The African Health Monitor is a magazine of the World Health Organization Regional Office for Africa (WHOAFRO) published four times a year. It is a multilingual publication with peer reviewed articles in English, French and Portuguese.

The aim of the African Health Monitor is to promote and facilitate evidence-based policy and decisions to strengthen programmes for health promotion, protection and restoration in the African Region. In order to achieve its aim, the Monitor serves as a medium for publication of articles that monitor the health situation and trends, and track progress toward the health-related Millennium Development Goals and other internationally agreed-upon goals. It will publish and disseminate relevant and scientifically rigorous public health information. It will also disseminate information on public health interventions carried out in the Member States with the cooperation of AFRO technical programmes.

Prospective authors should follow the Monitor stylesheet, which can be obtained by sending an email message to the Editorial Office at AHM@afro.who.int or by using this intranet link http://intranet.afro.who.int/guidelines/ahm.pdf

The African Health Monitor is to promote and facilitate evidence-based policy and decisions to strengthen programmes for health promotion, protection and restoration in the African Region. In order to achieve its aim, the Monitor serves as a medium for publication of articles that monitor the health situation and trends, and track progress toward the health-related Millennium Development Goals and other internationally agreed-upon goals. It will publish and disseminate relevant and scientifically rigorous public health information. It will also disseminate information on public health interventions carried out in the Member States with the cooperation of AFRO technical programmes.

Prospective authors should follow the Monitor stylesheet, which can be obtained by sending an email message to the Editorial Office at AHM@afro.who.int or by using this intranet link http://intranet.afro.who.int/guidelines/ahm.pdf

The African Health Monitor is to promote and facilitate evidence-based policy and decisions to strengthen programmes for health promotion, protection and restoration in the African Region. In order to achieve its aim, the Monitor serves as a medium for publication of articles that monitor the health situation and trends, and track progress toward the health-related Millennium Development Goals and other internationally agreed-upon goals. It will publish and disseminate relevant and scientifically rigorous public health information. It will also disseminate information on public health interventions carried out in the Member States with the cooperation of AFRO technical programmes.

Prospective authors should follow the Monitor stylesheet, which can be obtained by sending an email message to the Editorial Office at AHM@afro.who.int or by using this intranet link http://intranet.afro.who.int/guidelines/ahm.pdf

The African Health Monitor is to promote and facilitate evidence-based policy and decisions to strengthen programmes for health promotion, protection and restoration in the African Region. In order to achieve its aim, the Monitor serves as a medium for publication of articles that monitor the health situation and trends, and track progress toward the health-related Millennium Development Goals and other internationally agreed-upon goals. It will publish and disseminate relevant and scientifically rigorous public health information. It will also disseminate information on public health interventions carried out in the Member States with the cooperation of AFRO technical programmes.

Prospective authors should follow the Monitor stylesheet, which can be obtained by sending an email message to the Editorial Office at AHM@afro.who.int or by using this intranet link http://intranet.afro.who.int/guidelines/ahm.pdf

The African Health Monitor is to promote and facilitate evidence-based policy and decisions to strengthen programmes for health promotion, protection and restoration in the African Region. In order to achieve its aim, the Monitor serves as a medium for publication of articles that monitor the health situation and trends, and track progress toward the health-related Millennium Development Goals and other internationally agreed-upon goals. It will publish and disseminate relevant and scientifically rigorous public health information. It will also disseminate information on public health interventions carried out in the Member States with the cooperation of AFRO technical programmes.

Prospective authors should follow the Monitor stylesheet, which can be obtained by sending an email message to the Editorial Office at AHM@afro.who.int or by using this intranet link http://intranet.afro.who.int/guidelines/ahm.pdf
Editorial: Scaling up effective interventions to improve progress on health MDGs
Luis Gomes Sambo
— 2 —

Tuberculosis advocacy communication and social mobilization
Sarbani Sengupta, Wilfred Nkhoma, Oladapo Walker, Bah Keita, Daniel Kibuga
— 4 —

Informer, éduquer et communiquer pour prévenir le cancer en Afrique
Jean-Marie Dangou, Alimatou Djarra-Nama
— 7 —

Prévention et management du cancer du col utérin en Guinée
Jean-Marie Dangou, Namory Keita, Khadidiatou Mbaye
— 15 —

Multidrug-resistant and extensively drug-resistant tuberculosis in the African Region
Wilfred A C Nkhoma, Daniel Kibuga, Angelica Salomao, Bah Keita, Andre Ndongosiemie, Henriette Wembanyama, Jean Baptiste Roungou,
— 22 —

Disaster preparedness and response in the African Region: Current situation and way forward
Kalula Kalambay, Usman Abdulumumini
— 30 —

Framework for the African Public Health Emergency Fund
Benido Impouma, Jean Baptiste Roungou, Francis Kasolo, Michael Tukuru, Sanyang Yaya, Zabulon Yoti, Chris Mwikisa-Ngenda, Luis Gomes Sambo
— 35 —

Recurring epidemics in the WHO African Region: Situation analysis, preparedness and response
Benido Impouma, Francis Kasolo, Adamou Yada, Zabulon Yoti, Sanyang Yaya, Celia Woodfill, Jean Baptiste Roungou
— 42 —

Health systems strengthening: Improving district health service delivery and community ownership and participation
Habib Somanje, Saidou Pathé Barry, Babacar Dramé and Chris Mwikisa-Ngenda
— 48 —

Preventing and controlling substandard and counterfeit medical products in the WHO African Region
Jean-Marie Trapsida, Abayneh Tamer Desta, Ossy Kasilo
— 55 —

Communicable Diseases Epidemiological Report
— 63 —

News and events
— 71 —
Every year over 3.5 million children under five years of age in sub-Saharan Africa die of preventable and treatable diseases including infections, malnutrition and neonatal conditions. Only seven countries in the WHO African Region are on track to achieve Millennium Development Goal (MDG) 4 which is to reduce child deaths by two-thirds from the 1990 level by 2015. More than half of maternal deaths worldwide occur in the African Region. Newborn mortality is the highest in the world, estimated at 45 deaths per 1000 live births. Very few countries are showing adequate progress towards the MDG target on reducing maternal mortality.

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. Cancer of the cervix is the commonest cancer and the leading cause of cancer mortality among women in the African Region. These are some of the issues that are the focus of this issue of the *African Health Monitor*.

In 2000, world leaders adopted the United Nations Millennium Declaration and the Millennium Development Goals, setting the year 2015 as the date for reaching the targets. The MDGs constituted an unprecedented commitment by world leaders to comprehensively address peace, security, development, human rights and fundamental freedoms. The available evidence indicates that most of the countries in the African Region have not made sufficient progress towards the MDG targets. Supporting countries improve performance and progress towards the health-
related MDGs is an important priority of the WHO in the African Region as stated in the Strategic Directions (2010–2015).

Putting the health of mothers and children first is one of the six strategic directions. WHO is intensifying advocacy to have women’s health issues placed high on the political agenda of Member States and regional institutions. WHO is also providing enhanced support to countries to accelerate the implementation of the Child Survival Strategy for the African Region and other relevant Regional Committee resolutions. Support is also being provided to scale up essential services, namely, newborn care; infant and young child feeding; provision of nutrition services including micronutrient supplementation; immunization of mothers and children; prevention of mother-to-child transmission of HIV and malaria using insecticide-treated nets (ITNs) and intermittent preventive treatment; de-worming; and integrated management of childhood illness including care of children exposed to or infected with HIV.

Accelerated actions on HIV/AIDS, malaria and tuberculosis constitute another priority area included in the strategic directions. WHO will advocate strong country ownership and leadership for accelerated, evidence based and comprehensive scaling up of agreed cost-effective interventions for the prevention and control of HIV/AIDS, malaria and tuberculosis. The fifth strategic direction envisages intensifying the prevention and control of communicable and noncommunicable diseases (NCDs). WHO is advocating high-level political commitment of governments and engagement with partners in mobilizing the resources required for disease elimination and eradication programmes including polio eradication. Support is being provided for a large-scale assessment of the burden and trends of priority noncommunicable diseases including cardiovascular diseases, cancer, diabetes, sickle-cell anaemia, mental disorders, injuries and disabilities, and to identify risk factors and major determinants through the Integrated Disease Surveillance and Response (IDSR) and the WHO Stepwise approach to surveillance of risk factors (STEPS) surveys. The evidence gathered will form the basis for the elaboration of the African Health report on NCDs.

In 2000, world leaders adopted the United Nations Millennium Declaration and the Millennium Development Goals, setting the year 2015 as the date for reaching the targets.

Two papers deal with cancer: the first looking at the role of information, education and communication on prevention, while the second describes Guinea’s experience of a specific cancer.

All the articles in this issue of the Monitor deal with important issues in the African Region and thus would be useful reading to all health workers and policymakers.
Le présent article examine les activités de plaidoyer, communication et mobilisation sociale (PCMS) pour la tuberculose (TB) dans un certain nombre de programmes nationaux de lutte contre la TB de la Région africaine de l’OMS. Les résultats découlent d’une évaluation des activités PCMS pour la TB au Ghana, au Kenya, au Lesotho, au Malawi et en Afrique du Sud.

