimination**

Neonatal tetanus, Leprosy

##### **(iv) Other diseases of public health importance**

Diarrhoea (in children under 5), Pneumonia (in children under five), HIV/AIDS, STIs, Malaria, Trypanosomiasis, Tuberculosis

#### **Involvement of laboratories in surveillance**

19. In resolution AFR/RC43/R7, Member States were urged to develop well-staffed and equipped laboratory services as a step toward the strengthening of their disease surveillance systems. The major role of a laboratory in the integrated surveillance system is to provide on time and reliably the confirmation of suspected cases. The laboratory will also essentially monitor drug resistance and changes in the strains of disease agents. This calls for a thorough assessment of the current diagnostic capacity of each

country at all levels, the supply of recommended basic laboratory equipment for specific levels and spheres of activities and the fostering of in-service training of laboratory personnel in relevant laboratory techniques. In addition, strengthening existing laboratory facilities, concentrating on simple, cost-effective techniques for rapid diagnosis and establishing a referral laboratory network by defining the appropriate laboratory activity for different levels, are the key steps in strengthening the process. It is envisaged that viable referral channels for samples and results and the safe handling of specimens during storage and transportation will be assured.

#### **Antimicrobial resistance**

20. An increase in antimicrobial resistance in the last few years has affected the treatment and control of important diseases, leading to prolonged illnesses and epidemics and increased case fatality. Therefore, data will be collected from sentinel laboratories in order to document resistance patterns relating to malaria, tuberculosis, *S. dysenteriae*, chancroid, gonorrhoea, pneumonia (*S. pneumoniae*, *H. influenzae*).

#### **Data Management**

21. Surveillance data management includes the collection, collation, analysis and interpretation of surveillance data and the dissemination of information to those who take action or prepare the report.

#### **Data collection**

22. Only basic information on selected priority diseases is collected for routine programme monitoring and evaluation at all levels. However, health facilities are expected to record all necessary information regarding individual cases, for future use. For routine surveillance, monthly recording of the total number of cases and deaths, (including "zero reporting") for all the selected diseases is recommended, using an appropriately designed reporting format. However, each Member State will determine the minimum surveillance data required for national level use. Table 1 shows sources of surveillance data by disease and periodicity of reporting.

23. For epidemic-prone diseases, there is need to maintain immediate notification upon suspicion or diagnosis followed by weekly reporting during the epidemic period. In addition, the normal functions of the other supplemental surveillance systems such as laboratory-based surveillance for antimicrobial resistance, case-based or sentinel-based surveillance for other selected diseases will continue unchanged.



**Table 1:** Sources of surveillance data by disease and periodicity of reporting

<i>Sources of surveillance data</i>	<i>Disease</i>	<i>Periodicity</i>
Routine reports	All diseases	Monthly
Epidemic reports	cholera, cerebrospinal meningitis, yellow fever, plague, malaria, viral haemorrhagic fever, measles	Immediately, then weekly
Case-based reports	neonatal tetanus, poliomyelitis, dracunculiasis	as it occurs, immediately
Sentinel site reports	malaria (drug resistance), HIV sero-prevalence	monthly/ quarterly/ annually

24. The district health office compiles all reports from health facilities and sends them to the national level. The national level compiles all reports and sends them to the WHO country Office, which will eventually send them to the Regional Office.

### Data analysis and interpretation

25. Data analysis and interpretation are critical at all levels, especially at the health facility and district levels. At the district level, a continuous and systematic collation and analysis of all data derived from the lower level should help to keep track of the disease situation in the area. Data interpretation is equally emphasized in the integrated approach and should be practised at all levels, particularly at the health facility and district levels.

### Dissemination of information

26. Distribution of information to those who are responsible for taking action (programme managers) or using the information for managing intervention programmes (programme staff) is an important, but often neglected, component. Community leaders (at community level), administrators, police, staff of other sectoral and nongovernmental agencies (at district and national levels) are important players. Feedback to those who generate the information (health care providers) and those who transmit the reports to the next higher level (intermediate health agencies) will be strengthened.

### Decisions for action

27. A decision to take action follows data analysis and interpretation. The specific action will depend on the causes of the problem, types of diseases and level of structures. Health facility and district health team personnel are expected to take immediate action without necessarily waiting for approval from the higher level. The approach is to identify possible solutions for each problem identified during data analysis and interpretation and to take necessary action as promptly as possible, at each level.

### Communication Network

28. Communication of surveillance data from the health facility level right to the national and international levels and back to the community level (in the form of feedback loops) is important. In this connection, the means of communication used to transmit the information plays a vital role. In order to ensure timely receipt of surveillance data, the fastest means of communication should be used as appropriate, including e-mail, telephone, fax and radio communication. The recommendation is that transmission of surveillance data: (a) from the health facility to the district health office (DHO) could be by telephone or radio; (b) from the DHO to the national level could be by telephone, radio, fax or e-mail; (c) from the national level to the WHO country Office could be by e-mail or diskettes; and (d) from the WHO country Office to WHO Epidemiological Block and the Regional Office could be by e-mail. Consequently, it is planned that every WHO country Office will have e-mail.

### Strategic orientations

#### Capacity building

29. Strengthening disease surveillance systems, using the integrated approach, involves:

- (i) orientating and re-orientating intensified in-service training at all levels, using appropriate training materials, and targeting in particular the district health team and attending physicians and nurses;
- (ii) establishing a focal point or organ for coordinating the integrated disease surveillance activities at all levels, particularly at the national level;
- (iii) placing systems for computerized data management at central and intermediate levels and simple data presentation tools (tables and graphs) at district level;

- (iv) establishing inter-country collaboration and networking to exchange information on diseases of interest at international level;
- (v) establishing efficient communication networks within the country for prompt reporting; and
- (vi) building the capacity of laboratories, including that of networks at national and regional levels.

### **Promotion of integrated surveillance systems**

30. Integrated surveillance systems will be promoted at all levels (community, health care providers, health authorities, including decision and policy-makers) in order to create well informed groups with an enhanced sense of responsibility, urgency and ownership regarding the activity and to ensure maximum cooperation. This could be done through sensitization meetings, training workshops on integrated disease surveillance, advocacy campaigns, using different media channels, and surveillance activity or programmatic interventions.

### **Promotion of operational research**

31. Surveillance promotes research by identifying research issues and generating hypotheses, which are picked up by researchers as research issues. The findings of these research efforts could be used to modify and fine-tune control programmes.

## **Implementation framework**

### **At country level**

32. The community, health care providers, and health care agencies (at district, provincial and national levels) are key players in integrated disease surveillance. Activities and tasks for each level are outlined below. Those Member States with provincial or regional structures could adapt the activities to those levels since the functions are essentially the same.

33. At the community level, community leaders or health workers with instructions on how to recognize certain disease conditions could be used as contact persons in the community for the purpose of detecting and reporting suspected cases to the health facility. Tasks at community level comprise:

- (i) notifying the nearest health facility of the occurrence of the cases selected for community-based surveillance;
- (ii) supporting health workers during case or outbreak investigation;
- (iii) using feedback from health workers to take action, including action for health education, and to coordinate community participation.

### **At health facility level**

34. The first opportunity for disease surveillance occurs at this level when the clinician at the health facility sees the patient. At this level, clinicians will identify priority diseases, using case definition. Tasks at health facility level comprise:

- (i) diagnosing and managing cases;
- (ii) responding promptly to any epidemic alert by community leaders;
- (iii) submitting monthly summary reports and weekly reports during outbreaks;
- (iv) collecting specimens (if needed) and sending them to the district health office (DHO);
- (v) preparing tables and graphs and displaying derived data for monitoring the trends of diseases; and
- (vi) using available data to initiate action at the local level.

### **District level**

35. At this level, continuous analysis of surveillance data from the health facility is carried out in order to recognize outbreaks or changes in disease trends. This analysis is linked to responses from the investigations; the required interventions could also be assessed using the same data sources. Tasks at district level comprise:

- (i) analysing surveillance data from the peripheral level in order to identify epidemiological links and trends, and to achieve control targets;
- (ii) providing support for specimen transportation to the laboratory network for diagnosis or confirmation of suspected cases;
- (iii) initiating investigation of suspected outbreaks;
- (iv) providing feedback to the health facility level; and
- (v) sending to the central level monthly summary reports on selected diseases and outbreaks.

### **Central level**

36. By supporting the district level, the central level plays a key role in ensuring the proper functioning of the system. Analysis of overall disease trends is carried out continuously. The central level liaises with countries and international agencies to exchange information and mobilize resources. Tasks at central level comprise:

- (i) providing overall support and coordinating national surveillance activities, including preparation of the national plan of action;
- (ii) coordinating timely transportation of specimens to the national reference laboratory, if

- such service is only available at national level, and to regional or international reference laboratories and notifying the results;
- (iii) analysing data from the district level in order to identify epidemiological links, trends and to achieve control targets;
  - (iv) providing feedback to district level, possibly the health facility and, through them, the community;
  - (v) reporting to the WHO country Office; and
  - (vi) preparing national reports on the epidemiological situation.

### **At the WHO country Office**

37. At country level, the WHO country Office will be working closely with the Ministry of Health and liaising with WHO Epidemiological Block Teams and the Regional Office. Tasks at the WHO country Office will also comprise:

- (i) providing technical support to the Member State to make initial assessment of the national disease surveillance system, train personnel involved in surveillance, and prepare the national plan of action;
- (ii) providing resource materials such as training modules, guidelines and manuals;
- (iii) mobilizing resources to enhance the strengthening process; and
- (iv) providing feedback and disseminating data, whenever necessary, in accordance with WHO's mandate to monitor the cross-border movement of infectious diseases.

### **Intercountry and regional levels**

#### **Intercountry level**

38. At the intercountry level, it is necessary to establish mechanisms for the exchange of experiences and information on diseases among neighbouring countries, especially on cross-border movements of infectious diseases. Therefore, countries in each WHO epidemiological block are encouraged to organize regular meetings for the exchange of information and for discussions on issues concerning the integrated approach. Meetings of district health teams along common borders should also be organized. WHO teams in the epidemiological blocks should take the lead to arrange such meetings. This should be in close collaboration with sub-regional agencies, the WHO country offices and ministries of health.

#### **Regional level**

39. At the regional level, the implementation of the strategy is coordinated by the Integrated Disease

Prevention and Control Division, in collaboration with intercountry epidemiologists. The Task Force for Emerging and Re-emerging Communicable Diseases can play an advisory role; a subcommittee for surveillance could also be set up. The Regional Office will support the WHO teams in the epidemiological blocks to coordinate the intercountry meetings.

### **Partnerships**

#### **Actors and areas of collaboration**

40. Collaboration and partnerships of all potential partners at all levels will be further strengthened in all Member States in order to ensure better implementation of the integrated disease surveillance strategy. The main actors and areas of collaboration are summarised in Table 2.

#### **Managerial framework**

#### **Resource mobilization**

##### *Financial and material resources*

41. Resources will be required to support training, strengthen communication and laboratory networks and put in place data processing equipment. Governments are expected to mobilize local resources to keep the system going. Governments will also have to look for additional funds from partners to cover initial costs. The Regional Office will play a major role in mobilizing resources both from within and outside the Region to ensure the implementation of the integrated disease surveillance system.

##### *Human resources*

42. The staff required to implement the strategy will be mobilized by the governments. WHO will provide technical support to the ministries of health to build national expertise for ensuring sustainable system development.

#### **Coordination**

43. Coordination mechanisms will be set up under the leadership of the ministries of health to support the implementation of the integrated disease surveillance strategy. Coordination of activities instead of structures will be the focus of the strategy.

##### *At district level*

44. District health management committees could be entrusted with the responsibility of coordinating the integrated disease surveillance system. District health managers are expected to assume leadership as

**Table 2:** Actors and areas of collaboration by level

<i>Level</i>	<i>Actor</i>	<i>Area of collaboration</i>
Community	Community leaders	Notification of suspected epidemic-prone diseases, based on case definition.
District	Other governmental sectors	Use of their communication facilities; Notifying rumours and assisting investigation.
	NGOs and private practitioners	Reporting diseases under surveillance; Logistics support /transport facilities.
Central	Other government agencies	Participating in the central coordinating body.
	NGOs and UN agencies	Participating in the central coordinating body; Mobilizing and allocating resources.
Intercountry	WHO teams in the Epid. Block: – epidemiologists; – laboratory experts; Subregional agencies	Exchange of information, intercountry coordination and provision of technical support.
Regional	Regional Office, – *IDPCD. and other technical units; – Other divisions and appropriate units; Regional bodies (OAU) WHO collaborating centres	Same as above.

\*IDPCD = Integrated Disease Prevention and Control Division

secretariats of the committees, and to coordinate the partners at the district level (including community representatives). Technical advisory committees, chaired by district health managers, could be established to provide support on technical matters.

### *At country level*

45. All potential partners (other sectoral structures such as ministries of agriculture, universities, agencies of the United Nations system, bilateral and non-governmental agencies) need to be approached to form a central level committee to support the ministries of health in the coordination and streamlining of inputs for the surveillance system. Those Member States with task forces for the control of emerging and other communicable diseases could be given the additional task of coordinating the integrated disease surveillance system. Furthermore, a technical advisory committee could be set up to advise the coordinating committee on technical matters and to ensure linkage to public health action.

## **MONITORING AND EVALUATION**

46. Monitoring the process and the outcome of the integrated disease surveillance strategy will be devel-

oped to ensure the quality of the surveillance system. This will be done through supportive supervision and regular review meetings. Relevant indicators will be developed as part of the Integrated Surveillance Guidelines.

## **CONCLUSION**

47. A strong disease surveillance system is the foundation of effective disease prevention and control programmes. Strengthening of the surveillance system through an integrated approach is, therefore, the preferred strategy for Africa.

48. The success of this strategy will depend on the willingness of health care providers to report all cases and deaths at their facilities. It will also depend on the diligence of health officials and personnel at all levels to analyse and distribute information to all those responsible for taking action and to provide feedback to the peripheral level. Without doubt, commitment both by policy makers in terms of resource allocation and by all partners in terms of technical and financial support will contribute significantly to the success of the strategy.

49. The Regional Committee reviewed and adopted this strategy.

## 5.2 Oral health in the WHO African Region: A regional strategy 1999–2008 (AFR/RC48/9)

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### EXECUTIVE SUMMARY

1. *The important contribution of oral health to general community health and well-being has been highlighted in resolutions adopted at the World Health Assembly (WHA) and Regional Committees. However, these resolutions have had limited impact.*

2. *Previous approaches to oral health in Africa have failed to recognize the epidemiological priorities of the Region or to identify reliable and appropriate strategies to address them. Efforts have consisted in the provision of unplanned, ad hoc and spasmodic curative oral health services, which in most cases are poorly distributed and only reach affluent or urban communities.*

3. *There was, therefore, a compelling need to review existing strategies and develop a comprehensive strategic framework to support countries in the Region.*

4. *This document focuses on the most severe oral problems that people have to live with, like noma, oral cancer and oral consequences of HIV/AIDS infection. It proposes a strategy for assisting Member States and partners to identify priorities and interventions at various levels of the health system, particularly at the district level.*

5. *The strategy aims at strengthening the capacity of countries to improve community oral health by effectively using proven interventions to address specific oral health needs. It represents a new approach that has the potential to fundamentally improve community oral health in the African Region.*

6. *The Regional Committee reviewed and adopted the oral health strategy for the African Region for the period 1999–2008.*

### INTRODUCTION

1. Oral health describes the well-being of the oral cavity, including the dentition and its supporting structures and tissues. It is the absence of disease and the optimal functioning of the mouth and its tissues in a manner that preserves the highest level of self-esteem.

2. Oral diseases affect all human beings irrespective of location, country, nationality, race or colour. In the African Region, there is a disproportionate amount of oral disease, which has grave and often fatal consequences. Some of these diseases seem to be growing in prevalence as a result of the massive social disruption on the continent. Although many

oral diseases are not always life-threatening, they too are important public health problems because of their high prevalence, public demand and their impact on individuals and society in terms of pain, discomfort, social and functional limitations and handicap, and the effect on the quality of life. In addition, the financial impact on the individual and community is very high.

3. Because oral health is so fundamentally influenced by many of the environmental factors that influence general health, an effective oral health policy or programme must address both generic and specific influences on oral health. Such policy or programme may include:

- support for generic programmes that are effective in reducing poverty and promoting equity in the Region;
- support for generic programmes that are effective in providing clean water, proper sanitation and durable housing for all;
- participation in health promotion and education programmes to control tobacco and alcohol use and promote correct nutritional practices, including prudent use of sugar.

4. The strategy is a tool for assisting Member States and their partners to more systematically identify priorities and plan viable programmes, particularly at the district level. It aims to strengthen the capacity of countries to improve community oral health by effectively matching proven interventions to specific oral health needs. This in turn will require countries to refocus the education and training of the personnel required to address these new demands on the oral health system.

## **JUSTIFICATION AND POLICY BASIS**

5. There is a compelling need to review existing strategies and develop a comprehensive strategic framework to support countries, considering that:

- previous approaches to oral health in Africa have failed to recognize the epidemiological priorities of the Region or to identify reliable and appropriate strategies to address them;
- only 14 out of the 46 countries (30%) of the Region have a national oral health plan. Of these, very few countries have made any progress towards implementation and none have evaluated what has been done, which strongly suggests that such plans are fundamentally flawed or too ambitious;
- efforts have consisted in providing unplanned, ad hoc and spasmodic curative oral health services. An emphasis on the production of the kind of personnel demanded by this approach has compelled a number of African countries to create institutions, where students in the oral health sciences receive training in sophisticated and inappropriate forms of oral health care, while in others little or no training at all is available;
- the oral health care available in the Region is almost entirely curative and largely directed towards combating one main problem, namely dental caries. Severe oral diseases such as noma, oral cancer, the oral manifestations of HIV infection and trauma have been largely omitted in both public and

private care systems in the Region, as they have been from the educational programmes for oral health personnel. These are diseases that increasingly have the greatest morbidity and mortality of all oral conditions in the Region.

6. The important contribution of oral health to general community health and well-being has been highlighted in resolutions adopted at the World Health Assembly (WHA) and Regional Committee (RC) meetings, namely:

- resolution WHA36.14(1983), which called on Member States to follow available health strategies when developing their national oral health strategies;
- resolution AFR/RC24/R9 (1974), which requested the WHO Regional Director for Africa to provide for the establishment of dental advisory services within the Regional Office;
- resolution AFR/RC30/R4 (1980), which called on Member States of the African Region to integrate oral health into primary health care programmes;
- resolution AFR/RC44/R13 (1994), which called on Member States to formulate a comprehensive national oral health policy and plan, based on primary health care (PHC) and to develop appropriate training programmes for oral health care workers at all levels, particularly at the district level.

7. Furthermore, the Conference of Heads of Dental Health Services in the African Region (1969) and the Regional Experts Committee on Oral Health (1978) recommended the establishment of oral health services based on the public health approach. Various international conferences on oral health and other related initiatives have also endorsed the need for a comprehensive approach to oral health.

### **Oral health priorities**

8. Dental caries and periodontal disease have historically been considered the most important oral health problems around the world. However, in African countries, these appear to be neither as common nor of the same order of severity as in the developed world. The oral health profile of Africa today is very different from that perceived previously. This profile of oral disease is not homogeneous across Africa. Thus, oral diseases known to exist in each community need to be individually assessed in terms of the basic epidemiological criteria of prevalence and severity. This is a prerequisite for the

meaningful ranking of community needs and the development of intervention programmes with which to address them.

9. There is no doubt that the African Region has to urgently address a number of very serious oral conditions, because of either their high prevalence or the severe damage or death that can arise from them.

### Severe problems

10. Cancrum oris (NOMA) and acute necrotizing ulcerative gingivitis (ANUG), with which it is known to be associated, is still common among children in Africa. The most recently available annual incidence figure for NOMA is 20 cases per 100 000. About 90% of these children die without receiving any care. With increasing poverty and given the fact that many children are malnourished or undernourished and have compromised immune systems, the prevalence of conditions such as NOMA is likely to increase. The prevalence of oral cancer is also on the increase in Africa. Annual incidence figures for oral and pharyngeal cancer are estimated at 25 cases per 100 000 in developing countries. Rapid urbanization and increasing use of tobacco and alcohol are considered to greatly increase the incidence of oral pre-cancer and cancer. The highest prevalence of infections by Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS) is found in Africa. Studies have shown that oral manifestations of HIV/AIDS are very widespread and most commonly include fungal infections such as those caused by candida, necrotizing gingivitis or oral hairy leukoplakia. National surveys and smaller studies in Africa have shown the prevalence of dental caries to be quite low, but with substantial regional variations. Most of these cases (90%) remain untreated.

### Other problems

11. Maxillo-facial trauma has increased in many countries as a result of inter-personal violence, motor vehicle accidents and war. Chronic destructive periodontal disease is known to occur in a small proportion of most populations, regardless of location or socioeconomic status. Harmful practices such as the removal of tooth germs of deciduous canines, extraction of upper and lower anterior teeth and the trimming or sharpening of upper anterior teeth still prevail. Fluorosis is very common in certain parts of Africa such as the Rift Valley area of East Africa. The presence of malnutrition is known to increase the likelihood of fluorosis in children. Edentulism, congenital malformations and benign tumours occur but little prevalence data is available.

12. The African Region also faces an acute lack of recent, reliable and comparable data and the relative absence of processes for converting data into information for planning.

### Determinants of oral health problems in Africa

13. Poverty is an important determinant of health and ill-health. The prevalence of oral diseases closely mimics prevailing levels of social deprivation. In a continent where the majority of the population are desperately poor, preventable oral diseases such as NOMA and oral cancer are rife. High levels of bottle feeding in the urban parts of the Region have been associated with high rates of baby bottle tooth decay. Increasing urbanization has also been shown to lead to observable increases in the prevalence of oral disease. Greater access to alcohol is associated with higher levels of interpersonal trauma and oral cancer.

14. The presence of widespread poverty and underdevelopment in Africa means that communities are increasingly exposed to all the major environmental determinants of oral disease.

15. By adopting a predominantly Western model of oral health care, African health systems have failed to address these important determinants of oral health. Oral health systems in Africa are characterized by the predominance of dentists, most of whom are in private practice in urban settings. Where public or private oral health services do function, they are treatment-oriented, mainly providing for the relief of pain and sepsis and, occasionally, other curative forms of care.

### Development needs

16. It is clear from the above analysis of oral health in the African context that a successful approach to oral health in the Region needs to take account of these circumstances to effectively focus on the real determinants of oral disease.

17. The needs to be addressed, using this strategy, include equitable and universal access to affordable and appropriate quality oral health services through:

- community involvement in identifying oral health problems, needs and interventions;
- proper planning, administration and evaluation of services;
- prevention-oriented services and multi-sectoral action, especially in relation to participatory health education and promotion;

- proper balance between personnel types and population needs.
- begun to carry out essential research on oral health priority problems and needs.

## **THE REGIONAL STRATEGY**

### **Long-term vision**

18. Within the next 25 years, all people of the Region should enjoy improved levels of oral health and function through a significant reduction of all oral diseases and conditions that are prevalent in the Region, equitable access to cost-effective quality oral health care and adoption of healthy lifestyles.

### **Guiding principles**

19. The effective implementation of this strategy and its sustainability will be guided by the following principles:

- high priority to promotion of oral health and prevention of oral diseases;
- focus of oral health interventions on the district and its communities, with particular emphasis on children, pregnant women and other vulnerable groups;
- use of only interventions that have proven efficacy;
- integration of oral health programmes across all appropriate sectors;
- participation of communities in oral health activities that affect them.

### **Strategic framework**

#### ***Strategic objectives***

20. *Country targets:* It is expected that by 2008, all countries of the African Region would have:

- developed national oral health strategies and implementation plans, focusing on the district and community levels;
- integrated oral health activities in other health and related programmes and institutions (e.g. maternal and child health, nutrition, schools, water related programmes);
- strengthened their health facilities with appropriate oral health technologies, methods, equipment and human resources;
- integrated training in essential oral health skills in the curricula of health personnel and others who have the responsibility for oral health promotion;
- set up effective oral health management information systems;

#### ***Regional objective:***

21. To assist countries develop and implement oral health strategies and plans that will ensure equitable and universal access to quality oral health services through the district health system.

#### ***Priority programmatic areas***

22. Based on the oral health priorities indicated earlier, the following programmatic areas and objectives have been identified.

#### ***(a) Development of national oral health strategies and implementation plans***

*Objective 1:* To formulate national oral health strategies and plans.

#### ***(b) Integration of oral health into other programmes***

*Objective 2:* To integrate oral health into programmes for vulnerable groups and in the training programmes of primary and pre-school teachers.

*Objective 3:* To deliver optimal levels of fluoride through water supplies or other methods, where indicated and feasible, and introduce defluoridation water systems in areas where fluorosis is endemic.

#### ***(c) Delivery of effective and safe oral health services***

*Objective 4:* To ensure equitable population access to quality oral health care through the district system.

*Objective 5:* To ensure that district oral health service is adjusted to focus on community oral health needs and that appropriate forms of technology are selected.

*Objective 6:* To establish effective control measures for cross infection.

#### ***(d) Regional approach to education and training for oral health***

*Objective 7:* To share common approaches to oral health education for the level and type of care needed in the African Region.

#### ***(e) Development of effective oral health management information systems***

*Objective 8:* To gather and coordinate the collection of information needed for planning, monitoring and evaluating oral health activities.



### *Strategic orientations*

#### **(a) *Advocacy and social mobilization***

Implementation of the strategic orientations must be sustained through continued advocacy for oral health. This will involve using social marketing and participatory methods to mobilize support from policy-makers, political and community leaders, training institutions, NGOs, professional associations, business and social groups and industry.

#### **(b) *Capacity-building***

This will involve the development of human resources through appropriate training and re-training programmes related to the priority oral health problems. Training needs and processes should be coordinated and standardized as far as possible, and draw upon the combined expertise and resources of the Region.

#### **(c) *Information and education***

Appropriate information should be provided to individuals, families and communities for the promotion of healthy oral health behaviour and lifestyles. People should be involved in all stages of developing oral health education, promotion and information materials.

#### **(d) *Equitable access to quality oral health services***

This requires the achievement of greater equity in oral health and access to quality oral health services particularly for rural, peri-urban and underserved communities. Recent advances in oral health and available technical excellence must be adapted in the forms that are economically, technologically and culturally appropriate for the African Region.

#### **(e) *Promotion of operational research***

In order to strengthen research capacity and promote relevant research that responds to the oral health needs of communities, a research culture should be developed within national oral health programmes and the findings widely disseminated and used for planning purposes.

### **Implementation framework**

#### *At country level*

23. The district remains the location with the greatest potential for successful integration of oral health programme planning and implementation into other health and development programmes. An implementation matrix, which illustrates a framework for planning priority interventions, will be developed.

#### *At intercountry and regional levels*

24. Mechanisms to secure the exchange of experiences in implementing the oral health strategy need to be established between countries in the Region, in the spirit of Technical Cooperation among Developing Countries. Maximum use will be made of the expertise and resources of WHO collaborating centres for oral health, particularly in the areas of capacity building and research promotion. In collaboration with international partners, WHO will provide technical support to Member countries in the following areas:

- development of comparable national data systems on oral health and disease trends for use in planning, including the identification of suitable indicators with which to evaluate progress;
- development of effective interventions for the promotion of oral health;
- development of national oral health strategies and implementation plans;
- estimation of personnel needs and development of suitable training programmes for the effective delivery of oral health programmes.

#### *Partnerships*

25. Partners who can assist the process should be identified as early as possible. A wide network of interested parties must be established at country level to facilitate implementation of the strategy and mobilization of resources.

26. The district health management team has the primary responsibility for implementing the programmes, strategies and interventions. It is here that interaction and partnership between community interest groups, health and development workers occur in order to successfully operationalize district oral health plans. Districts will also benefit from sharing information, experiences and problems with one another and from collaborating in programmes of mutual interest.

27. Partners that may be engaged at the national level include professional associations, commerce, industry, dental, medical and allied professions, NGOs, aid agencies, WHO and other UN agencies. The national level must ensure that good communication occurs between all levels of the health system and various partners. It should, therefore, be well equipped to facilitate partnerships and collaboration.

## **Managerial framework**

### **Resource mobilization**

#### ***Financial resources***

28. Mobilization of internal and external resources is essential for the execution of national oral health programmes. The programmes should be adjusted to the funds that are actually available. The oral health sector should also set aside a share of the general health care budget allocated to fund integrated health programmes and activities of which oral health is a component. Ministries of health and NGOs will be encouraged to mobilize extrabudgetary funds for oral health. Other cost-sharing initiatives must also be explored to support oral health interventions.

#### ***Human and institutional resources***

29. At country level, government needs to support the training of adequate numbers of appropriate personnel to support implementation of the oral health strategies it has selected. Negotiations with training institutions, government and other stakeholders to establish appropriate post structures, career paths and job descriptions, etc. for staffing public oral health services will be necessary. At regional level, WHO will facilitate the training of experts who can provide technical support to the oral health strategy process and assist in the monitoring and evaluation of programmes. These experts will also support the development of country research capacities in collaboration with the International Association for Dental Research (African Division), World Dental Federation, Commonwealth Dental Association, *Aide Odontologique Internationale* and others.

#### ***Material resources***

30. Every effort should be made internally and externally to generate funding for oral health programmes. Development and acquisition of appropriate and robust equipment that suits the African environment should be promoted. Whilst bulk purchases of equipment and supplies should be undertaken where appropriate, more efficient ways of making available low cost toothpastes, toothbrushes, chewing sticks and other items should also be explored.

#### **Coordination**

31. The setting up of coordination mechanisms among partners is crucial for the implementation of the oral health strategy. Emphasis should be placed on the coordination of activities instead of struc-

tures, which should extend well beyond the mere sharing of information. Where a regional or provincial level exists in a country, it has the responsibility for providing support to district health activities and for coordinating programmes that extend across district boundaries. It has to provide the link between district and national levels of activity. It can help districts with coordination of tender processes, information collection and analysis activities, planning processes and resource allocation. The national level is primarily responsible for coordination, as opposed to programme or service delivery and must be properly equipped for this role. Existing subregional development organizations should also be involved in coordination efforts. At the regional level, implementation will be coordinated by the Division of Health Protection and Promotion in collaboration with existing WHO structures and governing bodies.

## **MONITORING AND EVALUATION**

### ***Monitoring***

32. It will be important to monitor the *process* of negotiating acceptance, adoption and dissemination of the strategy by WHO structures, country chief dental officers and their respective ministers of health. After this, the strategy must reach the provincial and district structures responsible for its implementation. This process must be monitored against the proposed time frame. After this, it will be important to monitor *outcome* indicators that reflect the extent to which the strategy and priority programmatic areas have been responded to and implemented. The indicators to be assessed include the country targets selected.

### ***Evaluation***

33. WHO has a particularly important role in facilitating the implementation process as well as monitoring and evaluating the progress of the strategy as a whole. Periodic reviews and evaluations will be undertaken and regular reports will be made available in accordance with WHO resolutions.

## **CONCLUSION**

34. This document has set out a process that WHO plans to follow to assist countries improve and sustain the oral health of their communities. It provides technical and managerial orientations that countries can use to streamline oral health services to efficiently and effectively deliver interventions that are affordable and that match the oral health needs of the

community. This strategy represents a new approach that has the potential to fundamentally improve community oral health in the African Region.

35. The Regional Committee reviewed and adopted the oral health strategy for the African Region for the period 1999–2008

**a) Resolution AFR/RC48/R5**

**Oral health in the African Region: A regional strategy**

The Regional Committee,

Bearing in mind that health and well-being directly influence oral health;

Concerned about the deterioration of oral health in the African Region;

Recognizing that previous approaches to oral health in the Region have neither taken account of the epidemiological priorities of the Region nor identified reliable and appropriate strategies to address them;

Noting that previous efforts have consisted of an unplanned and *ad hoc* evolution of curative oral health services which, in most cases, are poorly distributed and only reach affluent or urban communities;

Mindful of World Health Assembly resolution WHA36.14 and Regional Committee resolutions AFR/RC30/R4 and AFR/RC44/R13 adopted in the past; and

Having carefully examined the report of the Regional Director contained in document AFR/RC48/9 outlining a WHO regional strategy for oral health;

1. APPROVES the proposed strategy aimed at strengthening the capacity of the Member States to improve community oral health;

2. CALLS on the Member States to:

- (i) develop national oral health strategies and implementation plans with emphasis on prevention, early detection and management of oral diseases;

- (ii) systematically and meaningfully interpret oral health epidemiological information by describing oral disease prevalence, severity and age-wise distribution in the population;
- (iii) pay particular attention to the most severe oral problems that people have to live with (e.g. NOMA, oral cancer and oral manifestations of HIV infection/AIDS);
- (iv) develop appropriate and affordable programmes that match the oral health needs of the community;
- (v) integrate oral health activities into all primary health care programmes;
- (vi) integrate training into essential oral health skills in the curricula of health personnel and others who have the responsibility for oral health promotion;
- (vii) strengthen health facilities with appropriate oral health technologies, methods, equipment and human resources;
- (viii) undertake operational research on oral health priority problems and needs; and
- (ix) integrate oral health into national health management information systems; and

3. REQUESTS the Regional Director to:

- (i) provide technical support to the Member States for the development of national
- (ii) oral health strategies and implementation plans;
- (iii) provide support to all countries to enable them to strengthen or develop and
- (iv) implement cost-effective oral health care services, particularly at the district level;
- (v) provide guidelines and technical support that will facilitate the proper identification of oral health priority problems and appropriate cost-effective interventions;
- (vi) promote and support the development of suitable training programmes for effective delivery of oral health services;
- (vii) promote and support relevant research activities aimed at providing solutions to oral health problems; and
- (viii) report to the 50th session of the Regional Committee on the progress made in the implementation of the strategy.

*Tenth meeting, 2 September 1998*

**b) Epidemiological basis for ranking oral disease burden in low-economic status community**

	<i>Oral disease</i>	<i>Prevalence</i>	<i>Morbidity</i>	<i>Mortality</i>
1	Cancrum oris ( Noma)	High	High	High
2	Oral manifestations of HIV/AIDS	High	High	High
3	Oral cancer	Medium	High	High
4	Facial trauma	Very High	Medium	Medium
5	Congenital abnormalities	High	Medium	Medium
6	Harmful practices	High	Medium	Low
7	Dental caries	Medium	Medium	
8	Chronic periodontal disease	Medium	Low	Low
9	Fluorosis	Medium	Low	Low
10	Benign tumours	Low	Medium	Low
11	Edentulism	Low	Medium	Low

**c) Conclusions of the consultative meeting on implementation of the regional oral health strategy in African countries****Brief Summary**

In September 1998, the African Ministers of Health attending the forty-eighth session of the WHO Regional Committee Meeting in Harare, Zimbabwe, adopted the oral health strategy for the African Region for a ten-year period (1999–2008). A corresponding resolution was also adopted.

As a follow-up to the adopted regional oral health strategy, a Consultative Meeting, jointly organized by WHO/AFRO and WHO/HQ, took place in Harare, Zimbabwe from 30 March to 01 April 1999. The purpose of the meeting was to identify concrete actions to assist Member States in implementing the strategy.

There were thirty-nine participants from four main groups, namely: experts on oral health in Africa, chief dental officers (CDOs) from selected countries in the Region, some oral health partners and heads of some WHO collaborating centres for oral health. There were also representatives from WHO/HQ and WHO/AFRO.

In his opening address, the WHO Regional Director for Africa, Dr E.M. Samba noted that previous approaches to oral health in Africa had failed to recognize the epidemiological priorities of the Region or to identify reliable and appropriate strategies to address them. Efforts had consisted of an unplanned, ad hoc and spasmodic evolution of curative oral health services. Dr Samba stressed that the new strategy focussed on the most severe oral problems that people have to live with, like noma, oral cancer and the oral consequences of HIV/AIDS infection. The strategy was a tool for assisting Member States and partners to identify priorities and interventions at various levels of the health system, particularly at the district level. He further indicated that the strategy aimed at strengthening the capacity of countries to improve community oral health by effectively using proven interventions to address specific oral health needs. The Regional Director charged participants to identify practical cost-effective ways of implementing the regional oral health strategy.

The following are the main outcomes of the Consultative Meeting.

<i>Implementation Framework</i>					
<i>Strategic Orientations</i>					
<i>Priority Programmatic Area</i>	<i>Advocacy and social mobilization</i>	<i>Capacity building</i>	<i>Information, education and communication</i>	<i>Equitable access to quality oral health services</i>	<i>Promotion of operational research</i>
<p><b>Development of national oral health strategies and implementation plans</b></p> <p><b>Objective:</b></p> <p>1. <i>To formulate national oral health strategies and plans.</i></p>	<p>Raise awareness at policy and political levels on the need for national strategy and plan on oral health.</p> <p>Advocate for the implementation and evaluation of the prepared strategy and plan.</p> <p>Advocate for multidisciplinary approach.</p> <p>Mobilize the private sector and city/town health management to promote oral health.</p>	<p>Ensure there is institutional capacity for training appropriate oral health personnel.</p> <p>Assist and encourage the development of appropriate protocols where indicated.</p> <p>Include non- oral health personnel workers in training programmes.</p> <p>Promote collaboration for regional education and training.</p>	<p>Disseminate and explain the strategy and plan at all levels.</p> <p>Ensure that strategy and plan involve opinions and needs at the lowest levels of the system.</p> <p>Design and disseminate participatory oral health education and promotion materials for use in schools and communities.</p>	<p>Ensure priorities identified are directed at the most vulnerable.</p> <p>Allocate resources on the basis of need.</p> <p>Establish district- focused services.</p> <p>Promote use of appropriate technology.</p>	<p>Identify areas where existing data need to be strengthened and devise appropriate research protocols.</p> <p>Initiate operational research at all levels.</p> <p>Develop a simplified revised oral health survey methodology based on the perception of need, resource availability and potential outcome of interventions at the local level.</p> <p>Promote research in appropriate technology.</p>

<p><b>Integration of oral health into other programmes</b></p> <p><b>Objectives:</b></p> <p>2. To integrate oral health into all PHC programmes and into the training programme of primary and pre-school teachers</p> <p>3. To deliver optimal levels of fluoride through water supplies or other methods where indicated and feasible, and to introduce defluoridation water systems in areas where fluorosis is endemic</p>	<p>Advocate for integration of oral health into other programmes.</p> <p>Advocate for issues such as food and agricultural policy, tobacco use and alcohol consumption, drink and driving and road safety.</p> <p>Advocate for fluoridation and defluoridation, where indicated and feasible.</p> <p>Raise awareness that oral health arises from the same conditions as general health.</p>	<p>Train all district health personnel and school teachers on oral health education and promotion of oral diseases, their management and referral.</p>	<p>Disseminate information on the determinants of oral health and disease.</p> <p>Integrate oral health messages into:</p> <ul style="list-style-type: none"> <li>– MCH clinics and programmes.</li> <li>– curriculum of primary schools.</li> <li>– national nutrition programmes.</li> <li>– programmes for the elderly.</li> <li>– campaigns against violence.</li> <li>– campaigns against tobacco use</li> <li>– campaigns against alcohol consumption.</li> </ul>	<p>Expand oral health services within district health services.</p> <p>Provide adequate infrastructure for the provision of oral health care.</p> <p>Introduce oral health in safe motherhood programmes.</p>	<p>Support operational research into the provision of oral health services that are integrated into general health services and school programmes (e.g. Cost-benefit, outcome measures, early diagnosis, etc.)</p> <p>Promote research into the effectiveness of education and training for integrated services.</p>
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<i>Implementation Framework</i>					
<i>Strategic Orientations</i>					
<i>Priority Programmatic Area</i>	<i>Advocacy and social mobilization</i>	<i>Capacity building</i>	<i>Information, education and communication</i>	<i>Equitable access to quality oral health services</i>	<i>Promotion of operational research</i>
<b>Delivery of effective and safe oral health service</b>	Advocate for the creation of infrastructure necessary to ensure safe and effective delivery of oral health care at district level. Mobilize non-health sectors such as local authorities and NGOs to promote oral health.	Train all district health personnel on infection control measures. Ensure there are trained personnel or maintenance of equipment.	Disseminate information on infection control. Promote the use of evidence-based interventions.	Establish or expand oral health services to all districts as part of existing health services.	Promote recording and analysis of data relevant to the processes and intervention.
<b>Objectives:</b>					
4. <i>To ensure equitable population access to quality oral health care through the district system.</i>	Advocate for oral health materials and drugs to be part of the essential drug list (including fluoride toothpaste).	Train oral health personnel in research.	Promote campaigns against the use of tobacco and alcohol consumption.	Ensure allocation of appropriate resources and infrastructure based on need and vulnerability.	
5. <i>To ensure district oral health service is adjusted to focus on community oral health needs and that appropriate forms of technology are selected.</i>			Promote competition among oral health programmes.	Ensure availability of appropriate equipment and adequate stock of materials, instruments and spare parts.	
6. <i>To establish effective control measures for cross-infection.</i>				Ensure regular maintenance of equipment.	

<p><b>Regional approach to education and training for oral health</b></p>	<p>Advocate and mobilize countries of the Region to develop a common approach to education and training of personnel for oral health.</p>	<p>Ensure education and training are related to needs and strategies identified.</p>	<p>Inform relevant role-players of advantages of a regional approach.</p>	<p>Assess number, type and distribution of training institutions required.</p> <p>Ensure optimal use of existing institutions and their availability to all countries in the Region.</p>	<p>Develop measures to assess effectiveness and appropriateness of existing educational programmes.</p> <p>Continually assess geographical distribution of personnel found in each institution into the Region.</p>
<p><b>Objective:</b></p> <p>7. To share common approaches to oral health education for the level and type of care needed in the African Region</p>	<p>Advocate for system of common entry, based on needs of both country of origin and the Region as a whole.</p> <p>Advocate for the education and training of more auxiliaries</p>	<p>Develop capacity to collect, collate, analyse and interpret data at all levels especially at the district level.</p> <p>Develop computer skills where necessary.</p>	<p>Continually assess and define information for planning process.</p> <p>Communicate need to collect and use this data to all health workers</p>	<p>Ensure coordination of information at all levels.</p> <p>Ensure relevant information is collected and properly utilised</p>	<p>Determine the minimum data set.</p> <p>Assess appropriateness of the data collected</p>
<p><b>Effective integration of oral health in national health management information systems</b></p> <p><b>Objective:</b></p> <p>8. To gather and coordinate the collection of information needed for planning, monitoring and evaluating oral health activities</p>	<p>Advocate for the collection of data for planning, monitoring and evaluation at each level.</p> <p>Advocate for mapping of geographical areas with endemic fluorosis</p>	<p>Develop capacity to collect, collate, analyse and interpret data at all levels especially at the district level.</p> <p>Develop computer skills where necessary.</p>	<p>Continually assess and define information for planning process.</p> <p>Communicate need to collect and use this data to all health workers</p>	<p>Ensure coordination of information at all levels.</p> <p>Ensure relevant information is collected and properly utilised</p>	<p>Determine the minimum data set.</p> <p>Assess appropriateness of the data collected</p>



**FRAMEWORK TO ADDRESS PRIORITY AREAS OF PREVENTION AND OTHER INVENTIONS AT COUNTRY LEVEL**

**PREAMBLE:** The situation of each country and the nature of the oral health problem each country has to deal with are different. This means that each country needs to begin the process of oral health strategy development by identifying and prioritizing those problems that are particularly important to them. The framework provided below should assist in sifting through the available options for intervention that each country wishes to select, based on the resources they have and an assessment of which option is likely to work best for them. It is not a prescriptive list that countries should feel obliged to adopt in its entirety. For example, with noma, different countries/districts will require different levels and forms of training that is relevant to their needs. For each level a target may need to be set and these will vary from the earliest detection level in the village to specialist care level.

	<i>Surveillance</i>	<i>Prevention and Promotion</i>	<i>Disease Management</i>	<i>Research</i>	<i>Capacity Building/Training</i>
<b>Cancrum Oris/ Noma</b>	<p>(i) Establish a surveillance system based on identifiable records from all available sources of data.</p> <p>(ii) Include demographic, sociological intervention and other outcome variables.</p>	<p>(i) Improve environmental and personal hygiene and dietary practices.</p> <p>(ii) Early detection and referral (of precursor conditions), using existing social and health structures.</p> <p>(iii) Participation in national programmes and campaigns on improved nutrition and immunization.</p>	<p>(i) Primary care: Arranging for health services to treat patients.</p> <p>Making sure necessary drugs and nutritional supplements are available.</p> <p>(ii) Specialized oral care-surgery and rehabilitation: referring patients who have sequelae for surgical treatment, setting up specialized centres for treatment.</p> <p>(iii) Complex case management of social and psychological effects, including social integration after surgical treatment.</p>	<p>Promote basic and operational research.</p>	<p>Formulate targets for training at all levels for health personnel and other types of resource persons (parents, teachers, opinion leaders ) in:</p> <p>Identification of high-risk groups detection of intra-oral-oral lesions, and management at all levels of the disease.</p>

**HIV/AIDS**

**Oral Manifestations**

(i) Establish surveillance systems to monitor prevalence, severity and intervention outcomes for oral mucosal lesions associated with HIV/AIDS.

(ii) Set up selected additional surveys, where necessary

Participation of oral health personnel in national programmes and campaigns on prevention and control of HIV/AIDS.

(ii) Highlight transmission risk in health care services among health personnel.

(iii) Prepare manuals for patients and health workers on self care and prevention of HIV.

(i) Emphasis on careful and continuous oral hygiene / mouth care at home and treatment centres to maintain a healthy oral environment.

(ii) Utilize oral antiseptics and traditional medications.

(iii) Write treatment protocols.

(i) Devise a specific country plan for training.

(ii) Get a focal person to co-ordinate training.

(iii) Collaborate with AIDS units and other groups.

(iv) Train all oral health and general health personnel in identification and management of these conditions.

**Oral Cancer**

(i) Establish similar record-based surveillance systems as for HIV to monitor the prevalence of oral pre-cancer and cancer.

(ii) Establish a cancer register.

(i) Appropriate referral.

(ii) Management of cases in national and regional treatment centres.

(iii) Campaign for indigenous training of maxillo-facial oral surgery staff.

(i) Research on behaviour and lifestyles.

(ii) Kola nut investigations.

(iii) Link between viral infections and cancer.

