What are the national health priorities for the next five years?

Angola will continue working to reduce the burden of communicable diseases, taking into account the MDGs on reduction of maternal and child mortality and the burden of communicable disease, specifically malaria, tuberculosis, HIV/AIDS and, in our case, trypanosomiasis.

In addition to communicable diseases, we are starting to experience a double burden of chronic diseases and noncommunicable diseases and a significant burden of high blood pressure, strokes, diabetes and the nightmare of road accidents. The high prevalence of the latter means that trauma injury is one of the principal reasons for hospital admission in our country. Given this epidemiological picture, we need to strengthen our infrastructure. This has been done through the decentralization of health services, as a response to primary health care imperatives and the principal causes of diseases.

Angola has succeeded in interrupting the transmission of poliomyelitis. What lessons would you like to share with other countries?

Angola has a record of interrupting the transmission of poliomyelitis and has re-imported the virus three times. The main lesson we have learnt from polio are: high-quality immunization campaigns; maintaining a reliable system of epidemiological surveillance; and most importantly, maintaining high routine immunization coverage that performs effectively.

Health professionals should be aware of their responsibilities, but families must also be responsible for taking their children to be immunized.

What areas do you intend to promote in the Region during your mandate as Chairman of the WHO Regional Committee?

I will apply my efforts to support health systems strengthening; training of human resources; responding to epidemics, disasters and also noncommunicable diseases, with special emphasis on trauma injuries; seeking to ensure that traditional medicine is used as a valuable complement to conventional medicine, and seeking to give impetus to the work of our subregional organizations. I think it is important that each of the subregions should focus on specific issues and should do its utmost to address subregional problems.
What is your view on the role of AMREF in health services delivery?

Dr. Patience Monanoukal Minister of Health & Social Welfare of Lesotho

I take health as a fundamental right. Everybody must have access to health as a human right. Health should be accessible to all; it must be affordable irrespective of race, colour, religion, political affiliation, economic or social status. That is what we should embrace as health for all.

What are the key challenges faced by your country in the implementation of the right to health principle?

Dr. Patience Monanoukal Minister of Health & Social Welfare of Lesotho

The main one is limited resources. We have very limited resources and we are competing with other priorities such as fighting poverty. I don’t know whether you are aware that very recently, our Prime Minister declared an emergency against food shortage. We have severe shortage of food and it is an emergency in my country. We don’t have human resources for health. We don’t have our own doctors; nurses. They all left the country; we have failed to retain them. Without adequate human resource, we cannot deliver quality services. Another factor is the topography of my country- mountains. Roads and electricity especially to the remote areas is therefore a challenge. When I talk about health as a fundamental right I also emphasize that it should also be accessible even to those in the rural areas. My country is mountainous, roads are not good and sometimes electricity in those places is not dependable. Although we have a lot of water, unfortunately in some health facilities we don’t have clean running water.

What is the role of AMREF in health services delivery?

African Medical & Research Foundation (AMREF) was founded in 1957, fifty five years ago, as East African Medical Doctors. But since then, the role of AMREF has completely changed. We are an African international organization trying to find African solutions to African problems using African expertise. We focus on communities and we believe that communities if empowered and given the skills and means can transform within and make a lasting health change on their own health.

AMREF works with the poorest of the poor, the most vulnerable. We are in fact a small WHO at the Primary Health Care level. So we work in maternal and child health, HIV/AIDS, TB, malaria, water and sanitation, training and research. We work towards getting health services to the remote communities. We are the only organisation working both at community and at national level. We take what is working at the community level to the national level.

What needs to be done in order to empower communities to fully participate in health decision making?

First of all it is an approach. We need to approach communities with respect. We need to ask them their needs. Communities are not ignorant, they know what they need. But most times we go to them and say, we know what you need and we will do the best for you because this is what you need. Once communities are involved from the scratch in the interventions, then they will have full ownership and they will participate. We then have to give them skills and means for those to fully participate. If they don’t own something they cannot be accountable. So, we let them do it themselves and mentor them. In the end, they should maintain the intervention by themselves; we are not going to be there for ever. We are only there to develop and change them. That is the approach we are using but of course it takes time.

How can AMREF support WHO to implement the strategies and resolutions agreed upon in the Regional Committees?