RÉSUMÉ

Este documento centra-se no estado das actividades de advocacia, comunicação e mobilização social (ACSM) na área da tuberculose (TB) na Região Africana da OMS em programas nacionais de controlo da TB seleccionados. As conclusões decorrem de uma avaliação das actividades de ACSM da TB na África do Sul, Gana, Lesoto, Malawi e Quénia.

SUMÁRIO

All the countries assessed have tuberculosis as a major public health problem. The long-term vision for TB control is to reach a stage of transition where TB ceases to be a major public health problem in any region. The goal is to accelerate the reduction of TB related morbidity and mortality towards achieving TB-related MDG targets by 2015, i.e., reducing TB prevalence rates and death rates by half relative to 1990 data. Low knowledge of TB in communities is one of the causes for low detection rates and treatment outcomes. Involvement of communities in TB detection and treatment is minimal in most countries. A multipronged approach is appropriate, including activities to disseminate information through information, education and communication (IEC) materials and simultaneously initiating community-based activities by actively involving and sensitizing communities on TB. Such activities, when implemented in a planned and systematic manner will make communities TB-literate and mobilize them towards TB control activities.

For this reason advocacy, communication and social mobilization is recognized as an important component of TB control programme strategies.

This paper presents findings and recommendations arising from an assessment of the implementation of TB ACSM activities in five country programmes in AFRO.
METHODS

Missions were undertaken in five countries (Ghana, Kenya, Lesotho, Malawi and South Africa), each lasting two weeks, to conduct an evaluation of existing ACSM activities and assist countries to plan future activities. Official documents and reports were reviewed. Visits were conducted to relevant institutions, tertiary hospitals, rural and urban health facilities, partner NGOs, health promotion/education units and HIV testing and counselling centres. Interviews were held with various respondents at different levels of the health delivery system in both urban and rural settings, including among NGOs. ACSM practices and methods of implementation were observed. Interviews were also carried out with TB patients and clients in outpatient departments and in the community.

Most community workers exhibited knowledge gaps in ascertaining TB/HIV linkages, and in linking sensitizations to programme indicators. Sensitization methodology was mostly not structured and was not ongoing so as to ensure a good community recall. Owing to the lack of well-designed research-based evidence for developing IEC materials, the countries tend to follow a blindfold approach in designing and delivering ACSM services.

In this respect, IEC materials were not designed and tested for desired behavioural responses. There was little evidence in any country of engagement for advocacy to put TB high on the agenda at national as well as at peripheral levels, in order to mobilize adequate resources for TB control. Activities conducted were seldom linked to programme indicators and performance. None of the countries had a framework for monitoring and evaluating ACSM activities. Inconsistencies prevailed between proposed activities and actual verified activities. The provinces and districts also lacked operational action plans for ACSM activities.

RESULTS

All countries use a community approach in which health workers, community volunteers or treatment supporters offer counselling and health education. Although all these workers were providing health education and solving queries raised by patients and community members, the quality of the advice was found to be variable.

DISCUSSION

Implementation of ACSM activities requires a strategic approach. There is a strong need for a national ACSM strategy and comprehensive work plans to ensure optimal implementation at peripheral levels. IEC materials need to be made available in all major local languages, and a plan for distribution of materials must be in place to ensure constant visibility.

A well designed ACSM strategy will not only assist in understanding the knowledge, attitude, health-seeking behaviour and stigma-related issues regarding TB but will also help to develop future strategic planning for countries. A knowledge, attitude, practices (KAP) study is a pre-requisite to guide identification and implementation of ACSM activities at national level. The baseline data generated will also be useful for conducting impact assessments following implementation.

Development of IEC materials must go through scientific procedures such as needs assessment and pre-testing to ensure correct interpretations. Visibility of the IEC materials in the right places needs to be ensured. Health workers must be oriented on the systematic and correct use of IEC materials. There is also a need for the country programmes to develop tools for conducting community sensitization, such as pictorial flip charts with messages on
relevant aspects of TB, including TB/HIV, infection control and drug-resistant TB. These must be made available to all community health workers to aid their communication skills and in order to provide uniformity in the messages disseminated.

In order to be able to sustain effort and build the capacity of the workers conducting ACSM activities, a schedule for comprehensive training/refresher training based on identified needs must be prepared and adhered to. Countries must plan activities to target opinion leaders to build awareness and risk perceptions of the need for increased efforts towards TB control. Training of staff is also required for effective advocacy. Use of the existing structure of health promotion unit/education unit in countries should be maximized. These units should work in collaboration with TB personnel and public health workers at national and peripheral level for planning, implementation and monitoring of TB ACSM activities. This will facilitate closer integration of activities with the general health services.

**CONCLUSIONS**

Periodic review and evaluation of ongoing TB ACSM activities was found to be very useful. Field evaluation helped in the assessment of ACSM plans in terms of availability, feasibility, availability of infrastructure, resources and link to TB control programme indicators. It also facilitated the assessment of quality of implementation, relevance of activities, adequacy of TB ACSM delivery methods and adequacy of scope of content, with regard to the full package of the Stop TB Strategy. Evaluations also provided technical assistance to the countries to conduct situational analysis and also know-how to conduct assessment of ACSM activities. A generic framework for activity-based action plans was provided to the countries which will facilitate future planning.

During the subsequent biennium, AFRO support for implementation of TB ACSM activities will be sustained and more countries assessed in order to guide systematic planning and implementation of activities with a view to positively influencing programme performance indicators.

**REFERENCES**

INFORMER, ÉDUQUER ET COMMUNIQUER POUR PRÉVENIR LE CANCER EN AFRIQUE

Jean-Marie Dangou
Alimata J Diarra-Nama
Organisation Mondiale de la Santé, Bureau régional de l’Afrique
Auteur correspondant
Jean-Marie Dangou
E-mail : dangouj@afro.who.int

Les pays africains ont un besoin urgent d’améliorer l’information et la communication au sein de tous les acteurs de la lutte contre le cancer mais aussi entre les professionnels de la santé et les malades du cancer. L’Afrique subit une transition épidémiologique avec une montée en puissance des maladies chroniques non transmissibles telles que le cancer. Au sein de la Région africaine de l’OMS on assiste à une augmentation du nombre de personnes souffrant de cancer et leur pronostic demeure sombre. La survie de ces patients est très faible, accusant des variations inacceptables entre les pays. Une faiblesse voire un manque d’information et de communication de la part des acteurs de la lutte contre le cancer, y compris le personnel de santé, a été identifié comme l’une des raisons de ces mauvais résultats. Dans un contexte socioculturel particulier et un contexte économique défavorable, la prévention primaire est l’arme la plus efficace pour lutter à l’échelle individuelle ou collective contre le cancer en Afrique. Les populations africaines ainsi que les professionnels de la santé, quelque soit leur âge ou leur profil démographique, devront véhiculer les messages de prévention primaire contre le cancer grâce à de nouvelles voies de communication. Nous devons nous adapter à ce changement et nous appuyer aussi bien sur les réseaux de lutte contre le cancer mais aussi sur une information, une éducation et une communication adaptée à la prévention du cancer. Cet article identifie les goulots d’êtranglement et pose les problèmes spécifiques de l’information, de l’éducation et de la communication pour mieux prévenir le cancer dans la Région africaine de l’OMS et il propose des solutions adaptées au contexte.

SUMMARY

There is an urgent need in all African countries to improve knowledge and communication among professionals working in cancer and also between health professionals and patients. Africa is facing an epidemiological transition and a public health crisis in chronic noncommunicable diseases such as cancer. The WHO African Region has an increasing number of cancer patients and poor outcomes for care. Cancer survival is very low with unacceptable variations between different African countries. Previous studies have identified poor information/communication amongst all those involved in cancer care as one of the main reasons for these poor outcomes. Lack of cancer education of health personnel and communities makes this situation worse. Implementing population based or individual based primary prevention strategies is the most efficient way of addressing cancer in Africa, a continent facing a particular socio-cultural context and an unfavourable economic context. There is no doubt that people in Africa of all ages and demographic profiles, including cancer professionals, are using new communication channels. People are changing and for the future it is important to build on cancer networks, cancer information, communication and education. This article aims to address this issue by assessing the way cancer information, education and communication are carried out in the region, identifying the problems and suggesting solutions.

SUMÁRIO

Os países africanos têm uma necessidade urgente de melhorar a informação e a comunicação entre os profissionais que trabalham na área da luta contra o cancro, mas também entre os profissionais de saúde e os doentes. África está a passar por uma transição epidemiológica, com um aumento das doenças crónicas não transmissíveis tais como o cancro. A Região Africana da OMS tem assistido a um aumento do número de doentes com cancro, cujo prognóstico continua a ser pouco auspicioso. A sobrevivência dos doentes oncológicos é muito baixa, com variações inaceitáveis entre os diferentes países africanos. A falta de informação e de comunicação entre todos os actores envolvidos na luta contra o cancro, incluindo os profissionais de saúde, foi identificada como uma das principais razões para estes fracos resultados. Num contexto sociocultural particular e economicamente desfavorável, a prevenção primária é a forma mais eficaz de lutar com o cancro em África, tanto a título individual como colectivo. As populações africanas e os profissionais de saúde, independentemente da sua idade ou perfil demográfico, deverão transmitir as mensagens de prevenção primária contra o cancro através dos novos meios de comunicação. Devemos adaptarmo-nos a estas mudanças e apoia-nos-nos também nas redes de luta contra o cancro, mas também na informação, na educação e numa comunicação adaptada à prevenção do cancro. Este artigo identifica os obstáculos e apresenta os problemas específicos em matéria de informação, educação e comunicação para melhor se prevenir o cancro na Região Africana da OMS, propondo soluções adaptadas ao seu contexto.
Dans la Région africaine de l’Organisation Mondiale de la Santé (OMS), beaucoup de patients sont encore victimes d’un diagnostic tardif ; 80 à 90% des malades arrivent dans les structures de santé à des stades très avancés de leur maladie. Cette situation fait que l’annonce de la maladie est le plus souvent perçue comme l’annonce d’une mort certaine et prochaine. La charge émotionnelle qui entoure le cancer est très importante. De nombreux facteurs interagissent dans la causalité des cancers : l’allongement de l’espérance de vie, le tabagisme, l’inactivité physique, l’obésité, une mauvaise alimentation, certaines infections et le contact avec des substances toxiques présentes dans l’environnement ou sur les lieux de travail. Ces facteurs sont partagés par la plupart des maladies non transmissibles (MNT) et leur prévention permet d’éviter de très nombreux cancers.