(iv) Evaluate interventions.

(i) Train health personnel at district level in the early diagnosis of oral cancer and referral for appropriate management.

(ii) Teach recognition of suspicious lesions.

**Facial Trauma**

(i) Develop a record-based surveillance system to monitor the prevalence of facial trauma and its causes.

(i) Draft protocol for treatment at primary care level.

(ii) Early diagnosis and referral to appropriate hospitals.

(iii) Establish network of centres to share expertise for all types of reconstructive surgery.

(i) Research on behaviour and lifestyles, vehicles and road safety, etc.

(i) Train the community in first aid and health personnel in emergency management of facial injuries.

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	<i>Surveillance</i>	<i>Prevention and Promotion</i>	<i>Disease Management</i>	<i>Research</i>	<i>Capacity Building/Training</i>
<b>Fluorosis</b>	(i) Selective epidemiological studies on the extent of cosmetically disfiguring fluorosis that requires professional intervention and on skeletal fluorosis.	(i) Develop appropriate education programmes (ii) In areas where fluorosis is endemic, identify alternative water supply (and other fluoride sources).	(i) De-fluoridation of available drinking water in small communities. (ii) Appropriate restoration of affected anterior teeth.	(i) Into de-fluoridation technology. (ii) Fluoride exposure. (iii) Fluoride mapping; (iv) Sources of fluoride. (v) Utilization of fluoride.	(i) Train the community and health personnel on identification of dental and skeletal fluorosis and referral for appropriate management of cases.
<b>Dental Caries</b>	(i) Selected pathfinder type epidemiological studies on prevalence where existing data are inadequate.	(i) Integrate effective oral health promotion materials. (ii) Promote mouth cleaning, using indigenous and other oral hygiene aids, including chewing sticks. (iii) Integrate dietary measures into existing nutrition programme efforts to ensure avoidance of frequent excess sugar intake. (iv) Promote affordable fluoride toothpaste. (v) Consider viability	(i) Emergency treatment for pain relief (extraction, temporary fillings, etc). (ii) Preventive fillings, using ART technique.	(i) Simplified revised oral health survey method. (ii) Effectiveness of community oral health education. (iii) Process evaluation. (iv) Quality of care assessment. (v) Research effectiveness of traditional methods of oral health promotion and protection.	(i) Train authority members of the community such as teachers, MCH aids, nurses, PHC workers in oral health matters as part of general health education. (ii) Train appropriate health workers in screening and extraction during their pre-professional courses. (iii) Train district oral health workers in ART technique.
<b>Edentulism/mucation</b>	(i) Records based surveillance as for oral cancer.	(i) Promote healthy smile and other caries and periodontal disease prevention strategies	(i) Denture provision where infrastructure and resources permit.	(i) Cultural and professional determinants of tooth loss. (ii) Rapid cost-effective procedures production.	(i) Same as for other conditions above.

<b>Periodontal Diseases</b>	(i) Utilize existing data and record systems to monitor these conditions.	(i) Develop effective oral health education and promotion materials with strong messages on mouth cleaning.	(i) Referral to the next level of care.	(i) Effectiveness of community oral health education.	(i) Train PHC workers and school teachers on oral health education and promotion activities (see caries list above).
		(ii) Promote use of effective traditional methods of oral care (See caries above).	(ii) Emergency treatment for pain relief.	(ii) Aetiological and risk factor research.	
		(iii) Integrate oral hygiene practices into environmental hygiene promotion efforts by local health workers.	(iii) Selected use of scaling and other forms of treatment aimed at preventing plaque retention.	(iii) Interaction between systemic and other conditions related to periodontal diseases.	
			(iv) Complex treatment such as periodontal surgery.	(iv) Factors that cause progression of gingivitis to ANUG to noma.	
				(v) Traditional methods of prevention and self care.	

**Harmful Practices**

Deal with as for trauma above.

**Benign Tumours**

Deal with as for oral cancer above, depending on nature of the tumour.

**Congenital Malformations**

Deal with as for destructive facial conditions such as noma and other conditions requiring reconstructive surgery.

**Traditional (indigenous) interventions**

Traditional (indigenous) interventions are well-understood and accepted by many people in the Region, but the systematic evaluation of their benefits has yet to be completed. The table above reflects the need for research into the utilization of these practices known to work. Further research is needed and a data base developed for recording the practices and scientific evidence that exist in support of their use. This work will be initiated by the WHO Regional Office for Africa (AFRO).

## 5.3 Regional strategy for mental health 2000–2010 (AFR/RC49/9)

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### EXECUTIVE SUMMARY

1. *Mental health and the prevention and control of substance abuse are not treated as priority areas in a majority of the countries of the WHO African Region. These countries do not have national mental health policies; there is a shortage of specialized personnel, which is compounded by the constant brain drain. Widespread civil strife and the resulting violence and its consequences are a common occurrence on the African continent. All these factors call for the formulation of a regional strategy for mental health and the prevention and control of substance abuse.*

2. *In line with the WHO definition of health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity”, and taking into consideration the various resolutions of the World Health Assembly, the Regional Committee for Africa and the United Nations General Assembly inviting Member States to consider mental health and psychosocial issues as important aspects of health, this document proposes a strategy for mental health, including the prevention and control of substance abuse in the African Region, for the period 2000–2010. The strategy is expected to contribute to the development of national programmes in Member States with the involvement of governments and partners.*

3. *The Regional Committee reviewed and adopted this strategy and gave the necessary orientations for its implementation.*

### INTRODUCTION

1. Mental health is an essential and integral part of health as stated in the Constitution of the World Health Organization. Just as health is not merely the absence of disease, mental health is also not simply the absence of mental disorder or illness but represents a positive state of mental well-being.

2. Mental health can be defined as total balance of the individual personality, considered from the biological and psychosocial points of view. Mental disorders are illnesses characterized by abnormalities in emotional, cognitive or behavioural spheres. It is unfortunate that in its current usage the term ‘mental health’ is identified with mental disorders only. Prevention, treatment and rehabilitation of mental disorders are, however, part of the broader field of mental health.

3. Alcohol and tobacco abuse and drug-related problems are becoming major public health concerns for most countries in the African Region. Im-

provement of the quality of life of the general public, through the prevention and control of mental, neurological and psychosocial disorders and the promotion of healthy behaviours and lifestyles and mental well-being are the goals of national programmes for mental health and the prevention of substance abuse.

4. The regional strategy for mental health and the prevention and control of substance abuse for the period 2000–2010, as set forth below, is a tool for assisting Member States and their partners to identify priorities and develop and implement programmes at various levels of the health system, with particular emphasis on what can be done at district and community levels.

### JUSTIFICATION AND POLICY BASIS

5. Considering that previous approaches to mental health in the African Region have failed to identify priority areas and appropriate strategies to address

them, decision-makers are unaware of the mental health needs of their countries and there is a need for advocacy to address those needs. The status of mental health as an essential component of individual and community health has been stressed in various resolutions adopted by the World Health Assembly, the WHO Regional Committee for Africa, the United Nations General Assembly and the United Nations Drug Control Programme<sup>1</sup>. There is, therefore, an urgent need to review existing strategies and develop a comprehensive strategic framework for mental health and the prevention and control of substance abuse in the countries of the African Region.

## Situation analysis

### Magnitude of the problem

6. Populations in the African Region are beset by numerous mental and neurological disorders that are a major cause of disability. There is a lack of reliable information systems in most countries. However, some of the basic global figures are available and are given below.

7. It has been estimated that over 12.5% of the global burden of disease is caused by mental and neurological disorders, which might be also true for the African Region. In addition to the disability caused by these disorders, the problem is made worse by the social handicap brought about by the stigma attached to them. Some of the common mental conditions are discussed below.

*Common mental disorders:* These occur at a rate of 20–30% among the population, and up to 40% among those who attend general outpatient clinics. Unfortunately, these are not appropriately diagnosed by health workers and scarce resources are often wasted on laboratory investigation and inappropriate medication.

*Depression:* Major depression occurs in about 3% of the population, with attendant risks of suicide. It is often not properly diagnosed by primary health care workers and is, therefore, not treated appropriately in most cases. Factors contributing to depression include genetics, socioeconomic problems and insecurity, which are so common in the African Region.

*Schizophrenia:* It is estimated that 1% of the total population suffer from schizophrenia. This condition leads to serious disability and puts a considerable burden on the families and communities of the affected persons.

*Epilepsy:* The global prevalence of epilepsy is estimated to be between 0.5 and 1.0%, but according to

reports from some African countries, the rate could be much higher. Inadequate care at childbirth, malnutrition, malaria and parasitic diseases may be the cause of the high rate of epilepsy in Africa. Furthermore, the disease is still highly stigmatized, particularly because it is often considered infectious, leading to the social isolation of the sufferer. Simple and inexpensive anti-convulsion treatment can be very effective in preventing seizures.

*Children's mental health problems:* Half of the population of the Region is made up of children below the age of 15 years. It is estimated that, of those aged 0–9 years, about 3% suffer from a mental disorder. Many children suffer from poor psychosocial development because of neglect by their mothers and other caretakers. This neglect may be due to the lack of social support for the mother or to post-natal depression, which can lead to poor emotional and cognitive development of the child in later life. Brain damage is one of the main causes of serious mental retardation.

*Organic mental disorders:* Dementia is a chronic disorder that occurs more frequently among elderly people. In Africa, the population of elderly people is still low, with only 3–4% of the total population aged above 65 years. Other brain syndromes, which usually follow an infection or trauma of the central nervous system, are, however, common in the African Region.

*Post-traumatic stress disorders:* Many countries in the African Region are engulfed in conflicts and civil strife with their attendant adverse impact on the mental health and well-being of the affected populations.

*Psychoactive substance use and abuse:* Alcohol, tobacco and drug-related problems are becoming an increasing concern in the Region. Many of the countries in Africa are used as transit points for illicit drug trade, and these drugs are finding their way into local populations, adding to the indigenous problems associated with cannabis consumption.

*Tobacco:* As the demand for tobacco faces gloomy prospects in many countries in the North, there is growing pressure to increase tobacco sales in the developing world, where tobacco use is indeed growing rapidly and children are starting to smoke at a very early age. Member States will have to adopt the Tobacco-free Initiative as a means of achieving a tobacco-free status.

*Alcohol:* There is an increased demand for home-brewed beer or locally distilled liquor. In most countries, there are no national policies on alcohol or tobacco. Consequently, their advertising, distribution and sale are largely uncontrolled.

8. Increasing poverty, natural disasters, wars and other forms of violence and social unrest are major causes of growing psychosocial problems, which include alcohol and drug abuse, prostitution, street children, child abuse, domestic violence.

9. HIV infection has added considerably to the psychosocial problems already being experienced in many countries of the Region, creating a need for extra support and counselling for those affected and care for their surviving family members, especially children.

10. Many risk behaviours and social problems are the result of people's lack of mental maturity, self-esteem and self-confidence. Strong cultural beliefs about the causes and management of mental disorders in the Region also explain the non-utilization of conventional health services as a first choice.

### **Mental, neurological and psychosocial health services**

11. In most countries of the African Region, mental health programmes are limited to curative health care of poor quality, usually provided in decrepit hospitals located far away from residential areas. These conditions create a serious problem of access to and acceptability of the treatment. Hence, drop-out rates are very high, and follow-up treatment as an outpatient is seriously hampered. In those countries where some services are provided, these are mainly for adults with major psychiatric disorders, the needs of children not being catered for.

### **Weaknesses and strengths**

12. Major constraints to the development of mental health programmes at country level are: lack of awareness of the magnitude of the problem; lack of reliable information systems; insufficient human and financial resources, among others<sup>2</sup>.

13. A number of countries have, however, made progress in reducing their reliance on big psychiatric institutions. These countries have begun decentralizing mental health and integrating it into primary health care at the community level, based on the district health system approach, in accordance with Regional Committee resolution AFR/RC40/R9. Strong community and family ties in African societies have helped immensely in supporting patients by strengthening community-based care. There is a growing number of mental health training institutions in the Region that take into account the African realities. These institutions are being used for the training of both nationals and persons from other African countries, often under WHO fellowships.

In addition to these, there are a number of innovative mental health activities taking place in the Region, which are unfortunately not documented.

## **THE REGIONAL STRATEGY**

### **Aim**

14. The aim of the strategy for mental health and the prevention and control of substance abuse is to help prevent and control mental, neurological and psychosocial disorders, thus contributing to the improvement of the quality of life of the populations. This can be achieved through the formulation and strengthening of national mental health policies and the development and implementation of programmes in all Member States in the African Region.

15. While adopting and implementing the regional strategy, all Member States should integrate mental health and the prevention of substance abuse into their national health services. This will lead to:

- (i) a reduction in the incidence and prevalence of specific mental and neurological disorders (epilepsy, depression, mental retardation and psychosocial disorders due to man-made disasters) and other prevalent conditions;
- (ii) equitable access to cost-effective mental, neurological and psychosocial care;
- (iii) progress in the adoption of healthy lifestyles; and
- (iv) improvement in the quality of life.

### **Objectives**

16. The objectives of the strategy are:

- (i) to promote mental health and prevent mental, neurological and psychosocial disorders and drug abuse-related problems;
- (ii) to reduce disability associated with neurological, mental and psychosocial disorders through community-based rehabilitation;
- (iii) to reduce the use of psychoactive substances (alcohol, tobacco and other drugs);
- (iv) to change people's negative perceptions of mental and neurological disorders; and
- (v) to formulate or review existing legislation in support of mental health and the prevention and control of substance abuse.

### **Guiding principles**

17. The guiding principles for the implementation of the strategy are:

- (i) integration of issues related to mental health and the prevention and control of substance

abuse in the national health sector reforms agenda, particularly with regard to organization, legislation and financing;

- (ii) promotion of mental health and provision of health care, targeting especially the vulnerable and high-risk groups; and
- (iii) prevention of substance abuse (tobacco, alcohol and other psychoactive substances), especially among young people.

### Expected outcomes

18. *By the end of 2010:*

- (i) All Member States will have formulated national mental health policies and strategies;
- (ii) All countries in the Region will have established national programmes and action plans for the implementation of activities on mental health and the prevention and control of substance abuse, according to their priorities;
- (iii) Community-based psychosocial rehabilitation programmes will have been established, implemented and evaluated in countries in post-war situations;
- (iv) All Member States will have formulated or reviewed existing legislation in support of mental health and the prevention and control of substance abuse.

### Priority interventions

19. The priority interventions listed below are based on various elements which the countries may select from and focus on according to the availability of resources and their different settings.

20. *Policy formulation and programme development.* Policies on mental health and the prevention and control of substance abuse should be formulated in all Member States. Specific programmes and action plans should be drawn up for implementation, taking into account country priorities. Integration of mental health into general health services through a reliable health information system, decentralization, multisectoral collaboration and community participation should all be encouraged. Equitable access can be provided through the integration of mental health into primary health care. To achieve this, members of the primary health care team need to maintain close links with the specialist services so that they can receive regular support for their work. Services provided should be adapted to the economic, technological and cultural contexts of countries in the African Region.

21. *Capacity-building.* Appropriate policies for human resources development should be drawn up

according to country priorities. Training of staff should be considered a priority and encouragement must be given to the integration of modules on mental health and the prevention of substance abuse into the training courses of general health workers (e.g. doctors, nurses, social workers, and medical assistants). The involvement of communities is recommended. They can be sensitized through short-duration workshops, using locally-adapted teaching aids and participatory methods. Training *needs* and *possibilities* should be assessed and the use of national training institutions and WHO collaborating centres should be encouraged.

22. *Advocacy and social mobilization.* Social marketing of the importance of mental health and the prevention and control of substance abuse is an important element in the implementation of the strategy.

23. *Information and education.* Programmes for the promotion of mental health and the prevention of mental, neurological and psychosocial disorders can benefit from the appropriate use of information provided to individuals, families and communities. The information materials should be developed with the involvement of the target populations, taking into account their cultural background.

24. *Research.* A research culture should be developed within national programmes for mental health and the prevention and control of substance abuse. Priority areas of research should be identified in Member States and research findings should be widely disseminated and used for appropriate re-programming.

25. *Partnerships and collaboration.* Collaboration among ministries of health and other government departments as well as professional associations<sup>3</sup>, family groups, consumer groups, NGOs, community and religious leaders, traditional healers' associations, women and youth organizations, training institutions and other UN agencies should be encouraged.

26. Technical cooperation among countries of the Region and with WHO collaborating centres and other programmes of the Regional Office must be strengthened. Good communication and coordination would be needed to ensure better results from these partnerships.

### Implementation framework

#### Country level

27. Member States of the African Region should address the problems related to mental health and the prevention and control of substance abuse as a priority within their national health policies and health



development plans. National programmes should reflect the need for the promotion of mental health as well as the prevention and control of substance abuse (i.e. the abuse of tobacco, alcohol and other psychoactive substances). They should form an integral part of essential health care. A community-based approach must be encouraged, as set out in Regional Committee document AFR/RC40/10 Rev.1 (1990). A focal point should be designated in the Ministry of Health to manage the mental health programme.

### **Role of WHO**

28. WHO can play a key role in supporting and sustaining effective action to address the issue of mental health and the prevention and control of substance abuse in Member States. Funds should be allocated from WHO country budgets for the implementation of the programme. At the regional level, WHO will provide technical support to Member States in the following areas:

- (i) development of national programmes for mental health and the prevention and control of substance abuse;
- (ii) intercountry technical cooperation;
- (iii) integration of mental health and the prevention and control of substance abuse into the general health care system, using the community-based approach;
- (iv) strengthening of cooperation with WHO collaborating centres in the Region in research and training;
- (v) resource mobilization for the strengthening of national capacities;
- (vi) integration of different aspects of mental health and substance abuse issues into the health information system; and
- (vii) needs assessment and programme evaluation.

### **Human resources**

29. Training of adequate numbers of staff to provide services in the areas of mental health and substance abuse should be made an integral part of human resource development policies in Member States. WHO, at the regional level, will facilitate the identification and training of experts who can assist countries with programming, monitoring and evaluation.

### **Financial resources**

30. Ministries of health and social affairs should be encouraged to allocate funds from national sources as well as from WHO country budgets for the mental health programme. Other cost-sharing initiatives

must also be explored. Mobilization of external resources is also important and WHO has an important role to play in the formulation of guidelines which can be adapted by Member States to their specific circumstances.

### **Drugs and equipment**

31. The availability of essential psychotropic drugs needs to be ensured according to the prescribing capacity of health professionals at different levels of the health care system. Each level of the mental health care system should have the equipment necessary for and appropriate to that level for the treatment of neuropsychiatric disorders.

### **Infrastructure and services**

32. Mental health care should be delivered as part of general health care services such as health centres. The custodial type of care in old and big psychiatric hospitals must be discouraged. Hospitalization of persons with mental, neurological or psychosocial problems should be resorted to only when other alternatives of family and community care are not sufficient. The length of stay in hospitals must be reduced to the minimum and to what is absolutely necessary, and after-care services (day centres and sheltered accommodation) should be created, when possible.

## **MONITORING AND EVALUATION**

33. After the adoption and launch of the regional strategy, the development of activities at country level will be monitored and evaluated within the stipulated time frame of 2000–2010. Member States will be invited to establish specific programmes according to their priorities and available resources. WHO's contribution to the implementation of the strategy will be incorporated in the WHO regular programme budget.

34. Monitoring and evaluation indicators will be formulated to assess the implementation of the strategy. Periodic reviews and evaluations will be undertaken and regular country reports will be produced and analysed to update the regional mental health programme profile.

## **CONCLUSION**

35. The promotion of mental health, the prevention and treatment of mental, neurological and psychosocial disorders and the prevention and control of substance abuse are challenges for all the countries of the African Region.

36. This document sets out a strategy for the promotion of mental health and healthy lifestyles, the prevention of mental, neurological and psychosocial disorders and the treatment and rehabilitation of people suffering from those problems, in order to contribute to the improvement of the quality of life of the people. It is an important approach, which involves governments and their partners in the field of mental health and the prevention and control of substance abuse.

37. The Regional Committee reviewed and adopted this strategy and gave orientations for its implementation.

### **Resolution AFR/RC49/R3**

#### **Regional strategy for mental health 2000–2010**

The Regional Committee,

Aware of the magnitude and the public health importance of mental, neurological and psychosocial problems, which have been aggravated by the stigma attached to them;

Concerned about the growing poverty, the increasing frequency of natural disasters, and the escalation of war and other forms of violence and social disruption, which are causing growing psychosocial problems such as alcohol and drug abuse, prostitution, the phenomenon of street children, child abuse and domestic violence;

Recalling World Health Assembly resolutions WHA28.81 (1975) on the assessment of problems relating to alcohol abuse, WHA30.45 (1977) on the creation of the African Mental Health Action Group, Regional Committee resolution AFR/RC40/R9 (1990), which called on Member States to implement community mental health care based on the district health system approach, and AFR/RC44/R14 (1994) on accelerating the development of mental health in the African Region;

Appreciating the efforts already made by Member States and their partners to improve the mental health of their people and prevent and control substance abuse;

Recognizing the need to review existing approaches in this area and develop a comprehensive strategic framework for mental health and the prevention and control of substance abuse in the countries of the African Region;

Having carefully examined the report of the Regional Director as contained in document AFR/RC49/9, which sets forth WHO's regional strategy for mental health;

1. APPROVES the proposed strategy aimed at strengthening the capacity of Member States to improve the quality of life of their people by promoting health lifestyles, and preventing and controlling mental, neurological and psychosocial disorders;
2. REQUESTS Member States:
  - (i) to take into account mental health concerns in their national health policies and strategies; recognize the need for the multisectoral approach and integrate mental health into their general health services, particularly at the district level, with adequate community participation;
  - (ii) to establish or update national programmes and plans of action for the implementation of activities on mental health and the prevention and control of substance abuse, according to their priorities;
  - (iii) to promote mental health and healthy behaviour, using the commemoration of the World Mental Health Day (10 October);
  - (iv) to formulate or review legislation in support of mental health and the prevention and control of substance abuse;
  - (v) to designate a focal point in the ministry of health to manage the mental health programme thus established;
  - (vi) to provide financial resources for the implementation of the related activities and consider introducing cost-sharing schemes, where appropriate;
  - (vii) to intensify capacity-building, taking into account the mental health dimension, when drawing up national human resources development plans and to use regional health training institutions;
  - (viii) to ensure that a research culture is built into their national programmes;
  - (ix) to undertake community-based psychosocial rehabilitation interventions, targeting vulnerable and high-risk groups, especially displaced persons, refugees, victims of landmines, health workers, and people with chronic mental and neurological conditions as well as people living with HIV/AIDS;
3. REQUESTS the Regional Director:
  - (i) to provide technical support to Member States for the development of national policies and programmes on mental health and the prevention and control of substance abuse as well as development or revision of mental health legislation;
  - (ii) to take appropriate measures to enhance WHO's capacity to provide timely and effective technical

- support, at regional and country levels, to national programmes on mental health and the prevention and control of substance abuse;
- (iii) to increase support for the training of health professionals in mental health at different levels of the health system and promote the use of traditional medicine within the context of African realities;
  - (iv) to facilitate the mobilization of additional resources for the implementation of the mental health strategy in Member States;
  - (v) to develop operational plans for the implementation of the regional strategy for the period 2000–2001;
  - (vi) to report to the 51st session of the Regional Committee on the progress made in the implementation of the regional strategy for mental health.

## REFERENCES

1. WHA 28.81(1975) – on assessment of problems relating to Alcohol Abuse.
2. WHA 30.45(1977) – creation of AMHAG, the African Mental Health Action Group.
3. AFR/RC38/R1(1988) – Prevention and Treatment of mental and neurological disorders.
4. AFR/RC40/R9(1990) – on community mental health care based on the district health system approach in Africa.
5. AFR/RC44/R14(1994) – on accelerating the development of mental health in the African Region.
6. UN General Assembly Resolution 46/119(1991) on protection of persons with mental illness and the need for improvement of mental health care.
7. United Nations Declaration and Guiding Principles of Drug Demand Reduction (March 1998).
8. About 70–80% of the population in the Region lives in rural areas, where access to health care is difficult or is not available. There is lack of essential drugs for the treatment of the most common neurological and mental disorders. Many countries in the Region have no mental health legislation. Where it exists, it is outdated.
9. The World Federation for Mental Health, the World Psychiatric Association, the World Association for Psychosocial Rehabilitation, the International League Against Epilepsy and others.

## 5.4 Non-communicable diseases: A strategy for the WHO African Region

(AFR/RC50/10)

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### EXECUTIVE SUMMARY

1. *The attainment of health for all, proclaimed at the World Health Assembly in 1977, will remain a major objective for the foreseeable future.*
2. *For many years, the Region has been experiencing an accelerated increase in non-communicable diseases (NCDs), adding to the already heavy burden of communicable diseases. If no steps are taken now, NCDs might become the leading cause of morbidity and mortality by 2020. As pointed out in the Global Burden of Disease study, under all disease scenarios, NCDs are assuming increasing importance in Africa.*
3. *Many NCDs that pose public health problems share common risk factors like tobacco consumption, obesity, high alcohol consumption, physical inactivity and environmental pollution, and are amenable to health promotion and preventive action.*
4. *The strategy proposed here aims at strengthening the capacity of Member States to draw up policies and implement programmes for the prevention and control of NCDs, using comprehensive multisectoral approaches.*
5. *The major thrusts of this strategy focus on strengthening health care for people with NCDs, supporting integrated disease surveillance, promoting research for community-based interventions, improving the capacity of health personnel, and finding ways to reduce premature mortality and disability due to NCDs.*
6. *Countries must address NCDs within the general framework of health sector reform and find solutions to problems like equity, access to health care, allocation of resources and service management.*
7. *The Regional Committee examined and adopted this strategy and gave orientations for its implementation.*

### INTRODUCTION

1. The morbidity and mortality burden attributable to non-communicable diseases (NCDs) such as cardiovascular diseases, cancer and diabetes, is on the increase. In 1990, morbidity was 41% of the overall disease burden worldwide, and will rise to 60% in 2020.
2. In 1990, NCDs and injuries caused 28% of morbidity and 35% of mortality in sub-Saharan Africa<sup>1</sup>. If communicable diseases control programmes attain their goals, these figures will rise to 60% and 65% respectively by 2020. If those goals are not achieved

and communicable diseases persist, almost 50% of morbidity and mortality will be caused by NCDs.

3. The magnitude of NCDs in the Region varies from country to country. However, there is currently a rapid epidemiological transition, with NCDs adding to the burden of communicable diseases. This will become more significantly apparent in the coming decades if nothing is done about the situation. Furthermore, complications of NCDs such as kidney failure, stroke, heart failure, blindness, etc., are extremely costly. Action should start now, before countries are overwhelmed by NCDs.

4. The present regional strategy on NCDs is in response to requests by countries to the Regional Director during the forty-eighth session of the Regional Committee. Other problems related to NCDs have already been addressed through regional strategies or global initiatives. They include oral health, mental health, nutrition and health, tobacco control, disability prevention, rehabilitation and injury prevention. This document will, therefore, focus on other NCDs which are also of public health importance in the Region.

## SITUATION ANALYSIS AND JUSTIFICATION

### Situation analysis

5. Reliable information on NCDs in the Region is limited. However, studies carried out in certain countries have helped to determine the magnitude of NCDs and some risk factors. Some countries have even developed specific programmes. Lack of data is often mistaken for non-existence of the problem and often little attention is given to NCDs. These diseases are caused by a combination of factors that include poverty<sup>2</sup> and urbanization, which lead to changes in lifestyles. As African populations age, thanks to longer life expectancies, the importance of NCDs increases in relation to other causes of ill health. Indeed, by 2025, about half of Africa's population will be living in urban areas, while the number of Africans aged over 60 years will increase from the present 39 million to 80 million.
6. Therefore, conditions will exist for an increase in cases of NCDs, which will constitute some of the most threatening diseases in the Region. Genetic disorders like sickle cell disease are very frequent in certain countries of the Region. Health systems in most Member States are inadequate to deal with NCDs. Countries currently manage these diseases through the provision of expensive clinical services that have limited coverage and impact on the health status of the population. Moreover, NCDs generate considerable needs in essential drugs and psychosocial support and require organizational adjustments in health services and systems. These conditions are rarely met. As a result, NCDs are less effectively managed in primary health care facilities by staff who are not adequately prepared. This creates limited accessibility and greater inequity and leads to inappropriate management of patients with NCDs.
7. Many NCDs share some behavioural, environmental or genetic risk factors. Major risk factors that are amenable to preventive measures are smoking, obesity, high alcohol consumption, physical inactivity, diabetes mellitus and lipid disorders.
8. Hypertension is the most frequent and most important risk factor for cardiovascular diseases. Its prevalence is estimated to be about 20 million in the Region. Some 250 000 deaths could be prevented each year through effective case management. Complications of untreated hypertension include heart failure, chronic renal failure, stroke and coronary heart disease. The hypertension-related stroke rate in the Region is high and victims are generally relatively young.
9. Rheumatic heart disease is still frequent despite the availability of several potential cost-effective measures for preventing rheumatic fever. Its prevalence could be as high as 15 per 1000 among school children<sup>3</sup>. The disease continues into the second and third decades of life, leading to social and family problems and increased demand for health care.
10. The prevalence of diabetes in the Region is estimated to vary between 1% and 5% and is as high as 20% in some urban and ethnic groups. The public health consequences of poorly managed diabetes such as kidney failure, coronary heart disease, blindness, diabetic foot and coma are high.
11. The numbers of new cases and of deaths by cancer are higher in developing countries than in developed countries. Out of nine million new cases recorded in 1985, 55% were in developing countries. In 2015, out of 15 million cases, 66% will occur in developing countries. In Africa, it is estimated that infectious agents cause 40% and 29% of cancers affecting men and women respectively, which emphasizes the fact that some of the cases are avoidable. Effective preventive measures against liver and cervical cancers, for example, are available through immunization and general prevention of sexually transmitted diseases. Among African populations with high maize consumption, aflatoxin is a major cause of liver cancer. Exposure to radioactive and industrial waste that has been inappropriately stored or disposed of may account for an increase in the number of certain cancers.
12. So far, there are only a few cancer registries in the Region but the information they provide is highly useful. Cervical, breast and liver cancers are common among women, while liver, prostate and stomach cancers are common among men. Cancer of the lungs and oesophagus are also frequent, especially in southern Africa where they are linked to high tobacco consumption. In countries with a high prevalence of HIV infection, the incidence of cancer, especially skin cancer, is also high.

13. Asthma often starts in infancy and, if not adequately treated, may have serious consequences throughout life. Its prevalence is increasing as a result of urbanization, smoking and air pollution. Sudden and unexpected deaths caused by asthma have been reported in some Member States.

14. The most important risk factor for chronic obstructive pulmonary diseases (COPD) is smoking, although air pollution from burning domestic waste and exhaust fumes also contribute. Biomass and fossil fuels<sup>4</sup> are major sources of energy in the Region. It is necessary to assess the effect on health of the inhalation of smoke from these sources.

15. There are several important genetic diseases, many of which are aggravated by consanguinity. Among these are sickle cell disease, thalassemia, Glucose<sup>6</sup> Phosphate Dehydrogenase (G6PD) deficiency and various birth defects. Further research is required to assess the magnitude of the problem in the Region. Prevalence of the causative gene of sickle cell disease is estimated to vary between 10 per 1000 and 30 per 1000 in some populations in the Region<sup>6</sup>.

16. Trends in mortality and morbidity caused by injuries are likely to double in 2020, compared to 1990.

### **Justification**

17. The objective of WHO, as stipulated in its Constitution, is the “attainment by all peoples of the highest possible level of health”<sup>6</sup>. For more than thirty years, the World Health Assembly (WHA) has adopted resolutions<sup>7</sup> calling for the rapid development of long-term programmes to control cardiovascular diseases (CVDs), with special emphasis on research on the prevention, etiology, early detection, treatment and rehabilitation of patients. Various WHA resolutions have requested the Director General to intensify measures aimed at encouraging the prevention of cardiovascular diseases, as a model for all other NCDs; assist developing countries and others to control diabetes; and encourage the development of NCD prevention and control programmes<sup>8</sup>. Resolution EB 105.R12 calls for community-based prevention and control of non-communicable diseases.

18. As indicated earlier, the forty-eighth and forty-ninth sessions of the Regional Committee clearly expressed the concerns of Member States with regard to the increase in chronic diseases. This concern was reiterated during the fourth meeting of the Organization of African Unity (OAU) health ministers held in Cairo in November 1999.

19. NCDs, often occurring at ages of increased responsibility, deprive families of precious income and communities of productivity reserves. Given the limited resources for health in the face of numerous priorities, the management of NCDs based on the hospital-curative model alone cannot work. It is difficult to guarantee accessibility and equity when costs are virtually unbearable for both health systems and households. It is, therefore, necessary to develop a comprehensive and coherent community-based approach, using comprehensive health promotion strategies to encourage healthy lifestyles, particularly among the youth; prevent NCDs; detect cases early enough; and choose efficient clinical interventions. As it takes years to change risky behaviours, we should start now if we are to reverse the trend and reduce the burden of morbidity and mortality attributable to NCDs.

## **THE REGIONAL STRATEGY**

### **Aim and objectives**

20. The aim of this strategy is to alleviate the burden of NCDs through, inter alia, the promotion of healthy lifestyles among the peoples of the African Region.

21. The objectives of the strategy are:

- (a) to support integrated disease surveillance aimed at quantifying the burden and trends of NCDs, their risk factors and major determinants;
- (b) to strengthen health care for people with NCDs by supporting health sector reforms and cost effective interventions based on primary health care;
- (c) to support prevention approaches aimed at reducing premature mortality and disability due to NCDs;
- (d) to improve the capacity of health care personnel to manage and control NCDs;
- (e) to support research on effective community-based interventions, including traditional herbal medicines.

### **Guiding principles**

22. Success in the prevention and control of NCDs in the Region will depend on the following principles:

- (a) tackling the challenges of NCDs, guided by a clear vision and careful long-term planning within the health sector;
- (b) integrating NCD prevention and control within the health sector reform process;

- (c) focusing on cost-effective interventions within effective national programmes;
- (d) promoting equity by providing poor and marginalized groups with minimum acceptable standards of health care;
- (e) developing advocacy programmes, using staff in the field who are not only familiar with the culture and local conditions but also have the right information;
- (f) building partnerships to share responsibilities and resources for maximum impact.

### Priority interventions

23. Member States and WHO will need to address the following priorities in order to prevent and control NCDs:

- (a) assessment of the burden of diseases attributable to NCDs, their risks and major determinants;
- (b) preparation of strategies for the prevention and control of non-communicable diseases within health development plans;
- (c) integration of NCD surveillance existing surveillance systems;
- (d) enhancement of the capacity of health care workers;
- (e) development of operational research;
- (f) enhancement of partnership with all stakeholders;
- (g) development of sustained advocacy.

24. It is important to have a local data on the disease burden attributable to NCDs, their risk factors and major determinants. This knowledge will facilitate priority setting and adoption of appropriate actions. Wherever data are limited, specific baseline studies should be conducted. Evidence strengthens advocacy and facilitates decision-making.

25. A strategy for the prevention and control of non-communicable diseases should be prepared and incorporated into national health development plans. Countries must also consider NCDs in the general framework of their health sector reform agenda.

26. Poor and marginalized populations are more affected by NCDs and should benefit from health financing and social security schemes. The implementation of such schemes by countries constitutes an important contribution to the successful implementation of strategies for the prevention and control of non-communicable diseases.

27. Surveillance of NCDs should be adapted to mechanisms already existing such as integrated disease surveillance programmes. It may start in a district and expand to other districts as and when

human and material resources are developed. Implementation plans should be developed in collaboration with teams working at all levels of the health care system. This encourages ownership and motivation for action. The health sector should develop an efficient health information system; initiate cost-effective measures for the prevention and control of NCDs; establish a standard essential package for the treatment and surveillance of NCDs, including the use of traditional pharmacopoeia; and adopt positive practices with proven efficacy.

28. Enhancement of the pre-service and in-service capacity of health care workers to meet the challenges of NCDs in order to reduce premature mortality and disability should include training programmes in the management, control and prevention of NCDs. Changes in lifestyles in communities should be studied and the results thereof disseminated in order to facilitate the formulation of policies and implementation of programmes.

29. In order to generate sufficient data on NCDs, trigger community-based responses to these diseases and encourage the use of traditional medicine, countries should develop focused research plans.

30. The most efficient approaches for the prevention and control of NCDs are those based on comprehensive, multisectoral and multidisciplinary interventions implemented through partnerships with all stakeholders. These may involve setting up a common standard for water supply and waste treatment, promoting legislation and regulations on smoking, the quality of food and air pollution, and instituting an interactive information and education strategy on healthy lifestyles through schools, public media and the work place.

31. WHO will support the implementation of these approaches by immediately starting sustained advocacy with institutional partners in all programmes outside its mandate that are crucial in the prevention and control of NCDs. Human resource development for the effective prevention and control of non-communicable diseases will be promoted.

### Implementation framework

32. Implementation plans should be developed at the lowest possible level with the participation of communities. On the basis of clear national plans and programmes with realistic implementation time frames, ministries of health should mobilize funds to support NCDs programmes. It is advisable that countries engage partners early in their programme development process.

33. In developing programmes for the prevention and control of non-communicable diseases, priority should be given to comprehensive and integrated approaches. The designation of a national structure with responsibility for NCDs at the ministry of health would facilitate contacts, exchanges and collaboration. Countries with established structures should strengthen their management capacities and focus on surveillance, operational research and evaluation, particularly in terms of the comparative costs of different interventions.

34. Countries should facilitate the organization of national consensus workshops in order to disseminate the strategy and develop frameworks to implement their programmes within the primary health care system. They should strive to expand ownership of programmes by all stakeholders.

35. Emphasis will be placed on surveillance, improvement of the performance of the health system and the development of multisectoral strategies for reducing risk factors, particularly those related to tobacco use, unhealthy diets and physical inactivity.

36. WHO will step up advocacy for the implementation of the recommendations of this strategy within countries, particularly for the inclusion of NCDs in national priorities. Technical support will be provided to improve national capacities in the development, implementation, monitoring and evaluation of programmes. The exchange among Member States of information on good practices will be encouraged.

37. WHO will support the efforts of countries and specialized bodies to carry out research on the prevention and control of non-communicable diseases. It will promote inter-country cooperation, particularly through support of multi-centre research activities and the establishment of a network of relevant regional databases.

## **MONITORING AND EVALUATION**

38. Countries will adapt and use generic monitoring and evaluation indicators that will be developed by WHO and will conduct a mid-term review of the implementation of their national strategies. Countries should carry out the monitoring and evaluation of their programmes with the support of WHO.

39. WHO will take the lead in strengthening regional partnerships for the surveillance, prevention and control of NCDs and develop mechanisms and processes to help monitor activities that affect health across the various sectors of government. The Organization will also sensitize other partners and

strengthen the role of WHO collaborating centres in support of country activities.

## **CONCLUSION**

40. At the dawn of the 21st century, the African Region is confronted with a two-fold burden caused by the persistence of communicable diseases and the rapid emergence of NCDs. The problem is further complicated by the deterioration of the economic situation of many countries in the Region. This situation calls for an innovative response from Member States.

41. The present strategy aims at assisting African countries within the next ten years to implement a comprehensive strategy for the prevention and control of non-communicable diseases. It also underscores the importance WHO Member States attach to the prevention and control of NCDs as a means of contributing to the health and development of the peoples of the Region.

42. The Regional Committee examined and adopted this strategy and gave orientations for its implementation.

### ***Resolution AFR/RC50/R4***

#### **Non-communicable diseases: A strategy for the African Region (AFR/RC50/R4)**

The Regional Committee,

Aware of the magnitude and the public health importance of non-communicable diseases (NCDs), many of which have common risk factors;

Concerned about the accelerated increase in the prevalence of NCDs, adding onto the already heavy burden of communicable diseases;

Recalling resolutions WHA19.38, WHA25.44, WHA29.49, WHA36.32., WHA38.30, WHA42.35, WHA42.36, WHA51.18, WHA53.17 and EB105.R12 that called for intensified measures to prevent and control NCDs, and the recommendation by Member States adopted at the 48th and 49th sessions of the Regional Committee;

Appreciating all the efforts that Member States and their partners have made in the past to manage some NCDs and, thereby, improve the health of their population;

Recognizing the need to review the existing approaches and develop a comprehensive strategic framework for the prevention and control of NCDs in countries of the African Region;



Having carefully examined the Regional Director's report contained in document AFR/RC50/10 and outlining the WHO regional strategy for non-communicable diseases;

1. APPROVES the proposed strategy aimed at strengthening the capacity of Member States to improve the quality of life of their populations through the alleviation of the burden of NCDs by, inter alia, promoting healthy lifestyles and taking other appropriate interventions.

2. URGES Member States:

- (i) to develop or strengthen national policies and programmes targeting the prevalent NCDs affecting their populations;
- (ii) to support integrated disease surveillance aimed at quantifying the burden and trends of NCDs, their risk factors, the quality of the management of cases and their major determinants;
- (iii) to strengthen health care for people with NCDs by supporting health sector reforms and cost-effective interventions, based on primary health care;
- (iv) to support prevention strategies based on knowledge of the risk factors, aimed at reducing the occurrence of cases and, consequently, premature mortality and disability due to NCDs, using multisectoral approaches that include measures such as regulations and taxation, where applicable;
- (v) to improve the capacity of health care personnel in the management and control of NCDs;
- (vi) to support research on the identification of effective community-based intervention strategies, including traditional herbal medicines;
- (vii) to consider the experience and progress made in the prevention of prevalent genetic disorders when developing programmes for the community-based management of these diseases.

3. REQUESTS the Regional Director:

- (i) to provide technical support to Member States for the development of national policies and programmes to prevent and control NCDs;
- (ii) to increase support for the training of health professionals in NCD prevention and control, including monitoring and evaluation of programmes at different levels, and promote the use of training institutions in the Region taking into account the realities in the African Region;
- (iii) to facilitate the mobilization of additional resources for the implementation of the regional strategy in Member States;
- (iv) to draw up operational plans for the decade 2001–2010;
- (v) to report to the 53rd session of the Regional Committee, in the year 2003, on progress in the implementation of this regional strategy.

*Seventh meeting, 31 August, 2000*

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## 5.5 Control of human African trypanosomiasis: A strategy for the WHO African Region (AFR/RC55/11)

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### EXECUTIVE SUMMARY

1. *Human African trypanosomiasis (HAT) is caused by trypanosomes that are transmitted by the tsetse fly. HAT is the only vector-borne parasitic disease with a geographical distribution limited to the African continent. Populations in the age group 15–45 years living in remote rural areas are the most affected, leading to economic loss and social misery.*
2. *In the early 1960s, the prevalence of HAT had been reduced to very low levels (prevalence rate less than one case per 10 000 inhabitants). Unfortunately, due to lack of regular surveillance activities and reduced resource allocation to HAT as well as changing health priorities and non-availability of drugs, the disease has been neglected.*
3. *During the 1980s and 1990s, considerable progress was made in the development or improvement of epidemiological tools suitable for HAT control; however, these were not sufficiently used in the field. All this led to the resurgence of the disease in areas where it was previously controlled, reaching epidemic levels in some instances. WHO estimates are that infected individuals number between 300 000 and 500 000.*
4. *The proposed regional strategy for the control of HAT is aimed at eliminating the disease as a public health problem by 2015. To attain the set targets, the strategy proposes an integrated approach, consisting of continuous surveillance of the population at risk, passive and active case detection and treatment, reduction of animal reservoirs through selective or mass treatment of live-stock, and intense tsetse control in highly endemic and epidemic areas.*
5. *Implementation of this strategy should reduce morbidity and mortality due to human African trypanosomiasis and improve the economic and social status of the affected populations.*
6. *The Regional Committee examined and adopted the strategy.*

### INTRODUCTION

1. Human African trypanosomiasis (HAT), commonly known as “sleeping sickness”, is caused by trypanosomes that are transmitted by the tsetse fly. The disease was recognized centuries ago. HAT is the only vector-borne parasitic disease with a geographical distribution limited to the African continent. There have been three severe epidemics: one at the end of the nineteenth century, the second during the 1920s, and the third from the 1970s to the present.
2. The disease progresses through two stages, following an asymptomatic period of several weeks or

months. The early stage is usually characterized by malaria-like symptoms, including fatigue, headache, recurrent fever and swollen lymph nodes. In advanced stages, the disease affects the central nervous system, causing severe neurological and mental disorders and making the individual dependent on others. Infected individuals are weakened, often for many years, causing economic loss, poverty and social misery. HAT is completely fatal if untreated.

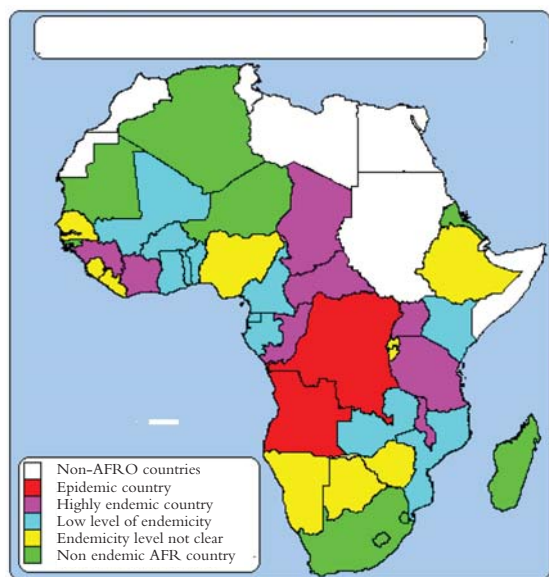
3. HAT constitutes a major public health problem in the African Region. Given the resurgence of both human and animal trypanosomiasis, the epidemic

potential, high fatality rate and significant impact on socioeconomic development, many countries requested more active WHO support to control the disease. The aims of this proposed strategy are to control the intensity of transmission in endemic and epidemic countries in the medium term and to eliminate the disease in the long term.