AMREF and WHO can work very well together because WHO is a normative, convening organisation while AMREF is an implementing organisation that supports communities. Before WHO produced guidelines, I think AMREF can help by getting ownership from the communities by getting the needs of those communities, district health workers and community health workers. So we can bring this input into the guideline at that level. When guideline are developed, most of the times they are not implemented. We can help WHO to implement the guidelines at Primary Health Care level. We can use our system which is already for this purpose.

We can also assist WHO with training at our international training centre for mid-level health workers. We cover more than 30 countries in Africa with our training and outreach programmes. We can also assist WHO with participation in decision making. Now days, you can no longer decide as member states only. If you really want to achieve the Millennium Development Goals, we need the civil society, government and the private sector. So we can be the intermediary between the communities, NGOs, civil society and the private sector.

The Executive Director of the Roll Back Malaria (RBM), Dr. Fatoumata Nafo-Traporé during a presentation to the participants of the 62nd Session of the Regional Committee mentioned that RBM was created in 1998 by African Heads of States. Fourteen years later, more than 500 partners from four continents have joined the founding member organization, the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), UNICEF and the World Bank.

She also said that the joint actions for implementation have been fruitful. For instance, 44 out of 47 Sub-Saharan countries have developed road maps, 33 have done Malaria Programme Reviews. Bottlenecks resolution actions and EB initiatives have also been undertaken.

Consideration and endorsement of the Brazzaville Declaration on NCDs by the 32nd World Health Assembly “Our continent has greatly advanced in the fight against the disease, but still faces the challenge of the double burden of the communicable and NCDs that is pointed out. Accordingly to Dr Nafo-Traporé, despite the global economic crisis, several African countries can still benefit from economic growth because they have natural resources.

She added that solidarity in Africa could also be difficult to translate into concrete actions. Cooperation will only exist if it invests in its people. Funding for our programs is difficult even for those demonstrating a high value such as vaccination.

Dr. Nafo-Traporé noted that efforts made by countries and significant results in the fight against non-communicable diseases (NCDs) and tuberculosis may be neglected by lack of resources.

Given this situation, the UN Special Envoy for Malaria, RBM, WHO, ALMA are working together to boost the mobilization of domestic and external resources.

“Let’s join forces to find innovative financing, inform more, and improve service management. This is a message of hope and I believe that the current mobilization of resources will continue and do more” she emphasised. She added that a significant reduction in child mortality is possible by scaling-up use of insecticide-treated nets and do more” she emphasised. She added that a significant reduction in child mortality is possible by scaling-up use of insecticide-treated nets and do more” she emphasised. She added that a significant reduction in child mortality is possible by scaling-up use of insecticide-treated nets and do more” she emphasised. 

To conclude, Dr. Nafo-Traporé mentioned The Big Push (Every Child, Every Woman) launched by Heads of States. Fourteen years later, more than 500 partners from four continents have joined the founding member organization, the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), UNICEF and the World Bank.

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BRAZZAVILLE DECLARATION ON NONCOMMUNICABLE DISEASES ENDORSED

Delegates to RS/C3 unanimously adopted the Brazzaville Declaration on ‘Noncommunicable Diseases Prevention and Control in the WHO African Region’. The Declaration is a result of a Ministerial consultation on NCDs held in New York in 2011 in Brazzaville. Congo is prepared to host the United Nations High-level Summit of Heads of State and Government on NCDs, held in New York in September 2011.

The Declaration recognizes NCDs such as cardiovascular diseases, diabetes, cancer, chronic respiratory diseases, haemoglobinopathies (in particular sickle cell disease), mental disorders, violence and injuries as a significant development challenge in the WHO African Region.

Delegates acknowledged that NCDs are not only emerging but have reached alarming proportions rising exponentially. They thus recognized the Brazzaville Declaration as “wake-up call”. They also noted that NCDs constitute an important challenge for the region requiring a multisectoral approach, within the Government, the private sector, Civil Society Organizations and communities.

Delegates highlighted the importance of primary prevention focusing on risk factors such as tobacco, harmful use of alcohol, physical inactivity and unhealthy diets in preventing and reducing the burden of NCDs. Community participation in NCDs was emphasized as well as the tactics of the tobacco industry in promoting their products.

NCD surveillance and early warning evidence gathering was singled out as being very critical in efforts to contain NCDs in the Region. Early warning and treatment for NCDs in addition to balancing prevention and care interventions were noted to be essential.

Finally, delegates recommended to WHO and other partners to provide technical assistance to countries in the implementation of the Brazzaville Declaration. Further, the WHO should undertake advocacy for NCD prevention and control and mobilization of resources to address NCDs.