En particulier, l’information, l’éducation et la communication (IEC) sur le cancer visent à maximiser la « ressource santé » des populations en diminuant les risques de survenue de cancers auxquels elles sont exposées.

En Afrique, le cancer étant considéré par beaucoup comme une maladie incurable relevant de la malédiction, l’information et l’éducation des malades, des familles, de la communauté et du personnel soignant semblent décisives pour répondre à une obligation de l’éthique médicale. La place de l’IEC dans les différentes composantes de la lutte contre le cancer est primordiale ; elle vise aussi bien un changement de comportement vis-à-vis des facteurs de risque du cancer, de la détection précoce, que du succès des traitements proposés aux patients, à l’amélioration de leur qualité de vie et leur réinsertion socioprofessionnelle.

Le morcellement des informations sur le cancer, la faiblesse des systèmes de santé, la dilution des responsabilités dans les ministères et organisations, la pénurie de ressources humaines et l’absence d’infrastructures et d’équipements adéquats ont empêché la plupart des pays de la Région de lutter efficacement contre le cancer. Des politiques et stratégies conçues et proposées par l’OMS, différentes résolutions et recommandations existent et sont autant de lignes directrices à une lutte globale contre le cancer. La prévention y est reconnue comme étant une priorité ; l’IEC devrait permettre la réduction de l’incidence du cancer suite à un changement de comportement des populations mais aussi à la prise en charge précoce des malades qui sont des acteurs de leur combat contre la maladie. Le présent document fait la revue des enjeux et perspectives de l’IEC sur le cancer afin d’améliorer et d’accélérer le changement de comportement des populations de la Région africaine de l’OMS. Il met en exergue la place prépondérante qui devrait être accordée à la prévention primaire du cancer en Afrique, eu égard aux contextes socioéconomique et culturel particuliers.
être prévenus. La prévention du cancer, aussi bien par l’information et l’éducation aboutissant surtout à des changements de comportement, intégrée dans le contexte global de la prévention des MNT du fait de facteurs de risque communs, pourrait réduire le fardeau des MNT d’environ deux millions d’ici 2020, et de 6,5 millions d’ici 2040. Cette prévention du cancer passe par l’amélioration des connaissances des populations sur la maladie. L’éducation pour la santé doit aboutir à un changement de comportement généralement obtenu après une longue période, changement difficilement quantifiable. Dans la plupart des pays de la Région, pour cela il n’existe aucun programme structuré à l’attention du public et des établissements de formation. Pourtant, la lutte contre le cancer devrait conduire à l’adhésion de tous les intervenants dans les domaines de la connaissance, la prévention et le traitement des cancers. La mobilisation communautaire consistant à créer ou à amplifier une réponse communautaire face au cancer devient une intervention prioritaire. Dans tous les pays où il existe une réponse communautaire effective pour certains programmes, il faudra soutenir les acteurs locaux et surtout les organisations non gouvernementales (ONG) et les organisations communautaires de base (OCB) à élargir leurs programmes de prévention au cancer afin de toucher plus de personnes, d’autres localités et d’autres populations-cibles. Il s’agira d’offrir aux populations des paquets complets et cohérents de services à travers des approches participatives de mobilisation communautaire ; leur intérêt sera suscité à la lutte contre le cancer et des associations locales de lutte contre le cancer seront promues. L’outil qui permettra d’obtenir cette mobilisation communautaire pour un changement de comportement se compose de l’information et de la communication mais aussi de l’éducation que nous aborderons plus tard.

INFORMATION
Les campagnes d’éducation pour la santé ne peuvent, par définition être « positives », cherchant à renforcer un comportement ; elles sont plutôt « négatives », cherchant à diminuer ou stopper une action qui peut avoir des conséquences néfastes pour la santé.

Elles peuvent prendre plusieurs formes :
- l’information classique : elle porte sur les questions de santé, telles qu’abordées en milieu scolaire, par exemple, elle ne prétend pas nécessairement induire une modification de comportement liée à une meilleure perception de soi et de son corps, mais seulement d’apporter des informations sanitaires et biologiques. Les curricula scolaires comporteraient des thèmes sur les facteurs de risque communs des MNT afin d’informer les élèves le plus tôt possible ;
- le travail sur les représentations : il consiste à se pencher sur le sens que chacun donne à sa vie, son corps, à ses relations avec les autres. Ce travail débutera chez des personnes adultes et tentera de faire le lien entre ces représentations et la maladie cancéreuse ;
- la création : elle fait appel à des supports externes tels que les livres, dessins, affiches et slogans dans un geste d’éducation. Au Nigéria par exemple, des manuels ont été élaborés afin d’aider des adolescents volontaires à informer leurs collègues et leur entourage sur les cancers et leurs facteurs de risque ;
- la créativité : elle se traduit par la création d’un support individuel à l’intention du public cible. Il n’y a donc pas imposition de modèle ou de représentation, mais projection des représentations propres à l’individu sur un support externe.

L’information sur le cancer doit être structurée, claire, validée et actualisée ; les populations sont plus aptes à prévenir le cancer.
lorsqu'elles sont correctement et suffisamment informées sur cette maladie. Dans la Région, il persiste dans toutes les couches de la population de nombreuses fausses idées véhiculées sur le cancer ; elles constituent un frein à la lutte. La plupart des sociétés africaines ont une perception du cancer qui leur est propre ; il faudra la déterminer et l'utiliser pour une bonne information aboutissant à un changement de comportement. Par exemple, dans certaines communautés à forte endémicité bilharzienne, l’hématurie est considérée comme un signe de virilité chez l’adolescent ou l’adulte jeune. Au Nigéria, le cancer du sein est considéré comme une maladie contagieuse alors que dans les zones rurales d’Afrique du Sud il est perçu comme un empoisonnement ou un mauvais sort jeté par un sorcier. Ces mythes doivent être utilisés à contrario pour la prévention à court terme de la bilharziose vésicale et à plus long terme la prévention du cancer de la vessie. Parfois une véritable mutation culturelle devra s’opérer mais, elle doit se faire dans la douceur en offrant aux personnes concernées une écoute humaine et attentive à leurs préoccupations.


Le tabagisme, facteur de risque du cancer, représente l’une des causes majeures de morts évitables à l’échelle mondiale avec environ 4,9 millions de morts par an. Aucun autre produit consommable n’est aussi dangereux ou ne tue autant que le tabac. S’il n’est pas jugulé, le tabagisme entraînera plus de 10 millions de décès liés au cancer (du poumon, pour la majorité) au cours des dix prochaines années. Des messages forts seront délivrés concernant le tabac pour mieux informer et sensibiliser les populations pour obtenir un changement de comportement pendant qu’une législation appropriée est mise en place. En février 2011, 41 pays de la Région avaient ratifié la Convention Cadre de l’OMS pour la lutte anti tabac. La mise en œuvre de cette Convention cadre démontre l’engagement politique des pays à combattre le tabagisme.

Par ailleurs, étant donné les influences multiples de l’alimentation sur le cancer, on encouragera la consommation de légumes, de fruits et en particulier de produits locaux. On conseillera d’éviter les mauvaises habitudes alimentaires, en particulier la consommation de grande quantité d’aliments pauvres en résidus et riches en graisses (beurre, sandwich et hamburgers). Des politiques relatives à la lutte contre l’usage abusif d’alcool et des mesures de promotion de l’activité physique seront développées au plan local. A cet effet, des stratégies sont proposées par l’OMS et leur mise en œuvre encouragée au niveau des pays.
En Ouganda, au Rwanda et en Tanzanie, les plans stratégiques élaborés pour la lutte contre le cancer du col de l’utérus\textsuperscript{9,10,11} comportent un volet important consacré à la sensibilisation sur les facteurs de risque du cancer du col de l’utérus. A cet effet, la connaissance et la compréhension des publics cibles est un préalable à toute activité d’information. Il faudra exploiter les données épidémiologiques existantes dans ces pays et réaliser des études précises en sciences humaines et sociales. Les cibles de l’information sur le cancer sont généralement le grand public, les publics cibles en fonction des types de cancer et des thèmes (hommes, femmes, enfants, sujets à risque, décideurs, leaders d’opinion, etc.), les malades et leur entourage, ainsi que les professionnels de santé. L’information portera sur les différentes composantes de la lutte contre le cancer (prévention, soins et accompagnement) mais aussi sur les repères du système sanitaire et social et comment faire valoir ses droits.