### SITUATION ANALYSIS

4. During the nineteenth century, HAT was an enormous public health problem. Currently, there are more than 250 active foci within the “tsetse belt” in sub-Saharan Africa, mainly involving countries of the WHO African Region and the Sudan. Within this area, sleeping sickness threatens over 60 million people. Less than 10% of the at-risk population are currently under surveillance. In recent years, an annual average of about 45 000 cases has been reported; however, WHO estimates that between 300 000 and 500 000 individuals are infected.<sup>1</sup>

5. The true number of endemic countries is unknown. It is reported that HAT is endemic in 35 countries in the African Region, but there are different levels of endemicity<sup>2</sup> (see Figure 1). Countries are classified as: (a) non-endemic with no case reported in five or more years; (b) unknown endemicity (0–25 new cases per year); (c) low endemicity (26–100 new cases per year); (d) moderate endemicity (101–500 new cases per year); (e) highly endemic or epidemic (more than 500 new cases per year). In 2003, countries reported about 17 000 new



**Figure 1:** Human African trypanosomiasis endemicity in the WHO African Region

cases to WHO. More than 80% of these cases were reported from Angola (3000 cases) and the Democratic Republic of Congo (11 000 cases).

6. Sleeping sickness is mainly a disease of poor, marginalized and rural populations who depend on their land and labour for a livelihood. HAT represents a major threat to economic development because it mainly affects the most productive age group (15–45 years) and sustains the disease-poverty-disease cycle.

7. A significant proportion of children are affected by HAT, and many will have considerable delay in mental development even after successful treatment. This will impact negatively on their school performance and eventual lifetime achievements.

8. According to recent estimates,<sup>3</sup> the disability-adjusted life years (DALYs) lost due to sleeping sickness was 2.05 million. The same source reported 66 000 deaths in 1999 due to HAT.

9. Given the negative socioeconomic impact of HAT, the Regional Committee, in 1982, adopted Resolution AFR/RC32/R1 recommending to Member States to implement trypanosomiasis control activities. This was later endorsed by World Health Assembly resolutions WHA36.31, WHA50.36 and WHA57.2.

10. The disease was brought under control in the early 1960s when the prevalence was dramatically reduced to very low levels (less than one case per 10 000). Active case detection by examination of lymph-node aspirates, treatment with toxic drugs, vector control and mobile teams were utilized.

11. Unfortunately, these successful results could not be sustained. Regular and systematic surveillance, which is the cornerstone of HAT control, was abandoned because of the progressive shortage of qualified personnel. Population movements following political upheavals and economic crises as well as changing priorities in national policies led to the allocation of fewer resources to the health sector. A substantial proportion of the inhabitants of endemic foci were no longer participating in screening activities. Hence, active case detection was greatly reduced, and drugs for treatment were often not available. All these factors contributed to the resurgence of the disease to epidemic levels.

12. In some countries, control efforts resumed, but the situation continued to worsen. Current HAT control in the Region faces a lot of constraints and challenges: insufficient financial allocations, severe shortage of skilled personnel, inadequate health infrastructure, diagnostic and treatment procedures

that are difficult to implement at peripheral level, severe drug side-effects, increased drug resistance, poor community awareness and participation in control activities, remote disease foci, and lack of multisectoral coordinated action to implement disease control programmes.

13. Strong enabling factors for human African trypanosomiasis control do exist. In affected countries, there is strong willingness and commitment to HAT control. The private sector, including pharmaceutical companies and the international community, is expressing willingness to offer support to neglected diseases, including HAT. New tools have been developed for diagnosis and vector control, which further facilitate the implementation of control activities.

## **THE STRATEGY**

14. The success of HAT control in the African Region will depend on the following guiding principles:

- (a) Formulation, adoption and implementation of a national policy for HAT control in each affected country;
- (b) Ownership of the control programme by governments and communities of the endemic countries;
- (c) Coordination of stakeholders by national control programmes;
- (d) Sustainability of control programme activities.

15. The goal of the human African trypanosomiasis strategy is to reduce the morbidity and mortality attributed to sleeping sickness in the African Region. The main objective is to support governments to develop HAT control plans and programmes.

16. The specific objectives are:

- (a) to strengthen capacities to plan, implement, monitor and evaluate national HAT control programmes;
- (b) to conduct baseline studies on HAT prevalence, incidence and mortality;
- (c) to promote and coordinate the involvement of public and private sectors in HAT control;
- (d) to promote operational research as a tool to identify and address issues arising from the implementation of national HAT control programmes.

17. The targets of the regional strategy are as follows:

- (a) By 2007, at least 80% of endemic countries in the African Region will have established national policies and control programmes for HAT;

- (b) By 2008, at least 60% of the endemic countries in the African Region will have deployed a sufficient number of skilled personnel for the implementation of national control programmes;
- (c) By 2010, at least 35% of endemic countries in the African Region will have a prevalence rate of one case or less per 10 000;
- (d) By 2012, targeted vector control interventions will have been implemented in epidemic and highly endemic areas (prevalence rates equal to or greater than 1%);
- (e) By 2015, all known endemic countries will have a prevalence rate of less than one case per 10,000 persons at risk.

18. Taking into account the diversity of conditions in the different foci, this strategy should be adapted to local conditions. Rapid reduction of the parasite reservoir in humans is the backbone of the control of human African trypanosomiasis, while reduction of the animal reservoir plays an important complementary role in the control of animal trypanosomiasis. To achieve the set objectives, various interventions should be implemented. These are capacity building, case detection and treatment, vector control, control of animal reservoir, surveillance, health promotion, advocacy and operational research.

19. Capacity building for HAT control should be undertaken as a matter of urgency, and training of nationals should be a priority. Detection and treatment centres should be appropriately equipped, and supervision should be instituted and enforced for strengthening capacity.

20. Case detection and treatment should be carried out at least once a year in each focus, especially in highly endemic and epidemic areas, to ensure rapid reduction of the parasite reservoir in humans. Activities will include setting up and equipping diagnostic and treatment centres; setting up, equipping and staffing mobile teams at district level; ensuring availability of drugs at district level; following-up serological suspects and tracking post-treatment patients.

21. The technology to be used for tsetse control should be determined by individual countries. They may opt for targeted tsetse control after an epidemiological assessment of the disease and vector, perhaps choosing cost-effective tsetse traps.

22. Communities should contribute to sustainability and minimizing costs. Local manufacture of tsetse traps, for example, will promote community ownership of the programme.

23. Strengthening control of the animal reservoir requires intersectoral linkages. All sectors should,

therefore, collaborate from planning to implementation phase for control of the animal reservoir in both animal and human trypanosomiasis. Treatment of livestock in areas reporting *T.b. rhodesiense* will reduce the reservoir population. The treatment could be either selective (after diagnosis) or comprehensive (treating all livestock). Farmers should be sensitized and mobilized to present their animals for examination and treatment. The role of animals in *T.b. gambiense* is not clear; therefore, treatment of livestock in endemic areas needs to be evaluated.

24. Efforts should be made to collect HAT data through the integrated disease surveillance approach. Sentinel sites should be set up, and the collected data could be used for mapping disease distribution, monitoring disease trends and resistance to drugs, establishing HAT data banks at decision-making and planning levels, epidemic preparedness and response, and case reporting. Other activities will be the development of data collection and management tools (such as TRY-DATA) and promotion of cross-border surveillance through information sharing and meetings.

25. Health promotion should be implemented within the context of the regional health promotion strategy. Individual and community knowledge of HAT can be increased through health education and information-education-communication. Health education should be included in the curricula at primary school level. HAT can be a component of national health education packages and other disease control programmes. Social mobilization can strengthen community action. National programmes should be encouraged to form partnerships with the media to disseminate information about HAT and its control.

26. Advocacy should be aimed at mobilizing resources at national and international levels for the implementation of national programmes. Governments should be encouraged to allocate funds for HAT control interventions to ensure sustainability. Advocacy is also crucial for building public-private partnerships.

27. The Regional Office should support operational research and research on health systems in collaboration with the WHO Special Programme for Research and Training in Tropical Diseases, the United Nations Development Programme and the World Bank. Research issues should arise as a result of the implementation of national HAT control programmes and include treatment failures; relapses; clinical trials of drug combinations; rapid methods for mapping; socioeconomic burden of the disease; knowledge, attitudes and practices of the communities. Meetings should be held to prioritize topics,

review findings and strengthen collaboration between research and control activities.

### Priority interventions

28. Priority interventions will include mapping disease distribution, case detection and treatment, setting up a surveillance system, and control of animal reservoirs and vectors. The starting point in HAT control is assessment of the disease situation. This will result in the mapping and delimitation of the foci where the disease prevails and allow better planning of control interventions.

29. Case detection should be passive and active; passive detection being when patients seek intervention on their own initiative; active detection is based on clinical surveys in the field. Interventions should emphasize active case detection, especially in highly endemic and epidemic areas; appropriate treatment based on specific drugs available at treatment centres close to patients' residences; adequately trained health workers; patient follow-up for a period of 18 months.

30. HAT control has been and will continue to be based on passive and active surveillance of populations at risk and the treatment of cases detected, coupled with vector control interventions in hyper-endemic and epidemic areas. Failure to maintain surveillance will result in resurgence and epidemics that will substantially increase morbidity and mortality and require expensive control measures.

31. It is important to carry out selective or mass treatment in order to minimize animal reservoir hosts (especially in *T.b. rhodesiense*). This mainly calls for the treatment of livestock in the endemic areas.

32. In highly endemic foci, case detection must be coupled with tsetse control to achieve more rapid and effective control. Ministries of livestock and agriculture should be involved in vector control activities. Trapping of tsetse flies is effective, simple, environmentally-friendly and preferable to insecticide spraying. Insecticide application in cattle dips can also be used. These methods should involve community participation.

33. The sterile insect technique still poses a series of technical, financial and logistic problems. Therefore, it is not yet recommended in epidemic situations.

### Roles and responsibilities

#### Countries

34. Ministries of health at national level should develop human African trypanosomiasis policies,

plans and implementation frameworks. These documents will be the basis for all stakeholder support and will ensure uniform control activities and strong partnerships.

35. Districts will be responsible for planning; implementing, supervising, monitoring and evaluating HAT control activities in countries. Communities should participate and thus own HAT control programmes; they should be involved from the conceptual phase.

36. A national HAT programme manager should be appointed in each country. Multidisciplinary task forces and committees for HAT control should be established at all levels to ensure intersectoral co-ordination.

37. Diagnosis and management will be decentralized in such a way that each affected district will participate in control of the disease. Vector control will be integrated with other control activities, where appropriate.

38. Coordination will ensure standards and uniformity of activities, while collaboration will aim at establishing strong partnerships at all levels. Inter-ministerial collaboration will ensure promotion of tsetse control and treatment of animal reservoirs.

39. Ministries of health are responsible for mobilizing resources for the programme and for providing overall coordination, supervision, monitoring and evaluation. They will offer technical support to districts and promote public-private sector partnerships.

40. The public sector will collaborate with the private sector and international bodies to ensure availability of HAT control products and technologies. According to their comparative advantages, non-governmental organizations will support national programmes and work closely with them. Partners will contribute in advocacy, resource mobilization and capacity building.

### **WHO responsibilities**

41. WHO will support the development and implementation of national control programmes through technical support and capacity building (including support to research institutions working on sleeping sickness). Intercountry teams based on epidemiological blocs will be strengthened. WHO will also promote linkages between this strategy and other relevant WHO regional strategies on integrated vector management, health promotion and integrated disease surveillance.

42. WHO will also collaborate with other international organizations and projects such as the African Union, the Food and Agriculture Organization, the United Nations Development Programme, the International Atomic Energy Agency, and the Pan African Tsetse and Trypanosomiasis Eradication Campaign to promote treatment of animal reservoirs and tsetse control. The Organization will monitor and evaluate the regional strategy and national programmes.

### **MONITORING AND EVALUATION**

43. Monitoring and evaluation of the national control programmes include continuous internal monitoring and periodic external review and evaluation. The progress and impact of the programme will be assessed and redirected, if necessary. Core indicators for monitoring and evaluation will be developed by the WHO Regional Office. Countries will be encouraged to adapt indicators to their specific contexts.

### **CONCLUSION**

44. Human African trypanosomiasis is endemic only in Africa, where the disease is of great public health importance. The continent is currently facing a third epidemic. The social and economic consequences of the disease impact negatively on the development of the affected countries.

45. HAT control necessitates close collaboration between public and private sectors and strong involvement of communities and NGOs.

46. Implementation of this strategy in the affected countries should reduce morbidity and mortality due to human African trypanosomiasis in the Region and, hence, eliminate the disease as a public health problem by 2015.

47. The Regional Committee examined and adopted the strategy.

### **Resolution AFR/RC55/R3**

#### **Control of human African trypanosomiasis: Strategy for the African Region**

The Regional Committee,

Having carefully examined the regional strategy for the control of human African trypanosomiasis (HAT) during the next decade;

Deeply concerned about the resurgence of African trypanosomiasis and its devastating effect on human and livestock populations, both of which

contribute to poverty accentuation on the African continent;

Aware of the public health importance of human African trypanosomiasis, the epidemic potential, the high fatality rate and the socioeconomic impact of the disease;

Noting that a significant proportion of children are affected by the disease and many of them suffer considerable delay in their mental development, which impacts negatively on their school performance and professional advancement;

Recalling Resolution AFR/RC32/R1 (1979) recommending to Member States to implement human African trypanosomiasis (HAT) control activities, which was later endorsed by the World Health Assembly resolutions WHA36.31 (1986), WHA50.36 (1997), WHA56.7 (2003) and WHA57.2 (2004);

Appreciating the commitment and efforts made so far by Member States and their partners to bring the resurgence of the disease under control;

Convinced that controlling human African trypanosomiasis will ultimately contribute to poverty alleviation in the affected rural communities;

1. APPROVES the proposed strategy, which aims at strengthening the capacity of Member States to eliminate the disease as a public health problem by 2015;

2. URGES Member States of affected countries:

- (a) to develop national policies, strategies and plans for the implementation of national control programmes for human African trypanosomiasis and tsetse control in line with the regional strategy;
- (b) to provide sufficient financial and human resources for the implementation of national human African trypanosomiasis control programmes, including capacity strengthening through training of health workers;
- (c) to ensure that active and passive case detection and treatment combined with targeted vector control in high prevalence areas and selective or

mass treatment of livestock, where appropriate, are implemented for HAT control;

- (d) to advocate for an increased awareness of the risks and consequences of HAT, with emphasis on community participation at all stages of the fight against this disease;
- (e) to mobilize and coordinate national and international stakeholders involved in the fight against sleeping sickness, including local communities, public and private sectors, NGOs, and bilateral and multilateral organizations;
- (f) to promote operational research as a tool for improved planning, implementation, monitoring, evaluation and integration of national HAT control programmes into the national health system;
- (g) to develop standardized guidelines for the implementation, monitoring and evaluation of the regional strategy;

3. REQUESTS the Regional Director:

- (a) to provide technical support to Member States for the development of national policies and strategic plans for HAT control;
- (b) to advocate for additional resources at national and international levels for the implementation of HAT and tsetse control activities in endemic Member States;
- (c) to report to the fifty-seventh session of the Regional Committee in 2007, and every three years thereafter, on the progress made in the implementation of the Regional Strategy for HAT control.

*Eighth meeting, 25 August 2005*

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## 5.6 Accelerating the elimination of avoidable blindness: A strategy for the WHO African Region

(AFR/RC57/6)

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### EXECUTIVE SUMMARY

1. *The number of blind people in the African Region is estimated at 6.8 million. Blindness is a real public health problem.*
2. *Several countries in the Region have blindness control programmes. However, the programmes have limited impact due to lack of appropriate structures and resources. The Global Initiative for the Elimination of Avoidable Blindness, also known as “Vision 2020: The Right to Sight”, launched in partnership with the International Agency for the Prevention of Blindness, is an opportunity and appropriate response to the challenges posed by blindness.*
3. *The present strategy is intended to help implement the Vision 2020 Initiative in the African Region.*
4. *Interventions proposed under the strategy are: (i) advocacy and development of policies and plans; (ii) integrating eye care activities in existing health systems; (iii) adopting specific approaches to controlling priority diseases; (iv) developing human resources and infrastructures; (v) strengthening partnership and mobilizing resources; (vi) developing research.*
5. *The Regional Committee reviewed and adopted the strategy to eliminate avoidable blindness.*

### INTRODUCTION

1. Visual impairment refers to low vision and blindness, which correspond to partial or total loss of sight as measured by a standard scale.<sup>1</sup> Blindness is preventable or treatable in 75% of cases.

2. Blindness is a real public health and socio-economic problem. In developing countries, it worsens the problem of poverty. The burden of blindness remains high despite all efforts.

3. “Vision 2020: The Right to Sight” is a global initiative that aims to eliminate avoidable blindness by the year 2020. The Initiative is a partnership between WHO and the International Agency for the Prevention of Blindness (IAPB), which is a broad coalition of nongovernmental organizations.

4. The World Health Assembly, by its Resolution WHA56.26,<sup>2</sup> urges Member States to commit

themselves to supporting this global initiative by developing national Vision 2020 plans in partnership with nongovernmental organizations, the private sector and civil society, and by starting to implement these plans by 2007 at the latest.

5. Resolution WHA59.25<sup>3</sup>, for its part, urges Member States to develop and strengthen eye care services, integrate them into existing health systems, train key categories of personnel, re-train health workers in visual health care and mobilize domestic financial resources.

6. The present strategy proposes specific interventions as part of the Vision 2020 Initiative for preventing and eliminating avoidable blindness in the African Region.



## SITUATION ANALYSIS AND JUSTIFICATION

### Situation analysis

7. Lack of reliable epidemiological data is a basic problem in Africa. About 161 million people have visual impairment worldwide; of these, 37 million are blind. It is estimated that the number of people with visual impairment in sub-Saharan Africa is 27 million, of whom 6.8 million are blind.<sup>4</sup>

8. The main causes of avoidable blindness in developing countries worldwide are: cataract (50%); glaucoma (12%); corneal opacity (5%); diabetes (5%); trachoma (4%), affecting especially women and children; childhood blindness due to vitamin A deficiency, measles and neonatal conjunctivitis (4%); onchocerciasis (0.8%); other causes (14%)<sup>5</sup>, including low vision and refractive errors.

9. Cataract is the main cause of blindness in the Region. It is either congenital or acquired (due to ageing, diabetes, injury) and corresponds to opacity of the lens, gradually leading to diminished vision. It is estimated that 3–4 million cataract cases are not operated upon, and only a small proportion of patients actually undergo surgery. Specifically, only 200 cases per million inhabitants undergo operation annually in the African Region, as opposed to 3000 to 5000 in the developed countries.<sup>6</sup> Difficulties of access to care and the high cost of surgery make this situation even worse.

10. Glaucoma, a condition linked to insidious rise in intraocular pressure, raises the problem of adherence due to long-term treatment. The main risk factors are high ocular pressure, age (over 40 years), family history and ethnicity (the black race at greater risk). Its treatment, whether by lifelong intake of medicines or by surgical intervention, requires expensive clinical services, yet the outcomes are modest.

11. Diabetic retinopathy is an ocular complication of diabetes. Globally, 2% of cases develop into blindness. Its rate of development into blindness in the African Region is unknown. This disease, which is a complication of uncontrolled diabetes, raises problems of case detection and management.

12. Lack of hygiene, poverty and difficulty of access to water are enabling factors for trachoma, an infectious eye disease whose complications and sequels can lead to blindness. A four-component strategy called SAFE (meaning Surgery, Antibiotics, Facial cleanliness and Environmental change), implemented in the 19 endemic countries of the Region,<sup>7</sup> can help reduce the burden of blinding trachoma.

13. Onchocerciasis is endemic in 30 countries of the Region. It has been controlled successfully in 10 out of 11 affected West African countries, thanks to the Onchocerciasis Control Programme (OCP) that ended in 2002. In the remaining 19 affected countries in the Region, the African Programme for Onchocerciasis Control (APOC) aims to eliminate the disease.

14. Childhood blindness is preventable or avoidable in the majority of cases, and its incidence has been reduced through integrated actions for combined elimination of vitamin A deficiency and measles (Global Child Survival Initiative). Preventive measures include immunization and prevention of both vitamin A deficiency and sexually-transmitted infections. Detection and management of congenital cataract and congenital glaucoma remain difficult in the Region. Only four pilot countries (Ethiopia, Ghana, Kenya and Mali) have the appropriate surgical facilities.

15. Refractive errors and low vision affect a significant proportion of the population. With the exception of Ethiopia, countries of the Region do not have reliable data on these two conditions. Some countries have initiated and started implementing specific programmes.

16. Eye care facilities are often inadequate, with obsolete and dysfunctional equipment. Lack of staff and shortage of medicines and other essential eye care products are frequent. The resulting rise in the incidence of diseases that cause blindness increases the threat to health in the Region. Adequate management of eye conditions in the Region would require a reorganization of care systems and services.

### Justification

17. Blindness is one of the main public health problems in Africa, even though 75% of the underlying causes are preventable. The World Health Assembly has already adopted two resolutions on blindness prevention. Vision 2020 is an appropriate response to the problem of blindness and provides an opportunity for governments, nongovernmental organizations, eye care professionals and the private sector to work together to eliminate avoidable blindness. This strategy for the African Region will facilitate the implementation of Vision 2020.

## THE REGIONAL STRATEGY

### Aim and objectives

18. The aim of this strategy is to help reduce the burden of avoidable blindness.

19. The objectives of the strategy are:

- (a) to help create a favourable political environment for the implementation of Vision 2020;
- (b) to integrate eye care services into primary health care;
- (c) to strengthen the development of human resources and appropriate technologies and infrastructure;
- (d) to strengthen partnership and resource mobilization;
- (e) to support studies on effective community interventions.

### **Guiding principles**

20. The proposed strategy is based on the following guiding principles:

- (a) adopting preventive, curative and rehabilitative interventions that are cost-effective;
- (b) promoting equity by ensuring that disadvantaged groups have access to quality care;
- (c) multisectoral and multidisciplinary partnerships, with the health sector playing a predominant role;
- (d) community involvement in obtaining adequate data on blindness, and fostering community responsiveness to eye diseases.

### **Priority interventions**

21. Priority interventions for improving blindness prevention and control are:

#### *Advocacy and development of policies and plans*

22. Creating and strengthening favourable conditions for **increasing advocacy and awareness** are crucial to decision making and resource mobilization for the implementation of interventions.

23. Data on avoidable blindness should be gathered to create an evidence base for use partly in the policy development process in order to convince stakeholders during discussions to support and guide interventions.

24. There is a need to strengthen the **development** and implementation of **national plans**. In addition, all blindness control stakeholders must be brought together for consultations leading to appropriate national programmes.

#### *Integrating eye care activities into existing health systems*

25. **Integration** of eye care will involve all existing levels of health care systems. It should be inspired by

primary health care principles, including the referral function. At the community level, promotional activities and health education should be integrated into common familiar activities and the activities of already-established associations. Basic eye care and the management of simple cases of refractive errors should be developed at the primary level under formative supervision.

26. Cases beyond the competency of the primary level, especially cataract cases recommended for operation and trichiasis cases in blinding trachoma recommended for surgery should be referred to the secondary level. Complicated and difficult cases beyond the competency of the secondary level should be referred to the tertiary level. Rehabilitation, training and research should be carried out at all levels.

#### *Adopting specific approaches to controlling priority diseases*

27. Vision 2020 provides specific orientations on interventions deemed appropriate for cataract, trachoma, onchocerciasis, childhood blindness and refractive errors. The need for countries to have access to these interventions will be stressed. Screening and surgery are the recommended interventions for cataract.

28. The SAFE strategy should be **intensified and better implemented** in countries where blinding trachoma is endemic. For countries where blinding trachoma and other parasitic diseases are co-endemic, the antibiotics component of the SAFE strategy should be integrated into programmes on neglected tropical diseases. Facial cleanliness and environmental hygiene should also be integrated within other water and sanitation programmes.

29. Implementation of the Yaounde Declaration of 2006 will help **accelerate** onchocerciasis elimination in the Region. To that end, activities, including surveillance, should be strengthened in countries in post-conflict situations and countries where there are pockets of onchocerciasis co-endemicity with loiasis, another parasitic disease. In addition, the activities must be extended to the ex-OCP countries.

30. Partnership with the Global Child Survival Initiative should be **strengthened**. Education and training of community health workers and traditional health practitioners should be developed. There is need to enhance the capacity of maternity and postnatal care providers and mothers to detect congenital eye conditions, particularly those linked to vitamin A deficiency and congenital cataract.

31. Refractive error cases involving children aged from 6 to 15 years and adults over 45 years should be

given priority. This will require **developing and strengthening** case detection within schools, colleges, associations and public places. This activity should be supplemented with a programme for supplying low-cost spectacles.

32. For glaucoma, there will be need to **develop and strengthen** health education, screening targeted at high-risk subjects and early management. Access to affordable, essential antiglaucoma medicines will be provided.

33. Primary and secondary prevention of diabetes should be **strengthened** to minimize the onset of diabetic retinopathy, which, once developed, is irreversible. Appropriate equipment and technology should be made available to stop the progression of blindness.

#### *Developing human resources and infrastructures*

34. **Strengthening** the capacities of all categories of eye care personnel is essential. **Training** should be provided for eye care personnel in order to fill the noted shortfalls in skills and abilities. The capacity of communities to conduct preventive and promotional activities and identify cases of visual impairment will be strengthened.

35. At the primary level, competencies in cataract and active trachoma detection in endemic countries and provision of basic eye care should be strengthened. The programme for initial training of paramedical staff should be improved by including basic notions of priority eye diseases.

36. At the secondary and tertiary levels, it will be necessary to train a larger number of ophthalmologists; cataracts surgeons from among general practitioners, and eye care assistants, based on the specific context of each country; other categories of essential medical and non-medical staff such as nurses specialized in ophthalmology, refractionists, low vision technicians, maintenance technicians and programme managers. The skills of ophthalmologists must be reinforced with additional sub-specialities.

37. Infrastructure should be rehabilitated, equipment renovated, and eye care consumables and medicines made available all year round. At the same time, new eye care services that meet the set standards in microsurgery and basic eye tests should be established.

#### *Strengthening partnerships and mobilizing resources*

38. It is essential to **strengthen** the mobilization of resources and the development of effective and coordinated partnerships among all actors at the

national, interregional and international levels in order to ensure and facilitate the implementation of interventions and optimize the use of resources. Existing partnerships should be strengthened.

#### *Developing research*

39. Countries will identify research priorities to support the implementation of avoidable blindness prevention and control programmes. They will be encouraged to **support** and finance research work, especially operational research. It will be helpful to **encourage** training of researchers and equip research institutions, schools of medicine and training centres.

#### **Roles and responsibilities**

40. Countries should:

- (a) develop and implement blindness control policies and plans and integrate eye care into existing health systems, based on field surveys;
- (b) strengthen health systems and blindness control capacities by fostering community involvement, collaboration with partners and operational research;
- (c) mobilize resources from domestic and external sources, establish national committees, coordinate the activities of all stakeholders and monitor blindness control programmes;
- (d) coordinate all partners;
- (e) undertake synchronized and integrated cross-border cataract campaigns.

41. WHO and partners should support countries to:

- (a) provide technical assistance for the development of policies and plans, and for data collection through surveys and data analysis and dissemination;
- (b) support countries to establish and implement control mechanisms and standards;
- (c) carry out advocacy among policy-makers, international partners and other key stakeholders for increased resources;
- (d) support training programmes;
- (e) support harmonization of country programmes.

#### **Resource implications**

42. Additional domestic and external resources are needed to support the strategy in the context of a broader partnership (bilateral and multilateral funding partners, NGOs and donors). Blindness control programmes in countries are currently supported mainly by partners with very limited contribution from governments. The proposed interventions will

require reorganization and concentration of resources to facilitate their implementation.

43. Available human resources adequately trained in eye care delivery at all levels; essential eye care equipment, medicines and consumables; and a community monitoring mechanism should be guaranteed.

## **MONITORING AND EVALUATION**

44. Establishment of a monitoring and evaluation system will help improve the implementation of interventions in accordance with the main objectives of this strategy. Countries will be provided with indicators for monitoring cataract surgery rates, the prevalence of trichiasis and active trachoma, implementation of the SAFE strategy in endemic countries, national onchocerciasis control programmes, measles immunization coverage, incidence of vitamin A deficiency, and prevalence of blindness and ocular disability due to uncorrected refractive errors.

## **CONCLUSION**

45. Blindness is a real and serious public health problem in the African Region. Existing interventions are highly cost-effective and will help achieve the objective of reducing avoidable blindness, which accounts for 75% of blindness cases. Emphasis must

be put on the need for advocacy to sensitize decision-makers, partners, health professionals and the populations to support the implementation of these interventions.

46. The Regional Committee reviewed and adopted the strategy to eliminate avoidable blindness.

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## 5.7 Diabetes prevention and control: A strategy for the WHO African Region

(AFR/RC57/7)

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### EXECUTIVE SUMMARY

1. Diabetes is a chronic disease characterized by chronic hyperglycaemia, which requires lifelong treatment. Its prevalence in Africa varies between 1% and 20%. Type 2 diabetes, which is the most common form, can be life threatening due to its complications, particularly, cardiovascular diseases. It constitutes a serious public health problem.
2. Diabetes, like other non-communicable diseases in the Region, receives lower attention than it deserves, despite its social, human and economic costs. Few countries have national programmes and basic facilities that are appropriate for the control of diabetes.
3. The present strategy urges Member States to evaluate the magnitude of diabetes and identify and improve areas of intervention in terms of primary, secondary and tertiary prevention activities.
4. Countries are encouraged to create the conditions required for prevention, early detection diagnosis, treatment, guarantee of equitable access to care, and availability of drugs at health facilities.
5. The Regional Committee examined and adopted the strategy for diabetes prevention and control.

### INTRODUCTION

1. Diabetes mellitus is a chronic disease whose global spread has given it the characteristics of a pandemic. The most frequent form is Type 2 diabetes which represents more than 85% of the cases. Other forms are Type 1 (10%), specific diabetes and gestational diabetes (5%).<sup>1</sup>

2. The disease presents with metabolic anomalies characterized by chronic hyperglycaemia, resulting from defective secretion or action of insulin (insulin resistance) or both. It is confirmed with a random venous plasma glucose higher than 2g/l (11.1 mmol), or fasting glycaemia that is higher than 1.26g/l (7.0 mmol/l) at two tests, or a fasting glycaemia higher than 2g/l (11.1 mmol) 2 hours after a glucose intake.<sup>2</sup>

3. Diabetes is serious due to its complications, namely: cardiovascular ailments, cerebral vascular accidents, renal insufficiency, blindness, sexual impotence and gangrene of the feet leading to amputation.

4. During the Forty-second World Health Assembly (1989), WHO adopted Resolution WHA42.36 on the prevention and control of diabetes, inviting Member States to evaluate the prevalence of diabetes at national level, take measures that focus on the population and are adapted to the local situation, and create a model for an integrated approach in the fight against diabetes at community level.<sup>3</sup>

5. In the African Region, efforts made to create an environment that enhances the fight against diabetes include adoption of resolutions AFR/RC50/R4 on non-communicable diseases: strategy for the African Region, in 2000, and AFR/RC55/R4: cardiovascular diseases in the African Region, in 2005. The World Health Organization and the International Diabetes Federation (IDF) jointly carried out other actions to contribute to it.

6. This document examines the situation of diabetes (Type 2) in the African Region and proposes a strategy for its prevention and control.

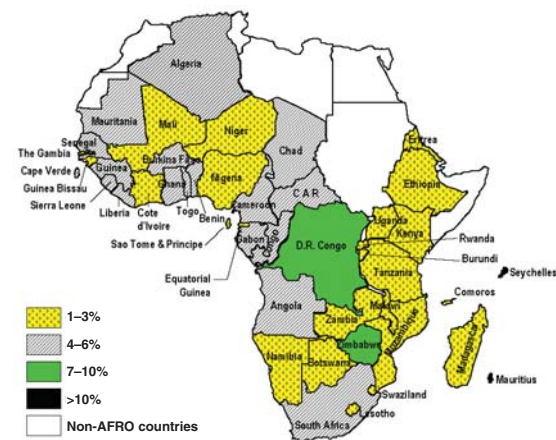
## SITUATION ANALYSIS AND JUSTIFICATION

7. Diabetes mellitus is no longer rare in Africa (Figure 1). Meta-analytic estimates and recent investigations based on the STEPwise approach<sup>4,5</sup> for monitoring the risk factors of non-communicable diseases indicate prevalence of between 1% and 20%. In some countries like Mauritius, it reaches 20%.<sup>6</sup> The global prevalence was estimated at 2.8% in 2000, with projections of 4.8% in 2030. The total number of persons affected would rise from 171 million in 2000 to 366 million in 2030 if no action is taken.<sup>7</sup>

8. The factors that affect the onset of diabetes are well-known. They comprise non-modifiable factors like old age (over 45 years of age), heredity (direct collateral) and the causes of diabetes in pregnancy. The modifiable factors are obesity, physical inactivity and excessive alcohol consumption.

9. Africa, which faces the dual burden of communicable and non-communicable diseases, is witnessing changes in traditional lifestyles that have disrupted feeding patterns. This in turn leads to physical inactivity that promotes obesity. The emerging Type 2 diabetes observed in the child and adolescent is linked to obesity.

10. The disease burden is very high. Unknown diabetes in Africa is in the order of 60% to 80% in cases diagnosed in Cameroon, Ghana and Tanzania.<sup>8</sup> The rate of limb amputations varies from 1.4% to 6.7% of diabetic foot cases. Annual mortality linked to diabetes worldwide is estimated at more than one million.<sup>9</sup> In some countries of the Region, the mortality rate is higher than 40 per 10 000 inhabitants.<sup>10</sup>



**Figure 1:** Diabetes prevalence rate in WHO African Region. Sources: 1. Infobase.who.int; 2. Sobngwi E *et al.* Diabetes in Africans: Part 1: epidemiology and clinical specificities, *Diabetes and Metabolism* 27(6): 628–634, 2001.

11. The dearth of specialists and health workers trained in diabetes makes its treatment difficult. General practitioners or traditional healers sometimes assure its management.<sup>11</sup> Very few countries have care facilities that are appropriate for diabetes management, and testing for glycaemia is not always carried out in health facilities.

12. In the Region, people affected by chronic diseases, including diabetes, seek care from facilities at the peripheral levels. Though these facilities are oriented toward acute problems, they are generally not adapted to provide care to those affected by chronic diseases.

13. Treatment compliance for diabetes, in the long term, remains problematic because of prohibitive cost and unavailability, or lack of, state subsidies. The annual direct cost of treatment by insulin is estimated at US\$ 229, with more than 70% of it used for the insulin.<sup>12</sup> The monthly cost using glibenclamide is equivalent to the salary for 6.1 working days in Nigeria and 16.6 working days in Uganda of an employee on minimum wage.<sup>13</sup> In Cameroon, the direct cost per patient in 2001 was US\$ 489, which includes 56.5% for hospitalization, 33.5% for drugs, 5.5% for tests and 4.5% for consultation.

### Justification

14. The present regional strategy on diabetes is based on the resolution<sup>14</sup> on non-communicable diseases in the Region. It responds, in a specific way, to the need to increase the impact, alas, still limited, of programmes based on an integrated approach in the fight against the common risk factors of non-communicable diseases.

15. In the Region, vulnerability to diabetes among the 45–65 age group exposes them to complications and premature deaths. It causes a decline in productivity, with an economic cost, which added to the cost of treating other types of diabetes (Type 1 and diabetes in pregnancy), constitutes an additional burden for the already weakened health systems.

16. Type 2 diabetes can be prevented by simple measures in 80% of cases. The efforts to fight diabetes in Africa fall far below the expected results. Also, it is advisable to revisit the in-patient care model for diabetes by integrating it into the primary health care system.

## THE REGIONAL STRATEGY

### Aims and objectives

17. The goal of this regional strategy is to contribute to the reduction of the burden of diabetes-related

morbidity and mortality and its associated risk factors.

18. The strategy aims:

- (a) to increase sensitization and advocacy in the fight against diabetes, using reliable epidemiological data for policy-makers and the general public;
- (b) to promote primary, secondary and tertiary prevention interventions in favour of diabetes;
- (c) to strengthen the quality of health care by integrating diabetes into primary health care in order to provide just and equitable access;
- (d) to improve the capacities of health personnel to better deal with diabetes and associated diseases;
- (e) to support research in community interventions, including traditional medicine.

### **Guiding principles**

19. For prevention and control of diabetes, the following principles must guide the implementation of the strategy:

- (a) comprehensive management of diabetes through cost-effective prevention, curative, rehabilitation and participatory actions;
- (b) integration of diabetes into a national programme for the prevention and control of non-communicable diseases;
- (c) equity and accessibility to quality care for people affected by diabetes;
- (d) multisectoral approach and partnerships, with the health sector playing a leading role, with civil society being involved and with enhanced cooperation from associations involved in the fight against diabetes;
- (e) community participation, gender sensitivity and consideration of local beliefs as necessary to better generate awareness on diabetes.

### **Priority interventions**

20. In order to better prevent and control diabetes, the following priority interventions are envisaged:

- (a) creation of conditions that enhance advocacy and action for diabetes;
- (b) prevention of diabetes and its associated risk factors;
- (c) targeted screening of diabetes and its complications;
- (d) early diagnosis and adapted treatment of diabetes and its complications;
- (e) strengthening of the capacities of health systems;
- (f) reorganization of health care to focus on the patient, family and community;

(g) support for operational research.

### ***Creating conditions that enhance advocacy and action***

21. Advocacy would centre on the importance of diabetes, placing it alongside the main NCDs, namely cardiovascular diseases and cancer. It must be based on real partnerships for increased sensitization. It must focus on the community level, using prevention and information messages that target the populations at risk of diabetes.

22. Collection of reliable data is required to guide and plan actions in favour of the control of diabetes and its associated risk factors. For that, STEPwise investigations should be planned and carried out throughout Africa, particularly Step 3 required for glycaemia testing.

23. Diabetes should be on the list of medical priorities, be legislatively recognized as a medico-social disease and be given adequate resources. National initiatives and plans for the fight against diabetes can serve as entry points for non-communicable disease programmes.

### ***Preventing diabetes and its risk factors***

24. Most risk factors for diabetes that are common to NCDs are modifiable and preventable. The implementation of the global strategy on food, physical exercise and health<sup>15</sup> is the primary key for diabetes prevention. This strategy, together with the fight against tobacco use and alcohol abuse, will be strengthened. These interventions should begin from childhood and reach educational establishments and adolescents.

### ***Detecting diabetes and its complications***

25. The targeted screening of people at risk of diabetes will have to be encouraged in health facilities. Testing for fasting glycaemia makes it possible to diagnose unknown diabetes, which, though evolving silently, is very often revealed by complications.

26. The status of impaired fasting glycaemia must be focussed on, particularly, those at risk of diabetes. Early diagnosis is interesting in identifying those at increased risk of developing the condition, thus leading to prevention and management.

### ***Early diagnosis, fast and better treatment***

27. Diabetes should be promptly managed. Indeed, there is a direct correlation between the level of glycaemia progression, onset of diabetes and

its complications, and outcome of treatment. Routine glycaemia testing would prevent or delay complications.

28. Testing for glycaemia should be carried out in all health facilities, using gluco meters whose reliability has been proven. Once the diagnosis has been made, counselling and guidance should be given, based on the protocol drawn up in the countries.

29. Secondary prevention activities should be based on treating cases that are declared in order to prevent or delay complications. The management of diabetes should be comprehensive, integrating effective treatment of diabetes, arterial hypertension, lipidic disorders, and activities for alcohol consumption cessation. Type 1 diabetes and gestational diabetes would be given specialized treatment.

30. Access to oral antidiabetic medications, insulin and basic supplies must be assured. A good drug policy should ensure accessibility and reduced prices of these drugs. Health centres and hospitals must be provided with affordable essential and generic drugs. Concerning oral antidiabetic medications, metformine and glibenclamide are recommended by consensus.<sup>16</sup>

31. Tertiary prevention remains crucial because of the many complications related to late diagnosis. Particular stress will be put on the prevention of blindness, renal insufficiency and especially on lesions of the foot, the cause of amputations. The care of diabetic feet will have priority in health centres.

### ***Strengthening the capacities of health systems***

32. It is essential to integrate the management of diabetes into primary health care facilities through the delivery of a minimum package of activities. This entails identifying the people (groups) at high-risk and referring them to the health facilities for screening, follow-up and monitoring of care. Health personnel will be trained in diabetes management, prevention and control as part of primary health care. This will ensure that the care usually administered only by the doctor can be undertaken by a multidisciplinary team trained and integrated within the health centres.

33. First referral levels and high quality of care will be of help to primary health care facilities in screening, diagnosis and initial treatment of patients. They should also manage complications which could be treated in integrated specialized clinics.

### ***Patient-focused care***

34. Routine care for diabetes requires a lifestyle change. The role and responsibility for treatment

make the patient an active actor. Health workers must guide the patient towards being independent. In proactive management of diabetes, the role of the family and the community enhances treatment.

### ***Supporting research***

35. To better target priority research areas and better prevent and control diabetes, countries will be encouraged to support and finance research activities, and also integrate traditional medicine. It will be necessary to encourage the training of researchers and equip universities, research institutions, schools of medicine and training centres.

### ***Roles and responsibilities***

#### ***Countries***

36. The countries should:

- (a) prepare and implement diabetes control policies and plans, integrated into the national programme for the prevention and control of non-communicable diseases; set up, at national level, integrated surveillance systems;
- (b) strengthen their health systems and capacities for diabetes control by promoting: (i) the participation of individuals and communities in the care and support of persons affected by diabetes; (ii) collaboration with partners; (iii) fundamental and operational research on diabetes;
- (c) mobilize internal and external resources and allocate them regularly, assure coordination of the interventions of the different actors, and the monitoring of the programmes for the control of diabetes and non-communicable diseases;
- (d) conduct and publish their STEPwise surveys;
- (e) strengthen partnerships with other stakeholders.

#### ***WHO and partners***

37. WHO and partners should:

- (a) provide technical assistance to countries for the analysis and development of policies; data collection and analysis, as well as their dissemination;
- (b) develop and make available standards and guidelines for the diagnosis and treatment of diabetes, its complications and its associated risk factors;
- (c) encourage the principal partners, namely the International Diabetes Federation and others, to allocate additional resources to interventions in favour of diabetes;
- (d) encourage and support research on diabetes in order to better prevent and improve the quality of life of the affected persons.



### Implications in terms of resources

38. Most countries already spend a considerable amount of resources, mainly in support of clinical management of diabetes. The interventions proposed in this document imply reorganizing and channelling resources to facilitate implementation. More specific is the need to ensure the availability of suitably trained human resources at different levels of the health care system, medicines and supplies needed for screening and treating those affected, and support for a mechanism of community follow-up.

39. In many countries, additional resources must be mobilized, firstly from national resources and then from partners. In this regard, countries using the information available on the costs of medicines and other necessary commodities should estimate their total needs to facilitate their resource mobilization programme.

### MONITORING AND EVALUATION

40. The surveillance of diabetes and its risk factors remains one of the major components of monitoring and evaluation. The STEPwise investigation is one of the indispensable tools, as is the diabetes register.

### CONCLUSION

41. Diabetes represents a real and growing health problem in the Region. Sustained commitment from the authorities would increase the ability to cope with the dual challenge of prevention and treatment on the one hand, and on the other, the lethal burden of complications, particularly cardiovascular diseases.

42. Multidisciplinary and multisectoral approaches are indispensable for the prevention and control of diabetes. In Africa more than elsewhere, they constitute the cornerstone of interventions, which should focus on the patient and the community, within the framework of primary health care.

43. The Regional Committee examined and adopted the strategy for diabetes prevention and control.

#### **Resolution AFR/RC57/R4**

#### **Diabetes prevention and control: A strategy for the WHO African Region**

The Regional Committee,

Noting the report of the Regional Director entitled "Diabetes prevention and control: A strategy for the African Region";

Aware of the rapid increase in the prevalence of diabetes and other non-communicable diseases and the high burden of communicable diseases, which constitute a double burden for health systems and a factor aggravating poverty among the people;

Recalling resolutions WHA42.361<sup>17</sup>, WHA53.171<sup>18</sup>, WHA57.161<sup>19</sup>, WHA57.171<sup>20</sup>, EB 120/221<sup>21</sup>, AFR/RC50/R41<sup>22</sup> and AFR/RC55/R4<sup>23</sup>, urging the intensification of measures to control diabetes and cardiovascular diseases and efforts by Member States and their partners in this area;

Recalling United Nations General Assembly Resolution 61/225 of December 2006 instituting World Diabetes Day;

Recalling further the relevance of primary prevention and the integrated approach to non-communicable disease surveillance and management, including the control of their common risk factors;

Acknowledging the need for sustainable community action to ensure better prevention and control of diabetes at all levels of the health system, especially the primary level;

Acknowledging further the importance of the continuing availability, accessibility, affordability and safety of medicines, particularly insulin, to diabetes patients;

1. APPROVES the document entitled "Diabetes prevention and control: A strategy for the WHO African Region";

2. URGES Member States:

- (a) to develop or strengthen national policies, plans, or programmes targeted at diabetes and non-communicable diseases;
- (b) to develop and implement integrated surveillance and primary prevention activities for non-communicable diseases, including diabetes, and based on the common risk factors approach;
- (c) to strengthen the mobilization and allocation of resources for diabetes prevention and control, and to ensure the availability, affordability and safety of medicines;
- (d) to conduct STEPwise surveys at least every three years;
- (e) to develop and implement strategies for the retention of their skilled human resources for health;
- (f) to develop partnerships with the pharmaceutical industry, scientific foundations and philanthropic organizations to accelerate the implementation of national strategies;

3. REQUESTS the Regional Director:

- (a) to provide technical support to Member States for surveillance and the development and strengthening of national policies and programmes for the control of diabetes and other non-communicable diseases;
- (b) to increase support for the training of health professionals in control of diabetes and other non-communicable diseases by evaluating the programmes implemented in the Region;
- (c) to maintain and strengthen WHO's collaboration with all the partners involved in diabetes control;
- (d) to promote the mobilization of additional financial resources for the implementation of the present strategy and bargain with partners and pharmaceutical companies on the availability and affordability of medicines;
- (e) to advocate for reduction in the cost of diagnostics and medicines for diabetes and non-communicable diseases.

Seventh meeting, 30 August 2007

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## 5.8 Cancer prevention and control: A strategy for the WHO African Region

(AFR/RC58/4)

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### EXECUTIVE SUMMARY

1. Cancer is a problem in the African Region, where 582 000 cases were recorded in 2002, a figure expected to double by 2020. While data on the burden and pattern of cancer in the Region are insufficient, the available studies and estimates show an increased incidence due to infectious agents and to growing tobacco and alcohol use, unhealthy diet, physical inactivity and pollution.
2. The most common cancers in the African Region are cancers of the cervix, breast, liver and prostate as well as Kaposi's sarcoma and non-Hodgkin's lymphoma. Enough knowledge and evidence exist for preventing one third of all cancers, providing effective treatment for a further one third and providing pain relief and palliative care for all cases. This strategy proposes interventions which, if promptly implemented, will contribute to reducing the burden of cancers.
3. Cancer control programmes should be established in a comprehensive and systematic framework and be integrated within national health plans. They should have adequate documentation, monitoring and evaluation systems. Country ownership, equity, partnership, accountability and integrated approach should guide the implementation of interventions.
4. Priority interventions should include development of policies, legislation and regulations; mobilization and allocation of adequate resources; partnerships and coordination; training of health personnel; acquisition of adequate infrastructure and equipment for primary, secondary and tertiary prevention; and strategic information, surveillance and research. These interventions, with primary and secondary prevention as top priorities, and availability, affordability and accessibility of drugs for cancer treatment, should be implemented and scaled up in countries.
5. The Regional Committee reviewed and adopted this strategy.

### INTRODUCTION

1. Cancer refers to a group of diseases characterized by abnormal cell proliferation with a tendency to invade adjacent tissues and produce metastases. It poses a real global problem, accounting for 12.5% of all deaths worldwide in 2005; by 2020, new cases of cancer are projected to reach about 15 million every year, 70% of which will be in developing countries, including over one million in the African Region.<sup>1</sup>

2. The main factors contributing to the increasing incidence of cancer in the African Region are growing tobacco and alcohol use, unhealthy diet, physical inactivity, environmental pollution and action of infectious agents. Most cancer patients have no access

to screening, early diagnosis, treatment or palliative care. Furthermore, the health systems of countries are not sufficiently equipped to provide cancer services.

3. Cancers impact negatively on the overall health status of the population in Member States and lead to loss of income and huge health expenditures. They mostly occur in the economically productive age group. Faced with a growing burden of non-communicable diseases (NCDs) and a high burden of communicable diseases, countries in the Region are having difficulties in providing adequate cancer prevention and treatment services.

4. There is now sufficient understanding of the risk factors such that at least one third of all cancers

worldwide are now preventable. Evidence is also available for early detection and effective treatment and cure of a further one third of cancer cases. In addition, treatment exists to help relieve pain and provide palliative care.

5. The declaration by Heads of State and Government of the African Union in Durban, in 2002, making a commitment to address cancer adequately in the development policies of countries; the WHO regional strategy for prevention and control of NCDs; the WHO regional strategy for health promotion; the Framework Convention on Tobacco Control; and the Global Strategy on Diet, Physical Activity and Health, are all part of the effort of the international community to address the problem of cancer.<sup>2</sup>

6. This document provides an overview of the cancer situation in the African Region and proposes a strategy for appropriate action by Member States and partners. The strategy builds on an existing World Health Assembly resolution (WHA58.22 on cancer prevention and control) and past achievements in the area of NCDs and proposes a set of public health interventions aimed at reducing the burden of cancer.

## SITUATION ANALYSIS AND JUSTIFICATION

7. Information on the burden and pattern of cancer in the Region is scarce because of lack of accurate population-based data and the weakness of health information systems. In 2002, Globocan, a worldwide database deriving estimates from available cancer registries, recorded 582 000 cases of cancer in Africa, a figure expected to double in the next two decades, if interventions are not intensified.<sup>3</sup>

8. Data from localized studies and derived estimates indicate that there is a high burden of cancer in the Region. The most common cancer recorded in the Region is cervical cancer, which accounts for 12% of all new cases each year. Other major cancers recorded in the Region are cancers of the breast (10%), liver (8%) and prostate, as well as Kaposi's sarcoma (5%) and non-Hodgkin's lymphoma (5%).<sup>4</sup> Cervical cancer and breast cancer are among the major public health problems in the Region, although tools for their screening and early diagnosis are available.

9. Infectious agents are at the origin of almost 25% of cancer deaths in the developing countries. They include hepatitis B and hepatitis C viruses, human papillomavirus (HPV), schistosomiasis, *Helicobacter*

*pylori*, Epstein-Barr virus and human immunodeficiency virus (HIV). Vaccines exist for some of these infectious agents, including hepatitis B and HPV. However, the vaccine for HPV is expensive and not yet widely available in the Region.

10. Kaposi's sarcoma has increased dramatically in parts of central, southern and east Africa where HIV prevalence is high. Liver cancer, caused by high levels of exposure to aflatoxins and chronic hepatitis B virus infection, remains very common across sub-Saharan Africa.<sup>5</sup>

11. Tobacco use is the most avoidable cause of cancer. It causes cancer of the lungs, larynx, pancreas, kidney, bladder, oral cavity and oesophagus. The prevalence of tobacco use in Africa is rising, with attendant increase in passive exposure to tobacco smoke. It is estimated that, in 2006, more than 50% of children in Algeria and Namibia<sup>6</sup> were exposed to passive smoke.

12. Access to prevention, diagnosis and treatment services and psychosocial care for patients and families in the Region are severely hampered by insufficient funding and general weakness of health systems. Infrastructure and equipment are inadequate, outdated and poorly maintained. Qualified personnel for cancer control are inadequately trained, and most health-care workers, especially at peripheral levels, have too little knowledge and skills with regard to cancer.

13. In almost all Member States, national cancer prevention and control programmes are either lacking or very weak; policies, legislation and regulations are found wanting; and actions of partners are fragmented and poorly coordinated. The few existing cancer diagnosis and treatment facilities are centralized in urban areas.

14. Most patients report to health services when the disease is already at an advanced stage, with the result that patients with five-year survival rates in the Region are among the lowest ever reported.<sup>7</sup> Chemotherapy and other treatment tools remain beyond affordability. Pain relief and palliative care services are limited because of insufficient awareness among health-care providers, patients and the general public, as well as excessive regulation of the use of opioids.

### Justification

15. The burden and risk of cancer in the Region are increasing. Most resources are used for treating cancers already at an advanced stage and for costly referral of patients abroad. In contrast, too little is

invested in cancer prevention, while health systems are not well prepared to combat the threat of cancers.

16. Implementing this strategy will contribute to reducing cancer risks and lead to a decrease in cancer incidence and mortality, thus resulting in improved health and quality of life.

## THE REGIONAL STRATEGY

### Aim, objectives and targets

17. The aim of this strategy is to help reduce cancer morbidity and mortality in the African Region.

18. The specific objectives are:

- (a) to provide Member States with an orientation for the development and implementation of national strategies and programmes for cancer prevention and control;
- (b) to scale up cancer prevention, cure and care services;
- (c) to provide a platform for advocacy for increased resource allocation, increased action, multisectoral collaboration and cancer control partnerships;
- (d) to promote cancer research and cancer data collection and use.

19. Targets:

- (a) By 2013, 20% of Member States will have achieved 10% reduction of passive exposure to tobacco smoke among youths aged from 13 to 15 years;
- (b) By 2013, 40% of countries in the Region will have developed and be implementing cancer control programmes, including primary, secondary and tertiary prevention;
- (c) By 2013, at least 35% of Member States will be equipped with cancer registries and adequately trained staff.

### Guiding principles

20. The guiding principles of this strategy are:

- (a) **Country ownership, leadership and fairness** in the implementation of this regional strategy;
- (b) **Equity and accessibility** of services, especially for the poor and rural communities;
- (c) **Partnership, team building and coordination**, with the involvement of all partners at various levels (government, private sector, civil society) in the development, planning and implementation of interventions; such coordination should be based on a clear definition and understanding of roles, responsibilities and mandates;

(d) **Innovation, creativity and accountability**, with the involvement of individuals, cancer patients, civil society and communities, and at all stages of decision-making, planning, implementation and evaluation;

(e) **Systematic and integrated approach** to step-by-step implementation of priority interventions as part of a national cancer action plan.

### Priority interventions

21. **Cancer prevention and control policies, legislation and regulations.** Cancer policies, legislation and regulations are **necessary** to ensure that all individuals in countries have access to cancer services. They must aim to prevent infectious agents from causing cancers and to reduce exposure to tobacco smoke, chemicals such as pesticides, toxins such as aflatoxins, pollution and radiation. A cancer prevention and control policy document should be adopted and implemented within an integrated national health policy and plan.

22. **Establishment of comprehensive national cancer control programmes.** Cancer control programmes<sup>8</sup> should comprise primary, secondary and tertiary prevention and include screening, early diagnosis, curative therapy and palliative care, as an integral part of NCD programmes. The interventions should be adapted to local settings and implemented in a cost-effective manner. The experience and lessons learnt should be documented for sharing. National, regional and subregional centres of excellence for cancer control should be designated and supported as part of a programme to build capacity and maintain quality care across the health system.

23. **Advocacy, resource mobilization and appropriate allocation.** Advocacy and resources are crucial to the implementation of cancer prevention and control programmes, and to their legislation and regulation within national health policies. These resources, to be mobilized from governments, individuals, the private sector and international partners, should be sustainable and equitably distributed among different levels of the health system. Member States should establish mechanisms for results-oriented resource allocation. There is a need for countries to advocate for the reduction of the cost of cancer medicines and the production of generic drugs for cancer treatment.

24. **Mobilization of partners and coordination of interventions.** It is necessary to clearly define partners' areas of contribution, as well as the relevance of their support in line with national priorities. Partners should work collaboratively within

international and national alliances and networks in order to support countries in building effective national programmes and strengthening health systems.

**25. Capacity development.** It is also necessary to improve the skills of decision-makers, health personnel and care providers at primary, secondary and tertiary levels of health systems. More specifically, cancer information for policy-makers and decision-makers should be reinforced for better understanding of technical and institutional aspects as well as international agreements and regulatory frameworks for cancer prevention and control. This information will prepare them to initiate, promote and better communicate national policies, legislation and regulations. At the same time, there is need to strengthen and develop community capacity for cancer prevention and control.

26. Given that many cancer risk factors, such as pollution and exposure to chemicals, are beyond the control of the health sector, it is necessary to implement interventions to strengthen cross-sector collaboration. Such collaboration should involve relevant government sectors and stakeholders such as professional associations, civil society, community representatives, nongovernmental organizations, and the private sector.

27. Development of human capacity at all levels of the health system should be strengthened for cancer prevention and control. This should include laboratory skills for diagnosis as well as telemedicine, a useful tool for medical education and diagnosis. At the same time, health systems should be strengthened to address the problem of cancer at various levels. This should include the provision of adequate infrastructure as well as equipment and their maintenance for screening, diagnosis and treatment at all levels.

**28. Primary prevention.** Primary interventions are cost-effective approaches to reduce exposure to the major risk factors at individual and community levels. They reach out to school children, adults, the elderly and people at risk.

29. Primary prevention ensures that preventable cancers are targeted by health promotion strategies through improved communication for behaviour change. Implementation should be done in a cross-cutting manner, linking communicable and non-communicable diseases, and starting at the community level. Specific interventions should be strengthened to reduce the incidence of AIDS-related cancers and HIV transmission and to improve the diet and physical activity of HIV patients.

30. Additional primary prevention interventions include using existing immunization programmes to make available suitable vaccine and to immunize populations at risk against the biological agents at the origin of carcinogenesis (hepatitis B viruses, HPV); reinforcing tobacco control; and involving traditional health practitioners in ensuring early referral of patients to health-care facilities.

**31. Secondary prevention.** Screening, early detection and diagnosis at the stages where cancers are curable should be given high priority in community interventions. Interventions in reproductive health and childhood cancers should be promoted and implemented at different levels of the health system. Techniques of visual examination for cervical cancer screening followed by immediate treatment by cryotherapy will reduce cervical cancer morbidity and mortality. A step-wise approach is recommended when starting or reorienting implementation so that each step will have a measurable outcome and progress can be monitored.

**32. Tertiary prevention.** Diagnosis and treatment strategies through tertiary prevention will ensure that the majority of patients have access to efficient diagnostic and sufficient treatment facilities. Cancer diagnosis and treatment should be carried out at the secondary and, eventually, primary level of health systems. Countries should ensure sustained availability of a minimum set of affordable and cost-effective medications for cancer management. The use of different mechanisms, including subregional economic communities, will ensure sustainable availability of these medicines. An enabling environment should be created, with palliative care integrated into the existing health delivery system. In addition, psychosocial support mechanisms based on collaboration between health services and communities should be developed at local level.

**33. Strategic information, surveillance and research.** Surveillance, research and knowledge management play pivotal roles in cancer control. Countries should establish cancer registries to monitor the trends of cancer incidence, prevalence and mortality as well as the risk factors. There is a need for increased investment in research; operational research should be promoted as an integral part of cancer prevention and control in order to identify knowledge gaps and evaluate strategies. Research on traditional medicines must produce evidence of their safety, efficacy, quality and appropriateness for use in cancer chemotherapy and palliative care. Findings of research on new cancer therapies, including gene therapy, should be recommended for wider use in the Region.

### Roles and responsibilities

34. Countries should:
- (a) adopt regulations and legislation aimed at reducing avoidable exposure to cancer risk factors and strengthen clinical practices;
  - (b) develop and strengthen comprehensive cancer control programmes tailored to the socio-economic context and integrated into national health systems;
  - (c) mobilize and allocate resources for cancer control programmes;
  - (d) create public awareness of cancer prevention methods;
  - (e) establish surveillance systems, particularly cancer registries, as part of the existing health information systems;
  - (f) establish a system for procurement and maintenance of cancer diagnosis and treatment equipment in relevant services;
  - (g) increase the knowledge and skills of health workers and non-health care providers in cancer prevention and control.
35. WHO and partners should support countries by:
- (a) mobilizing communities in the fight against cancer and by facilitating effective linkages, cooperation, collaboration and coordination among partners and stakeholders;
  - (b) carrying out advocacy for increased resource allocation especially for cancer prevention, infrastructure, equipment, medicines and research;
  - (c) providing technical and material support for establishing or strengthening national cancer control programmes;
  - (d) providing technical and material support for monitoring and evaluating cancer prevention and control programmes;
  - (e) establishing and generating evidence-based information and analysis to be used by governments to develop cancer prevention and control legislation.

### Resource implications

36. The existing level of financial allocation to cancer control is generally insufficient. The situation is worsened by referral abroad of many cancer patients. Additional resources are required to support the implementation of this strategy, particularly primary prevention, early detection, care and management components. This will reduce costs in the long term. Furthermore, there is a need to ensure the availability not only of trained human resources at different levels of the health-care system but also of the equipment and medicines needed for screening and treatment.

### MONITORING AND EVALUATION

37. Progress monitoring indicators include the availability and effective implementation of cancer control policy, legislation, regulations and programmes. Outcome and impact indicators include the reduction of cancer incidence and mortality, trends of morbidity and reduction of risk factors.
38. Continuous monitoring and evaluation are crucial to the success of cancer control programmes and should be based on progress, outcome and impact measurements. The progress indicators should be well managed to meet the requirements of national health management systems and of reporting mechanisms relevant to international bodies, including the African Union.

### CONCLUSION

- 39 The cancer prevention and control challenges facing the African Region include inadequate policies, legislation and regulations and limited access to prevention, diagnosis and treatment services. Comprehensive cancer control programmes require a multisectoral approach.
40. Strong advocacy and commitment at the highest political level are needed for cancer prevention and control in order that interventions can be successfully implemented. The interventions, with high priority to primary and secondary prevention, should be implemented promptly in Member States to reduce cancer morbidity and mortality.
41. The Regional Committee reviewed and adopted this strategy.

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## 5.9 Sickle-cell disease: A strategy for the WHO African Region (AFR/RC60/8)

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### EXECUTIVE SUMMARY

1. Sickle-cell disease (SCD) is an inherited disorder of haemoglobin. It is the most prevalent genetic disease in the WHO African Region. In many countries, 10%–40% of the population carries the sickle-cell gene resulting in estimated SCD prevalence of at least 2%.
2. The situation in the Region indicates that current national policies and plans are inadequate; appropriate facilities and trained personnel are scarce; and adequate diagnostic tools and treatment are insufficient.
3. Deaths from SCD complications occur mostly in children under five years, adolescents and pregnant women. Strategies and interventions to reduce SCD-related morbidity and mortality should focus on adequate management of these vulnerable groups.
4. This strategy provides a set of public health interventions to reduce the burden of SCD in the African Region through improved awareness, disease prevention and early detection. The interventions include improvements in health-care provision; effective clinical, laboratory, diagnostic and imaging facilities adapted to different levels of the health system; screening of newborns; training of health workers and development of protocols; genetic counselling and testing; accessibility to health care; establishment of patient support groups; advocacy; and research.
5. Success in implementing identified interventions will depend on the commitment of Member States to integrate SCD prevention and control into national health plans, and provide an environment conducive for various stakeholders to contribute to the reduction of SCD prevalence, morbidity and mortality.
6. The Regional Committee examined and adopted the sickle-cell disease control strategy.

### INTRODUCTION

1. Sickle-cell disease (SCD) is a genetic condition in which the red blood cells contain haemoglobin S (HbS), an abnormal form of the oxygen-carrying protein. Individuals who inherit sickle-cell genes from both parents are homozygotes and develop SCD, while those who inherit the gene from only one parent have the sickle-cell trait (SCT). Those with the trait are carriers, have no symptoms, but can pass the gene on to their offspring.
2. SCD is the most prevalent genetic disease in the African Region.<sup>1</sup> There are different subtypes of SCD in which the abnormal S gene ( $\beta^S$ ) coexists

with other abnormal haemoglobin genes. Structural studies of the  $\beta^S$  gene suggest that the sickle-cell mutation arose in at least four different places in Africa and a fifth mutation occurred in the Arabian peninsula.<sup>2</sup>

3. The SCT is widespread in the WHO African Region;<sup>3</sup> the  $\beta^S$  gene prevalence in at least 40 countries varies between 2% and 30%, resulting in high SCD-related morbidity and mortality. Deaths from SCD complications occur mostly in children under five years, adolescents and pregnant women.<sup>4</sup>

4. Because there is little genetic counselling available for prospective parents, unions between SCT

carriers result in the birth of SCD children. Most countries have inadequate national health policies and plans, and scarce facilities, diagnostic tools, treatment services and trained personnel. There is therefore, a need for urgent interventions to address this public health problem.

5. This document provides an overview of SCD in the Region and proposes a strategy for action by Member States and partners. It outlines a set of public health interventions to reduce the burden of the disease through national development or strengthening of policy; early identification; management; and community awareness.

## **SITUATION ANALYSIS AND JUSTIFICATION**

### **Situation analysis**

6. Sickle-cell disease prevalence depends on sickle-cell trait. Where the prevalence of SCT exceeds 20%, SCD is estimated to be at least 2%.<sup>5</sup> The  $\beta^S$  gene concerns the population of at least 40 countries in the Region, and in about 23 countries of west and central Africa the prevalence of SCT varies between 20% and 30%; it is as high as 45% in some secluded areas in western Uganda.<sup>6</sup>

7. Although more than 40 countries are affected, much of the data are still hospital-based and not population-based. Most SCD manifestations are readily amenable to treatment, using available interventions; however, the interventions are not accessed by the majority of patients, specifically the vulnerable groups: children under five years, adolescents and pregnant women. In addition, laboratory facilities for accurate diagnosis are limited.

8. Adequately trained health professionals are few, specialized health care facilities are insufficient and effective medicines, vaccines and safe blood transfusion are very limited. Presently, even in developed countries, where stem cell transplantation can be contemplated, there is no widely acceptable public health intervention for the clinical cure of SCD.<sup>7</sup> Consequently, the median survival of SCD patients in Africa is less than five years; about 50%–80% of the estimated 400 000 infants born yearly with SCD in Africa die before the age of five years.<sup>8</sup> The survivors suffer end-organ damage, which shortens their lifespan. Thus, to improve management of SCD there is a crucial need for early case identification and implementation of comprehensive health care management (CHCM).

9. Persons with SCD are often stigmatized, and SCD has major socioeconomic implications for

affected persons, families, communities and the nation. Recurrent sickle-cell crises interfere with the patient's life, especially regarding education, work and psychosocial development. In the Democratic Republic of Congo, 12% of children hospitalized in paediatric wards have SCD; the estimated annual cost for care is more than US\$ 1000 per patient.<sup>9</sup>

10. Despite logistic and economic constraints, neonatal SCD screening along with CHCM have been successfully practised in some parts of Africa. For example, in Benin, where neonatal screening and CHCM were practised, the under-five mortality rate of SCD was 15.5 per 10 000, which is ten times lower than the overall under-five mortality rate.<sup>10</sup> These findings are consistent with those from developed countries, demonstrating the benefit of newborn screening and close follow-up of children using CHCM.<sup>11</sup>

11. Research has been done in several countries in the Region to achieve better understanding of SCD,<sup>12</sup> but more remains to be done. The research includes issues related to efficacy of conventional and traditional medicines. The safety, efficacy and quality of some traditional medicines have been evaluated and appeared to be safe and effective in reducing crises associated with severe pain.<sup>13</sup> However, there is no substantive documented evidence to support the efficacy of traditional practice or herbal medications in curing SCD.

### **Justification**

12. The burden of sickle-cell disease in the African Region is increasing with the increase in population. This has major public health and socioeconomic implications. Despite recent high-level interest in SCD, including commitment from some African First Ladies and the adoption of a UN resolution recognizing SCD as a public health problem,<sup>14</sup> investment in SCD prevention and management, using effective primary prevention measures and CHCM, remains inadequate.

13. This strategy evolves around existing documents<sup>15</sup> and past achievements in non-communicable diseases control. The WHO resolution WHA59.20 emphasized the urgency for Member States to design, implement and reinforce in a systematic, equitable and effective manner, comprehensive national, integrated programme for the prevention and management of SCD. The African Union Assembly resolution 1(V) and the United Nations General Assembly resolution 63/237 both recognized SCD as a public health problem and urged Member States to raise awareness about SCD. The United Nations

Assembly also suggested making June 19 of each year the SCD Day.

14. The SCD strategy for the WHO African Region seeks to increase individual and community awareness about SCD and strengthen primary prevention, reduce disease incidence, morbidity and mortality, and improve quality of life. The Strategy also contributes toward the achievement of Millennium Development Goals 4 and 5.

## THE REGIONAL STRATEGY

### Aim, objectives and targets

15. The aim of the strategy is to contribute to the reduction in incidence, morbidity and mortality due to sickle-cell disease in the African Region.

16. The specific objectives are:

- (a) to identify priority interventions for Member States to develop and implement programmes and policies for SCD prevention and control at all levels;
- (b) to provide a platform for advocacy to increase resource allocation for prevention and control of SCD through multisectoral collaboration and action;
- (c) to establish mechanisms for monitoring, evaluation and research on SCD and apply the findings in policies and programmes.

17. Targets for 2020 are that:

- (a) 50% of the 23 Member States with high SCD prevalence should have developed and be implementing a clearly designed national sickle-cell disease control programme within the context of a national health strategic plan;
- (b) 25% of the countries in the African Region should have adopted the concept of comprehensive health care management of SCD;
- (c) at least 50% of all sickle-cell trait countries will have established a SCD surveillance system with adequately trained staff.

### Guiding principles

18. The guiding principles of this strategy are:

- (a) **country ownership, leadership, fairness and community participation** in the implementation of this regional strategy;
- (b) **effectiveness, cost-effectiveness and accessibility** of proven interventions and services, especially for the poor and for rural dwellers;
- (c) **integrated and evidence-based interventions and prevention-focused population-**

**based approach** for step-by-step implementation of priority interventions as part of the national health plan;

- (d) **partnership, team building and coordination** involving all players at various levels; co-ordination should foster clear definition and understanding of roles, responsibilities and mandates;
- (e) **cultural sensitivity, creativity and accountability** involving individuals, patients, civil society and communities in decision-making, planning, implementation and evaluation.

### Priority interventions

19. SCD control interventions for Member States of the African Region evolve around Primary Health Care and health promotion approaches to ensure policy development and implementation, legislation and regulation, expansion of primary and secondary prevention. These interventions include:

- (a) improvements in health care provision: clinical and laboratory management at all levels of the health system, screening of newborns, training of health professionals, and development of protocols;
- (b) genetic counselling and testing;
- (c) geographical and financial accessibility to health-care services;
- (d) public awareness in schools, communities, health institutions, media and associations;
- (e) establishment of patient support groups; advocacy; and policies on employment for SCD patients.

The following interventions should be adapted to local settings.

20. **Advocacy for resource mobilization and increased awareness.** Member States should develop and implement effective advocacy interventions to create awareness of SCD and enhance efforts for local and international resource mobilization in order to ensure availability of appropriate infrastructure, equipment, supplies and medicines. WHO and countries should collaborate in developing regional networks and global alliances to help reduce the burden of SCD. High-level advocacy should be explored and encouraged.

21. **Partnerships and social impact.** Partnerships should be fostered between health professionals, parents, patients, relevant community interest groups, nongovernmental organizations (NGOs) and the media. Partnerships will facilitate public education, which will increase awareness and encourage screening among members of the community. Partners

should support the prioritization of SCD interventions such as widespread provision of screening, laboratory equipment, and specific vaccines that are not part of routine national immunization programmes; the development of appropriate interventions to strengthen existing health delivery systems; and a multi-disease approach.

**22. Creation or strengthening of national SCD programmes within the framework of non-communicable disease prevention and control and in harmony with national maternal and child health programmes.** The development of these interventions is the basis for improving the health care of those affected by SCD. Essential areas of work include advocacy; prevention and counselling; early identification and management; data collection, surveillance and research; community education; and partnership. An integrated multisectoral and multidisciplinary team involving health and social workers, teachers, parents and concerned NGOs could be established to work on the practical aspects of care delivery as well as programme implementation and monitoring.

**23. Capacity-building.** Health professionals should be given pre-service and in-service training in SCD control, including prevention, diagnosis and management of cases, and complications. The basic requirements to meet these service needs at various levels of the health system should be provided. All members of the health-care team are important for successful programme establishment and implementation.

**24. Supportive activities for special groups, namely children under five years, adolescents and pregnant women.** Member States should reinforce national SCD supportive activities for vulnerable groups such as children under five years, adolescents and pregnant women who should benefit from financial packages for case management. Other supportive measures include early diagnosis and treatment of complications; special transfusion regimens; surgery; immunization; prophylactic antibiotics, folic acid and antimalarials; and special programmes for prenatal care, psychosocial and professional support to patients, and adaptive educational interventions.

**25. Primary prevention, including genetic counselling and testing.** Prevention entails setting up genetic counselling and testing interventions in high prevalence countries to reduce partnering between carriers. Genetic counselling and health promotion activities can lead to substantial reduction in the number of children born with the disease. Widespread community involvement and support are essential.

**26. Early identification and screening.** Ideally, the disease should be identified at birth as part of routine newborn screening or at any subsequent contact the child has with a health facility. Depending on national policy, early identification can be done by universal screening of all newborns, targeted screening of babies born to carrier mothers, and screening of pregnant women. Screening of babies should be done by collecting blood from a heel prick; testing can be done using iso-electric-focusing or high-performance liquid chromatography. Such services should be available alongside counselling and health education since diagnosis raises serious medical, ethical and cultural issues, which may differ from one country to another.

**27. Comprehensive health care management for SCD patients of all ages.** CHCM consists of the following: parent and patient education; adequate nutrition; adequate hydration; use of prophylactic antibiotics and antimalarials; folic acid supplementation; use of specific vaccines; continuous medical follow-up; and early detection and management of complications. These measures will reduce morbidity, prevent complications and improve quality of life. In line with the Ouagadougou Declaration, CHCM should also be integrated into health systems using the PHC approach to meet the needs of both rural and urban dwellers, including prevention of complications and patient referral to higher care centres when necessary. Family and community-based care should be integrated into the national programme. Implementation of CHCM requires trained personnel, adequate facilities and interventions adaptable to local needs of communities.

**28. Provision of affordable medicines for SCD management and pain relief.** The use of quality generic medicines as part of the national essential medicines list should be promoted. Subregional economic entities can help in the manufacture and purchase of these medications. Since many SCD patients tend to revert to traditional medicine practices, traditional pharmacopoeias should be fostered after proper testing, validation and standardization. Traditional health practitioners should be involved in SCD management and referral whenever possible.

**29. Strengthening laboratory and diagnostic capacity and supplies with nationwide coverage.** Tools for the diagnosis of SCD should be made available according to their complexity at all levels of the health system starting at primary care level. A system for maintenance and uninterrupted provision of supplies should be developed. Diagnostic and imaging facilities should be made available for early detection of complications.

**30. Initiate and enhance sickle-cell disease surveillance.** Community-based activities, including surveillance and supervision, monitoring at all levels of operation, and periodic evaluation at national level should be undertaken to reduce the burden of SCD. The information generated should be disseminated and used as evidence in policy-making as well as in day-to-day decision-making in the management of the programme.

**31. Research promotion.** It is important to describe the history of SCD, its clinical evolution and association with malaria and other diseases. In line with the Algiers Declaration, there is a need to promote innovative research in SCD directed towards basic knowledge and its transformation into new tools such as medicines, vaccines and diagnostic tools; it is also important to identify knowledge gaps and evaluate strategies. It is necessary to promote research in both conventional and traditional medicine to produce evidence of safety, efficacy and quality.

### Roles and responsibilities

32. Countries should:

- (a) develop, implement and reinforce comprehensive national integrated SCD programmes oriented towards the socioeconomic environment within which the health system operates;
- (b) mobilize and allocate resources for SCD programmes;
- (c) promote community awareness and involvement in SCD prevention, patient care and support;
- (d) integrate SCD surveillance within the national health information system;
- (e) improve the knowledge and skills of health and non-health care providers in SCD control;
- (f) collaborate with partners to undertake basic and applied research;
- (g) support and coordinate national associations working in SCD prevention and control.

33. WHO and partners should support countries by:

- (a) mobilizing the international community for prevention and effective management of SCD; and facilitating effective linkage, collaboration and coordination among partners and stakeholders;
- (b) advocating for increased resource allocation especially for prevention; provision of adequate infrastructure, equipment and medicines; and research;
- (c) providing technical and material support for establishing or strengthening national SCD poli-

cies and programmes, including monitoring and evaluation;

- (d) promoting and supporting partnerships to improve training and expertise of health personnel and to undertake research.

### Resource implications

34. The existing level of funding allocated to SCD prevention and control is generally insufficient. Additional internal and external resources will be required to support implementation of this strategy. Specifically, there is need to ensure the availability of trained human resources at different levels of the health system along with the provision of medicines and equipment.

### MONITORING AND EVALUATION

35. Continuous monitoring and evaluation are crucial to the success of SCD control programmes and should be based on process, outcome and impact measures. These indicators should meet the requirements of national health management systems and be reportable to relevant international forums over the next 5–10 years.

36. Indicators for monitoring progress will include availability and enforcement of SCD control policies, legislation, regulations, programmes and guidelines. Outcome and impact indicators will include reduction of SCD incidence, mortality, morbidity and risk factors; educational achievements; and job security of SCD patients.

### CONCLUSION

37. Despite being the most prevalent genetic disease in Africa, sickle-cell disease, along with its serious health and socioeconomic impacts, is largely neglected. SCD ultimately results in multiple organ failure and premature death, occurring mostly in children under five years, adolescents and pregnant women.

38. A comprehensive health care management agenda needs national promoters, committed leadership and effective action at all levels. Strong partnerships must be forged between Member States, WHO and other development partners, communities and individuals.

39. Implementation of the interventions suggested in this strategy would ensure prevention, care and support at all levels and result in improved quality of life and life expectancy of affected individuals. This will contribute towards the achievement of MDGs 4

and 5 and enable affected people to live more productive lives.

40. The Regional Committee examined and adopted the sickle-cell disease control strategy.

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# 5.10 Measles elimination by 2020: A strategy for the WHO African Region

## (AFR/RC61/8)

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### EXECUTIVE SUMMARY

1. *The African Region adopted measles mortality reduction goals starting in 2001 and has been implementing the WHO-UNICEF recommended strategies. Successful implementation of these strategies resulted in a 92% reduction in the estimated number of measles deaths in the Region between 2000 and 2008.*
2. *Despite the significant reduction in measles mortality, the reality is that measles vaccination coverage, the quality of measles supplementary immunization activities and the quality of disease surveillance in the African Region have not yet reached the levels required to avert resurgence of measles. In 2010, 28 countries in the African Region experienced measles outbreaks.*
3. *Measles elimination is biologically and programmatically feasible, building upon the experiences of measles mortality reduction in the past decade. The elimination efforts should be entirely led by countries, and implemented to strengthen immunization systems and promote equity of service delivery.*
4. *The priority interventions should include improving immunization coverage through systematically implementing a combination of approaches; providing a second opportunity for measles vaccination; conducting sensitive disease surveillance; building the capacity of health workers; improving the quality of immunization monitoring data; conducting sustained advocacy and mobilizing local and international partners; and scaling up operational research.*
5. *This document proposes a strategy for the elimination of measles by 2020 in the African Region. The Regional Committee examined and adopted this strategy.*

### INTRODUCTION

1. Measles elimination is defined as the absence of endemic measles cases for a period of twelve months or more, in the presence of adequate surveillance. Global measles eradication is the sum effect of measles elimination in all WHO regions.
2. The Millennium Development Goal 4 (MDG 4)<sup>1</sup> aims to reduce under-five mortality by two-thirds by 2015 compared with the 1990 level. Vaccination against measles will reduce measles mortality and contribute to the attainment of MDG4.
3. The African Region has adopted measles mortality reduction goals and has been implementing

the WHO-UNICEF recommended strategies since 2001.<sup>2,3</sup> These strategies include increasing the coverage of measles-containing vaccines (MCV) in routine immunization; providing a second opportunity for measles immunization through Supplementary Immunization Activities (SIAs); establishing case-based surveillance, including laboratory confirmation; and improving case management.

4. The strategies for measles mortality reduction have been implemented through collaboration between national governments and partners, and in a manner that promotes integrated delivery of child survival interventions. The successful implementation of the measles mortality reduction strategies resulted in 92% reduction in the estimated number of

measles deaths in the African Region between 2000 and 2008.<sup>4</sup>

5. The African Regional Measles Technical Advisory Group (TAG) proposed a pre-elimination goal of reducing measles mortality by 98% by 2012 compared with 2000 estimates, reducing measles incidence to less than five cases per one million inhabitants annually in all countries, and attaining the targets for the main surveillance performance indicators. The two main measles surveillance performance indicators are: (i) non-measles febrile rash illness rate (target of at least 2 per 100 000 people); and (ii) the proportion of districts that have investigated at least one suspected case of measles with blood specimen per year (target of 80% or more per annum).

6. In 2010, the Sixtieth session of the WHO Regional Committee for Africa adopted Resolution AFR/RC60/R4: Current status of routine immunization and polio eradication in the African Region: challenges and recommendations. The resolution expressed concern about the fragility of the gains in measles mortality reduction and requested Member States to increase immunization financing, strengthen immunization research and improve the quality of implementation of strategies for the control of vaccine-preventable diseases.<sup>5</sup>

7. This document proposes a strategy for the elimination of measles in the African Region by 2020.

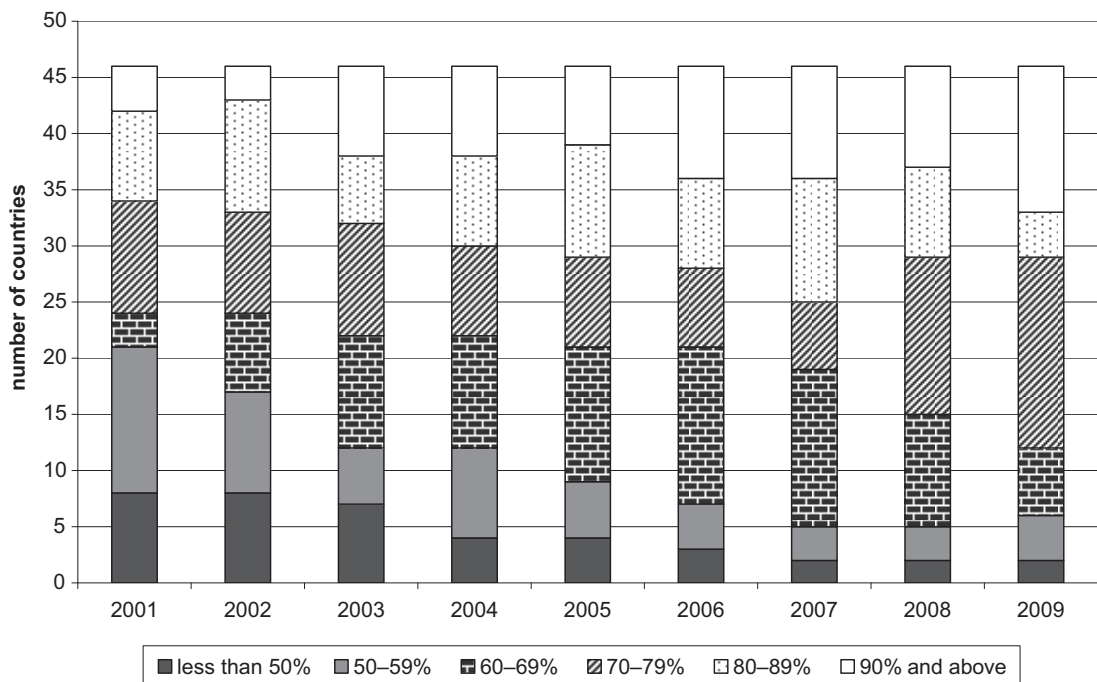
## SITUATION ANALYSIS AND JUSTIFICATION

### Situation analysis

8. Between 1980 and 1989, an average of one million suspected measles cases were reported in the African Region annually. This ten-year annual average dropped to 450 000 in the 1990s and to 250 000 between 2000 and 2009. Between 2006 and 2009, the average annual reported measles cases was below 100 000 for the whole Region.<sup>6</sup>

9. The WHO/UNICEF estimated coverage with the first dose of measles-containing vaccine (MCV1) in the African Region increased from 56% in 2001 to 69% in 2009.<sup>7</sup> Similarly, the number of countries with MCV1 coverage above 90% increased from four to thirteen, while the number of countries with coverage below 50% reduced from eight to two (Figure 1).

10. Four hundred and forty-five million children in 43 Member States<sup>8</sup> were vaccinated through SIAs between 2001 and 2010. Measles SIAs have provided a platform for cost-effective delivery of



**Figure 1:** Number of countries in the African Region by category of MCV1 coverage, 2001–2009 (WHO/UNICEF estimates).



high-impact child survival interventions, including the supply of vitamin A, insecticide-treated bednets (ITNs) and anti-helminths.

11. As of December 2010, 40 Member States<sup>9</sup> have established case-based measles surveillance supported by a network of 44 national laboratories, using standard procedures and tools to confirm measles cases, and undertaking regular quality control exercises.

12. In 2010, the non-measles febrile rash illness rate was 4.1 per 100 000 in the Region, with 25 countries<sup>10</sup> (63%) meeting the target. In addition, 29 countries<sup>11</sup> (73%) met the target of 80% or more of districts investigating measles cases.

13. In 2010, 28 countries<sup>12</sup> in the Region experienced measles outbreaks with a cumulative total of 223 016 reported cases and 1193 ensuing deaths. These outbreaks were due to the shift of epidemiological susceptibility to include older age groups, sub-optimal routine immunization coverage and gaps in SIAs coverage. In some countries in Southern Africa, resistance to immunization from certain religious communities contributed to large-scale outbreaks.

14. The problems identified in regard to the quality of immunization monitoring and surveillance data include inaccuracies in denominators, and gaps in the documentation and verifiability of immunization coverage data. Furthermore, surveillance and outbreak data are incomplete.

15. Detailed data are lacking as regards the reasons for the failure of immunization services to adequately reach target populations, underscoring the need for further operational research to identify the underlying reasons and the best approaches to address these weaknesses.

16. In 2009 and 2010, in 21 of the 30 follow-up measles SIAs, countries raised less than 50% of the operational costs from local sources. Such resource gaps have led to postponements of SIAs and undermined the quality of SIAs.

### Justification

17. In 2008, it was estimated that measles killed around 28 000 children annually in the African Region,<sup>13</sup> representing a significant decrease in measles mortality in the Region. However, these gains would be lost and measles deaths would increase again if Member States do not maintain high immunization coverage.

18. Feasibility studies done at the global level indicate that measles eradication is biologically and tech-

nically feasible and is cost-effective and beneficial to health systems strengthening.<sup>14</sup>

19. Regional measles elimination can build on the successes in the implementation of measles mortality reduction strategies and the lessons from the Polio Eradication Initiative.<sup>15</sup> Measles elimination will foster the integration of child survival interventions and contribute towards the strengthening of immunization systems by enhancing the skills of health workers, strengthening vaccine management systems, mobilizing communities, and reaching out to populations that do not normally benefit from routine service delivery.

20. Four of the six WHO regions<sup>16</sup> have already adopted measles elimination goals. The Region of the Americas has already achieved and maintained measles elimination since 2002 through high and sustained routine immunization coverage, high-quality measles SIAs, and sensitive surveillance.

## THE REGIONAL STRATEGY

Aim, objectives and targets

21. The aim of this Regional strategy is to achieve the elimination of measles in all Member States in the African Region by 2020.

22. The specific objectives are:

- (a) to reduce measles incidence in all countries;
- (b) to increase access to immunization services in all districts;
- (c) to improve coverage during all scheduled measles SIAs and outbreak response immunization activities;
- (d) to improve the quality of measles surveillance, as well as the epidemiological and virological investigation of measles outbreaks in all countries.

23. Targets: By 2020, all countries in the African Region will achieve and maintain:

- (a) measles incidence of less than 1 case per million population at national level;
- (b) at least 95% measles immunization coverage at national level and in all districts;
- (c) at least 95% coverage in all scheduled measles SIAs, and in outbreak response immunization activities;
- (d) at least 80% of districts investigating one or more suspected measles cases within a year, and a non-measles febrile rash illness rate of at least 2 per 100 000 population at national level.

## **Guiding principles**

24. The guiding principles of this strategy are:

- (a) **Country ownership and leadership** in the implementation of this regional strategy.
- (b) **Allocation of adequate resources** and their efficient use to attain the targets on time and maintain the gains of the regional elimination.
- (c) **Strengthening of partnerships** at local and global levels, and fostering sustainable **intersectoral collaboration**, given the need to institutionalize coordinated intersectoral action in order to improve health determinants.
- (d) **Community ownership** by ensuring that communities and civil society are actively involved and play a pivotal role in the implementation of the elimination strategies.
- (e) **Integration** of measles interventions into health services and using the opportunities created through the implementation of the measles elimination strategies to deliver additional high impact child survival interventions.
- (f) **Equitable access to essential health services** especially to people living in border areas, migrant and nomadic communities and other underserved segments of the population.

## **Priority interventions**

25. **Improve routine immunization coverage** through systematic implementation of a combination of approaches to reach everyone targeted for immunization. These approaches, including the Reaching Every District approach, the periodic Child Health Days and others, basically involve increasing community demand for immunization; improving service delivery through the use of information for programme management; expanding access to immunization, including outreach services; and improving and strengthening vaccine management systems.

26. **Provide a second opportunity for measles immunization** through high quality measles SIAs and/or the introduction of a second dose of measles immunization in the routine immunization schedule in eligible countries as a major strategic approach to maintain high population immunity. However, the target age group for SIAs and the interval between SIAs will have to be determined according to the local epidemiological patterns, the need to reduce the incidence of the disease in all age groups and build immunity levels so as to interrupt local transmission, and transmission driven by importations. Strategic approaches and best practices proven to

lead to high performance of SIAs and high coverage will be promoted and widely implemented.

27. **Improve immunization monitoring data quality.** Immunization programme managers should assess the quality of immunization coverage data and conduct regular data quality checks using standard methods such as Data Quality Assessment and multistage cluster coverage surveys, as appropriate, and use such information to ensure better management of the elimination programme.

28. **Improve the quality of disease surveillance.** Sensitive surveillance will be required in order to monitor the epidemiological situation and guide the immunization strategy. The implementation of measles surveillance should build on the existing vaccine-preventable diseases surveillance network. The geographical scale and the programmatic scope of the detection, investigation and reporting of suspected measles cases will have to be strengthened.

29. **Enhance information sharing among Member States.** High quality surveillance will require that countries regularly exchange epidemiological information between the public and private sectors and particularly in border areas where measures need to be taken collaboratively to rapidly respond to measles outbreaks. The expanded role of the national measles laboratories in an elimination context should be supported especially in viral strain identification and characterization.

30. **Promote operational research.** In the process of implementing these priority interventions, increased investment in operational research will be needed. Standard epidemiological research will be required for better understanding of the characteristics of the un-immunized populations, the reasons for immunization default, overall quality of immunization services and the development of innovative approaches to addressing immunity gaps in underserved populations.

31. **Ensure capacity building.** Appropriate quantitative and qualitative studies should be carried out to assess the training needs of health workers in addition to capacity building activities to address gaps in the capacity of health workers to plan, implement and monitor routine immunization services, implement high quality supplementary immunization activities, and carry out sensitive disease surveillance.

32. **Carry out sustained advocacy and resource mobilization.** There is need to undertake strong advocacy for, and champion measles elimination, develop advocacy materials, and engage partners and donors through regular meetings to ensure adequate

financing for the implementation of the measles elimination strategies. The experiences should be documented and best practices and lessons learnt disseminated.

**33. Mobilize partners and coordinate interventions.** It is important to continue to use the platform of the Interagency Coordination Committees (ICC) and other national and subnational forums to strengthen local partnerships and forge new ones when necessary. Member States should coordinate and lead the partnerships in a manner that will optimally utilize the inputs to achieve the measles elimination goal and contribute towards the strengthening of immunization systems.

**34. Ensure availability of quality and affordable vaccines and medicines.** There is need to strengthen the procurement, supply and management of vaccines and medicines, while ensuring accessibility and affordability to the population, in order to achieve universal coverage and better case management.