L’un des publics cibles qui mérite une attention toute particulière est celui des jeunes. Investir dans l’information des jeunes au sein des écoles, des associations culturelles et sportives est une approche qui s’inscrit dans la durée. Des informations concernant la prévention du cancer seront clairement incorporées dans les modules de connaissance des élèves en particulier pour les cancers les plus fréquents dans leur zone de résidence.

COMMUNICATION

La communication est un outil central de l’éducation des populations ; elle se fait de façon bidirectionnelle selon deux parties, l’envoyeur et le récepteur.\textsuperscript{12} Elle est ainsi perçue comme un processus dans lequel les parties en présence créent et partagent l’information entre elles, afin d’arriver à une situation de compréhension mutuelle. Il s’agit d’un processus continu lié aux événements antérieurs, présents et futurs. La communication pour un changement de comportement au sein d’une communauté dépend de facteurs tels que la connaissance, les attitudes et croyances des populations. Ces facteurs sont eux aussi dépendant des facteurs socioéconomiques ; leur maîtrise est indispensable pour réussir un projet de communication pour une amélioration de la santé des populations.\textsuperscript{13}

Afin d’obtenir un changement de comportement de la communauté, il faut aussi prendre en compte des données environnementales, éducationnelles, économiques, politiques et socio-sanitaires. Le but de la communication dans la lutte contre le cancer est d’obtenir des populations, qu’elles entendent, voient et comprennent le message qui leur est destiné, et qu’elles se l’approprient. Les messages audiovisuels véhiculés doivent être clairs, simples et accessibles à tous.\textsuperscript{14} En Afrique, les médias, en particulier les radios communautaires, la téléphonie mobile et les réunions des associations culturelles, religieuses et socioprofessionnelles sont autant de canaux qui permettront de convoyer les messages de lutte contre le cancer auprès des groupes cibles.

La mobilisation générale pour la prévention du cancer passe par une communication sociale sur des thèmes et des messages pertinents permettant d’agir sur les connaissances, attitudes, opinions et comportements du public.\textsuperscript{15} Les choix seront fondés sur des
faits validés scientifiquement et sur un travail d’experts. Les modalités d’intervention et les moyens de l’information seront judicieusement choisis ; les actions de communication de proximité, les actions locales ou les actions nationales, l’approche publicitaire, le partenariat avec des médias ou des organismes publics/privés sont autant de modalités d’intervention à adapter au contexte local. Les campagnes menées par le biais des médias, télévision, radio et cinéma, et les actions hors médias entreprises grâce à divers supports (brochures, dépliants, affichettes, posters, événements) permettront d’atteindre les publics cibles.

Il faut instaurer des relations entre la population et les structures de soins. Au-delà de leur contact dans les structures sanitaires, les professionnels et agents de santé devront aller dans la communauté afin d’y délivrer des messages sur la prévention du cancer. L’initiative « Médecins sans blouse » du Sénégal est un modèle novateur de mise en œuvre d’interventions de promotion de la santé basées sur une approche purement communautaire. Il est indispensable d’informer et d’éduquer la population, aussi bien féminine que masculine, et en particulier les enfants et les adolescents sur les cancers les plus fréquents dans les pays et sur les facteurs de risque des cancers. Les actions d’information et d’éducation doivent se dérouler au sein de la population, dans les établissements de soins et par l’intermédiaire de différents médias. Les groupes sociaux particulièrement ceux ayant des comportements à risque seront amenés à adopter un changement de comportement durable. D’où l’approche participative de prévention, de la communication pour un changement de comportement (CCC) qui est le fer de lance de cette composante. Elle mobilisera les leaders d’opinion des secteurs public et privé à tous les niveaux d’intervention.

ÉDUCATION

Une éducation en faveur de la prévention du cancer doit être engagée de façon intense au sein des populations par les services de santé, les ONG, les médias d’autant que plusieurs études menées en 2010 font état du manque d’informations correctes et des perceptions métaphysiques de la maladie cancéreuse par les populations en Afrique. Une telle stratégie permettrait de susciter une prise de conscience des populations sur la fréquence et la gravité des cancers, sur les moyens de les prévenir et, sur la nécessité de se soumettre régulièrement à un contrôle de santé. Le niveau d’éducation est, en soi, un facteur clé de la protection et du développement de « la ressource santé ». L’éducation pour la santé quelque soient l’âge, la culture, l’insertion sociale, le lieu où se trouvent les individus et leur statut vis-à-vis de la maladie, vise à stimuler leurs capacités et à rechercher des solutions en vue d’améliorer leur qualité de vie. Il s’agit d’un outil au service de la prévention et de la promotion de la santé qui permet de sensibiliser les personnes par rapport à leur santé et prenant en compte l’environnement socioculturel. L’éducation pour la santé encore appelée promotion de la santé, peut faciliter considérablement l’accès aux actions de prévention et aux structures de soins. Les démarches éducatives doivent stimuler les capacités d’intervention collective. Ce versant collectif des actions de promotion pour la lutte contre le cancer demeure faible en Afrique alors qu’il est essentiel pour les personnes en situation de précarité, dû à l’isolement culturel, géographique, social ou économique afin de renforcer leurs capacités individuelles et sociales. Les populations seront éduquées à reconnaître les signes et symptômes précoces des cancers. Il s’agit entre autre d’une toux persistante ou un enrhumement persistant de la voix, d’une constipation ou alternance de diarrhée et de constipation, de la présence d’une hémorragie
chronique et de localisation aberrante, d’un grain de beauté qui évolue ou une blessure qui ne guérit pas, de l’apparition d’une « grosseur » dans le sein ou en un autre endroit de l’organisme et d’une difficulté à avaler ou une indigestion chronique. On expliquera aux populations que tout cancer vu tôt donne le maximum de chance de guérison.

Une bonne éducation est sous tendue par une formation préalable adéquate des formateurs. L’Afrique subsaharienne est confrontée à une crise des ressources humaines en santé et plus particulièrement dans le domaine de la cancérologie. Le manque de spécialistes pour le diagnostic du cancer et ceux pour le traitement est manifeste. Des enquêtes réalisées au Nigéria sur les connaissances, attitudes et pratiques de personnel féminin de santé par rapport à la lutte contre le cancer du sein (facteurs de risque et détection précoce) ont mis en exergue un manque de connaissance qui nécessite des actions appropriées. Des représentants des malades doivent être associés au dispositif de formation. La formation des professionnels de santé à l’approche globale des patients aide ces derniers à accroître leurs capacités pour faire face à leur maladie, en prenant en compte leur propre expérience.

Cette formation doit aussi viser les approches d’IEC afin de maximiser les interventions de prévention du cancer aussi bien dans les communautés que dans les différents groupes socioculturels et professionnels. D’autres acteurs méritent aussi une attention toute particulière en matière de formation ; il s’agit des éducateurs du secteur général (écoles, collèges, lycées et universités), du secteur professionnel (école de formation professionnelle) et du mouvement associatif et caritatif. Ils bénéficieront d’une formation sur le cancer afin d’être des relais dans les actions d’information, de sensibilisation et de communication avec le public.

Il y a trois grandes catégories de moyens d’action qui permettent de promouvoir la performance des agents impliqués dans l’IEC sur le cancer : ceux qui portent sur le métier, sur les systèmes d’encadrement et sur le milieu de travail. Ces moyens ne sont pas systématiquement utilisables dans chaque contexte, mais réunis, ils constituent un véritable éventail d’options pour les décideurs. Il faut organiser le transfert d’une partie des compétences de certaines catégories professionnelles de la santé vers d’autres catégories, vers les patients et la population, notamment en matière de prévention et de comportements.
à risques. Transférer les compétences, c’est favoriser l’appropriation par les patients de la gestion de leur capital santé et de l’offre qui leur est faite par les professionnels.

CONCLUSIONS

L’amélioration de la qualité des actions de prévention et le renforcement de la compétence des acteurs sont deux leviers prioritaires pour développer une culture et des pratiques de prévention et d’éducation pour la santé face au cancer. Ces actions peuvent avoir une influence notable sur l’ensemble de la trajectoire de santé des personnes. Pour être efficaces, elles doivent être partagées et relayées par les acteurs du champ sanitaire et social tout au long de la vie de ces personnes. Les activités d’IEC visent à augmenter la prise de conscience, l’engagement et le développement d’attitudes favorables pour la lutte contre le cancer et mettre à la disposition des individus et des communautés, les informations nécessaires pour décider librement et en toute responsabilité de leur choix en matière de santé. Ces activités s’adressent à toutes les couches de la société, décideurs, individus et familles à travers l’éducation parentale ou scolaire et permettent de démonter les forteresses culturelles et psychiques établies sur le cancer en Afrique. Elles visent aussi l’amélioration de la qualité de l’offre de services par la formation des prestataires en IEC/counseling, la dotation de supports IEC et la création de la demande en services de prévention du cancer selon les besoins des groupes-cibles, y compris des programmes spécifiques destinés aux jeunes.