## Roles and responsibilities

### Member States

35. Member States should:

- (a) adopt a measles elimination goal to be attained by 2020;
- (b) develop strategic plans towards measles elimination by 2020;
- (c) mobilize and allocate adequate resources to implement strategic plans;
- (d) adopt, adapt or develop and use standards to facilitate the implementation of strategies;
- (e) develop sustainable mechanisms for regular co-ordination of stakeholders and partners in the implementation of the strategies, including across borders;
- (f) conduct operational research on the various aspects of strategy implementation in order to ensure the attainment of the targets;
- (g) document lessons from the measles mortality reduction efforts and identify best practices for emulation and scale up;
- (h) mobilize, involve and empower communities to effectively use immunization services.

### WHO and Partners

36. Taking into account the proposed priority interventions, WHO, in collaboration with UNICEF and other partners, including the Measles Initiative,<sup>17</sup> should:

- (a) provide technical assistance to countries for the development of strategic and operational plans and for the implementation of the measles elimination strategies;
- (b) support Member States to conduct operational research to better guide the implementation of measles elimination strategies;
- (c) develop and make available updated standards, including immunization schedules, and guidelines for the implementation of interventions;
- (d) support Member States to mobilize the necessary resources to achieve measles elimination by 2020;
- (e) scale up support to countries for cross-border surveillance and management of measles outbreaks;
- (f) undertake advocacy among global partners and donors for increased resources.

## Resource implications

37. Measles elimination will require high levels of national commitment and the financial support necessary for full implementation of comprehensive national immunization plans, which include measles elimination. Measles elimination efforts should be integrated into the overall health system strengthening, especially improving access to immunization services, ensuring safe immunization practices, and improving the capacity of health workers, laboratory networks, epidemiological surveillance and cold-chain systems.

38. It is estimated that a total of US\$ 2.6 billion will be required to attain measles elimination in the African Region by the year 2020. Forty-six percent of these costs are related to the existing programmatic costs of conducting routine immunization services.

39. It will be important to continue to promote global and local partnerships, building on the Measles Initiative model. Member States should create viable mechanisms for coordination of partners in order to pool resources from local partners and make optimal use of the opportunities created by the private sector, civil society organizations, faith-based organizations and other sectors.

## MONITORING AND EVALUATION

40. Monitoring of progress towards the elimination of measles in the Region will be done through ongoing monitoring of the coverage of routine measles immunization and monitoring of SIA coverage at national and district levels. In addition, the DPT1 – MCV1 dropout rate will be monitored and periodic coverage surveys will be carried out to validate administrative

coverage of routine immunization and SIA doses. Data analysis will be done in a disaggregated manner in order to monitor the equity of service delivery across geographical areas and populations.

41. High quality measles case-based surveillance, supported with laboratory confirmation of cases and outbreaks, will provide the crucial information needed to monitor the epidemiological situation and the incidence of measles. In addition, to cater for the gaps in case detection and notification, epidemiological modelling will provide estimates of measles deaths. The standard measles surveillance performance monitoring indicators will be monitored regularly to ensure that surveillance remains sensitive. The distribution and circulation of measles viral strains will also be monitored through laboratory characterization of viral strains in every measles outbreak.

42. Operational research will be conducted to determine the causes of non-immunization and will be used to develop new approaches to improve the delivery of immunization services through the routine programme and SIAs and to introduce new and upcoming technologies for measles case confirmation and measles vaccine delivery.

43. Progress towards the regional measles elimination goal will be independently assessed in 2015 and the results will be used to re-align and refine the implementation of the strategy. A comprehensive end-term evaluation of the strategy and its impact on immunization systems will be conducted in 2020.

## **CONCLUSION**

44. The WHO/UNICEF measles mortality reduction strategies have proven to be efficient in reducing measles deaths in the African Region. Measles elimination efforts will build on these experiences from the past decade in a manner that strengthens immunization systems, especially through building the competences of health workers to plan, implement and monitor immunization services, and through strengthening the cold chain system and vaccine management practices. Operational research will be required for enhanced understanding and better implementation of strategies to improve and maintain high level immunization coverage.

45. The implementation of the regional measles elimination strategy will be supported by a committed global and regional partnership as well as broad-based local partnerships in order to ensure the availability and efficient use of resources.

46. The elimination of measles is biologically and programmatically feasible. However, it requires in-

tensive implementation of priority interventions and adequate financing from both Member States and local and international partners.

47. The Regional committee examined and adopted this strategy.

### **Resolution AFR/RC61/R1**

#### **Measles elimination by 2020: A strategy for the African Region**

The Regional Committee,

Having carefully examined the document “Measles elimination by 2020: a strategy for the African Region”;

Recalling Resolutions AFR/RC52/R2 on the Regional strategy for immunization during the period 2003–2005; AFR/RC56/R1 on the Regional strategic plan for the Expanded Programme on Immunization 2006–2009; and AFR/RC60/R4 on Routine immunization and polio eradication in the African Region;

Appreciating the achievements made so far by Member States and partners in reducing measles mortality by 92% by 2008 as compared with 2000 estimates;

Noting the challenges concerning the accuracy of population estimates for the monitoring of immunization coverage;

Deeply concerned about the recent resurgence of measles in the African Region, and the fragility of the gains in measles mortality reduction;

Noting the changing epidemiological pattern of measles, with an increasing proportion of cases in young infants, older children and adults;

Recognizing the programmatic feasibility as well as the system-wide challenges of measles elimination;

Convinced that eliminating measles will contribute significantly to the attainment of MDG 4 and towards health systems strengthening;

1. ENDORSES the document aimed at the adoption of a measles elimination goal for the African Region;

2. URGES Member States:

- (a) to develop and implement national plans for the elimination of measles by 2020, in line with the Regional Strategic Plan;
- (b) to provide adequate financial and human resources for the implementation of national plans

- to sustain the gains in measles mortality reduction, in order to reach the measles pre-elimination targets by 2012, and ultimately attain measles elimination by 2020;
- (c) to mobilize national and international stakeholders from the public and private sectors, NGOs, bilateral and multilateral organizations, including local communities, and coordinate all activities in the measles elimination efforts;
  - (d) to generate reliable and updated population data to be used for monitoring measles immunization coverage.
3. REQUESTS the Regional Director:
- (a) to develop a Regional Strategic Plan for measles elimination;
  - (b) to provide evidence-based technical guidance on programmatic issues, including the age for measles vaccination;
  - (c) to provide technical support to Member States for the development and implementation of national plans for the elimination of measles;
  - (d) to advocate for additional resources at national and international levels for the elimination of measles in Member States;
  - (e) to report to the Regional Committee beginning in 2012 and, thereafter, every two years on the progress made towards the elimination of measles.

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8. All countries in the African Region except Algeria, Mauritius and Seychelles.
9. All countries in the African Region except Algeria, Comoros, Guinea-Bissau, Mauritius, Sao Tome and Principe and Seychelles.
10. Botswana, Burkina Faso, Burundi, Cameroon, Central African Republic, Congo, Ethiopia, Gabon, Gambia, Ghana, Kenya, Lesotho, Malawi, Mali, Mozambique, Namibia, Nigeria, Rwanda, Senegal, South Africa, Swaziland, Togo, Uganda, Zimbabwe.
11. Botswana, Burkina Faso, Burundi, Cameroon, Central African Republic, Congo, Côte d'Ivoire, Democratic Republic of the Congo, Eritrea, Ethiopia, Ghana, Kenya, Lesotho, Malawi, Mali, Mozambique, Namibia, Niger, Nigeria, Rwanda, Senegal, Sierra Leone, South Africa, Swaziland, Tanzania, Togo, Uganda, Zambia and Zimbabwe.
12. Angola, Benin, Botswana, Burkina Faso, Burundi, Cameroon, Central African Republic, Chad, Côte d'Ivoire, Democratic Republic of the Congo, Ethiopia, Guinea, Lesotho, Liberia, Malawi, Mali, Mauritania, Mozambique, Namibia, Niger, Nigeria, Senegal, Sierra Leone, South Africa, Swaziland, Togo, Zambia and Zimbabwe.
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## Strategic Direction 6

*Accelerating response to the determinants of health*





# 6.1 Health promotion: A strategy for the WHO African Region

(AFR/RC51/12 Rev.1)

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## EXECUTIVE SUMMARY

1. *Broad determinants of health, most of which are intertwined, underlie the double burden of communicable and non-communicable diseases in the Region. To reduce the impact of these determinants on health, it is necessary to apply integrative comprehensive approaches.*
2. *Health promotion facilitates increased social and community participation in health. While health education is central to health promotion, legal, fiscal, economic, environmental and organizational interventions are also essential. Health promotion contributes to programme impact through the prevention of disease, the reduction of risk factors associated with specific diseases, the fostering of lifestyles and conditions conducive to health, and increasing use of available health services.*
3. *Health promotion is a cost-effective approach, which has great potential for accelerating the realization of health for all in the Region. It is effected through the empowerment of individuals and communities, the changing of socio-economic conditions, mediation between different interests in society (through healthy public policies), reorientation of health services and advocacy for health.*
4. *The strategy proposed aims at supporting Member States to foster actions that enhance physical, social and emotional well-being and contribute to the prevention of leading causes of disease, disability and death.*
5. *The objectives of the strategy involve strengthening national capacities for health promotion, supporting priority programmes to achieve set objectives, implementing specific initiatives in order to achieve priority health objectives, increasing the recognition of health promotion as an integral component of socio-economic development and promoting the involvement of non-health public and private sectors in health development.*
6. *The priority interventions proposed are: advocacy, capacity building, development of country plans, incorporation of health promotion components in non-health sectors and strengthening of priority programmes, using health promotion interventions.*

## INTRODUCTION

1. Health promotion is a means of increasing individual and collective participation in health action and strengthening programmes through the integrative use of various methods. These methods are combined through comprehensive approaches, which ensure action at all levels of society, leading to enhanced health impact.

2. Health promotion practice has been in existence for a long time though the use of the term to refer to a specific field started only in the 1980s. The development of health promotion was greatly influenced by the evolution of other broad approaches to human development such as:

- (a) the increased demand for social justice and for the rights of women, children and minorities
- (b) the health for all concept



- (c) movements to protect and improve the physical environment and
- (d) the increased attention being paid to poverty as a major underlying cause of illness.

3. The development of health promotion is part of the global search for effective means of preventing disease and improving general living conditions. There has progressively been increased recognition of the need to address behavioural, lifestyle (harmful cultural practices) and other underlying socio-economic, physical and biological factors, referred to here as the broad determinants of health, so as to improve health.

4. By the mid-20th century, the Public Health model was well established and technologies for manipulating the physical environment were regarded as the ultimate answer to critical health issues. During this period, emphasis was placed on controlling specific diseases through biomedical interventions. Non-professionals played a minimal role in these developments.<sup>1</sup>

5. During the 1960s, the role of behavioural factors in ensuring improved health became widely recognized. It was then understood that besides biomedical care and improvements in the physical environment, individual lifestyles also influence morbidity and mortality. Health education became the main method of informing people on how to positively change their behaviour so as to prevent specific diseases and improve their health. At that time, health education was applied through a top-down approach to learning, often using general, untargeted messages, within a strictly biomedical understanding of health. The participation of communities and the lay public in health was still limited.

6. In the 1970s, the health for all concept and the primary health care strategy were developed. This development gave health education and related information, education and communication approaches a prominent role in health. Health education was then viewed as an activity for supporting the other primary health care components. Application of health education and related approaches in the Region resulted in increased participation of the public in health action, though many people, including policy-makers, still regard health development as the domain of health professionals.

7. The development of health promotion with a view to increasing social and community control and participation in health started in the 1980s. It

was motivated by the recognition of the impact of social, behavioural, economic and organizational factors on health status. Since most health problems have multiple causes, an integrated response to these problems became necessary.

8. Health promotion is any combination of health education with appropriate legal, fiscal, economic, environmental and organizational interventions in programmes to achieve health and prevent disease.<sup>2</sup> Other health promotion methods include information, education and communication, social mobilization, mediation, lobbying and advocacy. These methods are especially relevant in mobilizing non-health sectors to contribute to health development.

9. Health promotion action can significantly contribute towards the achievement of the Region's priority programme objectives, which include:

- (a) prevention of priority communicable diseases such as HIV/AIDS, tuberculosis and malaria;
- (b) prevention of priority non-communicable diseases such as mental illness, cardiovascular diseases, diabetes and cancer;
- (c) reduction of risk factors, such as conditions and behaviours that expose people to HIV/STI, tobacco use and other substance abuse, diabetes, and other priority communicable and non-communicable diseases;
- (d) fostering lifestyles and conditions that are conducive to physical, social and emotional well-being, such as healthy dietary practices, active living and use of life skills; and
- (e) increasing effective use of existing health services and stimulating demand for others.

10. Health promotion action contributes towards the achievement of priority health programme objectives<sup>3</sup> by:

- (a) increasing individual knowledge and skills using health education and information-education-communication (IEC);
- (b) strengthening community action through social mobilization;
- (c) creating environments that are protective and supportive of health using mediation and negotiation;
- (d) developing healthy public policies, legislation and economic and fiscal controls, which enhance health and development through lobbying and advocacy;
- (e) reorienting health services by emphasizing prevention and consumer needs.

## **SITUATION ANALYSIS AND JUSTIFICATION**

### **Situation analysis**

11. Countries in the Region are experiencing a double burden of disease: communicable diseases, which are highly prevalent and non-communicable diseases, which are increasing rapidly. The HIV/AIDS pandemic, malaria and the re-emergence of tuberculosis, etc. have further compounded this situation. Low levels of literacy (especially among women), poor sanitation, inadequate food, civil strife and risky behaviours (e.g., smoking, increasing sedentary living and unhealthy diets), which constitute broad determinants of health, underlie many health problems in the Region. "Poverty fuels the impact of these factors on health as it keeps people in poor health and poor health keeps people in poverty".<sup>4</sup>

12. WHO recognizes the need to involve all people in addressing these broad determinants to improve health. The WHO Constitution states that informed opinion and active cooperation on the part of the public are of the utmost importance in the improvement of the health of the people.<sup>5</sup> The Organization, therefore, encourages and supports countries to use health promotion to address the broad determinants.

13. Countries recognize the value of health education and also that to achieve its full potential, it has to be combined with other health promotion methods as proposed in this strategy.

14. A recent WHO survey in the Region reveals the existence of various health promotion approaches and methods institutionalized in diverse structures. Of a total of 37 countries, 15 have health education; 11 information, education and communication; five health promotion; two information, education and communication and health education; one information, education and communication and social mobilization; one other health education and social mobilization; and two have no specific approach.<sup>6</sup> Health promotion is being increasingly incorporated into non-health sectors, especially education and agriculture. Seventeen countries are already implementing the Health Promoting Schools Initiative.<sup>7</sup>

15. A report of an expert consultation shows that the implementation of health promotion and related approaches in the Region has traditionally been spearheaded by the health sector although the participation of individuals, communities and non-health actors is gradually increasing.

16. Reports from various countries indicate innovative use of entertainment and communication media in the Region. However, the main media used continue to be print. Radio, focus groups, folk media, interactive theatre, puppetry and television are also used to some extent.<sup>8</sup>

17. The major challenges relating to the implementation of health promotion in the Region include:

- (a) poor definition of expected health outcomes, specific factors and conditions to be influenced through health promotion;
- (b) lack of health promotion policies and guidelines for coordination of different methods and approaches;
- (c) inadequate capacity (especially in human resources) to develop, implement and evaluate health promotion programmes and activities;
- (d) insufficient intra- and intersectoral collaboration at national and regional levels;
- (e) low investment in preventive and promotive services within the health sector;
- (f) limited operational research and dissemination of information on good practices in health promotion;
- (g) lack of appropriate linkages between health promotion and the delivery of health services;
- (h) lack of full understanding of the effectiveness of health promotion by the public and policy makers;
- (i) political and social instability and poor governance, which impede the process of democratization and participation of civil society in health action.

### **Justification**

18. There is evidence that the application of health promotion leads to positive outcomes such as empowerment for health action, healthy public policies and increased community involvement.

19. Health promotion makes a unique contribution to health development by integrating various approaches and methods to address broad determinants of health. It is a necessary component in all health and related programmes. Health promotion plays a central role in the creation and management of enabling environments for health.

20. Health promotion has a rapidly increasing distinct body of knowledge, principles and methodology. It is important, therefore, that countries of the Region have a strategy to ensure its development and use.

21. Since 1986, five global health promotion conferences have been convened by WHO and key partners. The conferences have influenced the development and implementation of health promotion in countries. During the latest of these conferences (Mexico, June 2000), African participants called on the WHO Regional Office for Africa to develop a regional health promotion strategy. The strategy would help countries in the Region to adapt the Mexico framework for the development of health promotion within the African context.

22. Reports of five global health promotion conferences indicate, among other things, that there is a need to ensure the mobilization of new players in health by involving all sectors and cutting across sectoral, departmental and institutional boundaries. The challenge in the coming years is to unleash the potential for health promotion inherent in many sectors of society, communities and families.<sup>9</sup>

23. Various WHO resolutions prior to 1989 did not specifically deal with health promotion but emphasized the role of public information and education in health. The resolutions specifically urged Member States to develop infrastructure for health education and information, education and communication.<sup>10</sup>

24. WHO resolutions after 1989 deal specifically with health promotion.<sup>11</sup> The resolutions call upon Member States to develop health promotion as an essential element of primary health care and take steps to train health and related professionals in health promotion. Intercountry cooperation and exchanges of experience in health promotion are encouraged. The United Nations system, international and non-governmental organizations and foundations, donors and the international community are called upon to mobilize and cooperate with Member States to develop and implement health promotion strategies. Countries are urged to secure infrastructure for health promotion. The WHO Director-General thus gives top priority to health promotion, the development of which is supported within the Organization.<sup>12</sup>

25. A WHO Regional Committee for Africa's resolution calls on Member States to develop or strengthen information, education and communication strategies as essential elements of health promotion.<sup>13</sup> The resolution emphasizes the role of communication strategies in health promotion but does not address health promotion specifically.

26. The Regional Office recognizes health promotion as a necessary component in its priority programmes as part of the effort to achieve health for all in the 21st century.<sup>14</sup> The programmes include:

HIV/AIDS, Malaria, Tuberculosis, Immunization, Mental Health, the Tobacco Free Initiative and Reproductive Health. Though currently these programmes have elements of health promotion, the proposed strategy should facilitate strengthening and systematization of the application of health promotion to improve programme effectiveness and sustainability.

## THE REGIONAL STRATEGY

### *Aim and objectives*

27. The aim of the strategy is to foster actions that enhance physical, social and emotional well-being and contribute to the prevention of leading causes of disease, disability and death.

28. The objectives of the strategy are:

- (a) to strengthen the capacity of countries to design, implement and evaluate health promotion
- (b) to support priority health programmes to achieve set objectives
- (c) to implement specific health promotion initiatives to achieve priority health objectives
- (d) to increase recognition of health as a necessary component of socio-economic development
- (e) to promote the involvement of non-health public and private sectors in health development.

### **Guiding principles**

29. The success of health promotion interventions will depend on the following principles:

- (a) Existence in countries of knowledge and skills for implementation of evidence-based health promotion;
- (b) Integration of health promotion into all health programmes, with clearly defined goals and objectives;
- (c) Systematization of the use of the interventions to complement priority health programmes;
- (d) Recognition of health as a resource for development and achievement of equity in communities and within countries; of expenditure on health as an investment in human resources and development; of policies and practices that avoid harming individual health, protect the environment, restrict trade in or production of harmful goods and substances, and safeguard health in the workplace;<sup>15</sup>
- (e) Tapping the potential for health promotion in all sectors, creating partnerships and identifying non-health sector actors in support of peace, shelter, education, food, adequate income, a

stable ecosystem, social justice, respect for human rights and equity that are conditions for health and that can reduce poverty, which is the greatest threat to health.

### **Priority interventions**

30. Member States and WHO need to address the following priorities in order to develop and implement effective health promotion programmes and activities:

- (a) Advocacy on use of health promotion to improve health and prevent disease;
- (b) Capacity building for strengthening health promotion policies, mechanisms and interventions;
- (c) Country plans of action for strengthening the use and institutionalization of health promotion in health systems;
- (d) Incorporation of health promotion components into non-health sector interventions and programmes; and
- (e) Strengthening of priority health programmes through the use of health promotion methods and approaches.

31. Since health promotion is still being developed in many countries of the Region, there is a need for advocacy of its use in health development. The support of community and political leaders, academic institutions, NGOs, donors, professional associations and private enterprises should be solicited in order to accelerate the development and application of health promotion.

32. National health promotion policy should facilitate the coordination of activities, the mobilization of resources and capacity building. Health promotion practitioners should be orientated or trained as necessary, and training curricula should reflect health promotion components.

33. Health promotion should be integrated throughout the health system and plans of action should be developed for this purpose.

34. Collaborative mechanisms to support the implementation of health promotion in non-health sectors should be put in place. These should involve all potential players, including, but not limited to, the private sector, academia, NGOs and community-based organizations.

35. The health promotion component in priority health programmes should be strengthened. Available guidelines and examples of good health promotion practice should be used.

### **Implementation framework**

#### *At country level*

36. The technical leadership of the health sector is crucial to the implementation of this strategy. Countries will:

- (a) undertake advocacy to increase awareness and support for the use of health promotion, targeting both the health and non-health sectors and mobilizing new players for health;
- (b) develop and adjust policy, establish institutional frameworks and mechanisms, and mobilize and allocate resources for health promotion components in programmes;
- (c) establish mechanisms for linking health promotion interventions in non-health sectors with the national health system;
- (d) formulate action plans to facilitate the development of health promotion capacity and support at various levels; the plans should be based on a framework that includes situation analysis, problem definition, objectives, mechanisms for coordination, partnership building, monitoring and evaluation;
- (e) strengthen the health promotion component in priority programmes by adapting available guidelines for the Health Promoting Schools Initiative, the Tobacco Free Initiative, Immunization,<sup>16</sup> etc.

37. To plan, implement and evaluate health promotion efforts, each country will:

- (a) identify goals in terms of health outcomes to which the health promotion effort will contribute;
- (b) delineate the behaviours or conditions associated with each targeted health outcome that are to be influenced by the health promotion effort; and
- (c) define the specific changes that are intended to be achieved by the health promotion effort in order to influence targeted behaviours or conditions, focusing on:
  - increasing individual knowledge;
  - strengthening community action;
  - creating environments supportive of health;
  - developing, implementing and enforcing health-related policies; and
  - reorienting health services.

#### *At regional level*

38. WHO will continue to advocate for renewed political commitment and for the creation of environments that are supportive of health in accordance

with the health-for-all policy in the African Region for the 21st century.<sup>17</sup> More specifically, WHO will:

- (a) Support, technically and materially, countries of the Region to implement the recommendations of this strategy;
- (b) provide leadership and guidance to regional counterparts, international NGOs and agencies to enable them understand, support and use health promotion to address health and development;
- (c) mobilize and support countries to participate in intercountry consultations and to form health promotion partnerships;
- (d) advocate with governments and agencies to support the implementation of health promotion and sharing of experiences;
- (e) facilitate the training of designated national health promotion focal persons;
- (f) coordinate the development of guidelines and a regional implementation framework, including clearly defined targets, for strengthening health promotion in countries;
- (g) use health promotion actions to carry out regional initiatives and to support country efforts.

39. Partners in health development will support the use of health promotion in countries through the provision of resources and strengthening of the health promotion component in their programmes.

## MONITORING AND EVALUATION

40. Countries will agree on indicators to be used for monitoring the implementation of the strategy's objectives and country actions to increase capacity and support, and to plan, implement and evaluate health promotion.

41. Countries will monitor implementation of the strategy using agreed indicators.

42. WHO will collect information on the implementation of the strategy two years after its adoption and every three years thereafter.

43. Countries and WHO will carry out periodic intercountry evaluation of the effectiveness of health promotion.

## CONCLUSION

44. The major thrust of the strategy is the emphasis on health promotion as a means of integrating various methods and approaches to improve the health of the people. Integration of methods and actions at

several levels results in increased health knowledge, skills and community participation, healthy public policies and environments, which are supportive of health. Priority actions recommended include advocacy, capacity building, plans of action, involvement of all sectors and strengthening of health programmes.

### **Resolution AFR/RC51/R4**

#### **Health promotion: A strategy for the African Region (AFR/RC51/R4)**

The Regional Committee,

Aware that the physical, economic, social and cultural factors, known to be the broad determinants of health, underlie the double burden of communicable and non-communicable diseases and are responsible for the general health conditions in the Region;

Convinced about the necessity to apply, in an integrated manner, various health promotion approaches and techniques to address these factors and reduce their impact on health;

Recalling resolutions WHA27.27, WHA31.42, WHA42.44, WHA51.12 and AFR/RC47/R2, and Executive Board decision EB1.1.12, which called for the development and implementation of health promotion approaches, and the recommendation by Member States adopted at the 50th session of the Regional Committee, and the WHO Secretariat's report on health promotion to the Fifty-fourth World Health Assembly (A54/A/SR/7);

Appreciating the efforts made so far by Member States and their partners in developing and implementing various approaches which constitute health promotion;

Recognizing the need to integrate and consolidate existing approaches and develop a comprehensive framework for strengthening the application of health promotion in countries of the African Region;

Having carefully examined the Regional Director's report contained in document AFR/RC51/12, which outlines the regional strategy for health promotion;

1. APPROVES the proposed strategy, which aims at supporting Member States to foster actions that enhance the physical, social and emotional well-being of the African people and contribute of disease, disability and death;

2. URGES Member States:

- (a) to advocate for increased awareness of and support for the use of health promotion in the health and health-related sectors;
- (b) to develop national strategies incorporating policy, frameworks and action plans for strengthening the institutional capacity for health promotion, and provide support at various levels of the health system, as appropriate;
- (c) to strengthen the health promotion component of health and related development programmes, using available guidelines such as the ones for the Tobacco-free Initiative and the Community-Based Interventions for Malaria Control;
- (d) to plan, implement and evaluate health promotion actions which are comprehensive in nature, and focus on the following areas of intervention:
  - (i) increasing individual knowledge and skills
  - (ii) strengthening community action
  - (iii) creating environments supportive of health
  - (iv) developing, implementing and influencing health-related policies
  - (v) reorienting health services;
- (e) to mobilize new resources and players for health action from the public and private sectors, non-governmental organizations, communities and international and bilateral bodies;

3. REQUESTS the Regional Director:

- (a) to develop a generic framework and guidelines for the implementation of the regional strategy and to provide technical leadership to Member States to enhance the development and application of health promotion, including strengthening of the technical capacity of national focal points;
- (b) to facilitate operational research on health promotion and dissemination to Member States of the results on best practices through consultations, networks and workshops;
- (c) to mobilize additional resources and encourage partnerships among key actors for supporting the implementation of the Health Promoting Schools Initiative and related regional interventions;
- (d) to draw up operational plans for the period 2002–2012;
- (e) to report on progress made in the implementation of the regional strategy to the fifty-fourth session of the Regional Committee in 2004, and thereafter, every two years.

*Fifth meeting, 29 August 2001*

**REFERENCES**

1. Egger, G et al (1990). *Health Promotion Strategies and Methods*. McGraw-Hill Book Company, Sydney, p. 5.
2. Adapted from a statement in Tones, K. et al (1990). *Health Education: Effectiveness and efficiency*. Chapman and Hall, London, p. 4.
3. Adapted from WHO (1998). *Health Promotion Glossary* (WHO/HPR/HEP/98.1), p. 2. Action at all or most of these levels is motivated by the understanding that many causes of illness and death can be addressed through simple measures directed at the individual, the community and the environment.
4. WHO Regional Office for Africa, Report of the Regional Consultation on Poverty and Health. July 2000, Harare, p. 8.
5. Constitution of the World Health Organization, Section One, p. 1.
6. A questionnaire was sent to countries and these are the responses which had been received by September, 2000. Only two countries have full health promotion structures. Three others combine health promotion with health education or information, education and communication.
7. Health Promoting Schools Initiative is a school health focused programme introduced by AFRO in the Region with donor support. The programme encourages use of the school as a setting for health promotion. Health Promoting Schools Initiative interventions include school health policy development, service delivery, health education and environmental health activities.
8. African Medical and Research Foundation. Together in Hope: A report of an intercountry consultation on Health Promotion. Nairobi, March 2000, pp. 1–14.
9. The key reports are: The Ottawa Charter, The Adelaide Recommendations on Healthy Public Policy, The Sundsvall Statement on Supportive Environments for Health, The Jakarta Declaration on Leading Health Promotion into the 21st century, and the Mexico Statement for the Promotion of Health.
10. The relevant resolutions are: WHA27.27, WHA31.42 and WHA42.44.
11. The resolutions are: WHA51.12 and EB101/SR/12.
12. The Jakarta Declaration states that to address emerging threats to health, new forms of action are needed. The challenges require the mobilization of new players in health drawn from non-health public and private sectors. It also stresses partnerships for health.
13. Resolution AFR/RC47/R.2.
14. WHO Regional Office for Africa. Health-for-All Policy for the 21st Century in the African Region: Agenda 2020.
15. WHO (1997). Jakarta Declaration, p. 5.
16. The guidelines will be based on the use of settings, public health issues and specific population groups as the entry points for health promotion interventions.
17. Doc AFR/RC50/8Rev.1.

## 6.2 Environmental health: A strategy for the WHO African Region

(AFR/RC52/10)

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### EXECUTIVE SUMMARY

1. In spite of the commendable efforts of many governments and external support agencies for many decades, in the year 2000, some 276 million people in Africa still lacked access to safe water supply, while 284 million were without adequate sanitation (AFR/WSH/00.3). The pollution of scarce water sources, the contamination of soils by industrial, municipal and agricultural wastes containing toxic and hazardous chemicals and the rampant spread of disease vectors have rendered water treatment and vector control very costly.

2. It is also becoming increasingly evident that the future of health in the entire world, and in Africa in particular, will be determined by the environment. While other regions are faced with problems of one era, Africa is confronted by the combined problems of pre-industrial, industrial and post-industrial eras. Countries need to prepare themselves to face these challenges or else they will be overwhelmed by a future that they can plan for, using the resources at their disposal.

3. The strategy on environment and health, therefore, aims to stimulate the development of environmental health policies in the health sector. These policies should enable the health sector within countries to inform the policies of the other social sectors in order to make them health sensitive. The strategy should also enable the health sector to improve the knowledge and awareness of communities about the relationship between the environment and health. It is important for communities to make informed choices so as to improve their health status and quality of life and contribute to sustainable development.

4. The Regional Committee examined and adopted this strategy.

### INTRODUCTION

1. In spite of the commendable efforts of many governments and external support agencies over many decades, in the year 2000, some 276 million people in Africa still lacked access to safe water supply, while 284 million were without adequate sanitation (AFR/WSH/00.3). The pollution of scarce water sources, the contamination of soils by industrial, municipal and agricultural wastes containing toxic and hazardous chemicals and the rampant spread of disease vectors have rendered water treatment and vector control very costly.

2. It is widely noted that the contribution and benefits of the environment to other determinants of health are not well understood by policy-makers

and planners. This is reflected in the low level of resources allocated for the maintenance of an enabling environment to support life and health. The diseases that burden communities, in particular deprived communities and rural and urban fringe communities in Africa are mainly due to environmental conditions that can be avoided. The situation of deprived communities is worsened by poor environmental conditions that could easily be managed by environmental health services.

3. It is, therefore, *crucial* to differentiate between environment and health and environmental health. *Environmental health comprises those factors of human health, including quality of life, that are determined by physical, chemical, biological, social and psychosocial factors*

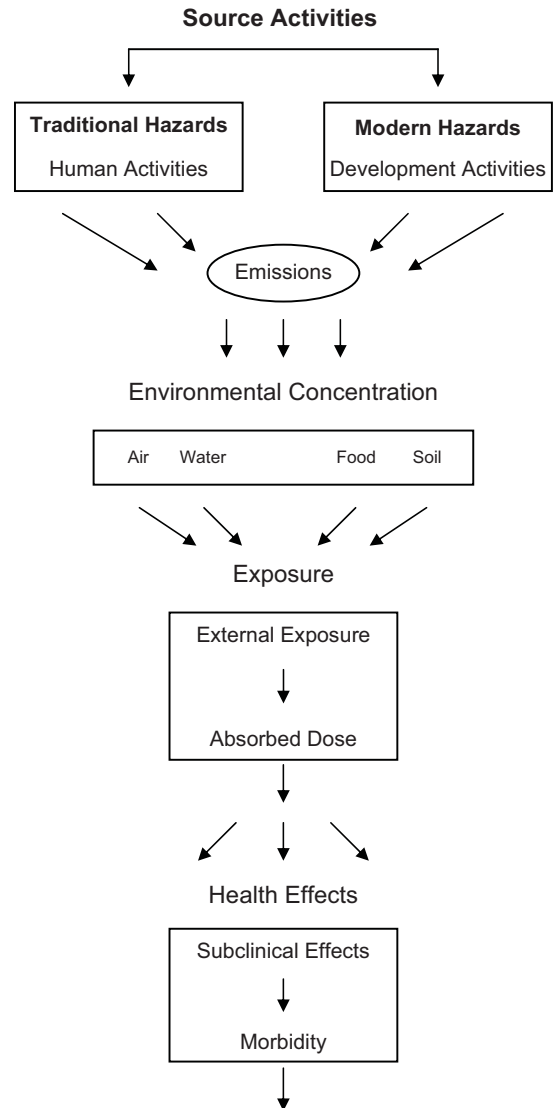
in the environment (WHO/EH/98.9). It also refers to the theory and practice of assessing, correcting and preventing those factors in the environment that can adversely affect the health of present and future generations. Thus, environmental health services can be defined as those services implementing environmental health policies through monitoring and control activities.

4. Environment and health refers to the interface between the environment on one side and health on the other. To explain this further, *the ability to link health and environmental data, and, thereby, understand relationships between levels of exposure and health outcomes, is vital in attempts to control exposures and protect health. This capability is particularly important in countries in which issues of environmental pollution have traditionally taken second place to demands of economic development (WHO/EHG/95.26).* Environment and health mainly deals with risk assessment and management of this interface (see conceptual framework at the individual level, Figure 1).

5. It is becoming increasingly evident that the future of health, particularly in Africa, will be determined by the environment. While other regions are faced with problems of one era, Africa is confronted by the combined problems of the pre-industrial era, of industrialization and of the twenty-first century. Countries need to prepare themselves to address these challenges or else they will be overwhelmed by a future that they can plan for, using the resources at their disposal.

6. The *Environment and Health* strategy aims to stimulate the development of environmental health policies in the health sector. These policies should enable the health sector within countries to inform the policies of the other social sectors in order to make them health sensitive. The strategy should also enable the health sector to improve the knowledge and awareness of communities about the relationship between the environment and health. It is important for communities to make informed choices so as to improve their health status and quality of life and contribute to sustainable development.

7. In order to address the above-mentioned problems, it is necessary to adopt an institutional arrangement to support the political commitment made by countries in the New Partnership for Africa's Development (NEPAD) and by ministers of health, through various regional efforts, to ensure healthy and safe environments for their people. The regional strategy aims to strengthen preventive and health promotion measures in all countries of the Region.



**Figure 1** The environmental health hazards pathways: conceptual framework at the individual level. Source: WHO/EHG/95.26, page 8.

## SITUATION ANALYSIS

8. In Africa, water-related diseases such as malaria, schistosomiasis and river blindness are some of the causes of high morbidity, which impact negatively on the economy and the health sector. Infectious diseases linked to poor environmental conditions kill one out of every five children in Africa. Diarrhoea and acute respiratory infections are two of the major killers of children and under-fives. Cholera is endemic in at least a dozen of the countries in the Region. In 1999, a total of 187 775 cases of cholera



with 7831 deaths were reported, representing a case fatality rate of 4% (WHO/EH 98.7).

9. Occupational injuries and diseases play an important role in developing countries, where 70% of the working population of the world lives. By affecting the health of the working population, occupational injuries and diseases have profound effects on work productivity and on the economic and social well-being of workers, their families and dependants, thus triggering a cycle of *low capacity, low revenue, low productivity and low consumption* that tend to trap societies into poverty.

10. Globally, chemical substances have brought about improvements in the lives and health of nations. Every year, more than a hundred new chemical substances enter the market even though the toxicology of a number of these chemical substances is not fully known. In the African Region, these chemical substances are used mainly in agriculture and in some cottage industries, with little or no understanding of their immediate and long-term effects. Chemical substances have cumulative effects in the body. They can cause both acute and chronic conditions resulting in very serious complications and death.

11. It is common occurrence for women workers to carry their babies with them, while working in the fields, thus exposing themselves and the babies to these chemical substances. WHO has developed a strategy, *The Health Sector and Chemical Safety in the 21st Century* (Cape Town, July 2001), for addressing chemical substances within the health sector that will act as a guide to countries.

12. Apart from exposure to chemical substances, there are periodic oil spillages and leakages in some countries in Africa, which further pollute the soil and water. These oil spillages and leakages sometimes cause fires and thus contribute to air pollution. Of particular interest are additives in petrol, particularly lead, which easily gains entry into the body through various ways. Lead limits the ability of children to learn, thereby triggering a cycle of illiteracy, which subsequently leads to poverty.

13. Pollution of indoor air results in various respiratory and other non-communicable diseases in the world. In Africa, the situation is further aggravated by overcrowding, poorly ventilated houses, use of biomass and kerosene for space heating and lighting, lack of information on the use of chemical substances, old and derelict motor vehicles and motor cycles. This has resulted in an increased disease burden within the populations. It also affects productivity, thus perpetuating the cycle of poverty. Children

under the age of five from high indoor air polluted localities are likely to suffer more from upper respiratory problems than those from less polluted localities. They are also more likely to underachieve in school compared to those from improved areas. This limits their ability and chances in life.

14. The effects of activities such as the burning of fossil fuel and use of chemical substances have contributed to the depletion of the ozone layer, thereby creating conditions favourable to the resurgence of diseases such as malaria, dengue fever and cholera.

15. The spread of unplanned, poorly constructed urban settlements in African cities and towns, often in unsuitable locations, not only impacts negatively on health but also undermines good values. These settlements put pressure on the environment and the existing infrastructure and hence overload the system and threaten the health of the people, particularly that of children. More often, governments will respond by providing water without improving waste control and sanitation though both are inseparable. It is a known fact that the quality of potable water provided in areas where sanitation is lacking or low will be affected.

16. The management of both solid and liquid waste is far from satisfactory in the African Region. The result is visible heaps of rubbish in uncontrolled dumping sites, which attract salvaging, vermin and disease vectors. This is due to lack of planning and implementation of waste disposal measures. Communities settle on unsuitable land that might have been used as dumping sites of general waste and are thus exposed to potent gases and explosion from built-up gases. Waste, when not properly managed, will directly or indirectly negatively affect the environment and health. Waste from health care activities in particular poses a special risk to the people of the Region and thus calls for undivided urgent attention. Yet, properly managed waste can create employment and alleviate poverty. If waste is carefully recycled, re-used and reclaimed, very little of it will be disposed of, which will save on space so desperately needed for other activities.

17. The safety and quality of food in its various forms is, therefore, affected by many of the unsafe conditions created. Its ability to support life is then greatly compromised. In fact, food then becomes dangerous to health and life. The way food is produced, stored, transported and handled as a commercial product is, therefore, very important as it determines the benefits that it may bring to people. Particular attention must therefore be paid to the handling of food and foodstuffs to ensure their safety

and quality. WHO treats food safety and hygiene as a separate very important aspect that needs a strategy of its own.

18. To ensure that determinants of success accompany such a strategy, there are three possible scenarios of environmental health development in the Region for 2020. The purpose of the scenario approach is to guide decision-making and to build a certain capability for anticipating events.

- Status quo – This scenario assumes little or no change in the Region. Besides the occasional success stories, environmental health considerations will continue to receive the scant attention and resources they now get. The explosive growth of peri-urban slums will continue unabated. In line with standard demographic projections, environmental health issues will become a serious problem in the urban areas of the Region, where most of the population will reside by 2020. Air pollution, unsafe water and food, poor housing and occupational health problems will continue to take a heavy toll on African populations.
- Catastrophe – The combination of rapid population growth, increasing poverty, natural resource depletion and extensive environmental pollution will simply overwhelm decision-makers. Consequently, they will operate in a state of denial of the issues being faced. Their interventions will focus on the privileged few at the expense of the majority. The sheer magnitude of the problem confronted will put them in a state of inaction and poor environmental health conditions will be considered as normal. It is only when these poor environmental health conditions have a direct impact on the lives of the privileged few that action will be taken to address the problem.
- The new age – Under this scenario, increased public participation in environmental health efforts, coupled with strengthened capacity, heightened awareness and strong political commitment will combine to drastically improve the environmental health situation of the continent. Thanks to sustained efforts, environmentally induced diseases (dysentery, cholera, malaria, etc.) will become a thing of the past. Potable water will be made available to all, and low-cost participatory sanitation practices will be institutionalized throughout the continent. In fact, the African success story will be widely

disseminated throughout other developing regions of the world. Emerging threats such as air pollution will have been largely controlled due to the adoption of new, appropriate technologies and political stability, as evidenced by the absence of political strife and conflict, will be the norm in most of the continent.

## **THE REGIONAL STRATEGY**

### **Long-term goal**

19. By 2020, an enabling environment that promotes health and contributes to sustainable development will have been created and maintained in the Region.

### **Objectives**

20. The overall goal of this strategy, is to influence these environmental conditions to impact on the determinants of health in order to promote positive outcomes for the people and communities, in particular for rural and urban fringe communities. Specific objectives are to support countries:

- (a) to develop their own policies on environmental health by 2010;
- (b) to establish appropriate structures for environmental health services by 2010;
- (c) to improve human resource capacities in environmental health in ministries of health by 2015; and
- (d) to foster sector collaboration and partnership.

### **Guiding principles**

21. Four guiding principles are necessary for the implementation of the environment and health strategy:

- (a) The participation of the people in decision-making implies involving all stakeholders in decision-making at the local level, particularly in natural resource management. Dialogue, the participation of the people and conflict resolution among stakeholders strengthen the acceptability of and readiness to adopt concepts, projects and programmes, thus rendering interventions more cost effective and more culturally appropriate.
- (b) The provision of environmental health services to all people means some for all rather than all for some. Equity, that is the absence of systematic potentially remediable differences in one or more aspects of health across the population or

population groups defined either socially, economically or demographically, is critical. In the context of least developed countries, equity in access to public health services has become a more important objective from the poverty alleviation perspective.

- (c) A pro-poor focus ensures that the main objective of planning is to benefit poor people. Otherwise, the poor will remain peripheral to the planning and development process.
- (d) Intersectoral collaboration between various social-sector departments, particularly housing, local government, land, agriculture, transport (roads), environment and water, should ensure integrated planning and implementation.

### Priority interventions

22. In an effort to address the numerous and complex environmental determinants of health, the health sector will have to implement the following priority interventions:

- (a) improve the capacity of institutional structures to respond to challenges;
- (b) coordinate the use of resources to benefit the Region, particularly the poor and deprived population groups;
- (c) bring countries together to share experiences and expertise;
- (d) seek indigenous knowledge and encourage its application, where appropriate;
- (e) undertake risk management as one of the basic approaches in environmental health service delivery;
- (f) use proven approaches such as healthy settings, cities, neighbourhoods, markets, etc. – and participatory hygiene and sanitation transformation (PHAST); WHO has developed guidelines on these approaches;
- (g) introduce environment and health as a life-long lesson in educational curricula; and
- (h) support research on the implementation of cost-effective measures that benefit communities.

### Roles and responsibilities

23. To address the issues stated above pertaining to environment, development and health and to ensure that the strategy succeeds, the following roles and responsibilities are assigned to the main stakeholders:

#### Countries

24. Ministries of health in countries should take the lead in the development of policies that enable them to address and implement environmental determi-

nants of health. They are, therefore, expected to create conditions that ensure success, namely adequate resource allocation to environmental health services to enable them to undertake risk management, provide inputs for the development of policies for the other sectors and foster collaboration and community participation.

25. Communities and other social sectors within countries are expected to be involved in the health sector. It is also important for communities to participate in policy development and implementation and in the monitoring and evaluation of projects and programmes.

26. The expertise of the private sector is crucial for policy development and implementation and service delivery. This creates a conducive environment for communities to participate in the private sector, thereby, helping to defuse tension between the private sector and communities, which may arise from misconceptions.

27. The participation of institutions of higher learning and research helps these institutions to understand the direction developments are taking. In this way, they are able to develop relevant human resources and to initiate and undertake relevant research for priority activities. This also empowers ministries of health and facilitates continuous professional development.

28. Other partners such as the ministries in charge of housing; land; environment; trade and industry; local government; agriculture; transport; mining, water and education have to work closely with the ministry of health in developing policies. It will also benefit the people if the social sectors support initiatives for sector collaboration and include in their development of human resources the culture of integrated planning and implementation. For the education sector in particular, the inclusion of environment and health as part of life-long learning will help to shift the paradigm.

#### WHO and partners

29. The World Health Organization, in collaboration with its partners (UNEP, UNDP, IPCS, World Bank) should assist in the adoption of *Environmental Health: A Strategy for the African Region* by ministers of health of the Region. In addition, WHO will develop guidelines for environmental health policy and norms and standards for use by countries to develop their own policies. WHO will also assist in identifying enhancers and disabling in the development of policies and in improving capacities and

capabilities for environmental health service delivery. It will also foster cooperation between countries in the sharing of resources, expertise and experiences and encourage the mobilization of communities to participate in health development programmes. WHO will help to mobilize the private sector to take part in and provide support for environmental health service delivery. In-built monitoring and evaluation mechanisms will be encouraged to enable countries to measure progress in the implementation of their projects and programmes.

## MONITORING AND EVALUATION

30. The following will be used to monitor progress in the achievement of the environment and health goal and objectives:

- (a) development of an environmental health policy by countries and ministries of health;
- (b) development by countries of relevant institutional arrangements to plan and implement policies for addressing environmental and health concerns;
- (c) improvement by countries of human resource capacities in environmental health within their ministries of health;
- (d) development by countries, through the ministries of health, of mechanisms for collaboration with other social sectors and cooperation with partners;
- (e) mobilization of communities to take part in environment and development issues affecting health; and
- (f) development of research capacities and agendas for environmental determinants of health.

### Determinants of success

31. Determinants of success range from the stewardship role of the government to the use of strategic tools:

- (a) Governments in the Region should commit themselves politically, financially and socially to implementing policies on environmental determinants of health.
- (b) Greater awareness and appreciation by professionals of the linkages between environment, health and sustainable development is fundamental to the adoption and implementation of the strategy for the Region.
- (c) There is a need for a shift from the *status quo* mindset to a multiple alternatives approach to addressing both current and emerging issues and concerns.

- (d) The availability of trained personnel in the African Region to utilize tools such as *Environmental Health Hazard Mapping* and *Environmental Impact Assessment* to better deliver environmental health services is critical.

## CONCLUSION

32. This strategy is an attempt to address the cycle of environment, development and human health issues. It particularly targets the poor and deprived populations. The strategy deliberately uses the primary health care approach, with emphasis on health prevention and promotion, as a primary tool. This approach has been adopted by all countries of the world, including those of the African Region, to ensure maximum health benefits for their countries and people.

33. Sufficient knowledge has been gained and appropriate tools developed to enable the health sector to contribute to health outcomes and sustainable development. Africa has, since the Rio Earth Summit in 1992, developed consensus through various efforts on environment and health for sustainable development. It is time to consolidate those efforts.

34. Environmental factors that contribute to poor health and, therefore, to poverty have been identified, as have critical factors that help to improve them in order to ensure health gains and enhance the quality of life of the people. Countries themselves, in collaboration with other partners, have to cooperate in dealing with these factors. Communities as partners and beneficiaries will be mobilized to ensure that they take charge of their own health and well-being.

35. Ministries of health in particular are expected to take the lead in the promotion of environmental health because it is the health sector that has to carry the burden resulting from unsafe policies. By ensuring that social policies are sensitive to the health needs of the people and are easily understood and implemented, countries stand a better chance of making improvements not only in health but also in the economy, life expectancy and quality of life years.

36. The Regional Committee examined and adopted this strategy.

### Resolution AFR/RC52/R3

#### Health and environment: A strategy for the African Region

The Regional Committee,

Aware of the intricate link between health, environment and development;

Concerned about the increasing poor quality of life and the negative health outcomes resulting from neglect and deterioration of the environment in the WHO African Region;

Recognizing the efforts of countries to improve the health of their populations through various regional and country instruments, notably the Pretoria Declaration on Health and Environment (1997) and Promoting environmental health in countries of the WHO African Region: The role of ministries of health (AFR/RC48/TD/1);

Appreciating the contribution of sectors outside health and of communities and partners in pursuit of improved health and environment;

Determined to consolidate efforts towards attainment of the highest quality of life affordable within the Region, especially in advocating for the improvement of environmental determinants of health;

Having carefully examined the report of the Regional Director as contained in document AFR/RC52/10 (Health and environment: A strategy for the African Region), which is aimed at improving the health of the people through the development and implementation of policies for the management of environmental determinants of health;

1. APPROVES the proposed strategy;

2. REQUESTS Member States:

(a) to take account in their national policies and strategies of health problems resulting from the environment;

(b) to develop or review their national programmes and plans of action, with emphasis on advocacy, awareness-raising and education in health and environment;

(c) to collaborate with institutions of higher learning to develop and improve capacity for human resources to better manage health and environment programmes;

(d) to identify, mobilize and allocate resources for health and environment programmes to better respond to challenges;

(e) to collaborate with other sectors outside health, with partners and civil society in pursuance of improved health by targeting environmental determinants of health;

(f) to conduct research in the use of indigenous technologies and innovations that are effective, affordable and sustainable in pursuit of improved health of communities;

3. REQUESTS the Regional Director:

(a) to improve the capacity of WHO to effectively provide technical support to Member States for the development and implementation of policies on health and environment;

(b) to support the improvement of the capacity of countries to implement and monitor programmes and action plans;

(c) to update the Regional Committee in 2005 on the progress made in the implementation of the strategy;

4. APPEALS to other relevant specialized agencies and partners for technical and financial support.

## 6.3 Poverty and health: A strategy for the WHO African Region

(AFR/RC52/11)

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### EXECUTIVE SUMMARY

1. *The paradox of the African Region is the extreme and increasing poverty of its people who face various forms of deprivation (ill-health, illiteracy, unemployment, inadequate housing, poor governance, etc.) in a land so richly endowed with natural resources. This paradox is increasingly visible in the light of the changes in the world poverty profile: while poor people in Africa represented only 16% of the world's poor in 1985, this proportion had risen to 31% by 1998. In the next 20 years, poverty is likely to decline in every other part of the world except in Africa, where a dramatic increase is projected.*
2. *Many policies and strategies have been adopted in the health sector in the recent past in order to improve the health status of people in developing countries in general and in the African Region in particular. The most recent of these was the Health-for-all Policy for the 21st Century, adopted by the 49th session of the Regional Committee for Africa. The health-for-all policy aims to significantly improve the health status of African people by promoting healthier lifestyles, preventing the occurrence of disease, increasing life expectancy at birth and reducing mortality. It also aims to arrest the increasing morbidity due to malaria, TB and HIV/AIDS.*
3. *Health constitutes a strong entry point for poverty reduction and economic growth. In this context, this strategy provides a framework of analysis and interventions at three levels: (a) increasing advocacy and mobilization of all stakeholders inside and outside the health sector; (b) implementing health systems reform to redirect interventions towards the poor; and (c) targeting the priority needs of the poorest, with specific interventions that ensure universal access to basic health services.*
4. *The success of this strategy is based on its implementation in Member countries as consistent with national health policies.*

### INTRODUCTION

1. Poverty is a multidimensional and cross-sectoral phenomenon. To facilitate a comparative analysis of the different poverty profiles across the world, a standard definition of poverty, based on daily consumption, has been adopted. This definition considers as "poor" anyone who cannot afford a daily consumption of US\$1.
2. Using this US\$1 as the universal poverty-line definition, more than two billion people worldwide can be counted as poor<sup>1</sup>. In the WHO African Region, more than 45% of the population fall under this category. Poverty is more prevalent in rural

areas, where the majority of the African populations live. Unfortunately, the incidence of poverty is on the rise in Africa, causing deterioration in social and health indicators, particularly life expectancy, child and infant mortality, maternal mortality and morbidity due to malaria, TB and HIV/AIDS.

3. Yet, health impacts upon and is affected by issues of the environment, transportation, water, energy, urbanization and employment. Consequently, health presents an optimal entry point in order to adopt a comprehensive development approach, which is consistent with the internationally-agreed objectives of poverty reduction and development.

4. In the African context, the heavy burden of disease causes significant loss of output which, in turn, accentuates the gap between the actual and the potential economic growth. Reducing the burden of disease in Africa, a noble objective in itself, will directly release countries' potential to increase production and achieve the high growth rates that are vital for poverty reduction.

5. In many African communities, the linkages between ill-health and poverty are well perceived. For example, reports from the 'Voices of the Poor' survey, conducted in Ghana, Malawi, Mauritania and Zimbabwe in 2000, showed how individuals, families and communities linked their capacity to earn adequately to their health status. Some respondents equated health with wealth, which underscores the importance of good health as a critical factor for living a decent life.

6. On the basis of the clear linkages between poverty and ill-health, this strategy explores the potential contribution of health to poverty reduction, economic growth and human development. It builds on the current profiles of poverty, health and socioeconomic indicators.

7. The regional strategy proposes a paradigm shift from an overly biomedical approach to a more preventive and promotional pattern of health interventions. Such a reorientation is necessary in the light of the inability of current health interventions to meet the health needs of the poor in the African Region.

## SITUATION ANALYSIS

8. Overall, about 45% of the African population are living below the poverty line. The incidence of poverty in Africa is higher in rural areas, although urban poverty is an explosive problem. The Region is facing many health challenges, especially HIV/AIDS. Although 92% of the causes of death in poor countries are related to communicable diseases, 60% of deaths are attributable to a few diseases, namely, tuberculosis, malaria, HIV/AIDS and some childhood illnesses. There has also been a very significant rise in non-communicable conditions (cancers, cardiovascular diseases, accidents and mental illness) due to changes in lifestyles. Malnutrition is a persistent problem, particularly in children and women. It accounts for 45% of child deaths.

9. Furthermore, environmental degradation, primarily poor water and waste management, has contributed to the outbreak of diseases. Rapid and uncontrolled urbanization has also had serious health consequences. Only 45% of the total population of

the Region have access to safe water and less than 40% have access to sanitation. The Region has a low primary-school enrolment rate and a high adult illiteracy rate (especially of women), which have direct repercussions on infant and maternal mortality rates, which remain the highest in the world.

10. The link between poverty and health is very clear. The poor in the African Region are caught in a complex poverty trap in which *low incomes lead to low consumption, which in turn results in low capacity and low productivity*. This concept was brilliantly illustrated by the landmark report of the WHO Commission of Macroeconomics and Health, which demonstrated that the disease burden attributable to three diseases (malaria, tuberculosis and HIV/AIDS) annually reduces GDP growth by as much as 1.3%.

11. Addressing the health needs of the poor has been a long-standing preoccupation of the health sector. The Alma-Ata Conference, which endorsed the principle of primary health care and led to the Health-for-all policy by the year 2000, was very much influenced by the need to ensure that health care was accessible to the majority of the population. In the African Region, the adoption of the three-phase Health Development Scenario (1985) reaffirmed the validity of the primary health care approach at district level, and the Bamako Initiative (1987) highlighted the need for community participation in health development and also underscored the need to address the vulnerability of women and children.

12. Nevertheless, the health sector, despite formulating different strategies (e.g. Alma-Ata, Bamako Initiative) has not implemented explicit interventions targeting poverty. The time is ripe to develop such a strategy. The central role of health in the development process is increasingly recognized, and national and international goodwill for improving health, especially of the poor, has never been so evident.

13. Therefore, alleviating the disease burden of poor countries will contribute to the improvement of their social status. Combating the diseases that afflict the poor will reduce their vulnerability to poverty-inducing health shocks and increase their productivity. This will help to increase economic growth so as to reduce poverty.

## THE REGIONAL STRATEGY

14. Considering the multidimensional nature of health, the contribution of the health sector to poverty reduction will include interventions both

outside and within the health sector. This endorses the leadership role of the health sector as a valid entry point to poverty reduction and the need for intersectoral approaches.

### **Objectives**

15. The overall objective of the strategy is to have the health sector, because of its comparative advantage, contribute to poverty reduction by improving health. Specifically, the strategy will:

- (a) **Outside the health sector:** develop and maintain a strong advocacy platform targeting stakeholders and partners operating outside the health sector in order to sensitize them on the contribution of health to poverty reduction, and to provide orientations on how other sectors (education, agriculture, transport, energy, water and environment, finance and planning, housing, sanitation) should incorporate health considerations into policies and practices to improve health outcomes;
- (b) **At health system policy level:** address the reforms with a view to shifting the focus of health systems away from an overly curative approach to a more preventive and promotional pattern of health interventions, with a view to accelerating the improvement of the health status of the poor; and
- (c) **At the implementation level:** target the most vulnerable population groups (the handicapped, women and children) and direct specific interventions towards their concerns by strengthening and promoting their capacities, instead of focusing on limiting their vulnerability.

### **Guiding principles**

16. To attain these objectives, the following principles will guide the implementation of the strategy:

- (a) **Equity and fairness of services.** If equity and equality of opportunities are not ensured, any additional investments will only increase existing inequalities.
- (b) **Quality, accessibility and sustainability.** Because poor people usually have access only to public health services, it is important that financial and geographical accessibility as well as quality are ensured on a sustainable basis.
- (c) **Community participation and gender sensitivity.** Many health interventions fail to achieve their objectives in Africa because of inherent gender bias and lack of community involvement. These two aspects are critical in interventions focused on the poor.

- (d) **Intersectorality and partnership.** Health issues are development issues. Achieving health outcomes, therefore, calls for the contribution of other sectors, especially as concerns maternal and child health. Hence, partnerships based on a clear definition of the roles and responsibilities are critical to meeting the concerns of the poor.
- (e) **Strong monitoring and evaluation mechanism.** To ensure that the set objectives of the complex interventions are met, it is necessary to measure improvement, efficacy and efficiency as well as qualitative aspects such as equity, fairness, gender sensitivity and community involvement.

### **Priority interventions**

17. In the light of the increasingly recognized and appreciated role of health in the development process and in view of the substantial increase in resources available to the health sector, derived particularly from the HIPC/PRSP mechanism, the Global Fund to fight HIV/AIDS, tuberculosis and malaria, and other financial instruments, per capita expenditures on health are progressively being scaled up to meet the expenditure levels required to ensure a minimum package of health services for all.

18. At the community level, empowerment by increasing accessibility to health services, providing health information, etc., should be the strategic option. At the national level, health-promoting services (hygiene, education, nutrition, immunization, food safety, water and sanitation) should be strengthened.

19. Specifically, the priority interventions include:

- (a) generating evidence on the linkages between health and other socioeconomic sectors (education, transport, agriculture, energy, chemicals, tourism) for advocacy outside the health sector;
- (b) setting up a transparent resource allocation and utilization mechanism with a view to recording the responsiveness of interventions to poverty reduction objectives;
- (c) extending health coverage (infrastructure, mobile units and health services, including antenatal care and birth attendance) to underserved areas for the benefit of vulnerable populations as well as improving the local production of drugs and traditional medicines;
- (d) reinforcing immunization programmes against childhood illnesses through regular monitoring and mobilization of adequate funding;
- (e) strengthening environmental health services, including safe water, nutrition, safe food and hygiene education;



- (f) strengthening health promotion initiatives to improve health and prevent diseases, particularly those afflicting the poor;
- (g) scaling up interventions against malaria, tuberculosis, HIV/AIDS, other priority diseases and childhood illnesses.

20. Such health interventions will create new opportunities for poor people to enter the labour market with increased capacities and thus result in higher productivity. This, in turn, will help to reduce poverty insofar as it affects the individual, the community and the nation.

### **Roles and responsibilities of the different stakeholders**

21. The contribution of all stakeholders in the health and non-health sectors is required for achieving overall poverty-reduction objectives. For example, child nutrition and health are critical for the achievement of universal primary education. The specific roles and responsibilities of each stakeholder, therefore, need to be clearly defined.

### **Roles and responsibilities of countries**

22. Governments, particularly ministries of health, should:

- (a) undertake regular assessments of poverty and epidemiological profiles, focusing on health-related poverty determinants;
- (b) implement the institutional changes required for reorienting health-care delivery by moving away from an approach which is too biomedical to a more promotive and preventive approach (e.g. extending health coverage, both personnel and infrastructure, to underserved areas); expanding health promotion activities to cover all levels of the health system; and developing budget frameworks that are responsive to interventions targeting the poor;
- (c) encourage more micro-interventions (e.g. through the Healthy Settings approach), especially at community level, with increased involvement of the beneficiaries.
- (d) strengthen the technical competencies of community practitioners, e.g. traditional birth attendants, community care-givers;
- (e) document indigenous best practices;
- (f) devise performance-based indicators to capture community contribution.

### **Roles and responsibilities of WHO**

23. In addition to identifying and disseminating best practices among the countries of the Region, WHO should:

- (a) provide sustained technical support for policy analysis, formulation and implementation;
- (b) mobilize partners to allocate additional resources to health-related poverty reduction interventions;
- (c) assist countries in formulating and implementing the health component of their national poverty reduction programme.

### **Roles and responsibilities of partners**

24. New cooperation mechanisms that promote development and which are more beneficial to poor countries (e.g. the Global Fund to fight HIV/AIDS, tuberculosis and malaria) should be encouraged. Global partnerships of all development partners, including bilateral and multilateral agencies, involved in the PRSP process should also be consolidated.

## **MONITORING AND EVALUATION INDICATORS**

25. The monitoring and evaluation indicators are based on the sectoral targets of the Health-for-all policy for the 21st century. They reflect the health sector's contributions to poverty reduction in the Region. The framework of objectives, strategic interventions and the role and responsibility of stakeholders constitute the measures of attainment. Therefore, by 2020:

- (a) one-hundred per cent of countries of the Region will have developed health components of Poverty Reduction Strategy Papers;
- (b) seventy-five per cent of the population in the Region will have access to safe water and adequate sanitation;
- (c) seventy per cent of the population in countries will have safe mechanisms for dealing with chemical and industrial waste that are public health risks;
- (d) the health sector will help to reduce the incidence of poverty in the Region by half;
- (e) health systems will provide quality health services for 80% of the population;
- (f) infant mortality will be reduced by 50%;
- (g) the current burden of malaria will be reduced by 75%.

## CONCLUSION

26. The strategy highlights the comparative advantage of the health sector in poverty reduction and provides guidance on health-related poverty reduction policy content. Specifically, it argues that to achieve health-related poverty reduction objectives, it is critical and necessary to shift the paradigm reorienting the pattern of public health expenditures from curative care to preventive and promotional health care.

27. The countries of the Region will have to rely on their own capacities to improve the quality of life of their people. The recent creation of the African Union (2002) and the adoption of the New Partnership for Africa's Development (NEPAD, 2001) already reflect the strong political commitment to poverty reduction and development in the Region.

### **Resolution AFR/RC52/R4**

#### **Poverty and health: A strategy for the African Region (AFR/RC52/R4)**

The Regional Committee,

Aware of the intricate and complex linkages between poverty and health, especially in African countries;

Concerned about the deterioration of the health status of the majority of African people during the last decade, in addition to the heavy burden of disease on adults and children;

Recalling resolution AFR/RC50/R1 related to the regional strategy entitled 'Health-for-All Policy for the 21st Century in the African Region: Agenda', and the recommendations of the Commission on Macroeconomics and Health to scale up investments in the health sector in order to reduce poverty and foster economic growth in African countries;

Appreciating the efforts Member countries and the international community have made in recent years through the Highly-Indebted Poor Countries (HIPC)/Poverty Reduction Strategy Paper (PRSP) framework in order to improve policy implementation towards poverty reduction objectives;

Recognizing the necessity for WHO to fully play its critical role in reducing poverty and catalysing economic growth and social welfare, consistent with the internationally-adopted Millennium Development Goals;

Having carefully examined the Regional Director's report contained in document AFR/RC52/11 outlining the regional strategy for poverty and health, and aiming at supporting the health sector for a significant contribution in achieving national poverty reduction objectives;

1. APPROVES the proposed strategy;
2. URGES Member States:
  - (a) to undertake appropriate reforms in the health sector in the context of broader public reforms that effectively improve, in the short term, the health status of the poor;
  - (b) to update national health policies based on a long-term strategic planning approach;
  - (c) to increase the budget allocated to the health sector in accordance with the Abuja Declaration, which commits countries to allocate 15% of their total budget to the health sector;
  - (d) to support efforts made by civil society and other stakeholders to improve the health of the poor at the grass roots level in order to increase the absorptive capacity of the health sector and improve the responsiveness of public sector management to poverty reduction goals;
  - (e) to advocate at the national and international levels for more resources to be allocated to the health sector, and to develop a transparent mechanism for managing, monitoring and evaluating such resources;

REQUESTS the Regional Director:

- (a) to provide technical support to Member States for the development of national health policies and programmes for poverty reduction;
- (b) to increase support, through training institutions, to national professionals in the field of health and development in order to strengthen their capacity for policy analysis, monitoring and evaluation;
- (c) to assist in mobilizing additional resources for the implementation of this strategy;
- (d) to report to the fifty-fifth session of the Regional Committee in 2005 on the progress made in the implementation of this strategy.

*Sixth meeting, 10 October 2002*

## REFERENCES

1. Poverty reduction is a complex exercise, which broadly follows this sequence:
  - (i) Analysis of prevailing poverty profile;

## COMPENDIUM OF RC STRATEGIES

- (ii) Measurement of the different magnitudes of incidence, income gap, severity, etc;
- (iii) Identification of the poor, according to the findings of (ii);
- (iv) Diagnosis of their livelihood;
- (v) Assessment of current interventions for reducing poverty;
- (vi) Formulation of relevant strategies, i.e.: (a) setting goals; (b) formulating a framework of analysis and implementation, including indicators for monitoring/evaluation and the institutional changes required.

## 6.4 Food safety and health: A strategy for the WHO African Region

(AFR/RC57/4)

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### EXECUTIVE SUMMARY

1. *The burden of foodborne diseases in the African Region is difficult to surmise, but available data for diarrhoea due to contaminated food and water estimate mortality to be around 700 000 persons per year in all ages. African children suffer an estimated five episodes of diarrhoea per child per year, mostly due to contaminated infant food. Microbial and chemical contaminants are of concern. Unless these issues are addressed, countries will have difficulty in achieving the health-related Millennium Development Goals.*

2. *Despite efforts by governments and both multilateral and bilateral agencies, weaknesses remain in national food control systems. Absence of enforceable policies, regulatory mechanisms, resources and coordination in addressing challenges may be the cause. Assuring food safety is a shared responsibility that requires the common vision of all stakeholders.*

3. *This strategy will assist countries to define their food safety challenges and design national action plans with specific interventions for effective outcomes. The guiding principles of the strategy include country ownership and leadership; holistic and risk-based actions; intersectoral cooperation and collaboration; community participation; strengthened health systems; individual responsibility; and participation of women and communities. Priority interventions include formulation and implementation of policies and regulations; capacity building in foodborne disease surveillance and inspection; and health education. Particular attention must be given to ensure food safety in school feeding programmes.*

4. *The Regional Committee reviewed and adopted the proposed strategy.*

### INTRODUCTION

1. Food security is defined as physical and economic access to sufficient, safe and nutritious food to meet dietary needs.<sup>1</sup> Food safety is an integral part of food security and is defined as protecting the food supply from microbial, chemical and physical hazards that may occur during all stages of food production, including growing, harvesting, processing, transporting, retailing, distributing, preparing, storing and consumption, in order to prevent foodborne illnesses. Because of insufficient food to meet demand on the African continent, the majority of people are only concerned with satisfying hunger and do not give due attention to the safety of food.

2. Bacteria, parasites and viruses are the major causative agents of foodborne diseases in the African Region. Outbreaks of cholera, which occurs due to contaminated water, are common in the Region and available data show an upward trend.<sup>2,3</sup> Foodborne zoonotic diseases and chemical contamination of food from pesticides and veterinary drug residues are also of concern. There are multiple sources of contamination from the environment, and contaminants could enter food during production, harvest, storage, retailing and preparation for consumption.

3. It is imperative that food safety remain a concern in all situations in order to derive maximum benefit from even the little available food. Strong political will and relevant food safety systems are essential

from production to consumption. Resolution AFR/RC53/R5 of the WHO Regional Committee for Africa, urging countries to strengthen food safety programmes, was endorsed in 2003; since then, many countries have initiated activities to improve food safety.

4. This strategy on food safety consolidates past gains and provides a framework for protecting public health and economic development through reduction of the burden of foodborne diseases.

## SITUATION ANALYSIS AND JUSTIFICATION

### Situation analysis

5. The incidence of foodborne and waterborne diarrhoea is estimated at five episodes of diarrhoea per child per year.<sup>4</sup> Due to microbial contamination, introduction of complementary foods is associated with increased diarrhoea.<sup>5</sup> The estimated annual mortality rate for diarrhoea in all ages is around 700 000. Massive displacement of people and unhygienic environmental factors compound the situation during emergencies.

6. In 2004, an outbreak of acute aflatoxicosis from consumption of contaminated maize in Kenya resulted in 317 cases and 125 deaths.<sup>6</sup> Lead and other chemical contaminants have been detected in some foods in several countries.<sup>7,8</sup>

7. Unsafe food not only results in ill-health but also has economic consequences due to absenteeism, hospital fees and international trade losses. In Nigeria, the Food and Drug Administration destroyed aflatoxin-contaminated food worth more than US\$ 200 000.<sup>9</sup> Available data show that a cholera outbreak in Tanzania in 1998 resulted in a loss of US\$ 36 million in fish exports to the European Union (EU);<sup>10</sup> likewise, in 1997, a ban on Ugandan fish exports to EU markets resulted in a similar loss.<sup>11</sup>

8. The estimated disability adjusted life years lost to foodborne and waterborne diarrhoeal diseases is 4.1% globally, as compared to 5.7% to 7.1% in Africa.<sup>12</sup> However, food safety along with its health and economic benefits, has received little attention in diarrhoeal disease control programmes in Africa.

9. Preparation, protection, sale and consumption of street foods in inappropriate places are on the increase. Street foods are sources of nourishment and income for the urban poor. Some street foods are microbiologically safe and provide alternative sources of safe food.<sup>13</sup> However, the hygiene of most street foods is substandard due to incorrect handling

as well as lack of sanitation, running water, washing facilities, refrigeration and disinfection. Washing of hands is rare, and food is often exposed to flies and other insects.<sup>14</sup> The preparation of food well in advance of consumption and manual food preparation were additional risks factors. Certain cold foods, such as salads, meats and sauces, when sold at ambient temperature, have the greatest potential for disease transmission.

10. Few countries have foodborne disease surveillance systems. Only Cameroon, Ethiopia, Madagascar, Nigeria, Senegal and South Africa report data to Global Salm Surv, a global network of laboratories and individuals involved in surveillance, isolation, identification and antimicrobial resistance testing of *Salmonella* and other foodborne pathogens. Capacity building in surveillance, microbiological and chemical testing of foods is currently ongoing in 12 countries.

11. Data from all Member States in the WHO African Region indicated that 45 countries have proposed food control legislation, but only 13 countries have enacted any laws.<sup>15</sup> In a recent survey, data from 36 respondent countries showed that 29 had national standards authorities that establish food standards based on Codex Alimentarius guides.<sup>16</sup> A few countries had legislation on pesticide residues, food additives and contaminants, biotoxins, and genetically-modified foods. Of the 26 countries that provided data, 21 had import-export inspection and certification systems, but most of these control export products.

12. Genetically-modified foods, defined as food products containing some quantity of genetically-modified organisms (GMOs) as an ingredient, were discussed extensively in the African Region during the southern African famine in 2002.<sup>17</sup> GMOs have certain potential benefits, including increased agricultural yield due to resistance to plant diseases and increased nutritional content as in vitamin A rice. There are a number of concerns about safety, environmental effects, displacement of traditional stocks and permanent loss of traditional genetic material. Genetically-modified varieties of maize, sorghum, soya beans, cotton, fruits and vegetables may be available in some countries. The lack of laboratory facilities for testing foods on the market makes it difficult to ascertain the level of GMOs being consumed in Africa, as well as to monitor food imports to avoid dumping of food that is not fit for human consumption.

13. The Codex Alimentarius Principles cover food safety and risk assessment, while the Cartagena

Protocol on Biosafety covers environmental safety.<sup>18</sup> Only a few countries have established regulatory frameworks on food derived from modern biotechnology, including genetically-modified foods. The issue of labelling had been before the Codex Committee for Food Labelling for more than ten years. Some Member States, such as Ethiopia and South Africa, have regulations for labelling GMOs, while others do not accept genetically-modified food as aid.

14. In the African Region, some countries have several ministries or departments involved in food safety regulation. The result is overlap as mandates are often not clear. Lack of collaboration and coordination results in conflict; duplication of efforts; and inefficient use of human, material and financial resources.

15. The food safety challenges facing the African Region include unsafe water and poor environmental hygiene; weak foodborne disease surveillance; inability of small- and medium-scale producers to provide safe food; outdated food regulations and weak law enforcement; inadequate capacity for food safety; and inadequate cooperation among stakeholders.

### Justification

16. Food is central to the prosperity, health and social well-being of individuals and societies. Strengthening food safety within the Region will help to decrease the burden of foodborne diseases, reduce poverty and achieve Millennium Development Goals 1, 4 and 8.

17. Member States have expressed their commitment to improving food safety at various forums. In May 2000, the Fifty-third World Health Assembly unanimously adopted Resolution WHA53.15 on food safety, which confirmed food safety as a public health concern. The WHO Global Strategy for Food Safety was endorsed by the WHO Executive Board in January 2002. Further impetus was provided by the FAO/WHO Regional Conference on Food Safety for Africa, which recommended a five-year strategic plan for adoption by the United Nations and the African Union in 2006. Additionally, the Regional Office *Strategic orientations for WHO action in the African Region* (2005) emphasized the importance of food safety in disease prevention. The following strategy consolidates existing guidelines to provide countries with a single document.

## THE REGIONAL STRATEGY

### Aim

18. The aim of the strategy is to contribute to the reduction of morbidity and mortality due to contaminated food.

### Objectives

19. The specific objectives are:

- (a) to provide a platform for advocacy for food safety;
- (b) to provide Member States with a framework for the development and implementation of national policies for food safety;
- (c) to strengthen food control systems, including foodborne disease surveillance and food monitoring for prevention, detection and control of emergencies;
- (d) to facilitate the development of intersectoral collaboration and partnerships for food safety.

### Guiding principles

20. The implementation of the strategy will be guided by *country ownership and leadership, equity and fairness*.

21. *Holistic, comprehensive and risk-based actions* apply the farm-to-fork paradigm and risk-based approaches such as the Hazard Analysis and Critical Control Points (HACCP) along the entire food chain. Countries should proactively ensure responsibility by producers, processors, retailers and consumers in order to facilitate voluntary compliance to food safety regulation rather than detection of faults for prosecution.

22. *Intersectoral coordination, cooperation and collaboration* involve all partners at various levels of government, in the private sector and in international partnerships for development, planning and implementation of interventions. Such coordination should be based on clear definitions of roles, responsibilities and mandates.

23. *Individual responsibility, participation of women and community participation* involve communities, consumers, civil society and particularly women in decision-making. Initiatives such as the Healthy Cities Initiative and the Healthy Food Market Projects assure ownership and sustainability of interventions.

### Priority interventions

24. The proposed priority interventions are based on the farm-to-fork paradigm and also apply in emergencies. Important linkages require interventions based on a coordinated and collaborative approach.

25. **Food safety policies, programmes, legislation and regulation** will be developed to assure the safety of food from production to consumption. National action plans will be developed that offer mechanisms for intersectoral involvement in food safety interventions. This includes interaction with other sectors, in particular water and sanitation, and case management programmes in the planning of evidence-based policies and strategies that have a direct bearing on implementation of food safety plans.

26. Food legislation will be developed to provide the foundation for national food safety programmes and play its pivotal role in directing the food control efforts of inspectors. Government commitment is essential for comprehensive review of food laws, regulation, standards and harmonization of national and international standards.

27. **Capacity building** will be developed and improved to provide analytical skills for monitoring foods on the market. Monitoring of microbiological and chemical contaminants will be strengthened to reassure communities of safe food supply, identify potential risks and provide data to regulatory authorities. Capacity will also be built for foodborne disease surveillance and research to provide data for rapid detection and response to outbreaks, estimation of burden of diseases, programme evaluation, advocacy, decision-making and allocation of resources. As an essential public health objective, capacity will be built for public health laboratories to conduct both laboratory-based and epidemiological surveillance as part of national and regional integrated surveillance systems.

28. Food inspectorates will be strengthened as integral parts of food control systems. They will ensure that strong food safety legislation and policies are effectively enforced. In order to ensure effective participation, including harmonization of national standards, further capacity will be developed in the work and procedures of the Codex Alimentarius Commission.

29. Transparent **health promotion** systems and procedures will be established to ensure that producers, processors, retailers, consumers and other stakeholders are properly informed on safe food handling as well as food safety emergencies. Particular attention

must be given to ensure food safety in school feeding programmes.

30. **National, regional and international cooperation, collaboration and coordination** are essential. Governments, the food industry, the private and public sectors, consumers and other stakeholders will develop systems to enable them to work in a concerted manner. Countries will be guided to improve their participation in international standard setting to ensure that the process serves all parties rather than only those attending Codex meetings. The intrinsic link between food security, quality and safety requires close collaboration between WHO, the Food and Agriculture Organization of the United Nations and the World Food Programme; this will ensure articulation of health concerns in the implementation of interventions.

### Roles and responsibilities

#### Countries

31. National governments are urged:

- (a) to include food safety in overall national development plans and health policies as well as provide the legal basis for national food safety assurance;
- (b) to strengthen national analytical capacity for foodborne disease surveillance and research through appropriate training; capacity-building; establishment of quality assurance protocol and procedures; as well as services for inspection and export and import certification;
- (c) to establish diverse approaches to enhance consumer awareness and participation in food safety activities, including promotion of food safety education;
- (d) to develop effective links and coordination among food safety agencies for reviewing responsibilities and capabilities as well as clarifying overlaps in regulatory roles.

#### World Health Organization and partners

32. WHO and partners will support countries by:

- (a) carrying out advocacy among policy-makers, international partners and other key stakeholders for increased resources;
- (b) providing norms, standards and guidelines for adaptation and use;
- (c) providing evidence-based options for food safety;
- (d) providing technical and material support for planning implementation as well as monitoring and evaluation of priority interventions;

- (e) facilitating effective participation in relevant committees of the Codex Alimentarius Commission;
- (f) strengthening joint efforts in capacity-building; international standard setting; information sharing; food contamination monitoring, including establishment of regional reference laboratories;
- (g) facilitating effective linkage, cooperation, collaboration and coordination among food safety agencies.

### **Resource implications**

33. Financial, material and human resources will be required for the implementation of this strategy. Although countries have been allocating resources for food safety, these are generally insufficient. Member States may need to reallocate existing resources or mobilize additional funds to facilitate the implementation process.

### **MONITORING AND EVALUATION**

34. The core indicators for monitoring and evaluation will include trends in morbidity from foodborne diseases; reduction in mortality associated with foodborne diseases; availability and enforcement of food safety policy and legislation; and availability of food safety education programmes.

### **CONCLUSION**

35. The food safety challenges facing countries in the African Region include inadequate commitment; unsafe water and poor environmental hygiene; weak foodborne disease surveillance; inability of small- and medium-scale producers to produce safe food; outdated food regulations and weak law enforcement; inadequate capacity for food safety; and inadequate cooperation among stakeholders. A number of priority interventions have been proposed to improve food safety and thus contribute to improved public health, increased food trade, continued economic development and achievement of the health-related Millennium Development Goals.

36. The Regional Committee reviewed and adopted the proposed strategy.

### **Resolution AFR/RC57/R2**

#### **Food safety and health: A strategy for the African Region**

The Regional Committee,

Guided by the WHO Constitution, which includes mandates on food safety for the Organization;

Acknowledging the World Health Assembly Resolution WHA53.15 of May 2000 recognizing food safety as an essential public health function;

Mindful of the Regional Office *Strategic orientations for WHO action in the African Region 2005–2009*, emphasizing the importance of food safety in disease prevention;

Recalling Regional Committee Resolution AFR/RC53/R5 of September 2003 entitled “Food safety and health: A situation analysis and perspectives”;

Recognizing that most contaminants in food originate from unhygienic environments, low awareness and inadequate knowledge of the role of toxins, pesticides and pathogens in disease causation;

Concerned that contaminated food and water continue to cause up to five episodes of diarrhoea per child per year, resulting in 5.7% to 7.1% of lost disability-adjusted life years in the African Region;

Cognizant of the fact that lack of surveillance and research hinders the early detection of food safety incidents and evidence-based interventions;

Approving the document entitled “Food safety and health: A strategy for the WHO African Region”;

1. URGES Member States:

- (a) to include food safety in overall national development policies and the fight against poverty as well as provide the legal framework for national food safety assurance;
- (b) to include food safety in education curricula at all levels;
- (c) to strengthen national and regional analytical capacity through appropriate training, capacity-building and establishment of quality assurance protocols and procedures;
- (d) to strengthen national laboratory capacity to monitor foods, especially food imports containing GMOs;
- (e) to strengthen foodborne disease surveillance as part of national and regional integrated disease surveillance and response systems;
- (f) to strengthen multisectoral food safety inspection from production to consumption and proactively ensure compliance;
- (g) to establish a diversity of approaches to enhance consumer awareness and participation in food safety activities and promotion of food safety education, including the integration of food safety into maternal and child survival programmes as well as healthy settings, poverty alleviation, and health promotion initiatives;



- (h) to ensure individual responsibility as well as participation of women, communities and consumer associations in decision-making;
  - (i) to develop effective links and coordination among food safety agencies, including reviewing of responsibilities and capabilities as well as clarifying overlaps in regulatory roles;
2. REQUESTS the Regional Director:
- (a) to continue carrying out advocacy among policy-makers, international partners and other key stakeholders on food safety and food security;
  - (b) to strengthen joint efforts in capacity-building, international standard setting, effective participation in the relevant committees of the Codex Alimentarius Commission, food safety monitoring, information sharing, etc;
  - (c) to facilitate effective linkage, cooperation, collaboration and coordination among agencies involved in food safety;
  - (d) to provide technical and material support for planning, implementation as well as monitoring and evaluation of interventions;
  - (e) to report to the Regional Committee for Africa every two years.

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## 6.5 A strategy for addressing the key determinants of health in the WHO African Region

(AFR/RC60/3)

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### EXECUTIVE SUMMARY

1. *The past few decades have witnessed increased interest in commitment to greater equity in health through addressing the social determinants of health and their consequences. Health gaps exist in countries of the African Region and are widening in some cases. This document proposes a strategy for closing this health equity gap through action on the key determinants of health.*
2. *The strategy proposes priority interventions in line with the three overarching recommendations of the WHO Commission on the Social Determinants of Health, namely: (i) improving the daily conditions of living; (ii) tackling the inequitable distribution of power, money and resources; and, (iii) measuring and understanding the problem and assessing the impact of action. The interventions are divided into those that are within the immediate remit of the ministry of health, and those that come under other sectors or are cross-sectoral.*
3. *The proposed intervention takes cognizance of the widening health equity gap within and among Member States. The strategy places emphasis on addressing the structural causes of ill-health and premature death associated with access, affordability and availability, and addresses issues even beyond the risk factors.*
4. *Member States are called upon to reduce the health equity gap through action on the social determinants of health. The prerequisite for success is political commitment to provide an enabling environment for all to contribute to reducing health inequities through action on the social determinants of health, including measures to improve living conditions, tackling uneven distribution of power, money and resources, and routine monitoring of the health equity gap.*
5. *The Regional Committee reviewed and adopted this strategy.*

### INTRODUCTION

1. According to the Constitution of the World Health Organization, the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being.<sup>1</sup> Health<sup>2</sup> is not just the outcome of genetic or biological processes. It is influenced by the social and economic conditions, in which people are born, grow, live, work and age, and the systems put in place to deal with illness. These conditions, commonly referred to as the 'social determinants of health' (SDH), can help create or destroy peoples' health.

2. These conditions include income, wealth and their distribution, early childhood care, education, working conditions, job security, food security, gender, housing, including access to safe water and sanitation, and social safety nets. Governance, and social and economic forces, in turn, shape these conditions.<sup>3</sup> For different social groups, unequal access to these social and economic conditions gives rise to unequal health outcomes.

3. Although health inequalities exist worldwide, between and within countries, the majority of them are avoidable. For many common indicators of

socioeconomic status, people living in poverty face a higher risk of adverse health outcomes than those who are better off.<sup>4</sup>

4. The Final Report of the WHO Commission on Social Determinants of Health (CSDH) calls for a new global agenda for health improvement and health equity. It advocates for an approach to health and human development in which equity is a fundamental objective of reform.<sup>3</sup>

5. The Sixty-second World Health Assembly passed a resolution calling for a reduction of health inequities through action on the social determinants of health, as recommended by the CSDH report (see Resolution WHA62.14 annexed herewith). Similar calls have been made in the World Health Report 2008,<sup>5</sup> the Algiers Declaration,<sup>6</sup> the Libreville Declaration,<sup>7</sup> the Ouagadougou Declaration,<sup>8</sup> and the Nairobi Call to Action.<sup>9</sup>

6. This document proposes a strategy for reducing health inequities through action on the social determinants of health.

## SITUATION ANALYSIS AND JUSTIFICATION

### Situation analysis

7. In the 1980s and 1990s, most parts of sub-Saharan Africa witnessed increasing economic deprivation and poverty, diminishing food security, devastation by the HIV/AIDS pandemic, environmental destruction, increasing unemployment, and general reversal of human development indicators.<sup>10</sup> Extreme poverty increased from 47% in 1990 to 50% in 2009.<sup>11</sup> Women, the elderly and displaced populations were the worst affected groups.

8. The African Region lags behind most other WHO regions in its overall health attainments. Life expectancy at birth was estimated at only 52 years in 2007. This contrasts with 64 and 65 years in the WHO regions of the Eastern Mediterranean and South East Asia, respectively and with the global average of 68 years.<sup>12</sup> Improvements in child survival in many countries in the Region have not reflected in higher life expectancy because these have been eroded by higher levels of adult mortality due to HIV/AIDS and conflict.

9. Progress towards achieving the Millennium Development Goals in the Region has been slow but perceptible.<sup>13</sup> Although reliable data on income poverty is lacking, available information suggests that progress towards reducing poverty is slow.<sup>14</sup> Only eight countries are on track to achieve the

target of halving, between 1990 and 2015, the proportion of people who suffer from hunger.<sup>15</sup> Twenty countries in the Region have developed MDG-consistent (second-generation) poverty reduction strategies or national plans.

10. The Region made very little progress towards reducing under-five mortality. The vast majority of countries in the Region made only negligible improvements in reducing under-five mortality by about 2% between 1990 and 2005. Only six countries<sup>16</sup> are on track to achieve this target.<sup>17</sup> There was only a marginal improvement in infant mortality rates (from 110 to 99 per 1000 live births) between 1990 and 2005. However, Malawi and Mauritius recorded improvements exceeding 5%. The Region made virtually no progress towards achieving the MDG target of reducing maternal mortality, although there was a 30% increase in access to contraceptives among currently married women. In general, the prevalence of HIV/AIDS has stabilized but the challenge of providing support and treatment for cases remains.

11. Most countries are likely to achieve gender parity by 2015. Ten countries achieved gender parity in primary education in 2005.<sup>18</sup> Seventeen countries had a gender parity of over 0.90,<sup>19</sup> while six others achieved net rates of enrolment in primary education in excess of 80%.<sup>20</sup> Between 2004 and 2005 Ethiopia, Kenya, Mozambique and Zambia recorded increased enrolments in primary education in excess of 4%. Ethiopia, Ghana and Tanzania maintained the momentum of high enrolment achieved in previous years, posting growth rates in enrolment of 6.5%, 4.2% and 17.3% respectively between 2005 and 2006.

12. Despite the progress noted in some of the MDG indicators as set out above, most MDG targets are not likely to be met. Even in those countries that are making some progress, although improvements in national averages for the health and other MDG indicators are likely, the situation of the poor and vulnerable groups is not likely to change. Consequently, there is need to address the social determinants of health in countries in order to ensure that as countries strive to achieve the MDGs targets, the poor are not left behind.

13. Widespread health inequalities exist in various health outcome measures such as infant and child mortality, maternal mortality and stunting, and in access to health service indicators.<sup>21</sup> The health system, itself a determinant of health, has not been adequately prepared to address the “causes of the causes” as regards the major communicable diseases,

maternal and child health problems and the increasing prevalence of chronic diseases.

14. There are wide inequities, within and between countries, in health services coverage, safe water supply and sanitation, and health outcomes.<sup>21</sup> In the majority of countries, some common patterns are observed as regards urban/rural location, education and gender. The patterns are: urban dwellers generally live longer than rural inhabitants; higher education results in higher life expectancy; and females live longer than males. In some countries, there are major disparities in health status between the rich and the poor, while for others the difference is insignificant. Disparities across households are also increasing.<sup>21</sup>

15. Globalization, trade, urbanization, climate change, information technology, and civil conflicts are among the major external drivers that have an impact on social, cultural and behavioural practices and ultimately on health outcomes across population groups. These factors, which are structural and intermediate, are beyond the remit of the health sector apart from environmental issues related to water supply and sanitation traditionally linked with public health. However, they have a huge cumulative impact on health due to their influence on lifestyle-related factors such as food consumption, use of tobacco, alcohol, drugs and other psychoactive substances, physical activity, violence, sanitation and hygiene, unsafe sex, health information seeking and high-risk behaviours, among others.

16. Climate change is threatening to erode the gains made in economic growth and poverty reduction. Sub-Saharan Africa suffers from natural fragility, with two-thirds of its surface area being a desert land or arid land. In addition, it is exposed to spells of drought and flooding predicted to intensify due to climate change.<sup>22</sup> Malaria, one of the major killer diseases in the Region, is spreading to previously non-endemic areas usually of high altitude.<sup>22</sup> In addition, the global economic crisis threatens to worsen the current health situation if the limited resources available are diverted from health to other areas accorded greater priority.

### **Justification**

17. The health inequities that exist within and between countries of the African Region are hampering progress in attaining the Millennium Development Goals (MDGs).<sup>23</sup> In order to improve health outcomes and attain the MDGs, countries should promote sectoral policies that address the key

determinants of health, the upstream factors and the fundamental 'causes of causes'.<sup>24</sup>

18. The responsibility for tackling many of the key determinants of health rests with ministries other than the ministry of health. The challenge, therefore, is how the ministry of health can influence actions by these other ministries. Although WHO and Member States are already addressing these challenges through various initiatives,<sup>25</sup> there is an urgent need for a more coherent approach. This strategy should be seen also as an opportunity to streamline and implement World Health Assembly Resolution WHA62.12, which strongly reaffirms the values and principles of primary health care, including equity, solidarity, social justice, universal access to services, multisectoral action, decentralization and community participation as the basis for health systems strengthening.

## **THE REGIONAL STRATEGY**

### **Aim and Objective**

19. The aim of this strategy is to assist Member States to promote actions to reduce health inequities through intersectoral policies and plans in order to effectively address the key determinants of health. The objective is to provide Member States with a structured approach to implementing the CSDH recommendations in line with World Health Assembly Resolution 62.14<sup>26</sup> and to promote their uptake in countries. The overall goal is to ensure that all countries in the Region address the social determinants of health, using a "whole-of-government" approach.

### **Guiding principles**

20. In this regard, there is a need to adhere to the following general guiding principles:<sup>27</sup>

- (a) levelling up i.e., health equity policies should strive to raise the health status of individuals and groups at the bottom of the ladder;
- (b) equity for all i.e., the health system should be built on principles of fairness;
- (c) universal participation i.e., all voices, including those of marginal groups, should be heard;
- (d) partnerships i.e., implementation should be based on partnership between the country and all development partners;
- (e) multisectorality i.e., implementation should be the responsibility of all sectors;
- (f) ownership i.e., there should be a sense of ownership by country and relevant stakeholders.

## Priority interventions

21. The priority interventions presented below emanate from the overarching recommendations of the CSDH:

- (a) improve day-to-day living conditions by improving the circumstances in which people are born, grow, live and age;
- (b) address the inequitable distribution of power, money and resources; and
- (c) measure and understand the problem and assess the impact of action.