RÉFÉRENCES BIBLIOGRAPHIQUES

In Africa, cancer of the cervix appears in women of low socioeconomic status aged 30–49 years old. Cancer of the cervix is the first cancer in women of Guinea with an age standardized incidence of 56.3 per 100 000. Thus, it represents a public health concern. Cancer of the cervix prevention is based on an organized screening programme in which health personnel at all levels are skilled in the implementation of screening and management interventions and in monitoring and evaluation activities. The authors of this paper report their experience in Guinea, where the regional francophone centre for training in prevention and control of gynaecological cancer and the World Health Organization tested the feasibility and acceptability of visual inspection methods and immediate treatment of precancerous lesions in rural and urban locations. This publication aims at suggesting concrete actions for tackling cancer of the cervix in Africa.
Le cancer du col de l’utérus survient en Afrique chez les femmes de faible statut socio-économique entre 30 et 49 ans. En Guinée, il représente 50% de tous les cancers. C’est le premier cancer gynécologique de la femme guinéenne avec une incidence standardisée en fonction de l’âge de 56,3 pour 100 000 ; par ordre de fréquence décroissant, il est suivi par le cancer du sein (16,8 pour 100 000), le cancer de l’ovaire (3,3 pour 100 000) et le cancer de l’endomètre (1,9 pour 100 000). Ces cancers constituent un véritable problème de santé publique.

Or, le dépistage de lésions précurseurs ou états pré-néoplasiques du col utéral revêt un intérêt majeur dans le cadre d’une action de santé publique. Ces lésions peuvent évoluer à bas bruit pendant 10 à 15 ans permettant ainsi d’envisager un dépistage durant cette phase de latence et leur traitement éradicateur. Le dépistage doit être facile, simple et peu coûteux, permettant ainsi une prévention efficace du cancer. Pour être rentable et assurer une réelle action de santé publique, le dépistage doit être fait à grande échelle, atteignant le plus grand nombre de femmes à risque particulièrement les femmes entre 25 et 59 ans.

L’organisation du dépistage repose sur la formation du personnel à tous les niveaux du système de santé, sur la mise en œuvre d’activités de dépistage et de prise en charge des patientes et, sur le suivi et l’évaluation des interventions. C’est pour répondre à ces préoccupations que le Centre régional francophone de formation à la prévention des cancers gynécologiques de Guinée a été créé avec le soutien de l’Organisation Mondiale de la Santé. Il a expérimenté la faisabilité et l’acceptabilité des techniques visuelles de dépistage et de traitement instantané des états pré néoplasiques du col utéral dans des zones urbaines et rurales. Le but de cette publication est de rapporter l’expérience de la Guinée et de proposer des actions concrètes pour la lutte contre le cancer du col utérin en Afrique.

UN PROGRAMME BASÉ SUR DES EVIDENCES

ÉVALUATION DES MÉTHODES ALTERNATIVES DU DÉPISTAGE DU CANCER DU COL

En 2004, cinq pays africains (Guinée, Burkina Faso, Congo, Mali et Niger) ont participé en même temps que l’Inde à une évaluation de méthodes alternatives au frottis de dépistage du cancer cervical portant sur l’inspection visuelle après application d’acide acétique à 3–5% (IVA) et l’inspection visuelle après application de solution de lugol (IVL). Cette étude multicentrique a été initiée par le Centre international de recherche sur
le cancer de Lyon (CIRC) en collaboration avec l’Alliance pour la prévention du cancer du col (ACCP) et le financement fut assuré par la Fondation Bill et Melinda Gates. Les résultats de cette évaluation ont montré que l’IVA et l’IVL effectuées par du personnel paramédical (sages-femmes, infirmières) ont une très bonne capacité de détection des lésions précancéreuses.5 Ces résultats concordent avec d’autres études qui, en plus du dépistage visuel, ont associé et validé des traitements simples et sans danger tels que la cryothérapie, la résection à l’anse diathermique (RAD) et la conisation chirurgicale au bistouri à froid. Des données provenant de sept essais cliniques randomisés et de vingt-cinq études de suivi ont montré que le taux global de guérison pour tous les degrés de CIN (Cervical intra epithelial neoplasia) était de 89,5% (87,3–91,7%).6–9 Les tableaux 1 et 2 comparent les caractéristiques de différentes méthodes de dépistage qui ont été utilisées.

Tableau 1. Caractéristiques des tests de dépistage5,6,7

<table>
<thead>
<tr>
<th>Tests</th>
<th>Nombre de femmes</th>
<th>Sensibilité en % (par sites étudiés)</th>
<th>Spécificité en % (par sites étudiés)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cytologie</td>
<td>22 633</td>
<td>58 (29–77)</td>
<td>95 (89–99)</td>
</tr>
<tr>
<td>Test HPV</td>
<td>18 065</td>
<td>67 (46–81)</td>
<td>94 (92–95)</td>
</tr>
<tr>
<td>IVA</td>
<td>54 981</td>
<td>77 (58–94)</td>
<td>86 (75–94)</td>
</tr>
<tr>
<td>IVAM</td>
<td>16 900</td>
<td>64 (61–71)</td>
<td>87 (83–90)</td>
</tr>
<tr>
<td>IVL</td>
<td>49 080</td>
<td>92 (76–97)</td>
<td>85 (73–91)</td>
</tr>
<tr>
<td>IVA + ou IVL +</td>
<td>49 080</td>
<td>94</td>
<td>81</td>
</tr>
<tr>
<td>Total</td>
<td>49 080</td>
<td>79</td>
<td>89</td>
</tr>
</tbody>
</table>

HPV: human papilloma virus; IVA: inspection visuelle avec application d’acide acétique; IVL: inspection visuelle après application de solution de lugol
Sites étudiés: rurale et urbaine

Tableau 2. Performance de l’IVA et de l’IVL dans la détection des néoplasies cervicales en Afrique3

<table>
<thead>
<tr>
<th>Études</th>
<th>IVA</th>
<th>IVL</th>
<th>IVA</th>
<th>IVL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Sensibilité</td>
<td>Spécificité</td>
<td>Sensibilité</td>
<td>Spécificité</td>
</tr>
<tr>
<td></td>
<td>Valeur</td>
<td>95% IC</td>
<td>Valeur</td>
<td>95% IC</td>
</tr>
<tr>
<td>Burkina Faso</td>
<td>93.9</td>
<td>79.8–99.3</td>
<td>74.2</td>
<td>72.2–76.1</td>
</tr>
<tr>
<td>Congo</td>
<td>80.0</td>
<td>75.5–84.0</td>
<td>76.6</td>
<td>75.5–77.6</td>
</tr>
<tr>
<td>Guinée</td>
<td>90.3</td>
<td>81.0–96.0</td>
<td>93.2</td>
<td>92.6–93.8</td>
</tr>
<tr>
<td>Mali</td>
<td>70.0</td>
<td>60.0–78.8</td>
<td>90.7</td>
<td>89.9–91.5</td>
</tr>
<tr>
<td>Niger</td>
<td>60.0</td>
<td>26.2–87.8</td>
<td>93.8</td>
<td>92.6–94.9</td>
</tr>
</tbody>
</table>

ÉTUDES DU COÛT/ EFFICACITÉ
Une étude du coût/efficacité, comparant test visuel, recherche du virus du papillome humain (VPH) et cytologie conventionnelle10 réalisée par l’ACCP à partir des données d’Afrique du Sud, d’Inde, du Kenya, du Pérou et de Thaïlande, a montré que les programmes basés sur un dépistage unique chez des femmes entre 35 et 40 ans, avec IVA ou test VPH suivi d’une cryothérapie pour les femmes éligibles (avec un résultat positif) réduirait le risque de cancer du col utérin de 25 à 35% au cours de la vie. Le coût par années de vies sauvées serait inférieur au revenu par tête d’habitant dans chaque pays.11 Une étude antérieure basée sur des données recueillies en Thaïlande en 2002 avait estimé que le dépistage tous les 5 ans réduirait l’incidence du cancer cervical de 11% si la cytologie est utilisée seule, de 20% si c’est le test HPV qui est utilisé et de 35% si les méthodes visuelles sont pratiquées. L’IVA pratiquée à 5 ans d’intervalle avec traitement immédiat chez les femmes de 35 à 55 ans est dans cette étude l’option la moins chère et celle qui a sauvé le plus grand nombre de vies.12

ESSAI CLINIQUE
Un essai clinique randomisé mené en Inde évaluant l’effet du dépistage visuel sur l’incidence
et la mortalité du cancer du col, et publié dans *The Lancet* a montré les résultats suivants :

- une réduction de 25% de l’incidence et de 35% de la mortalité du cancer du col utérin dans le groupe intervention par rapport au groupe témoin ;
- la réduction de l’incidence dans le groupe cible était notable dès après la première année de suivi ;
- une réduction des stades II et plus après la troisième année de suivi ;
- l’effet du dépistage visuel sur la courbe de mortalité a commencé à être notable à partir de la cinquième année de suivi.

Sur la base de ces évidences, la Guinée a inscrit la lutte contre les cancers en général, et le cancer du col utérin en particulier, dans son Plan national de développement sanitaire (PNDS) et son Programme national de Santé de la reproduction (PNSR). Un programme national de lutte contre le cancer a été élaboré et mis en œuvre. Pour un passage de la recherche à l’action de santé publique, l’hôpital universitaire Donka, en collaboration avec l’OMS, a mis en place en décembre 2003 deux projets pilotes : l’un en zone rurale (Khorira), l’autre en zone urbaine (Conakry) pour valider différentes options relatives aux activités de dépistage et traitement des lésions précancéreuses du col de l’utérus. Ces projets ont ainsi permis de : (i) tester différentes méthodes de sensibilisation de la population ; (ii) évaluer le système d’information pour le suivi des performances des projets ; (iii) estimer la participation de la population et ; (iv) mettre en place un processus de formation.