22. The proposed interventions are grouped into two broad categories, namely: interventions specific to the health sector; and interventions in sectors other than health, including cross-sectoral actions.

### (A) Interventions specific to the health sector

**23. Strengthen the stewardship and leadership role of the ministry of health** to coordinate and advocate for multisectoral and multidisciplinary interventions to reduce the health equity gap through addressing SDH. The responsibility for action on health and health equity should itself be assigned to the highest level of government.

**24. Build capacity for policy development, leadership and advocacy to address SDH.** There is need to build the capacity of the staff of the ministry of health to provide leadership in developing policies and programmes for improving health literacy, knowledge transfer and research on social determinants of health, using multisectoral and multidisciplinary approaches.

**25. Advocate for legislations and regulations to ensure a high level of protection of the general population** from harm and from the impact of some social and economic determinants of health e. g., globalization, commercialization, urbanization.

**26. Create health systems based on universal and quality health care.** Health systems in the Region should be built on the basis of the principles of equity, disease prevention, and health promotion. Quality health care services should be aimed at universal coverage of primary health care. Leadership of the public sector in equitable health care should be strengthened. The health workforce should be developed or strengthened and their capabilities to act on SDH should be strengthened.

**27. Enhance fairness in health financing and resource allocation.** The role of the ministry of health should be to advocate for fair allocation of financial and technical resources. Countries should

strengthen or mobilize public finance for action on SDH by building capacity for progressive taxation. They should consider establishing mechanisms to finance cross-government actions on SDH and allocate funds fairly between geographical regions and social groups.

### (B) Interventions in sectors other than health, including cross-sectoral actions

**28. Ensure social protection throughout the life-course.** Countries should establish and strengthen comprehensive universal social protection policies that support a level of income sufficient for healthy living for all.

**29. Develop or promote policies for healthy places and healthy people.** Health equity between rural and urban areas should be promoted. There is need for investment in rural development and for addressing the exclusionary policies and processes that lead to rural poverty, landlessness, and displacement of people from their habitats. For urban areas, there is need to place health and health equity at the heart of urban governance and planning. There is need also to ensure economic and social policy responses to climate change and environmental degradation, taking into account health equity. Countries will need to take measures for increased resilience and for protection against adverse changes in the climate.

**30. Ensure health equity in all policies.** Countries should place the responsibility for action on health and health equity at the highest level of government and ensure its coherent consideration across all policies. Health and health equity should be the corporate business of the entire government, supported by the head of state and should be a marker of government performance.

**31. Assess and mitigate the adverse effects of international trade and globalization.** Countries should institutionalize health impact assessments of major global, regional and bilateral trade agreements and ensure and strengthen the representation of public health in domestic and international economic policy negotiations.

**32. Enhance good governance for health and health equity.** Countries and development partners, including civil society, should make health equity a shared developmental goal as part of ensuring social corporate responsibility e.g., in the areas of trade, urbanization and climate change, among others. There is need for a framework with appropriate indicators for monitoring progress, taking into consideration country contexts.

**33. Invest in early childhood development to ensure equity from the start.** Countries should commit themselves to implementing a comprehensive approach to early life, building on existing child survival programmes and expanding interventions in early life to include social, emotional, language and cognitive development. Depending on the availability of resources, quality compulsory primary and secondary education should be provided for all children.

**34. Promote fair employment and decent work.** Full and fair employment and decent work should be a central goal of national social and economic policy making. Decent work should be a shared objective of national institutions and a central part of national policy agendas and development strategies with strengthened representation of workers in the creation of policy, legislation and programmes relating to employment and work, including occupational health.

**35. Mainstream health promotion.** Priority should be given to mainstreaming health promotion in all policies and programmes to reduce the equity gap through community empowerment. Priority actions should be implemented within the primary health care (PHC) approach to advocate for health; invest in sustainable policies and infrastructure; build capacity for policy development and leadership; ensure high level protection from harm through adequate regulation and legislation; and build partnerships with various players to create sustainable intersectoral action.

**36. Mainstream and promote gender equity.** Countries should address gender biases in the structure of society: gender-based cultural and social biases; biases in national and local government laws and their enforcement; biases in the way organizations are run, how interventions are designed, how economic performance is measured. Policies and programmes aimed at bridging the gaps in education and skills and supporting female economic participation need to be developed and adequately financed. There is need to expand investments in sexual and reproductive health services and programmes geared towards universal coverage and respect for human rights.

**37. Address social exclusion and discrimination.** Addressing social exclusion, promoting social inclusion and respecting diversity should be key public policy priorities. Public service delivery should be equitable, culturally sensitive, appropriate to diverse needs and accessible to people with disa-

bilities and other vulnerable groups and communities. If appropriate, information about health and welfare entitlements and public services should be made available in a broad range of formats and languages. Data collection strategies should ensure that adequate information about the social and geographical patterns of health of the population is routinely available.

**38. Enhance political empowerment.** All groups in society should be empowered through fair representation in decision-making about how society operates, particularly in relation to its effect on health equity and the creation and maintenance of a socially-inclusive framework for policy making. Civil society should be empowered to organize and act in a manner that promotes and realizes the political and social rights in regard to health equity.

**39. Protect/improve SDH in conflicts.** Countries need to improve SDH and promote human rights through building health care systems that promote health equity and community participation in conflict situations.

**40. Ensure routine monitoring, research and training.** There is urgent need:

- (a) to ensure that routine monitoring systems for health equity and SDH are in place and to strengthen vital statistics and health equity surveillance systems to collect routine data on SDH and health equity;
- (b) to conduct social, cultural and behavioural studies applying social science research methodologies to determine social factors likely to hinder or promote the bridging of the equity gap through action on social determinants of health that have an impact on priority public health issues such as control of communicable and non-communicable diseases. This will complement the action of countries in implementing and monitoring the Algiers Declaration, the Libreville Declaration and the Ouagadougou Declaration.
- (c) to provide training on the social determinants of health for policy actors, stakeholders and practitioners, and invest in raising public awareness.

## **Roles and Responsibilities of Member States, WHO and Partners**

### **Member States**

41. In addition to the actions requested of Member States in World Health Assembly Resolution WHA62.14, countries should:

- (a) In the short term:
- (i) strengthen the stewardship role of the ministry of health to coordinate and advocate for inter-sectoral action to reduce health inequities through action on social determinants of health;
  - (ii) institutionalize mechanisms for advocacy, evidence gathering and dissemination in order to act on socially-determined health inequities both within and outside the health sector;
  - (iii) cooperate with training and research institutions in order to document the situation with respect to the distribution of the key determinants of health. This analysis would further consolidate the evidence-base on the impact of SDH in order to inform policy making and establish a baseline for evaluation of the outcomes of these policies;
  - (iv) build national capacity to advocate for reducing the health equity gap through addressing SDH in all priority public health concerns such as HIV/AIDS, NCD, mental illness and TB;
  - (v) adapt a “whole-of government” approach to health promotion through multisectoral and multidisciplinary collaboration by establishing a “Social Determinants of Health Task Force” to, among others, identify and build support for health in all policies, at all levels of government and across all sectors;
- (b) In the long term:
- (i) ensure that health policies, plans and programmes are oriented to addressing the key SDH;<sup>28</sup>
  - (ii) review health and other training curricula to ensure that linkages between health and SDH are included in all training activities and in research funding criteria;
  - (iii) provide the financial resources required to support activities for implementing these actions;
  - (iv) advocate for good governance and corporate social responsibility at local and global levels since the widening health equity gap results from structural forces such as globalization, trade and urbanization.

### WHO and Partners

42. In addition to the actions requested of WHO in Resolution WHA62.14, WHO and partners should:

- (a) hold consultations and discussions on priorities and add them to already identified areas of collaboration;

- (b) establish a mechanism for annual monitoring of the progress that countries are making in addressing SDH and reducing health inequities;
- (c) ensure greater coordination within WHO in order to provide the necessary technical support and guidance to countries in reducing the health equity gap through action on SDH.

### Resource Implications

43. Implementing this strategy will require new and additional resources. Countries, WHO and partners are called upon to mobilize resources for implementation of this strategy.

### MONITORING AND EVALUATION

44. The following three elements of monitoring and evaluation are crucial to the implementation of this strategy: (a) monitoring the overall implementation of the strategy over the next 3–5 years; (b) monitoring country progress in implementing the recommendations; (c) tracking and documenting health equity trends for intercountry comparisons.

### CONCLUSION

45. This regional strategy proposes interventions for addressing SDH. The priority interventions outlined fall into three key areas of action contained in the CSDH Report. They are: (a) improving the conditions of peoples’ daily life; (b) tackling the inequitable distribution of power, money and resources – the structural drivers of the conditions of daily life; and (c) measuring and understanding the problem.

46. The strategic interventions are grouped into two areas, namely (a) those that are specific to, or driven by, the health sector; and (b) those that are driven by sectors other than health, including cross-sectoral actions.

47. Reducing health inequities through action on SDH requires committed leadership and bold action at all levels. It requires strong partnerships between Member States, WHO and other development partners, communities, and individuals.

48. Member States are encouraged to implement the proposed interventions, integrate SDH across sectors and settings, and provide an enabling environment for all stakeholders to contribute to the reduction of health inequities.

49. The Regional Committee reviewed and adopted this strategy.

**Resolution AFR/RC60/R1**

**A strategy for addressing the key determinants of health in the African Region (Document AFR/RC60/3)**

The Regional Committee,

Having examined the document entitled “A strategy for addressing the key determinants of health in the African Region”;

Recalling the report and recommendations of the WHO Commission on Social Determinants of Health (CSDH);

Noting global and regional calls and commitments to reduce the health equity gap by addressing the risk factors and their determinants, namely, the Bangkok Charter for Health Promotion in a Globalized World (2005); and the Nairobi Call to Action for closing the implementation gap (2009); the Ouagadougou Declaration and the Libreville Declaration;

Noting the global consensus through United Nations to achieve the Millennium Development Goals by 2015 and the concern about inadequate progress in many countries of the African Region to achieve these goals to date;

Welcoming, in this regard, Resolution WHA61.18, which requires annual monitoring by the Health Assembly of the achievement of health-related Millennium Development Goals;

Taking note of Resolution WHA62.14 on “Reducing health inequities through action on the social determinants of health” adopted by the 62nd Session of the World Health Assembly 2009;

Acknowledging that health inequities and inequalities exist within and between countries of the African Region and that the structural drivers include education, trade, globalization, employment and working conditions, food security, water and sanitation, healthcare services, housing, income and its distribution, unplanned urbanization and social exclusion;

Noting that most of these key determinants of health are rooted in political, economic, social and environmental contexts and are, therefore, linked to good governance and social justice for all particularly the poor, women, children and the elderly;

Concerned that growing poverty, the global financial crisis, climate change, pandemic influenza, globalization and urbanization could further widen the health equity gap by differentially impacting on

population groups and result in increased premature deaths, disability and illness from preventable causes;

Acknowledging the efforts by individual Member States of the African Region to reduce the health equity gap and the progress made by some of the Member States;

Recognizing the growing evidence suggesting that action on the equity gap and its determinants is possible;

Noting the need for Member States to integrate health equity into all policies and programmes, advocate for reduction of the equity gap through action on determinants of health, and document the evidence;

1. ENDORSES the Regional Strategy for addressing the key determinants of health in the African Region as contained in Document AFR/RC60/3 and expresses its appreciation for the work done by the WHO Secretariat and the Commission on Social Determinants of Health;

2. URGES Member States:

- (a) to deliberate on the recommendations of the CSDH Report and identify recommendations that are relevant to the contexts of countries;
- (b) to establish sustainable national leadership, policies and structures to coordinate intersectoral action to address the determinants of health across population groups and priority public health conditions;
- (c) to monitor the health equity trends and document and disseminate the findings to strengthen policy and programme implementation across priority public health conditions;
- (d) to promote both quantitative and qualitative research in order to understand factors influencing the health equity trends, including the role of cultural beliefs and values;
- (e) to establish or strengthen national institutional mechanisms for monitoring the implementation of the regional strategy and document the findings;

3. REQUESTS the Regional Director:

- (a) to strengthen the leadership role of WHO and the ministries of health to advocate and coordinate intrasectoral and intersectoral actions by providing guidelines, policies and strategies to address the social determinants of health across sectors and priority public health conditions;
- (b) to support countries to establish routine monitoring systems that include the collection of disaggregated data and health equity analysis;



- (c) to support national and regional research on social, cultural and behavioural risk factors and the determinants likely to influence health outcomes;
- (d) to strengthen the capacity of Member States to empower individuals, families and communities through increased literacy in determinants of health within the context of revitalizing primary health care;
- (e) to report to the Sixty-second session of the Regional Committee (2012) on the progress made in the implementation of this resolution.

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## 6.6 Reduction of the harmful use of alcohol: A Strategy for the WHO African Region (AFR/RC60/4)

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### EXECUTIVE SUMMARY

1. *Public health problems related to alcohol consumption are substantial and have a significant adverse impact on both the alcohol user and the society. In the African Region, the alcohol-attributable burden of disease is increasing with an estimated total of deaths attributable to harmful use of alcohol of 2.1% in 2000, 2.2% in 2002 and 2.4% in 2004. However, with new evidence suggesting a relationship between heavy drinking and infectious diseases, alcohol-attributable deaths in the African Region could be even higher.*

2. *No other product so widely available for consumer use accounts for so much premature death and disability as alcohol. Alcohol-related problems and their adverse impact result not only from the quantities of alcohol consumed but also from the detrimental patterns of use. Effective and adequate policy measures and interventions, surveillance mechanisms and public awareness need to be developed or enforced in the Region.*

3. *The Strategy aims to contribute to the prevention and reduction of harmful use of alcohol and related problems in the Region. It reviews the regional situation and provides a framework for action in Member States and for the Region, taking into consideration the global developments. The Strategy is intended to provide balanced guidance on priority interventions to be implemented, taking into account the Region's economic, social and cultural diversity.*

4. *The Regional Committee reviewed and adopted this strategy.*

### INTRODUCTION

1. Public health problems related to alcohol consumption are substantial and have a significant adverse effect on people other than the alcohol user. Intoxication and the chronic effects of alcohol consumption can lead to permanent health damage (e.g. foetal alcohol syndrome, delirium tremens), neuropsychiatric and other disorders with short- and long-term consequences, social problems (e.g. unemployment and violence) and trauma or even death (e.g. road traffic accidents). There is also increasing evidence linking alcohol consumption with high-risk sexual behaviour and infectious diseases such as tuberculosis and HIV.

2. The alcohol-attributable burden of disease is increasing in the African Region, with an estimated total of deaths attributable to harmful use of alcohol of 2.1% in 2000, 2.2% in 2002 and 2.4% in 2004.<sup>1</sup>

However, with new evidence suggesting a relationship between heavy drinking and infectious diseases, alcohol-attributable deaths in the African Region could be even higher.

3. In 2007, at the Fifty-seventh session of the WHO Regional Committee for Africa, Member States expressed concern about the impact of harmful use of alcohol<sup>2</sup> on public health and emphasized the need to strengthen response in the Region. At the Fifty-eighth session of the Regional Committee, a set of evidence-based actions that would serve as a basis for developing national policies was adopted<sup>3</sup> and countries called for a Regional Strategy.

4. At the global level, Member States requested the submission to the Sixty-third World Health Assembly, in 2010, of a global strategy to reduce harmful use of alcohol.<sup>4</sup> In the process of collaboration to develop the draft global strategy, the WHO African

Region has gathered information from Member States about existing evidence-based strategies and their applicability globally and in the Region, taking into account local needs and various national, religious and cultural contexts including national public health problems, needs and priorities, and differences in Member States' resources, capacities and capabilities.<sup>5</sup>

5. This document analyses the situation in the African Region and proposes a strategy for appropriate action. The strategy builds on existing World Health Assembly resolutions and on discussions at regional and global levels, proposing a set of public health interventions aimed at reducing the harmful use of alcohol.

## SITUATION ANALYSIS AND JUSTIFICATION

6. Although alcohol constitutes an important source of income and its use is part of social and cultural practices and norms in many countries of the Region, alcohol-related health and social costs cannot be ignored. No other product so widely available for consumer use accounts for so much premature death and disability as alcohol. Alcohol-related problems and their adverse impact result not only from the quantities of alcohol consumed<sup>6</sup> but also from the detrimental patterns of use. Public awareness, especially of specific types of harm, is low in many of the countries.

7. Recent studies and surveillance data provide an insight into harmful use of alcohol in the Region.<sup>7</sup> The two main characteristics that describe alcohol consumption patterns in the Region are the high level of abstention in some countries and the high volume of consumption by drinkers, with severe health and social consequences. Overall, the adult *per capita* consumption of alcohol in the WHO African Region in 2004 was estimated at 6.2 L of pure alcohol.

8. In 2008/2009, countries collaborated in the WHO Global Survey on Alcohol and Health. This process showed that out of the 46 countries in the Region, only 10 countries had recent alcohol policies and 16 countries had advertising regulation. In many countries, regular and systematic surveillance and monitoring systems with appropriate financial and human resources are still non-existent; basic indicators are not defined; and even when data are available they are often scattered among different departments and, therefore, difficult to collect.

9. Adequate policies are few and coordination with relevant sectors and within government is lacking. Multisectoral approaches involving the private sector, professional associations, civil society, the informal sector, traditional healers, political and community leaders are not developed. At the community level, there is a low level of awareness and nongovernmental organizations are not engaged in addressing the problem.

10. Within the health system, alcohol problems are often not recognized, tend to be minimized or are not properly addressed due to lack of appropriate skills, knowledge, adequate resources or lack of coordination and integration among different health programmes.

11. Although alcohol and illicit drugs share common neurobiological, psychological and behavioural characteristics, their related health hazards are often seen and treated separately, thus increasing the resources needed to address substance abuse in general. In the Region, there is a lack of integrated approaches to dealing with substance use disorders.

12. The absence or misplacement (in psychiatric hospitals) of effective and adequate interventions, ranging from brief interventions in primary care to more intensive treatment in specialized settings, is a reality in the African Region. Access to prevention, screening and treatment services and psychosocial care for patients and families are severely hampered by low or nonexistent budgetary allocations, general weakness of health systems and lack of public health infrastructure.

13. Interventions such as enactment of drinking and driving laws, taxation, restrictions on advertising and community information are already being used in the Region. Even so, they are used in an *ad hoc*, informal and fragmented manner, and frequently lack adequate control and enforcement systems.

14. It is estimated that unrecorded consumption accounts for about 50% of the overall consumption of alcohol in African countries.<sup>8</sup> Despite concerns about the potential health hazards arising from unregulated or illicit production, there is little information on the problem and the issue is often overlooked or not given the necessary consideration in policy development.

### Justification

15. The reduction of public health problems caused by harmful use of alcohol and the required interventions by governments to control alcohol-related harm are an essential step to improving the health of

the populations in the Region. Important and effective alcohol control measures are available.

16. Therefore, the development and implementation of a regional strategy in the African Region is a timely and needed response. At the Fifty-eighth session of the WHO Regional Committee, in 2008, Member States requested WHO to support the development, implementation and evaluation of national policies and plans to combat the harmful use of alcohol and, to this end, submit a Regional Strategy to the Committee.

17. The magnitude and nature of alcohol-related harm clearly underscore the need for concerted action not only at national level, but also at regional and global levels. Strengthening national and region-wide capacities will enhance the capacity to respond effectively to the magnitude of the problem.

## THE REGIONAL STRATEGY

### Aim and objectives

18. The aim of this Strategy is to contribute to the prevention or at least reduction of harmful use of alcohol and related problems in the African Region.

19. The specific objectives are:

- (a) to provide a platform for advocacy for increased resource allocation, strengthening of action and intersectoral and international collaboration in responding to the problem;
- (b) to provide guidance to Member States for the development and implementation of effective alcohol control policies, based on public health interests;
- (c) to address low awareness on alcohol related harm in the community;
- (d) to promote the provision of adequate health-care interventions for preventing harmful use of alcohol and managing the attendant ill-health and conditions;
- (e) to encourage the creation of systems of systematic surveillance and monitoring of alcohol production, consumption and harm in countries.

### Guiding principles

20. This strategy is based on five key principles, which should guide policy development at all levels in countries:

- (a) Policies should be based on **best available evidence** and be sensitive to national contexts.
- (b) Citizens, especially those at risk, should be **protected** from alcohol-related harm, particularly

harm from other people's act of drinking, and from pressures to drink.

- (c) Strong **political commitment, leadership and appropriate funding** will ensure that effective approaches to alcohol problems are formulated, taking into account public health principles.
- (d) Actions should be undertaken in a **coordinated, strategic and integrated** manner jointly with key agencies and with appropriate involvement of all partners and stakeholders at all stages of decision-making, planning, implementation and evaluation.
- (e) **Equitable and non-stigmatized access** to effective prevention and care services should be given to all individuals and families; human rights should be respected.

### Priority interventions

21. **Develop and implement alcohol control policies.** Alcohol control policies, legislation and regulations should be based on clear public health goals and best available evidence and should reflect national consensus regarding their implementation at country level. The policies require strong leadership and political commitment and are necessary to ensure transparency, continuity and sustainability of the measures adopted by all the relevant partners. Policy options can be grouped into the following areas:

22. **Leadership, coordination and partners' mobilization.** Coherent, consistent and strong action with relevant actors such as producers, retailers, health workers and communities, is fundamental for effective implementation and reinforcement of national policies and action plans. It is necessary to clearly define partners' areas of contribution, their roles in implementation, their responsibilities and mandates and the relevance of their support, in line with national priorities. An appropriate coordination mechanism is, therefore, important to bring together all intervening agencies, organizations and stakeholders.<sup>9</sup> The capacities of local authorities and the role of NGOs in this drive should be strengthened.

23. **Awareness and community action.** Provision of information for decision-makers and communities should be strengthened in order to increase commitment to public health protection, recognition of alcohol-related harm in the community and active participation in policy measures and in implementation. A dedicated day or week should be established to increase community and political awareness.

**24. Information-based public education.** Providing alcohol education and information to the public, and religious and community leaders is fundamental to support alcohol control policy measures and to increase community participation in their implementation. Efforts are needed to improve its quality and keep it under the responsibility of public bodies. The harmful use of alcohol should be integrated into the school curriculum. Community action programmes should be usefully combined with interventions in schools and other settings such as workplaces to mobilize public opinion to address local determinants of the increasing alcohol consumption and related problems. Local community action should be based on rapid assessment and involve the community and young people in problem identification, planning and policy implementation.

**25. Improvement of health sector response.** Efforts are needed to improve health sector response through adequate training, infrastructures and funding and by strengthening integrated approaches to alcohol problems at different levels of the health system in both urban and rural areas. Early detection and management of alcohol-related harms at primary care level and effective treatment of people with drinking-related disorders are vital. Health professionals have an essential role to play in educating the community and mobilizing and involving players within and outside the health sector.

**26. Strategic information, surveillance and research.** Surveillance and monitoring, research and knowledge management play pivotal roles in alcohol control. Countries should establish information systems to monitor alcohol production, consumption and related health, social and economic indicators as well as the application of existing laws and regulations and their effect on the general population. Alcohol indicators with direct relevance to national policy priorities need to be identified and opportunities to integrate alcohol indicators into other surveillance systems should be adequately utilized. New partnerships with research entities should be explored and operational research should be promoted as an integral part of alcohol control in order to map unrecorded drinking patterns and document effective alcohol policy interventions.

**27. Enforcing drink-driving legislation and countermeasures.** Drink-driving countermeasures, including setting and enforcing a maximum limit of 0.5 g/l for blood alcohol concentration,<sup>10</sup> frequent random-breath testing by the police and sobriety check-points, should be a high-priority intervention. The visibility of such measures, rigorous and sustained enforcement of existing legislation

accompanied by regular public awareness and information campaigns have a sustained effect on drink-driving.

**28. Regulating alcohol marketing.** There is a need to regulate the content and scale of alcohol marketing and the promotion of alcoholic beverages, in particular sponsorship, product placement, as well as internet and promotional merchandising strategies. Public agencies or independent bodies should closely monitor the marketing of alcohol products. Effective systems of deterrence should be put in place and enforced.

**29. Addressing accessibility, availability and affordability of alcohol.** Commercial licensing systems that regulate the production, importation and sale (wholesale and retail) of alcoholic beverages should be put in place. Stricter regulation of the formal and informal sector and licensing of traditional outlets is crucial to ensure that beverages meet safety requirements and that they are controlled in order to protect most vulnerable groups such as adolescents and the low income population. There is a need to enact and enforce legislation on the minimum age at which alcohol drinking and purchasing is authorized and to restrict the times and places of sale. At the point of sale in supermarkets, alcoholic beverages should not be displayed together with water and other non-alcoholic drinks. Taxation should be increased<sup>11</sup>, with regular review of prices, based on the inflation rate, income levels and alcohol contents. To that end, adequate enforcement mechanisms should be established.

**30. Addressing illegal and informal production of alcohol.** The illegal and informal production of alcoholic beverages<sup>12</sup> is seen as a major impediment to the adoption of effective policies. Nevertheless, this situation impacts on health and on tax revenues and reduces the ability to control production. This needs to be addressed and included in the national policy response. Some measure of quality control is needed including licensing and training of producers and introduction of appropriate enforcement measures. In addition, it is important to raise awareness among the general population and consumers about the dangers inherent in the consumption of certain forms of alcoholic beverages and to find funding to assist local informal producers to establish alternative income-generating business.

**31. Resource mobilization, appropriate allocation and integrated approach.** Resources are crucial to the implementation of the measures needed to reduce alcohol-related problems. These resources, to be mobilized by governments, from

individuals, the private sector and international partners, should be available on sustainable basis and distributed among the different levels of the health system according to relative needs. There is a need to include harmful use of alcohol as a priority in the health development plans of countries. The development of an integrated approach to prevention and treatment can facilitate the use of existing resources in other areas or programmes for implementing the necessary interventions.

### Roles and responsibilities

32. Countries should:

- (a) develop and implement comprehensive alcohol policies that are evidence-based and focus on public health interest; to facilitate this task, a coordination body such as a national alcohol council should be established;
- (b) mobilize and allocate resources for alcohol policies;
- (c) create public awareness on alcohol-related harm and mobilize communities to support the implementation of evidence-based policy;
- (d) adopt and enforce regulations and legislation aimed at reducing alcohol consumption and related harm and strengthen clinical practices;
- (e) promote and strengthen independent research in order to assess the situation and monitor national trends and the impact of adopted policy measures;
- (f) reinforce training and support for all those engaged in alcohol control policy activities in an attempt to increase knowledge and skills and facilitate policy implementation;
- (g) establish systems for monitoring and surveillance in order to capture the magnitude of alcohol consumption and related health, social and economic harms, provide information on existing laws and regulations and contribute to the exchange of alcohol surveillance information between regions and countries.

33. WHO and partners should support countries by:

- (a) developing and providing evidence-based tools and guidelines for policies, interventions and services;
- (b) maintaining a regional information system and providing technical support to Member States in surveillance, monitoring and evaluation of alcohol consumption and related problems;
- (c) providing them technical support in the development and review of effective and comprehensive alcohol policies and strategies;

- (d) facilitating the creation and capacity building of Intercountry networking for exchange of experiences;
- (e) facilitating effective linkages, cooperation and collaboration among international agencies, partners and stakeholders.

### Resource implications

34. Resources are required to support the implementation of this strategy, particularly the implementation surveillance and recording systems, policy monitoring, including enforcement measures, research and early detection and treatment components. This will reduce costs in the long term. Furthermore, there is a need to ensure the availability not only of trained human resources at different levels of the health care system but also of treatment structures. In most countries in the Region, part of the revenues gathered from alcohol taxes should be allocated to support the implementation of this strategy.

### MONITORING AND EVALUATION

35. Continuous monitoring and evaluation will be based on progress, outcome and impact measurements, formulated under a regional plan of action, and reported every two years to the Regional Committee. Progress monitoring indicators include:

- (a) the availability and effective implementation of policies to reduce alcohol consumption and related harm;
- (b) the implementation of sustainable national monitoring systems capable of collecting, analysing and disseminating data for evidence-based policy decisions;
- (c) the development and implementation of appropriate health care interventions at all levels of the health system, ranging from early interventions to adequate treatment.

36. Outcome and impact indicators will require the availability of data on trends and alcohol-related harm.

### CONCLUSION

37. The African Region is faced with the growing burden of harmful alcohol consumption and lacks appropriate mechanisms to respond to this situation. The main challenge is how to develop such mechanisms for effective implementation of national actions that will contribute to reducing harmful use of alcohol and strengthen global initiatives.

38. This strategy outlines actions needed to reduce alcohol-related harm and facilitate policy development and implementation at the country level. In order to reduce alcohol-related morbidity and mortality in countries, Member States are invited to take guidance from this document according to their specific needs and situation. This strategy will pave the way for action region-wide, including stronger cooperation among Member States, stakeholders and partners. Strong advocacy and commitment at the highest political level are fundamental elements for its success.

39. The Regional Committee reviewed and adopted this strategy.

### **Resolution AFR/RC60/R2**

#### **Reduction of the harmful use of alcohol: A strategy for the African Region**

The Regional Committee,

Having examined the document entitled “Reduction of the harmful use of alcohol: A strategy for the WHO African Region”;

Recalling World Health Assembly resolutions WHA58.26 on public-health problems caused by the harmful use of alcohol; WHA61.4 on strategies to reduce the harmful use of alcohol; and the endorsement at the Sixty-third World Health Assembly, in May 2010, of the global strategy to reduce harmful use of alcohol;

Having considered the report of the Regional Director on “Harmful use of alcohol in the WHO African Region: situation analysis and perspectives” and on “Actions to reduce the harmful use of alcohol”, respectively presented at the Fifty-seventh and Fifty-eighth sessions of the WHO Regional Committee for Africa;

Recognizing that the alcohol-attributable burden of disease is increasing in the African Region and that public health problems related to alcohol consumption are substantial and can adversely affect people other than the alcohol user;

Acknowledging that a significant proportion of alcohol consumed in the Region is produced informally and that it may entail additional health hazards;

Concerned about the increasing evidence linking alcohol with illicit drugs consumption and with high-risk sexual behaviour and infectious diseases such as tuberculosis and HIV/AIDS;

Noting the lack of public awareness and the low recognition of alcohol-related harm;

Conscious of the need to ensure government leadership in order to protect at-risk populations, youths, and people affected by harmful drinking of others;

Noting the existing opportunities to mobilize the community, the health sector and partners to improve surveillance and develop evidence-based interventions;

Mindful of the need to consider multisectoral approaches and coordinate with key intervening agencies, organizations and stakeholders;

1. endorses the Regional Strategy to reduce harmful use of alcohol in the WHO African Region, as proposed in Document AFR/RC60/PSC/4;

2. URGES Member States:

- (a) to acknowledge harmful use of alcohol as a major public health issue and accord it priority in their national health, social and development agendas;
- (b) to develop, strengthen and implement evidence-based national policies and interventions and adopt and enforce necessary regulations and legislation in this area;
- (c) to mobilize and ensure appropriate financial and human resources to implement national alcohol policies and consider using revenues resulting from alcohol taxes to support the implementation of this Strategy;
- (d) to set up the necessary research, surveillance and monitoring mechanisms to assess performance in alcohol policy implementation and ensure regular reporting to the WHO Secretariat;
- (e) to ensure intersectoral coordination through the creation of an intersectoral committee bringing together all relevant governmental sectors, agencies and governmental and nongovernmental organizations;
- (f) to create public awareness on alcohol-related harm and encourage the mobilization and active engagement of all the social and economic groups concerned in reducing harmful use of alcohol;

3. REQUESTS the Regional Director:

- (a) to continue to support and give priority to prevention and reduction of harmful use of alcohol and to increase efforts to mobilize necessary resources to implement this Strategy;
- (b) to provide technical support to Member States in building and strengthening institutional



- capacity to develop and implement national policies and evidence-based interventions to prevent harm from alcohol use;
- (c) to provide technical support to Member States for integrating prevention and treatment interventions for harmful use of alcohol into the primary health care approach, and to strengthen country capacity for adequate treatment, care and support for those with alcohol use disorders and their families;
  - (d) to support further collection and analysis of data on alcohol consumption and its health and social consequences and reinforce the WHO regional information system on alcohol and health;
  - (e) to facilitate research on and dissemination of best practices among African countries through conferences and facilitate the implementation of this Strategy by organizing a regional network of national counterparts;
  - (f) to draw up a regional action plan for implementing this Strategy;
  - (g) to organize regional open consultations with representatives of the alcohol industry, trade, agriculture and other relevant sectors on how they can contribute to reducing harmful use of alcohol;
  - (h) to report on progress made in the implementation of the regional strategy to the Regional Committee every two years and at regional or international forums as appropriate.

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9. Policies to reduce the harmful use of alcohol must reach beyond the health sector and engage such sectors as development, transport, justice, social welfare, fiscal policy, trade, agriculture, consumer policy, education and employment.
10. Over the years, the stipulated maximum level has been lowered. It is as low as zero or 0.2g/l in a number of countries, and 0.5g/l or lower in most countries in Europe.
11. Several studies have found mean price elasticity of –0.46 for beer, –0.69 for wine, and –0.80 for liquor, meaning that if the price of beer is raised by 10%, beer consumption would fall by 4.6%; if the price of wine was increased by 10%, wine consumption would fall by 6.9%; if the price of spirits was increased by 10%, consumption of liquor would fall by 8.0%. Anderson, P et al. Effectiveness and cost-effectiveness of policies and programmes to reduce the harm caused by alcohol. *Lancet* 2009; 373: 2234–46.
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# **Annexes**



# 1. MALARIA

## 1.1 Roll back malaria in the WHO African Region: A framework for implementation (AFR/RC50/12)

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### EXECUTIVE SUMMARY

1. Malaria remains a disease of major public health concern in the WHO African Region. There are 270–480 million cases annually in the continent, representing ninety per cent of global malaria deaths per year. In 1997, the total annual cost of the disease was more than US\$ 2000 million and is projected to reach US\$ 3600 million by the year 2000. In recognition of this, OAU Heads of State adopted a Declaration in 1997 calling on Member States to intensify the fight against malaria. In response, the Director General (DG) of WHO established the Roll Back Malaria (RBM) initiative in July 1998.

2. RBM in the African Region builds on the accelerated implementation of malaria control, the Regional Strategy for Malaria Control and the African Initiative for Malaria (AIM) Control in the 21st Century.

3. RBM approach emphasizes the technical aspects of malaria control as well as building of partnerships at all levels: regional, country and district. The implementation of RBM would be multisectoral, involving governments, NGOs, the private sector, research institutions and, more importantly, the communities.

4. RBM in the African Region will contribute to strengthening the health systems. Capacity building at all levels with emphasis on managerial aspects constitutes one of the ways in which RBM would contribute to strengthening health systems. In addition, RBM would lead to improved delivery of quality health care and address equity by focusing on the poor and marginalized people.

5. It is expected that RBM implementation in the African Region will bring stronger social mobilization and additional support so that by the year 2030, malaria will not be a significant public health problem.

6. This document proposes a framework for the implementation of RBM in our Region. It provides orientation on the implementation process and the roles of Member States, WHO and other partners.

7. The Regional Committee considered the proposed framework and provided orientation for the adoption and implementation of RBM in the Region for the purpose of achieving the set objectives.

## INTRODUCTION

1. Malaria is a major public health problem in the WHO African Region. In 1991 and 1992 respectively, regional and global strategies for malaria control were developed. In 1995, the World Bank and WHO/AFRO decided to develop long-term collaboration on malaria control.

2. The political support given to malaria control during the 1997 Organization of African Unity (OAU) Summit led to the establishment, in April 1998, of the African Initiative for Malaria Control in the 21st century (AIM). In July 1998, the DG of the WHO established the RBM initiative. Since the goals and the concept of the two programmes were similar, it was agreed that AIM would be called RBM in the African Region.

3. With its focus on health sector reforms and an enhanced role for communities in the implementation process, RBM is in line with the Regional Health for All policy. The purpose of the current document is to provide Member States with an adaptable framework for RBM implementation.

## SITUATION ANALYSIS

4. Estimated 270–480 million cases of the disease occur in the continent annually. This amounts to about one million deaths, representing 90% of global malaria deaths. Eighty per cent of these deaths occur among children under the age of five years. Malaria is a major contributing cause of poverty and absenteeism in endemic areas. It may account for loss of up to 5% of the GDP.

5. Weak health systems and inadequate coverage of control interventions complicate the scenario. Previous efforts to control the disease have suffered from fragmentation, lack of coordination, and inadequate consideration of socio-cultural factors.

6. The accelerated implementation of malaria control in the African Region took off in 1995, enhanced by funds of US\$ 18 million from WHO in 1997 and 1998 and support from partners.

7. Some of the achievements of the accelerated implementation of malarial control are:

- (a) plans of Action for Malaria Control developed in 38 African countries
- (b) development of monitoring indicators and establishment of monitoring and evaluation activities
- (c) improvement in malaria case management
- (d) development of antimalarial drug policies

- (e) increase in capacity building at the regional, national and district levels
- (f) introduction of Insecticide Treated Nets (ITNs) into 30 countries
- (g) increased advocacy, including increased visibility of national malaria control programmes
- (h) improved collaboration among partners.

8. The challenges encountered were:

- (a) addressing epidemiological surveillance of malaria and other priority diseases as part of efforts to take technical interventions to scale within health sector reforms;
- (b) improving accessibility and quality of care at facility level;
- (c) sustaining and boosting the interest of key players in malaria control;
- (d) developing information, education, and communication (IEC) programmes based on local knowledge, attitudes, perceptions and beliefs in order to influence the behaviour and practices of individuals and communities;
- (e) mobilizing resource at all levels;
- (f) ensuring patient compliance with prescribed dosages;
- (g) increasing the coverage of insecticide treated nets;
- (h) assuring malaria control in emergency situations;
- (i) integrating priority actions at operational level of primary health care;
- (j) developing and implementing effective anti-malaria policy;
- (k) assuring mandatory intersectoral collaboration for effective result.

## RBM IN THE AFRICAN REGION

### Goal

9. The goal of Roll Back Malaria (RBM) in the WHO African Region is to reduce malaria burden to a level where it is no longer one of the major contributors to mortality and morbidity in the African Region.

### Objectives:

10. The objectives of RBM in the African Region are:

- (a) to reduce mortality due to malaria
- (b) to reduce morbidity due to malaria
- (c) to maintain malaria free areas
- (d) to expand areas where malaria is controlled
- (e) to reduce the adverse socio-economic consequences of malaria.

**Targets:**

11. The targets of RBM are:

By 2001:

50% of 42 malaria endemic countries in the Region will have introduced RBM and developed plans of action;

75% of 42 malaria endemic countries will have introduced IMCI;

80% of 42 malaria endemic countries will have increased the coverage of Insecticide-treated nets (ITNs) to 25%;

countries that are malaria free in 2000 will remain malaria free.

By 2005:

50% of households in targeted districts will have at least one ITN

25% of childhood fevers will be correctly managed using IMCI

countries that are malaria free in 2000 will remain malaria free.

By 2010:

all countries in the Region would be fully implementing RBM

reduction of malaria morbidity by 50% of the 2000 levels<sup>1</sup>

reduction of malaria mortality by 50% of the 2000 levels<sup>1</sup>

countries that are malaria free in 2000 will remain malaria free.

By 2015:

further reduction in malaria mortality by 50% of the 2010 figures

further reduction in malaria morbidity by 75% of the 2010 figures

areas where malaria is controlled in the countries will increase by 50% of 2000\* figures

countries that are malaria free in 2000 will remain malaria free.

By 2025:

further reduction of malaria mortality by 50% of the 2015 figures

further reduction in malaria morbidity by 80% of the 2015 figures

areas where malaria is controlled in the countries will increase by 20% of 2015 figures

countries that are malaria free in 2000 will remain malaria free.

By 2030:

malaria mortality reduction maintained at the 2025 levels

malaria morbidity reduction maintained at the 2025 levels

countries that are malaria free in 2000 will remain malaria free.

**IMPLEMENTATION STRATEGIES**

12. The seven pillars of RBM implementation are:

- (a) ownership;
- (b) contributing to health sector reform;
- (c) integration of malaria control activities into PHC, and socio-economic development activities;
- (d) increasing the coverage of cost-effective technical interventions;
- (e) building and strengthening partnerships;
- (f) strengthening community participation;
- (g) strengthening health information system and research.

**Ownership**

13. RBM will have to be country-driven to ensure that malaria control efforts are planned and implemented according to country priorities and community needs as well as to assure sustainability. This requires the ownership of the RBM by countries, including active total involvement of communities.

**Contributing to health sector reforms**

14. RBM in the African Region will contribute to the overall national health system performance through:

- (a) capacity building for malaria programme management
- (b) improved planning and management as part of ongoing health sector reforms
- (c) increased decision capacity for malaria programme managers
- (d) coordination and implementation of RBM activities within a decentralized health system.

15. Integration of malaria control within health sector reform will assist to ensure:

- (a) improved access to and availability of services, through appropriate design of services for effective coverage, including for groups at greatest risk;
- (b) improved quality of care and utilization of services;
- (c) linkage to human development and poverty reduction and the promotion of mechanisms to enhance utilization of services by targeted groups;
- (d) improved overall health structure, including better organization and management systems for

drugs, personnel, equipment, referrals, transport, communications, and maintenance, thus impacting positively on other programmes such as safe motherhood, HIV/AIDS, EPI, IMCI, etc.

### **Integration of malaria control activities into primary health care approach**

16. To achieve the targets in the African Region, RBM will be implemented within evolving national health systems. Its activities will be integrated within PHC, to ensure wide accessibility to the communities and address equity issues.

### **Increasing the coverage of cost-effective technical interventions**

17. In order to achieve the RBM targets, an appropriate mix of proven cost-effective technical interventions must be taken to scale. These interventions must target the following priorities:

- (a) early diagnosis and prompt effective treatment at home, the community and health facility;
- (b) preventive measures, including selective cost-effective anti-vector control activities e.g. ITNs;
- (c) promotion of health information and education activities;
- (d) epidemiological surveillance;
- (e) forecast, early detection, prevention and control of epidemics;
- (f) research on traditional medicines;
- (g) drug development from traditional medicines;
- (h) regular assessment of country malaria situation in order to improve control activities.

### **Building and strengthening partnerships**

18. A broad-based, multisectoral RBM partnership forum will be established under country leadership. It will promote and ensure:

- (a) coordination of national efforts
- (b) comprehensive RBM policies
- (c) point planning, monitoring and evaluation
- (d) improvement in mobilization and allocation of resources
- (e) enhanced public and private sector collaboration.

### **Strengthening community participation**

19. At the community level, RBM will promote:

- (a) ownership of malaria control activities by the communities;
- (b) improved quality in home care;
- (c) capacity building of communities for implementation and sustainability of activities;

- (d) linkage of malaria activities with gender-based development activities;
- (e) broadening of the resource base at community level by facilitating community-based financing initiatives to ensure sustainability of malaria activities;
- (f) mobilization of all segments of the society for relevant activities;
- (g) integration of RBM activities into other community-based activities such as Bamako Initiative, IMCI, EPI, etc.;
- (h) linking of community activities with national efforts to control malaria.

### **Strengthening of Health Information System and Research**

20. RBM, in collaboration with Integrated Disease Surveillance, will contribute to the strengthening of health information systems through:

- (a) capacity building in data collection, analysis, interpretation, information sharing and decision-making and practice at district and national levels;
- (b) capacity building in research, particularly operational research, at all levels;
- (c) strengthening epidemiological surveillance capacity and capability, particularly at the operational level.

### **Roles and responsibilities**

#### **Countries**

21. Countries will develop five- or six-year evidence-based RBM plans of action that confer priority on capacity building in order to ensure sustainability. They will also play the following roles:

- (a) advocacy
- (b) consensus building
- (c) resource mobilization and coordination
- (d) human resource development
- (e) planning and implementation of RBM plans
- (f) monitoring and Evaluation.

#### **World Health Organization**

22. WHO will:

- (a) facilitate building of sustainable partnerships at the regional and country levels
- (b) by strengthening and expanding collaboration with multilateral and bilateral agencies, NGOs and the private sector;
- (c) by strengthening collaboration with IMCI, Integrated Disease Surveillance and other

- programmes and sectors that have malaria related activities;
- (d) contribute to advocacy and resource mobilization for country and inter-country activities;
  - (e) provide technical support, including orientation, to countries in the implementation of RBM.
23. National capacity and capability building is high priority.
24. Technical support will include:
- (a) provision of technical guidelines
  - (b) development of strategy documents
  - (c) strengthening country-level expertise
  - (d) support to implementation of planned activities
  - (e) monitoring and evaluation.
25. Country Office will provide active support to countries in terms of RBM activities coordination.

### Other Partners

26. Other partners' support to the development and implementation of country RBM plans of action will be provided through their efforts in:
- (a) areas of comparative advantage
  - (b) national capacity development
  - (c) resource mobilization
  - (d) agreed plan of work.
27. Eleven countries will serve as "spotlight" for developing the RBM experience.
28. A regional-level partnership for RBM will be built and developed through the annual meeting of the Task Force for malaria control in Africa.

### Resources

29. The quantum of resources required to support country plans of action is expected to grow significantly to cover major investments for scaling up RBM activities. Countries will be expected to increase the levels of resources allocated to RBM activities. RBM partnership at global, regional and country levels will also be expected to mobilize financial, human, and material resources for the implementation of the planned activities.
30. Investment in malaria control currently stands at about US\$ 12 million. To meet the commitments of RBM, the resources needed at country level between the year 2000 and 2005 has been put at more than 10–15 times the current investments. By the year 2015 when it will be at full implementation, it might go up to 40 times the current budget.
31. Resources will, therefore, need to be mobilized at all levels. Given the need for RBM to remain

country-driven and sustained, country partnerships will be significant for mobilizing in-country resources, including untapped private and community resources.

32. A clear system to ensure easy flow of resources as well as accountability, transparency and information sharing would be set up at country, regional and global levels. Emphasis will be on allocation of resources to country and local levels.

### Phases of implementation

33. The districts will constitute the first level for the implementation and evaluation of RBM as follows:

**Phase 1:** Introduction and Implementation – 2000 to 2015

*Stage 1:* Preparatory and planning (up to end of 2000): In this phase, the priority processes will be:

- (i) inception meetings
- (ii) strengthening of priority actions
- (iii) development and assessment of the strategy and plan of action.

*Stage 2:* Implementation from 2001 to 2005 and expansion from 2005 to 2015.

Activities will focus on strengthening implementation, assuring availability of services and monitoring. Expansion will follow by 2005, drawing on lessons learned.

**Phase 2:** Consolidation – 2016 to 2025

Countries, with the support of RBM partnerships, will have instituted sustainable mechanisms for disease control and strengthened the health systems. The results from country level would have started to have impact on mortality and morbidity.

**Phase 3:** Maintenance – 2026 to 2030

During this stage, efforts would be made to keep the burden of disease low and maintain gains made. This will include efforts at continued capacity building re-orientation and re-training of personnel.

### MONITORING AND EVALUATION

34. For the evaluation process, the following indicators will be used at country level:

- (a) malaria-related mortality among the under-five
- (b) percentage of the under-five sleeping under ITNs
- (c) number of malaria epidemics detected within two weeks of onset and control measures initiated



- (d) percentage of severe malaria cases properly managed in clinics
- (e) percentage of malaria-free areas.

35. Monitoring is, of course, a continuing process. However, programme monitoring will be conducted annually and programme evaluation every five years. Programme review will take place at intervals determined by the countries and the Regional Office.

## CONCLUSION

36. RBM with its additional resources will bring to scale technical interventions for malaria control, with emphasis on community-based activities.

37. RBM will be country-specific and country-driven. It is expected to contribute to the strengthening of health systems for the purpose of ensuring

equity, accessibility, efficiency and delivery of quality services.

38. The development of multisectoral partnerships, including opportunities like IMCI, will feature high in the implementation strategy of RBM in Africa.

39. The implementation of RBM in the African Region will contribute to the control of the disease and to assuring the socio-economic well-being of the society.

40. The Regional Committee approved the present framework as a tool to ease and facilitate the implementation of RBM in the Region.

## REFERENCE

1. The level will be determined through surveys undertaken in year 2000.

## 1.2 Accelerated malaria control: Towards elimination in the WHO African Region (AFR/RC59/9)

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### BACKGROUND

1. Africa is the continent most affected by malaria, accounting for 86% of the estimated 247 million malaria episodes and 91% of malaria deaths worldwide in 2006. Malaria also accounts for 25%–45% of all outpatient clinic attendances and between 20% and 45% of all hospital admissions. Furthermore, it is estimated that malaria represents 17% of under-five mortality in the WHO African Region.<sup>1</sup>

2. In high endemic countries in the Region, it is estimated that malaria reduces economic growth by an annual average rate of 1.3%, mainly from absences from work or school.<sup>2</sup> The poorest people are most exposed to malaria and its complications because of inadequate housing, poor living conditions and limited access to health care.

3. Since 1991, several initiatives, resolutions and meetings have put malaria back at the top of the public health agenda.<sup>3</sup> In 1998, the Roll Back Malaria initiative was launched to advocate for and coordinate malaria control efforts aimed at halving the malaria burden by 2010. Roll Back Malaria progressively led to increased commitment to malaria prevention and control, culminating in the 2006 Abuja African Union Heads of State call for universal access to HIV/AIDS, tuberculosis and malaria services by 2010 and the call for malaria elimination. This was followed by the UN Secretary-General's call for 100% coverage of malaria control interventions by 2010.

4. Malaria control results from deliberate efforts to reduce the disease burden to a level where it is no longer a public health problem. Malaria elimination, for its part, is an interruption of local mosquito-borne malaria transmission in a defined geographic area.<sup>4</sup> Moving from malaria control to elimination should be seen as a continuum with the ultimate goal of interrupting malaria transmission.

5. The key malaria interventions are vector control, using insecticide-treated nets (ITNs), indoor residual spraying (IRS), intermittent preventive treatment of malaria in pregnancy (IPTp) and effective treatment. Artemisinin-based combination therapy (ACT) is now the treatment of choice in 41 of the 43 malaria-endemic countries; 20 countries are implementing ACT country-wide. By the end of 2007, IPTp had been adopted in all the 35 endemic countries where it was recommended, and 20 countries are implementing IPTp country-wide.<sup>5</sup>

6. Between 2000 and 2006, ITN distribution increased three- to ten-fold in most countries. Subsidized or free ITNs have increased bednet coverage. ITN distribution is often linked to antenatal care, routine immunization services and campaigns. By the end of 2007, 17 of the 43 malaria-endemic countries in the African Region were using indoor residual spraying as one of the key malaria control interventions, while six countries were pilot-testing IRS in a few selected districts.

7. A rapid decline in malaria burden is possible when a comprehensive package of malaria prevention and control interventions is implemented in the same geographic area at the same time, as has been shown in Botswana, Eritrea, Ethiopia, Kenya, Rwanda, Sao Tome and Principe, South Africa and Swaziland.<sup>6</sup>

8. The purpose of this document is to give guidance to countries on how to accelerate implementation of malaria prevention and control interventions towards eventual elimination.

### ISSUES AND CHALLENGES

9. Some countries do not have comprehensive policies and strategies to guide the scaling up of malaria control. The private sector is not usually engaged or

involved during adoption of national policies for access to malaria prevention and treatment services. The long wait between policy adoption and implementation has delayed efforts to control the disease in many countries, as shown, for example, by the wide gap between the adoption of artemisinin-based combination therapy policy and its actual country-wide implementation.

10. While access to any antimalarial medicine ranges from 10% to 63% for children under five years of age with fever, access to ACT for the same group has remained at only 3% in the 13 countries with data for 2006.<sup>7</sup> The continued use of artemisinin monotherapy, particularly in the private sector, remains a major setback, potentially contributing to the emergence of resistance and the shortening of the useful therapeutic life of ACT.

11. Although progress has been made by countries in scaling up ITNs and IRS, many countries have not yet reached the internationally agreed targets. This is due to lack of capacity for large-scale IRS campaigns. As a result, in 2006, only five African countries reported IRS coverage sufficient to protect at least 70% of people at risk of malaria. By the end of 2007, 34% of households in 18 countries of the African Region owned at least one ITN. However, there is a gap between ownership and effective use of ITNs, which needs to be addressed through operational research. While uptake of the first dose of intermittent preventive treatment of malaria for pregnant women ranges from 23% to 93%, coverage for the second dose is still low and ranges from 5% to 68%.<sup>8</sup> The challenge is to ensure that all pregnant women take their recommended doses of IPTp and also that all households with ITNs use them.

12. Malaria treatment is characterized by gross over-diagnosis and over-treatment. Studies have shown that 32% to 96% of febrile patients receive antimalarial treatment without parasitological diagnosis. In some cases, it has been shown that only 30% of febrile patients receiving ACT are proven to have malaria.<sup>9</sup> Such improper diagnostic practices undermine the correct management of malaria and non-malarial fevers.

13. Although many endemic countries have established national malaria control programmes, there is inadequate human resource capacity at all levels to ensure efficient utilization of resources available for scaling up the various interventions. Weak health information systems also make it difficult to report on programme performance and impact.

14. Despite the increased inflow of external resources, inadequate funding for malaria control is still an

issue. By the end of 2008, none of the malaria-endemic countries had fulfilled the Abuja commitment to allocate 15% of government expenditure to the health sector. Resources from African governments represent only 18% of the US\$ 622 million disbursed in 2007.<sup>10</sup> Furthermore, many countries have difficulties accessing international funds, or managing them appropriately, where they are available.

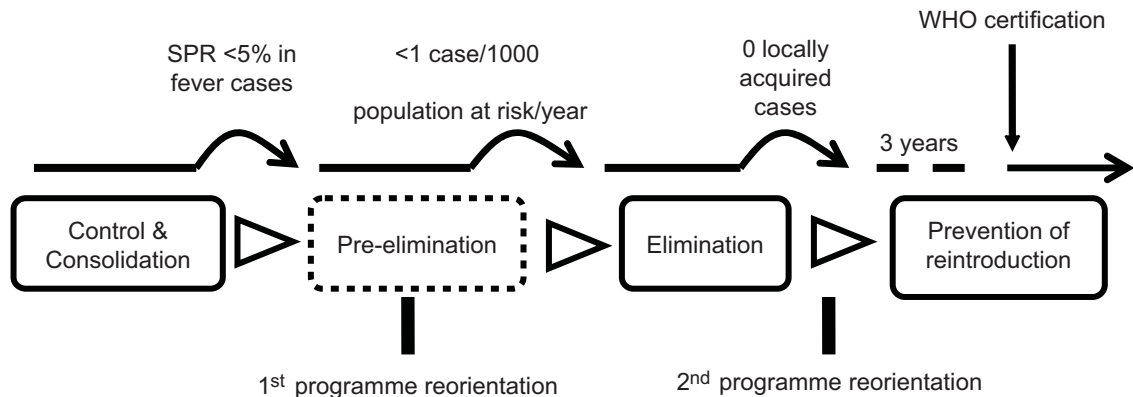
15. The prevailing socioeconomic environment in sub-Saharan Africa further compounds the malaria situation. Poor households in malaria-endemic countries spend significant proportions of their income on malaria treatment, which pushes them further into poverty. The ongoing climate change related to global warming could further expand malaria transmission areas and put more people at risk.<sup>11</sup>

16. Global and regional political commitment has led to increased interest in malaria elimination in the African Region. Figure 1 shows malaria programme phases and transitions from control to elimination. Countries in stable transmission areas should complete the consolidation phase before engaging in stepwise reorientation of the programme to pre-elimination and then elimination and prevention of reintroduction, as per the milestones shown.

17. All malaria-endemic countries in the African Region are in the control phase but lack reliable data to enable them proceed to programme reorientation. Weak health systems in most moderate and low transmission settings in the Region need to be strengthened in order to cope with the demands of an elimination programme. A major challenge is posed by the large asymptomatic reservoir coupled with high vector capacities in many sub-Saharan countries. Currently, malaria control relies on a limited number of insecticides and medicines for prevention and treatment.<sup>12</sup> Resistance to some insecticides and medicines has already occurred. Therefore, global elimination of malaria is likely to require research and development of new biomedical tools, operational research, behaviour change and adjustment of existing interventions to meet country-specific requirements.

18. In many countries there is an increasing number of partners investing in malaria control; however, coordination is still a major challenge. In many instances, fragmented implementation of malaria control is a consequence of project-based approaches.

19. Significant progress has been made thanks to the opportunities offered by high-level political commitment and the increased resources from various partners such as the Global Fund to Fight AIDS,



SPR – slide or rapid diagnostic test positivity rate. These milestones are only indicative: in practice, the transition will depend on the malaria burden that the programme can realistically handle, including case notification, case investigation etc.

**Figure 1** Malaria programme phases and milestones on the path from control to elimination in a country or area with low to moderate endemicity. Source: adapted from WHO, *Malaria elimination: a field manual for low and moderate endemic countries*, Geneva, World Health Organization, 2007.

Tuberculosis and Malaria, the World Bank Booster Programme, the US President's Malaria Initiative, the Affordable Medicines Facility for malaria (AMFm), and the Bill and Melinda Gates Foundation. However, important issues and challenges remain at national and international levels. Various actions to address these issues and challenges are needed for countries to accelerate the scaling up of malaria elimination in the African Region.

## ACTIONS PROPOSED

### 20. Update malaria policies and strategic plans.

Where required, the national health policy should be updated and correctly implemented. It is important to undertake comprehensive country programme reviews in order to identify the gaps between the targets and the current situation; it is also necessary to assess the interventions and resource gaps in order to minimize the time lag between planning and implementation. Health system bottlenecks should be identified and addressed in order to accelerate and scale up programme implementation.

**21. Strengthen national malaria control programmes.** The structures of national malaria control programmes should be based on the national health strategic plan, human resource strategic plan and the local epidemiological setting. It is important to ensure that enough financial resources are provided so that key functions related to programme

management, planning, partnerships, resource mobilization, case management, integrated vector management, surveillance, monitoring and evaluation, procurement and supply management, and community-based interventions are carried out. Countries should decentralize their programmes to ensure appropriate flow of resources and work towards appropriate integration at the operational level.

**22. Procure and supply quality antimalarial commodities.** Countries should ensure uninterrupted availability of quality, affordable malaria medicines and commodities, while avoiding stock-outs by implementing adequate procurement and supply-chain management systems. This can be done by strengthening quantification, forecasting, acquisition, stock and logistics management, distribution, quality assurance, appropriate use, information system management, and pharmacovigilance, involving both the public and private sectors in the context of existing national systems for essential medicines and health technologies procurement and management.

**23. Accelerate the delivery of key interventions for universal coverage and impact.** Countries should ensure that a comprehensive package of interventions is progressively implemented nationwide for impact. Interventions for prevention include long-lasting insecticide-treated nets (LLINs), indoor residual spraying (IRS), **using an integrated vector management approach** and

intermittent preventive treatment **of malaria** in pregnancy (IPTp). Interventions for case management are parasitological diagnosis and effective treatment. Quality control and assurance systems for microscopy and rapid diagnostic tests (RDTs) must also be ensured. The interventions should be delivered free-of-charge or at an affordable cost through health facilities and community structures and integrated with other programmes. Community involvement is critical for accelerating implementation of proven interventions. Where effectively implemented, community-based interventions, including appropriate use of case management guidelines and algorithms, contribute significantly to the scaling up of interventions.

**24. Consolidate malaria control achievements in high endemic countries.** Areas which were formerly of high stable transmission and which achieve a marked reduction in the burden of malaria should have a consolidation period before embarking on pre-elimination if their slide positivity rates are less than 5%. Cross-border collaboration should be promoted and supported by regional economic communities and partners to maximize impact.

**25. Move from control to pre-elimination and elimination when appropriate.** In some countries, natural conditions or control efforts have reduced the risk of malaria transmission to low levels and have localized unstable transmission in well-defined areas. Such countries should conduct comprehensive malaria programme reviews followed by programme reorientation to pre-elimination. In the pre-elimination phase, the surveillance system should be adapted to detect and respond to all malaria outbreaks by active case detection, parasitological diagnosis, effective treatment and focal vector control.

**26. Strengthen surveillance, monitoring and evaluation.** There is need to strengthen malaria surveillance in the routine work of health information systems and integrated disease surveillance and response, including reporting confirmed malaria cases. The surveillance, monitoring and evaluation systems should use the health information system as the main source of data, complemented by surveys. Drug efficacy and insecticide susceptibility tests should be performed annually to enable timely identification of resistance as well as the necessary actions and policy decisions.

**27. Scale up partnership coordination and alignment as well as resource mobilization.** Partner coordination and alignment, using the established mechanisms, should be strengthened at

country, regional and global levels to avoid duplication of efforts and to improve efficiency. Strong advocacy for increased and sustained funding as well as effective and efficient use of existing resources to fill existing gaps needs to be maintained at all levels for sustainable impact on malaria. To maximize resources and to address the socioeconomic determinants of health, the fight against malaria should be linked to poverty alleviation programmes.

**28. Strengthen malaria research.** For countries in the control phase, operational research, including behavioural aspects should focus on the best approaches and tools to quickly deliver and sustain the main interventions at community and health facility level. For countries which have achieved sustained impact, operational research should focus on the technical and financial feasibility of moving to pre-elimination and elimination. Countries and partners should advocate for operational research to expand the knowledge base as well as research and development for new tools.

29. The Regional Committee examined and endorsed the actions proposed in this document and adopted the resolution attached.

### *Resolution AFR/RC59/R3*

#### **Accelerated malaria control: towards elimination in the African Region**

The Regional Committee,

Having examined the document entitled “Acceleration of malaria control: towards elimination in the African Region”;

Recalling Regional Committee Resolution AFR/RC50/R6 on Roll Back Malaria in the African Region: a framework for implementation; the 2000 and 2006 Abuja OAU and AU Summits’ commitments on HIV and AIDS, tuberculosis and malaria; Resolution AFR/RC53/R6 on scaling up interventions against HIV/AIDS, tuberculosis and malaria; Resolutions WHA58.2 and WHA60.18 on malaria control and establishment of Malaria Day and the UN Secretary-General’s 2008 Malaria Initiative, which called for universal access to essential malaria prevention and control interventions;

Aware of the persisting heavy burden of malaria in the African Region and its devastating consequences on health and socioeconomic development;

Recognizing that lack of evidence-based policies, comprehensive strategies, delays in implementation, weak health systems and inadequate human resource

capacity negatively influence programme performance;

Mindful of the fact that coordination and harmonization of partner activity for resource mobilization and efficient utilization are critical for national and regional performance in malaria control;

Aware that scaling up cost-effective interventions [Long Lasting Insecticidal Nets (LLINs), Indoor Residual Spraying (IRS), Intermittent Preventive Treatment of malaria in pregnancy (IPTp), Artemisinin-based combination therapies (ACTs)] for universal coverage results in a critical reduction of the malaria burden and that malaria control currently relies on a limited number of tools;

Confirming the usefulness and effectiveness of IRS, using DDT as a major intervention for malaria control within the provisions of the Stockholm Convention;

Acknowledging the invaluable support received from multilateral and bilateral cooperation partners, foundations, malaria advocates and community-based organizations;

Analysing the new opportunities provided at the international level to control and eliminate malaria [the UN, AU, World Economic Forum, GFATM, Affordable Medicines Facility for malaria (AMFm), the World Bank Booster Programme, the US President's Malaria Initiative (US/PMI), the Bill and Melinda Gates Foundation];

1. ENDORSES the document entitled 'Accelerated malaria control: towards elimination in the African Region';

2. URGES Member States:

- (a) to integrate malaria control in all poverty reduction strategies and national health and development plans in line with the commitments of UN, AU and regional economic communities and mobilize local resources for sustainable implementation and assessment of the impact of accelerated malaria control;
- (b) to support health systems strengthening, including building of human resource capacity through pre- and in-service training for scaling up essential malaria prevention and control interventions;
- (c) to support ongoing research and development initiatives for new medicines, insecticides, diagnostic tools and other technologies for malaria control and elimination and invest in operational research for informed policy and decision-making in order to scale up and improve programme efficiency for impact;

- (d) to strengthen the institutional capacity of national malaria programmes at central and decentralized levels for better coordination of all stakeholders and partners in order to ensure programme performance, transparency and accountability in accordance with the 'Three Ones' principles;
- (e) to lead joint programme reviews, develop comprehensive need-based and fully-budgeted strategic and operational plans with strong surveillance, monitoring and evaluation components;
- (f) to strengthen health information systems, integrated disease surveillance and response and undertake appropriate surveys in order to generate reliable evidence, facilitate translation of knowledge into successful implementation and inform programmatic transitions;
- (g) to invest in health promotion, community education and participation, sanitation, and increase human resource capacity with emphasis on mid-level and community health workers for universal coverage of essential interventions using integrated approaches;
- (h) to ensure rigorous quantification, forecasting, procurement, supply and rational use of affordable, safe, quality-assured medicines and commodities for timely and reliable malaria diagnosis and treatment at health facility and community levels;
- (i) to develop cross-border malaria control acceleration initiatives based on proven cost-effective interventions and taking into account existing subregional mechanisms;

3. REQUESTS partners involved in supporting malaria control efforts in the Region to increase funding for malaria control in order to reach the UN targets of universal coverage, reduce malaria deaths to minimal levels, and achieve health-related Millennium Development Goals to which malaria control contributes;

4. REQUESTS the Regional Director:

- (a) to facilitate high-level advocacy, coordination of partner action in collaboration with the UN, RBM, other partner institutions, the AU and regional economic communities for adequate resource mobilization and efficient technical cooperation;
- (b) to support the development of new tools, medicines, applied technologies and commodities and help revitalize drug and insecticide efficacy monitoring networks;
- (c) to report to the sixty-first session of the Regional Committee, and thereafter every other year,

on the progress made in the implementation of accelerated malaria control in the African Region.

*Ninth meeting, 2 September 2009*

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## 2. HIV/AIDS

### 2.1 Scaling up interventions against HIV/AIDS, tuberculosis and malaria in the WHO African Region

(AFR/RC53/13rev.1)

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#### EXECUTIVE SUMMARY

1. *HIV/AIDS, tuberculosis and malaria contribute to high morbidity and mortality in the WHO African Region, accounting for more than 90% of the global cases and deaths associated with these diseases. They exert an enormous economic burden on governments, communities and families, trapping millions in a vicious cycle of poverty and ill-health.*
2. *A number of innovative and cost-effective interventions have been developed over the years to reduce the burden of the three diseases. The Region has adopted strategies, frameworks and resolutions, and countries have developed and are implementing plans of action in line with these decisions.*
3. *The following achievements have so far been made: increased political commitment, development of national strategic plans and partnership building for accelerating implementation of interventions; ongoing capacity building for the prevention and control of the three diseases; increased knowledge about HIV/AIDS and safe blood for transfusion; increased tuberculosis (TB) case detection rates and implementation of the DOTS strategy; and more capacity to plan, implement, monitor and evaluate malaria prevention and control programmes in almost all countries.*
4. *Despite these achievements, coverage and access to interventions remain low. Only 6% of the adult population has access to voluntary counselling and testing, 40% of countries have nationwide use of directly-observed treatment short-course services and coverage of insecticide-treated nets is 5%. Trends in these diseases are not declining. This has largely been due to limited human and financial resources, unaffordable drugs for prevention and treatment, and poor infrastructure. These constraints are compounded by inadequate approaches to the implementation of existing strategies for the programmes.*
5. *Implementation of the approaches outlined in this document will significantly contribute to scaling up interventions for the three diseases. The Global Fund to Fight AIDS, TB and Malaria, the Global Drug Facility and the Roll Back Malaria initiative offer enormous opportunities to scale up implementation of activities. The Regional Committee is therefore requested to consider and adopt this framework.*



## INTRODUCTION

1. AIDS, tuberculosis and malaria are the most important communicable diseases in the African Region. During the past decade, the Region has experienced a resurgence of tuberculosis as a direct result of the HIV/AIDS epidemic. In 2000, the Region harboured 24% of the global TB cases and 21% of new smear positive cases. Effective malaria case management is being threatened by rapidly increasing levels of *Plasmodium falciparum* resistance to commonly used antimalarial drugs, and 13 countries have changed their antimalarial drug policy in the last decade. The three diseases exert an enormous economic burden on governments, communities and families, trapping millions in a cycle of poverty and ill-health.

2. In response, the Regional Committee has passed a number of resolutions<sup>1</sup> on the prevention and control of the three diseases in order to stimulate country action. Countries have developed and are implementing plans in line with these resolutions.

3. Despite these efforts, coverage and access to interventions against these diseases remain low and their impact limited. This has been due to limited human and financial resources, unaffordable drugs for prevention and treatment, and poor infrastructure. These constraints are compounded by inadequate approaches to the implementation of existing programmes and strategies.

4. There is an urgent need to scale up the available cost-effective interventions for the prevention and control of these diseases in order to reduce the associated morbidity and mortality. Recent initiatives<sup>2</sup> such as the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), the United Nations General Assembly Special Session on HIV/AIDS (UNGASS), the World Bank Multisectoral AIDS Programme (MAP), the Global TB Drug Facility (GDF), the Roll Back Malaria (RBM) initiative and the Abuja Declarations provide opportunities for increasing coverage and access to the interventions for these diseases. This document provides a framework for scaling up these interventions.

## SITUATION ANALYSIS

### Magnitude of the problem

5. The WHO African Region accounts for about 29.4 million people living with HIV/AIDS. Approximately 3.5 million new infections occurred in the Region in 2002, while the epidemic claimed the lives of an estimated 2.4 million people;<sup>3</sup> ten million young people aged 15–24 years and almost three

million children under 15 years are living with HIV/AIDS. Despite reports of observed reductions in new infections in a few countries, the incidence has continued to increase in most countries.

6. Several countries in the Region have experienced huge increases in the number of notified TB cases. Between 1995 and 2000, the Region experienced a 95.1% increase in total reported cases and a 131.7% increase in reported new smear positive cases. Some countries of the Region have some of the highest TB prevalence rates in the world, ranging from 100 to over 700 per 100,000 in the general population.<sup>4</sup>

7. Malaria currently causes more than 270 million acute episodes and over 900,000 deaths per year in Africa.<sup>5</sup> It accounts for about 30% to 50% of all outpatient clinic visits and hospital admissions. The problem has further been compounded by the evolution of parasites that are resistant to the commonly used antimalarial drugs, particularly chloroquine. Economic loss due to malaria in the Region is estimated at US\$ 12 billion annually.<sup>6</sup>

### Achievements

8. A number of innovative and cost-effective interventions exist for the prevention and care of the three diseases. Most prevention activities rely on health promotion; information, education and communication (IEC); voluntary counselling and testing (VCT); early diagnosis and treatment as well as preparedness.

9. Countries in the Region have made several achievements. HIV prevalence has declined in a few countries; 94% of blood for transfusion is screened for HIV, and over 70% of countries have established surveillance systems to monitor trends in HIV prevalence.<sup>3</sup> For TB, 85% of the countries are implementing the DOTS strategy for TB control, 40% of these attained 100% population coverage by 2000, and case detection rates increased from 35% to 41% between 1995 and 2000.<sup>1</sup> The capacity to plan, implement, monitor and evaluate malaria prevention and control interventions and monitoring of antimalarial drug efficacy has been strengthened or developed in over 80% of countries. Initiatives to provide ITNs to target groups is ongoing in 43 countries.<sup>8</sup>

### Constraints

10. Despite these achievements, coverage and access to interventions remain low and disease trends are not declining. Various constraints have been identified.

11. *Confusion about multisectoral action:* The application of multisectoral action has posed numerous challenges but often slowed down activities in HIV/AIDS; at the same time, it has not been adequately exploited for TB and malaria. In many countries, the lack of a clear definition and separation of the respective roles of national AIDS councils and ministries of health have led to confusion and conflict, thus slowing down implementation of programmes.

12. *Inadequate linkage between health systems development and interventions:* Many countries are engaged in health sector reforms with a view to enhancing the responsiveness and effectiveness of health systems. However, there are often weak linkages between these reforms and key interventions for these diseases. The essential packages of care, which have been developed as part of mainstream health reform, often fail to adequately reflect the needs of programmes to address the three diseases. The three programmes have established vertical planning, resource mobilization, logistics and management systems. The roles of other departments and units of health ministries such as clinical services, essential drugs, laboratory services and training are not clearly defined. These often have little access to the resources available to the three programmes and, thereby, are unable to contribute adequately to implementation of activities.

13. *Centralization of programme planning and management:* The strategies for HIV/AIDS, TB and malaria are well-defined. However, dominant centralized planning and management, and inappropriate composition of coordinating bodies often hamper their operationalization. In many cases, national strategic plans are developed at the central level, with little participation from district and sub-district levels. This leads to insufficient action plans and interventions for beneficiary groups.

14. *Failure of financial resources to reach operational levels:* Implementation of district plans is often hampered by failure of disbursement of allocated and approved budgets. In many countries, district health plans do not adequately reflect the strategies that are included in the strategic plans at central level.

15. *Weak interaction between health services and communities:* Community participation often forms part of most health development policies and strategies. However, implementation is often weakened by lack of orientation and skills for health workers to effectively facilitate the interface with communities. Community-based organizations usually have no

access to funding which would enable them to take their own initiatives, create demands and force health systems to respond.

16. *Weak partnerships with the private sector (both for-profit and not-for-profit):* Workplaces provide ample opportunities for service delivery, but they are insufficiently exploited. The regulatory role of governments in ensuring compliance of private health care providers with national standards and guidelines for case management of HIV/AIDS, TB and malaria is often weak. Some of the technical capacities available in countries outside ministries of health are often insufficiently utilized.

17. *Increasing poverty, civil unrest and conflict:* Worsening poverty has limited the ability of countries to allocate appropriate resources to health systems in general and HIV/AIDS, TB and malaria programmes in particular. Access to essential health services is compromised, as households are less able to pay out of pocket or through health insurance. This is aggravated by the prolonged and increased situations of civil unrest and conflict in the Region, which result in population displacement and facilitates transmission of the three diseases.

### **Challenges and opportunities**

18. Key challenges include ensuring effective decentralization of services, strengthening human capacity (in both numbers and skills), increasing financial resources, improving the infrastructure, ensuring uninterrupted provision of affordable drugs and supplies, and increasing the involvement of communities, NGOs, CBOs and the private sector.

19. There are now enormous opportunities to scale up implementation of activities in countries. Political commitment at both national and international levels has increased during the past few years. The Abuja declarations<sup>2</sup> of 2000 and 2001 clearly set out the aspirations of African Heads of State for the actions to be taken in intensifying the response to malaria, HIV/AIDS, tuberculosis and other related infectious diseases. The 2001 United Nations General Assembly Special Session on HIV/AIDS Declaration, the World Bank Multisectoral AIDS Programme, Roll Back Malaria, Global TB Drug Facility, Global Fund to Fight AIDS, TB and Malaria, the New Partnership for Africa's Development and other initiatives for poverty reduction further re-affirm the global commitment and provide additional resources for accelerating actions against these diseases.

## OBJECTIVES

20. The general objective is to contribute to the acceleration of the reduction of morbidity and mortality associated with HIV/AIDS, TB and malaria.

21. The specific objectives, in accordance with the Abuja and UNGASS declarations, are to:

- (a) increase the coverage of HIV/AIDS, TB and malaria prevention and treatment interventions;
- (b) increase access to effective medicines and supplies for treatment and prevention of HIV/AIDS, TB and malaria;
- (c) ensure availability of the human and financial resources required to reach the targets.

## GUIDING PRINCIPLES

22. In scaling up implementation of control activities against the three diseases, the following guiding principles need to be considered:

- (a) **Country ownership:** The scaling up process should be country-driven to ensure that interventions are planned and implemented according to country priorities and community needs.
- (b) **Equity:** Access to services, particularly for the poor and the difficult-to-reach, should be taken into consideration during the planning and implementation of interventions in countries.
- (c) **Sustainability:** In order to ensure sustainability and participation of the community in the implementation of activities, strategies should take into account cultural acceptability and human resource capacity, especially at district and peripheral levels.
- (d) **Partnerships:** Strong and effective partnerships should be developed at the global, regional, national, district and community levels in order to enhance coordination of programme activities, avoid duplication of efforts and maximize the use of resources.

## IMPLEMENTATION APPROACHES

23. The scaling up of interventions against HIV/AIDS, TB and malaria requires increased geographical and programmatic coverage in a way that will make them available, accessible and affordable to the majority of the people in need. Hence, various approaches are proposed to reinforce effective implementation of already existing strategies for the three diseases. Particular attention and local adaptation need to be ensured in countries affected by emergencies.

24. **Advocacy:** There is need to advocate for a health sector that is responsive to the needs of people and that focuses on increasing coverage, equity, quality and efficiency in the provision of services at all levels. Appropriate policies and legislation should be put in place to create a supportive environment. Partnerships should be established with the media, both public and private, including local and rural radio stations for regular information and education activities to create demand for services and for behaviour change. Interpersonal communication should also be used.

25. **Enhancing multisectoral action:** The potential benefits of the multisectoral approach must be exploited fully and at all levels of service delivery. Roles and responsibilities must be defined clearly and agreed upon for each of the sectors involved. Ministries of health must play a leadership role in the health sector response and a catalytic role in enhancing responses from other sectors according to their comparative advantages.

26. **Harnessing capacity for service delivery at country level:** There is a need to increase the quantity and quality of staff involved in the delivery of services. These requirements must be estimated at the planning stage. Countries must exploit the opportunities that exist within and outside ministries of health, and at all levels, in order to harness the underutilized human capacity for the delivery of the intervention packages. The following approaches may be used:

- (a) identifying and engaging new partners such as academic institutions, NGOs and CBOs, using innovative methods such as contracting for human resources development;
- (b) providing orientation to private health care providers, the corporate sector, NGOs, CBOs and professional associations on the interventions for the three diseases to enable them to participate in service delivery;
- (c) intensifying training for all three diseases through in-service short courses, simplified modules for lower cadres and pre-service training;
- (d) expanding service delivery efforts to workplaces in collaboration with the private sector.

27. **Strengthening programme management and resource allocation:** The increased commitment expressed nationally, regionally and globally to control the three diseases has brought about the establishment of Country Coordination Mechanisms (CCMs) made up of core partners, public, private and civil society in many countries in the Region. These committees have been central to the

development of proposals for the Global Fund to fight AIDS, Tuberculosis and Malaria. They should be appropriately constituted and strengthened to facilitate partnership and joint planning processes at country level, with emphasis on micro-planning involving all partners at district level and ensuring clearly defined roles for the implementing partners.

28. To efficiently deliver services at district and community levels, decentralization of services is important and this will include:

- (a) delegating and supporting planning, implementation, monitoring and evaluation to local and district levels, based on national strategic frameworks;
- (b) building district and local level capacity for management and service delivery through partnership with locally-based NGOs;
- (c) developing mechanisms for resource allocation and disbursement, management and monitoring of resources, especially at district and local levels;
- (d) ensuring that district activities are captured in instruments for resource mobilization such as Poverty Reduction Strategy Papers and Highly Indebted Poor Countries initiatives;
- (e) including packages of intervention for the three diseases in the essential health package for district level;
- (f) strengthening referral systems between appropriate levels and ensuring effective monitoring and supportive supervision at all levels.

**29. Enhancing integrated service delivery at district level:** It is essential that key interventions are integrated at the point of service delivery. All service providers (including community development officers and community resource persons) and service delivery points (mother and child health clinics, Expanded Programme on Immunization service delivery points, pharmacies) should be given orientation to provide services for the three diseases to the communities and mobilize them for behaviour change.

**30. Integrating a service into another that is already being offered:** Large-scale integration can be used as a means to hasten scaling up. For example, voluntary counselling and testing services can be integrated into outpatient services for sexually transmitted infections and tuberculosis. Where feasible, TB clinic staff could be trained and equipped to do HIV counselling and testing among TB patients.

**31. Strengthening partnerships with communities for service delivery:** Communities should be consulted and involved in the planning, develop-

ment and management of interventions and services at local level. Health workers should be provided with adequate orientation and skills through the use of participatory approaches in situation analysis and needs assessment as well as planning, monitoring and evaluation to enable them to effectively facilitate the interface with communities. Efforts should be made to build on community-based initiatives such as the Bamako Initiative in order to enhance better service delivery for HIV/AIDS, TB and malaria. Partnership with the traditional health sector should be expanded, including more focus on research into traditional medicines for the prevention and treatment of the 3 diseases.

**32. Ensuring availability of drugs and commodities at all levels:** Drug supplies, diagnostic facilities and other related commodities are crucial for effective implementation of the intervention packages for the three diseases. Innovative ways to make these accessible and affordable to the beneficiary groups must be vigorously pursued. For example, drugs, diagnostic equipment and other commodities that are locally manufactured could be procured and distributed in pre-packed form to operational levels through partnership with local manufacturing companies. For imported drugs, bulk purchasing mechanisms could be established for groups of countries in order to lower costs. Mechanisms should be put in place to prevent leakages of drugs purchased at reduced prices to developed country markets.

**33. Promoting operational research for improved management and service delivery:** More attention should be paid to operational research, particularly at the implementation level. Operational research should be incorporated and funded as part of district health plans. This would ensure that solutions to implementation constraints and the most effective approaches to scaling up programmes are identified. New cost-effective interventions to address the three diseases should continue to be explored.

**34. Ensuring financial resource mobilization and disbursement at operational level:** Even at the current low levels of coverage, considerable amounts of resources are being spent on the response to HIV/AIDS, TB and malaria. Resource mobilization from national and external sources for the three diseases should be integrated into the national development planning process; programme needs should be considered in the plans and budgets of government ministries. Governments must establish efficient and accountable mechanisms to ensure

that funds allocated to districts are disbursed for implementation. Innovative methods for mobilizing resources from the private sector and communities should be pursued. In addition, ministries of health should ensure that the needs of the three diseases are incorporated into Poverty Reduction Strategy Papers. Special funds such as the GFATM and GDF should be accessed and national resources reallocated to meet the increasing needs for prevention and care.

## MONITORING AND EVALUATION

35. Monitoring and evaluation of interventions and activities at country level are important to ensure that programme targets are being reached and should be used to accelerate implementation. The OAU summit targets for malaria, HIV/AIDS, TB and other related infectious diseases provide frameworks for monitoring and evaluation. In addition, existing indicators, tools and guidelines for monitoring and evaluating implementation of the regional strategies should be used.

36. The Regional Office will monitor progress in scaling up the implementation of interventions against the three diseases through periodic reviews and reports to the Regional Committee. Core indicators for assessing progress in implementation will be developed based on the Abuja and UNGASS declarations as well as Millennium Development Goals.

## ROLES AND RESPONSIBILITIES

### Countries

37. Ministries of health have a key leadership role in developing plans and mobilizing both internal and external resources for scaling up implementation of activities. In addition, it is the responsibility of countries to implement planned activities, monitor and evaluate programmes, and ensure coordination of partners.

### WHO

38. WHO will provide technical support for the development of strategic plans and plans of action for scaling up interventions as well as support for programme implementation, monitoring and evaluation. WHO will also advocate for more resources internationally and assist countries in coordinating partner support for scaling up interventions at national level.

### Other partners

39. Other partners will participate at all levels in the development of national strategic frameworks and implementation plans, monitoring and evaluation as well as provide financial and technical inputs at all levels, based on their comparative advantages. In addition, they will support national capacity building relevant to implementation of interventions at all levels.

## CONCLUSION

40. Despite the achievements made in the response to HIV/AIDS, TB and malaria, coverage and access to these interventions still remain low, and trends in these diseases are not declining. Inadequate health services, insufficient human and financial resources, unaffordable drugs and supplies for prevention and treatment, and limited involvement of communities, NGOs and private sector are the major challenges. The adoption and implementation of the approaches outlined above will enable countries to scale up HIV/AIDS, TB and malaria prevention and control activities.

41. There are now enormous opportunities to scale up implementation of interventions against HIV/AIDS, TB and malaria. The Regional Committee considered and adopted this framework.

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## 2.2 Acceleration of HIV prevention in the WHO African Region: Progress report (AFR/RC59/INF.DOC/1)

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### BACKGROUND

1. In 2005, ministers of health adopted resolution AFR/RC55/R6 on acceleration of HIV prevention in the African Region, calling upon Member States to accelerate HIV prevention and declaring 2006 the Year of Acceleration of HIV Prevention in the African Region. The resolution also requested the Regional Director to develop a strategy for acceleration of HIV prevention, provide the necessary technical support to countries, help mobilize additional resources and monitor implementation.

2. The strategy document, "HIV prevention in the African Region: strategy for acceleration and renewal," was developed and subsequently adopted at the fifty-sixth session of the Regional Committee. The strategy includes targets<sup>1</sup> to be met by 2010, particularly in areas of HIV testing and counselling (HTC); blood safety; prevention of mother-to-child transmission (PMTCT) of HIV; prevention and control of sexually transmitted infections (STIs); condom use; and access to comprehensive prevention, treatment and care.

3. This report complements the previous one submitted at the fifty-eighth session of the Regional Committee. It provides updated information on key health sector HIV prevention indicators defined in the strategy, and it highlights issues that should be taken into consideration for moving the HIV prevention agenda forward in the health sector.

### PROGRESS MADE

4. Between 2007 and mid-2008, all districts reported at least one HTC facility, and the proportion of health facilities providing HTC services increased from 17% to 22%.<sup>2</sup> Innovative approaches to scale up HTC include mobile and home-based HTC and HIV testing weeks. However, in sub-Saharan Africa, on average, only 16.5% of people living with HIV are aware of their HIV status.<sup>3</sup>

5. In 2007, 40 countries reported that 100% of the blood used for transfusion was screened for HIV; this compared to 98% in 2004.<sup>4</sup> Eleven countries<sup>5</sup> are implementing specific programmes<sup>6</sup> to strengthen infection prevention and control; however, reports indicate that 50% of medical injections administered in developing countries were given with re-used, non-sterilized equipment.<sup>7</sup>

6. Uptake of PMTCT increased from 10% in 2005 to 34% in 2007, ranging from 11% in western and central Africa to 43% in eastern and southern Africa.<sup>8</sup> Botswana has reached the 80% target and five other countries<sup>9</sup> are moving towards the target. In addition, available data from 19 countries<sup>10</sup> in the Region indicate that by mid-2008, 13 174 antenatal care facilities were providing PMTCT, as compared to 10 600 in 2007. This represents an increase from 31% to 40% in only six months.

7. STIs remain a burden in the Region, and *Herpes simplex* virus type-2 has become the leading cause of genital ulcer disease. Updates of treatment protocols were reported from 31 countries,<sup>11</sup> and integration of comprehensive STI case management into training and reproductive health programmes is under way.

8. By June 2008, over 2.6 million patients were on antiretroviral therapy, representing a 24% increase in just six months. Approximately 22% of tuberculosis patients were screened for HIV and 89% of tuberculosis patients with HIV were on cotrimoxazole preventive therapy, while 37% of them were on antiretroviral therapy.<sup>12</sup>

9. Demographic and Health Surveys carried out between 2005 and 2008 indicate that condom use for last high-risk sexual encounter among people aged 15–49 years ranged from 26% to 71% for males and 14% to 47% for females, with a median of 45% for males and 26% for females. Condom use among 15–24-year-olds engaging in high-risk sex increased in 10 out of 14 countries with trend data.<sup>13</sup>

10. Other notable developments include initiatives to scale up male circumcision for HIV prevention in 12 countries,<sup>14</sup> analysis of modes of epidemic transmissions and responses for strengthening HIV prevention in 14 countries,<sup>15</sup> and implementation of school-based HIV prevention through training of teachers in 25 countries.<sup>16</sup>

11. HIV prevention is firmly on the agenda of Member States and development partners. Despite progress made, prevention programmes have not yet adequately reached the most-at-risk populations, including young females, sex workers, injecting drug users, prisoners and men who have sex with men. Challenges include weak health systems to support scaling up of effective HIV prevention interventions, addressing multiple and concurrent sexual partnerships, translating research findings on male circumcision into programme implementation, and limited use of available data.

## NEXT STEPS

12. Scaling up of HIV testing and counselling should be accelerated, using all possible entry points, and coverage of antenatal care should be increased for greater PMTCT uptake. Effective scaling up of HIV prevention interventions also requires strengthened health systems, effective community participation and strategic partnerships.

13. Multisectoral collaboration is needed to address sexual transmission of HIV. Greater attention should be given to targeting those who are most-at-risk, controlling STIs, strengthening the control of HIV-TB dual infection, and intensifying prevention programmes that target people living with HIV/AIDS. Recent evidence<sup>17</sup> calls for addressing multiple concurrent sexual partnerships and scaling up male circumcision services, particularly in high prevalence countries.

14. There is need to strengthen strategic information to better assess the driving factors of the epidemics and the impact of interventions, ensure effective monitoring and better understand the impeding factors.

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# CONCLUSION

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It is disheartening that the African Region lost almost 10.9 million human lives in 2008<sup>1</sup> from various diseases and health conditions. According to the WHO Commission on Macroeconomics and Health<sup>2</sup> most deaths and disability can be prevented because effective health interventions already exist to either prevent or cure the priority diseases. These interventions do not reach a significant proportion of those in need. The Commission argues that scaling up essential interventions and making them available region-wide would alleviate countless suffering, dramatically reduce illness and deaths, concretely reduce poverty and ensure economic growth and security.

Unfortunately, health care coverage in the African region is low due to weak and under-resourced health systems. Some of the weaknesses can be attributed to challenges related to leadership and governance; health workforce; medicines, vaccines and other health technologies; information; financing; and services delivery. Full contextualized implementation of regional strategies for the development of human resources for health; promoting the role of traditional medicine in health systems; blood safety; health financing; and knowledge management would enable countries to address some of the above mentioned challenges. The guidance provided in the strategic health research plan is still very pertinent for strengthening national health research systems; which are vital for generating, archiving and disseminating information and evidence need for decision-making and for policy development and planning.

The African Region infant mortality rate of 75 per 1000 live birth, under-five mortality rate of 119 per 1000 live births and maternal mortality ratio of 480 per 100000 live births in 2010 were 6.8-fold, 8.5-fold and 24-fold higher than those of the European Region<sup>3</sup>. The relatively high infant, child and maternal mortality rates are largely attributed to low coverage rates of existing effective public health interventions. Complete implementation of the Integrated Management of Childhood Illness Strategic

Plan, the Road Map for the Attainment of the MDGs Related to Maternal and Newborn Health, and regional strategies on adolescent health, women's health, child survival and measles elimination could save most of those deaths.

The HIV/AIDS, malaria and tuberculosis caused 160, 94 and 30 deaths per 100 000 population in the African Region; which was 24.6-fold, 37.6-fold and 1.9-fold higher than those of the Eastern Mediterranean Region.<sup>3</sup> Once again, cost-effective interventions for combatting the three diseases are known, and thus, full implementation of the regional strategies for HIV prevention, and tuberculosis and HIV/AIDS could prevent majority of premature deaths and improve quality of life.

In 2008 cancer, cardiovascular diseases and diabetes, and chronic respiratory conditions caused 147, 382 and 92 deaths per 100 000 population aged between 30 and 70 years in the African Region. These deaths rates are higher than those reported in the Eastern Mediterranean Region – 127 per 100 000 population from cancer, 344 per 100 000 population from cardiovascular diseases and diabetes, and 46 per 100 000 population from chronic respiratory conditions.<sup>3</sup> Complete implementation of the regional strategies on non-communicable diseases (NCDs), diabetes, cancer, sickle cell diseases, mental health and elimination of avoidable blindness could avert many deaths and enormous suffering caused by NCDs.

It is worth mentioning that health sector response alone will not be enough in preventing and controlling disease. There is need to address the inequities in health. As eloquently pointed out by the WHO Commission on Social Determinants of Health, these inequities in health, avoidable health inequalities, arise because of the circumstances in which people grow, live, work, and age<sup>4</sup>. This calls for concerted inter-sectoral action to tackle the broad determinants of health such as economic development, peace, security, governance, shelter, education, gender, food security, nutrition and environment. The appropriate guidance for accelerating



response to the determinants of health is outlined in the regional strategies for addressing the key determinants of health, health promotion, environmental health, poverty and health, food safety and health, and reducing harmful use of alcohol.

We strongly encourage governments and partners to allocate adequate resources for full implementation of public health strategies adopted by the WHO Regional Committee for Africa in order to avert premature deaths and suffering.

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