**PROJET PILOTE DE DÉPISTAGE EN ZONE RURALE**

**PRÉPARATION DE L’INTERVENTION**

Située dans la préfecture de Dubreka, à 75 km de Conakry, la sous-préfecture de Khorira a été retenue par tirage au sort pour cette phase pilote. Elle abrite 20 000 habitants dont 752 femmes de plus de 35 ans. La combinaison de l’IVA et de l’IVL à la colposcopie a été utilisée comme méthode de dépistage. Avant le démarrage des activités, quinze prestataires de soins de la zone contre le cancer a été élabore et mis en œuvre. Pour un passage de la recherche à l’action de santé publique, l’hôpital universitaire Donka, en collaboration avec l’OMS, a mis en place en décembre 2003 deux projets pilotes : l’un en zone rurale (Khorira), l’autre en zone urbaine (Conakry) pour valider différentes options relatives aux activités de dépistage et traitement des lésions précancéreuses du col de l’utérus. Ces projets ont ainsi permis de : (i) tester différentes méthodes de sensibilisation de la population ; (ii) évaluer le système d’information pour le suivi des performances des projets ; (iii) estimer la participation de la population et ; (iv) mettre en place un processus de formation.

PROJET PILOTE DE DÉPISTAGE EN ZONE RURALE

PRÉPARATION DE L’INTERVENTION

Située dans la préfecture de Dubreka, à 75 km de Conakry, la sous-préfecture de Khorira a été retenue par tirage au sort pour cette phase pilote. Elle abrite 20 000 habitants dont 752 femmes de plus de 35 ans. La combinaison de l’IVA et de l’IVL à la colposcopie a été utilisée comme méthode de dépistage. Avant le démarrage des activités, quinze prestataires de soins de la zone ont été formés aux techniques d’inspection visuelle. Grâce au porte-à-porte, des mobilisateurs locaux avec la collaboration des leaders communautaires ont invité les femmes à faire le test de dépistage. Une clinique mobile équipée et dotée de consommables se déplaçait chaque semaine allant de village en village jusqu’à couvrir toute la sous-préfecture de Khorira. Le personnel de la clinique mobile était composé d’agents du centre de santé (médecins, infirmières, sages-femmes) de Khorira, de l’hôpital préfectoral de Dubreka et de l’hôpital Donka. Enfin, il a été décidé qu’au cours d’une même visite, les femmes positives à l’une des deux techniques de dépistage (IVA ou IVL) seraient traitées instantanément par cryothérapie (technique du « double freezing »). Il a été ainsi alors que les femmes présentant des lésions non éligibles pour la cryothérapie étaient convoquées dans un délai de deux semaines à l’hôpital préfectoral pour une RAD ou une conisation. Les femmes avec une suspicion de cancer invasif étaient orientées vers l’hôpital Donka.

**RÉSULTATS DE L’INTERVENTION**

Au total trente-deux sorties de l’équipe mobile ont été effectuées. Mille trois cent deux clientes sur 2063 femmes ayant reçu l’information ont été dépistées, soit un taux moyen de participation de 64%. La population était très motivée et les sous-préfectures environnantes ont montré un grand intérêt pour le projet.

Le taux de positivité des deux tests IVA et IVL dans cette étude était particulièrement faible ; 1,7% avec 1,5 et 1,9% pour l’IVA et pour l’IVL respectivement. Le
taux de dysplasie de bas grade était de 5,2%, celui de dysplasie de haut grade de 15,7%. Enfin celui de cancer invasif était de 10,5%.

Soixante quinze pour cent des cas positifs à IVA/IVL et éligibles pour la cryothérapie ont été traitées le jour même du dépistage. Dix-sept pour cent des patientes ont eu un traitement différé par RAD ou conisation au bistouri à froid ou à l'hôpital préfectoral ou au CHU et 8% ont été traitées par colpo-hystérectomie au Centre hospitahlo-universitaire de Donka. Dans tous les cas l’évolution a été favorable : une seule complication hémorragique a été enregistrée après cryothérapie et résolue par simple massage. Un an après la prise en charge, aucun décès, récidive ou reprise évolutive n’ont été enregistrés.14

**PROJET PILOTE DE DÉPISTAGE EN ZONE URBAINE**

**PRÉPARATION DE L’INTERVENTION**


**RÉSULTATS DE L’INTERVENTION**

A l’hôpital Donka, 250 femmes ont été dépistées pendant les deux premiers jours de la mise en place du programme ; cette forte participation des femmes montre l’intérêt de la population. Durant les 6 premiers mois du programme qui se déroulait simultanément en zone rurale et en zone urbaine, de mai à novembre 2004, 1 252 femmes ont été recrutées à Khorira en zone rurale parmi lesquelles 50% avait un âge égal ou supérieur à 35 ans.

Le taux global de participation était de 64%, celui de positivité des deux tests IVA et IVL était de 5,83% soit 4,2% et 5,4% pour l’IVA et l’IVL respectivement. Le taux de dysplasie de bas grade après examen histologique de confirmation était de 10%, celui de dysplasie de haut grade de 8% et celui de cancer invasif de 5,5% (94% de cancer épidermoïde et 16% d’adénocarcinome).

Les patientes présentant des lésions précancéreuses plus étendues et non éligibles pour la cryothérapie ont eu un traitement différé. Parmi les patientes éligibles pour la cryothérapie, 91% ont été effectivement traitées le même jour. Pour celles éligibles pour la RAD ou la conisation au bistouri à froid, 78% ont effectivement reçu leur traitement. Le counseling pré et post test de dépistage qui a été réalisé a permis d’obtenir une bonne participation et adhésion au traitement. Parmi les cas de cancer invasif identifiés, seuls 47% ont reçu un traitement chirurgical, 12% ont eu une palliation plus ou moins bien conduite et 41% ont été perdues de vue. S’agissant des lésions précancéreuses aucune complication post-thérapeutique n’a été observée. Un décès à 6 mois a été observé dans le groupe des cancers invasifs pris en charge par la chirurgie.15

Les résultats obtenus au niveau des deux sites du projet (tableau 3) montrent que pendant la période de 2001 à 2004 plus de 300 lésions précancéreuses et plus de 100 cancers invasifs ont été dépistés et traités. Le taux de positivité des tests visuels pour les lésions de bas grade était plus faible en zone rurale qu’en zone urbaine. Par contre ces tests visuels ont permis de mettre en évidence un grand nombre de lésions pré néoplasiques de haut grade et de cancers invasifs. Les cas ainsi décelés ont été pris en charge au plan thérapeutique réduisant ainsi
la morbidité et la mortalité par cancer du col utérin. Au total les résultats des tests de dépistage, les résultats du traitement des lésions précancéreuses ainsi que l’adhésion des patientes à ces interventions sont en concordance avec la plupart des résultats publiés dans la littérature. Nous avons noté un engouement des populations surtout dans la zone rurale de Khorira dû au faible coût des interventions comparé à ceux de la cytologie de dépistage. Ce projet pilote a montré l’efficacité des interventions et sa bonne acceptabilité par les populations aussi bien en zone rurale qu’en zone urbaine. Cependant, le projet connaît aujourd’hui d’énormes difficultés financières. Les activités dans la zone rurale de Khorira se sont arrêtées. Elles se poursuivent à l’hôpital Donka et de façon sporadique au centre de santé de Boulibinet. Dans ce dernier centre, les femmes avec des lésions détectées grâce à l’IVA ou l’IVL sont orientées dans la semaine vers l’hôpital Donka pour une confirmation du diagnostic et un traitement qui sera pratiqué si nécessaire au cours d’une même visite.

### EXTENSION DU PROGRAMME

En 2005, dans le cadre des activités décentralisées du Centre régional de formation à la prévention des cancers gynécologiques de Guinée, l’appui de l’Agence américaine pour le développement (USAID) a permis l’extension du programme à trois villes de la Haute-Guinée : Faranah, à 470 km au nord-est de Conakry ; Kankan, à 662 km et ; Siguiri, à 827 km. A l’instar des deux premiers programmes en zones rurale et urbaine, ce programme a suivi les différentes étapes de mise en place : formation, sensibilisation, invitation au dépistage et organisation du dépistage dans les centres de santé urbains (CSU) et à l’hôpital publique de référence de la localité, diagnostic et prise en charge des cas positifs et suivi/évaluation.

La mise en œuvre de ce programme avait été confiée à l’organisation non gouvernementale PRISM-Guinée («Pour renforcer les interventions en santé maternelle – Guinée») branche locale de l’institution MSH (Management Sciences for Health), une organisation américaine à but non lucratif qui soutient les programmes de santé à travers le monde. Le dépistage et le traitement des lésions précancéreuses ont ainsi été rendus disponibles à l’Hôpital régional de Kankan et 6 CSU de la région, à l’Hôpital régional de Faranah et 2 CSU associés et à l’Hôpital préfectoral de Siguiri et 3 CSU associés.

### QUELLES PERSPECTIVES ?

Les résultats de ce programme mis en œuvre aussi bien en zone rurale qu’en zone urbaine sont très prometteurs et encourageants. Le rapport coût/efficacité et la bonne acceptabilité par les populations de la méthode visuelle de dépistage et du traitement des lésions précancéreuses appellent une mise à l’échelle du programme au niveau de la Guinée. Cependant le principal enjeu est celui de la pérennité de l’intervention qui reste largement tributaire de l’appui extérieur. Malgré leur utilité et la possibilité d’une réponse nationale adéquate, la continuité des activités est menacée quand cesse l’assistance financière des partenaires.

Néanmoins, l’expérience guinéenne dans la lutte contre
le cancer du col utérin en utilisant les méthodes visuelles de dépistage peut être mise à l'échelle et capitalisée par d'autres pays africains. Aussi, nous recommandons les mesures suivantes aux pays africains ayant une forte incidence de cancers du col de l'utérus de :

- renforcer et étendre les mesures d'information, d'éducation et de sensibilisation des différentes couches sociales sur les avantages du dépistage des cancers gynécologiques ;
- assurer la formation et le recyclage du personnel de santé au dépistage et au diagnostic des lésions précancéreuses ou du cancer débutant du col de l'utérus ;
- introduire le dépistage du cancer du col utérin par les méthodes visuelles dans les activités de routine du personnel de santé à tous les niveaux et l'associer aux programmes en charge de la santé maternelle tels que ceux sur les infections sexuellement transmises, le VIH/Sida, etc ;
- mettre en place des unités de traitement palliatif et de prise en charge psychosociale pour les cancers avancés ;
- procéder à l'introduction progressive des tests rapides de diagnostic de l'infection par le virus du papillome humain (VPH) dans les programmes de dépistage du cancer du col utérin ;
- contribuer à l'introduction des vaccins anti VPH dans la prévention primaire du cancer du col utérin ; et
- assurer le plaidoyer auprès des autorités nationales, des donateurs et de tous les partenaires pour la mobilisation et l'allocation de ressources dans le cadre de la lutte contre le cancer du col utérin.

**RÉFÉRENCES**


**REMERCIEMENTS**

Les auteurs remercient tous ceux qui ont contribué à cette expérience en Guinée et à l'étranger, et plus particulièrement au Ministère de la Santé de Guinée, au Centre international de recherche sur le cancer (CIRC) de Lyon, à la Fondation Bill et Melinda Gates et, à l'Alliance pour la prévention du cancer du col de l’utérus (ACCP). Ils remercient aussi le Dr AJ Diarra-Nama et le Dr T Ketsela pour leurs appréciables contributions.
Tuberculosis remains a high-priority communicable disease in the African Region. With approximately 12% of the world's population, the region accounted for 30% of all notified TB cases in 2010. Of the cases notified, approximately 55% tested positive for HIV, making HIV the most important risk factor for TB incidence. Despite significant progress in implementing internationally recommended directly observed treatment, short-course (DOTS) based programmes, TB control in the region faces a number of challenges, notably poor programme performance indicators, limited access to health services, poor health infrastructure, inadequate laboratory testing facilities, weak surveillance systems, inadequate infection control measures and for drug-resistant TB, inadequate availability of second-line medicines and poor capacity to manage drug-resistant TB. National programmes are also constrained by inadequate resources for scaling up control interventions.

Since 2006, drug-resistant TB has emerged as a new threat. To date, multidrug-resistant TB (MDR-TB) has been reported in 42 of the 46 countries, 8 of which have also reported extensively drug-resistant TB (XDR-TB) cases. Ministers of Health from four MDR-TB countries in the Region (Democratic Republic of Congo, Ethiopia, Nigeria and South Africa) were party to the Beijing Call for Action against drug-resistant TB that was adopted in April 2009 and several global health initiatives, including the Global Fund, are in place to support TB control in the Region. The key actions to combat the drug-resistant TB problem in the Region include developing and scaling up programmatic management of drug-resistant TB, establishing laboratory-based surveillance systems for drug-resistant TB, improving the supply of second-line medicines, implementing TB infection control measures and expanding regional networks to diagnose and monitor multidrug-resistant and extensively drug-resistant TB.
BACKGROUND

Tuberculosis is a high-priority communicable disease in the WHO Africa Region. Latest available information (2010 Global TB Control Report),\(^1\) indicates that the African Region has the highest TB incidence rates (Figure 1) and with only 12\% of the world population contributed 30\% of notified TB cases in 2009. Case notification rates have increased from 82 per 100 000 in 1990 to 170 per 100 000 in 2009. At the same time, 55\% of TB patients tested in the same year were HIV-positive, making HIV infection the single most important risk factor for TB incidence in the Region. This trend needs to be reversed for the Region to meet the Millennium Development Goals (MDG) targets for TB control.

Recognizing the threat posed by the TB epidemic, the WHO Regional Committee for Africa at its 53rd session in 2003 adopted Resolution AFR/RC53/R6 calling for scaling up of interventions against HIV/AIDS, TB and malaria in all Member States. Subsequently, at its 55th session in Maputo, Mozambique, in 2005, the Regional Committee declared TB an emergency in the African Region\(^2\) calling upon Member States to implement urgent and extraordinary actions to quickly bring the epidemic under control.

Notwithstanding, subsequent to this resolution, the region has been experiencing an increasing magnitude of multi-drug resistant TB forms, and reported the first ever outbreak of extensively drug-resistant TB in 2006. While initially thought to be a rare occurrence, more and more countries in all subregions have since begun to identify and set up treatment programmes for M/XDR-TB control (Table 2). The need for accelerated action is vital.

This paper seeks to chronicle the emergence of drug-resistant TB forms in the Region and actions proposed for its urgent control.

EMERGENCE OF DRUG-RESISTANT TB FORMS IN THE REGION

SITUATION ANALYSIS

Since 2006, the Region has witnessed the increasing emergence of multidrug-resistant TB and extensively drug-resistant TB cases defined respectively as TB caused by organisms that are resistant to at least isoniazid and rifampicin, and MDR-TB organisms that are also resistant to any one of the fluoroquinolone family of anti-TB medicines and to at least one of four injectable second-line drugs (amikacin, capreomycin, kanamycin and viomycin). Between January 2004 and December 2011 (tentative...
<table>
<thead>
<tr>
<th>Country</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>Total to date</th>
<th>Percentage of notifications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Algeria</td>
<td>0</td>
<td>74</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>56</td>
<td>130</td>
<td>0.2</td>
<td></td>
</tr>
<tr>
<td>Angola</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>5</td>
<td>0.0</td>
<td></td>
</tr>
<tr>
<td>Benin</td>
<td>15</td>
<td>28</td>
<td>21</td>
<td>11</td>
<td>4</td>
<td>14</td>
<td>15</td>
<td>3</td>
<td>111</td>
<td>0.2</td>
</tr>
<tr>
<td>Botswana</td>
<td>0</td>
<td>12</td>
<td>0</td>
<td>139</td>
<td>126</td>
<td>101</td>
<td>106</td>
<td>31</td>
<td>515</td>
<td>1.0</td>
</tr>
<tr>
<td>Burkina Faso</td>
<td>0</td>
<td>3</td>
<td>6</td>
<td>31</td>
<td>16</td>
<td>19</td>
<td>31</td>
<td>106</td>
<td>0.2</td>
<td></td>
</tr>
<tr>
<td>Burundi</td>
<td>10</td>
<td>6</td>
<td>28</td>
<td>17</td>
<td>0</td>
<td>24</td>
<td>79</td>
<td>1.1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cameroon</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>24</td>
<td>0</td>
<td>35</td>
<td>28</td>
<td>87</td>
<td>0.2</td>
<td></td>
</tr>
<tr>
<td>Cape Verde</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>5</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>0.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Central African Republic</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>12</td>
<td>7</td>
<td>9</td>
<td>5</td>
<td>0.1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chad</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>0.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Comoros</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>0.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Congo</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>21</td>
<td>0</td>
<td>0</td>
<td>21</td>
<td>0.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Côte d’Ivoire</td>
<td>36</td>
<td>47</td>
<td>0</td>
<td>24</td>
<td>43</td>
<td>50</td>
<td>200</td>
<td>0.4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Democratic Republic of the Congo</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>15</td>
<td>128</td>
<td>91</td>
<td>87</td>
<td>322</td>
<td>0.6</td>
<td></td>
</tr>
<tr>
<td>Equatorial Guinea</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>5</td>
<td>0</td>
<td>0</td>
<td>7</td>
<td>0.0</td>
<td></td>
</tr>
<tr>
<td>Eritrea</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>11</td>
<td>11</td>
<td>0.0</td>
<td></td>
</tr>
<tr>
<td>Ethiopia</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>145</td>
<td>130</td>
<td>233</td>
<td>140</td>
<td>648</td>
<td>1.2</td>
<td></td>
</tr>
<tr>
<td>Gabon</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gambia</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ghana</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>7</td>
<td>2</td>
<td>0</td>
<td>4</td>
<td>16</td>
<td>0.0</td>
<td></td>
</tr>
<tr>
<td>Guinea</td>
<td>1</td>
<td>20</td>
<td>25</td>
<td>36</td>
<td>72</td>
<td>69</td>
<td>31</td>
<td>254</td>
<td>0.5</td>
<td></td>
</tr>
<tr>
<td>Guinea-Bissau</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kenya</td>
<td>8</td>
<td>44</td>
<td>89</td>
<td>82</td>
<td>102</td>
<td>150</td>
<td>112</td>
<td>615</td>
<td>1.1</td>
<td></td>
</tr>
<tr>
<td>Lesotho</td>
<td>4</td>
<td>0</td>
<td>0</td>
<td>46</td>
<td>0</td>
<td>0</td>
<td>527</td>
<td>577</td>
<td>1.1</td>
<td></td>
</tr>
<tr>
<td>Liberia</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>0.0</td>
<td></td>
</tr>
<tr>
<td>Madagascar</td>
<td>10</td>
<td>0</td>
<td>2</td>
<td>5</td>
<td>6</td>
<td>3</td>
<td>3</td>
<td>29</td>
<td>0.1</td>
<td></td>
</tr>
<tr>
<td>Malawi</td>
<td>9</td>
<td>0</td>
<td>12</td>
<td>25</td>
<td>6</td>
<td>40</td>
<td>19</td>
<td>111</td>
<td>0.2</td>
<td></td>
</tr>
<tr>
<td>Mali</td>
<td>8</td>
<td>2</td>
<td>0</td>
<td>11</td>
<td>7</td>
<td>22</td>
<td>12</td>
<td>7</td>
<td>0.1</td>
<td></td>
</tr>
<tr>
<td>Mauritania</td>
<td>0</td>
<td>1</td>
<td>7</td>
<td>14</td>
<td>6</td>
<td>0</td>
<td>35</td>
<td>73</td>
<td>0.1</td>
<td></td>
</tr>
<tr>
<td>Mauritius</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>6</td>
<td>0.0</td>
<td></td>
</tr>
<tr>
<td>Mozambique</td>
<td>75</td>
<td>115</td>
<td>129</td>
<td>163</td>
<td>181</td>
<td>140</td>
<td>165</td>
<td>966</td>
<td>1.8</td>
<td></td>
</tr>
<tr>
<td>Namibia</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>291</td>
<td>221</td>
<td>301</td>
<td>214</td>
<td>1121</td>
<td>2.1</td>
<td></td>
</tr>
<tr>
<td>Niger</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>52</td>
<td>24</td>
<td>39</td>
<td>117</td>
<td>0.2</td>
<td></td>
</tr>
<tr>
<td>Nigeria</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>45</td>
<td>23</td>
<td>28</td>
<td>21</td>
<td>187</td>
<td>0.3</td>
<td></td>
</tr>
<tr>
<td>Rwanda</td>
<td>0</td>
<td>35</td>
<td>0</td>
<td>105</td>
<td>79</td>
<td>78</td>
<td>90</td>
<td>27</td>
<td>414</td>
<td>0.8</td>
</tr>
<tr>
<td>Sao Tome and Principe</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0.0</td>
<td></td>
</tr>
<tr>
<td>Senegal</td>
<td>20</td>
<td>0</td>
<td>0</td>
<td>10</td>
<td>7</td>
<td>11</td>
<td>38</td>
<td>86</td>
<td>0.2</td>
<td></td>
</tr>
<tr>
<td>Seychelles</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0.0</td>
<td></td>
</tr>
<tr>
<td>Sierra Leone</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0.0</td>
<td></td>
</tr>
<tr>
<td>South Africa</td>
<td>3219</td>
<td>4120</td>
<td>5774</td>
<td>7429</td>
<td>8198</td>
<td>9070</td>
<td>7386</td>
<td>45196</td>
<td>84.0</td>
<td></td>
</tr>
<tr>
<td>Swaziland</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>110</td>
<td>170</td>
<td>0</td>
<td>326</td>
<td>609</td>
<td>1.1</td>
<td></td>
</tr>
<tr>
<td>Togo</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>4</td>
<td>2</td>
<td>3</td>
<td>0.0</td>
<td></td>
</tr>
<tr>
<td>Uganda</td>
<td>17</td>
<td>46</td>
<td>0</td>
<td>67</td>
<td>26</td>
<td>57</td>
<td>93</td>
<td>71</td>
<td>377</td>
<td>0.7</td>
</tr>
<tr>
<td>United Republic of Tanzania</td>
<td>4</td>
<td>10</td>
<td>13</td>
<td>169</td>
<td>24</td>
<td>24</td>
<td>34</td>
<td>20</td>
<td>298</td>
<td>0.6</td>
</tr>
<tr>
<td>Zambia</td>
<td>37</td>
<td>0</td>
<td>50</td>
<td>27</td>
<td>56</td>
<td>29</td>
<td>0</td>
<td>199</td>
<td>0.4</td>
<td></td>
</tr>
<tr>
<td>Zimbabwe</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>29</td>
<td>28</td>
<td>118</td>
<td>177</td>
<td>0.3</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>3501</td>
<td>4577</td>
<td>6120</td>
<td>9031</td>
<td>9751</td>
<td>12563</td>
<td>11771</td>
<td>2514</td>
<td>53798</td>
<td>100</td>
</tr>
</tbody>
</table>
data), a total of 53,798 MDR-TB cases were reported by 42 countries (Table 1). At the same time, 3,231 XDR-TB cases were reported from 8 countries, 84% and 96.8% of them respectively from South Africa alone.

While 42 countries have ever notified cases of MDR- and or XDR-TB, only 28 of these are known to have structured treatment programmes in place. Even where treatment programmes exist, not all confirmed cases are receiving treatment mostly due to the unavailability of adequate supplies of second-line anti-TB medicines.

**Response Analysis**

The Stop TB Strategy, launched in 2006, addresses among others the global threat of drug-resistant TB. Responding to this launch, the Regional Office published a framework for the control of drug-resistant TB in 2007 that was complemented by the 2008 emergency update of the Global Guidelines for Programmatic Management of Drug-Resistant TB. To respond to new developments especially in the area of diagnostics, WHO published a revised version of the Global Guidelines for Programmatic Management of Drug Resistant TB (PMDR-TB) in 2011 which is now being implemented by Member States alongside the 2008 emergency update.

In April 2009, 27 MDR-TB high-burden countries including the Democratic Republic of the Congo, Ethiopia, Nigeria and South Africa met in Beijing, China, where they issued a Call for Action against drug-resistant TB.

At its 62nd session, in May 2009, the World Health Assembly adopted Resolution WHA62.15 on Prevention and Control of multidrug-resistant TB and extensively drug-resistant TB which was then adopted in the WHO Africa Region. Several global health initiatives including the Global Fund are in place to support TB control in the Region.

Given the importance of the emergence and spread of drug-resistant TB, this paper seeks to highlight the issues and challenges, and proposes the way forward in the prevention and control of MDR-TB and XDR-TB in the WHO African Region.

### Issues and Challenges

Despite universal adoption by Member States of the internationally recommended (DOTS) Strategy, the African Region has some of the highest TB notification rates on record, and the highest TB/HIV co-infection rates leading to unprecedented increases in TB incidence over the past two decades.

Even though rising over time, the TB treatment success rate for new smear positive cases in the Region stands at only 80% compared with the 87% global target, mostly due to very high rates of preventable unfavourable outcomes such as patient default, transfer out and proportion of patients not evaluated at the end of treatment (see Figure 2).
The recent emergence of drug-resistant TB forms has further complicated TB control efforts in the Region, especially in the presence of high TB/HIV co-infection and general lack of infection control measures in communities and health facilities, increasing the likelihood of cross infection with TB including drug-resistant forms.

In most national TB control programmes, control policies, manuals and guidelines have not been updated to include prevention and management of drug-resistant TB. National MDR-TB guidelines are also not universally available due to the little attention that drug-resistant TB received in national programmes until the emergence of XDR-TB in the Region in 2006.

In addition, health system challenges such as poor health infrastructure, poor access to diagnostic and treatment services, inadequate human resources for health and weak-to-ineffective systems of patient follow-up during treatment significantly hamper efforts to identify and effectively treat drug-resistant TB cases. Inaction in establishing strong TB programmes with sound policies for drug-resistant TB may lead to a new epidemic with serious consequences for public health.

Diagnosis of drug-resistant TB is primarily bacteriological requiring the existence of laboratory technologies and a network for TB bacterial culture, antigenic or molecular analysis, and anti-TB drug susceptibility testing. Notwithstanding, provision of quality-assured laboratory services poses a major challenge to many countries in our Region. By the end of 2010, there were at least 12 countries in the Region that had no local capacity to perform TB culture and susceptibility testing to first-line anti-TB medicines for confirmation of MDR-TB. Even worse, only Algeria and South Africa have local laboratory capability to conduct susceptibility testing of second-line anti-TB medicines to exclude XDR-TB.

The true magnitude of drug-resistant TB in the Region remains unknown due to lack of reliable data collection systems for drug-resistant TB cases in the majority of Member States. Surveillance and public awareness of drug-resistant TB are generally lacking, and only Botswana has routinely and regularly undertaken repeat representative countrywide surveys to determine the profile of drug-resistant TB over time. Between 2007 and 2010, ten countries carried out representative countrywide TB drug-resistance surveys as well as XDR-TB surveys.

Considering the airborne nature of TB transmission including MDR-TB and XDR-TB, it is important to ensure early diagnosis and containment of infectious cases while adhering
to the best possible standards of care and infection control. Isolation facilities are generally lacking in health facilities and communities, hampering the containment of MDR-TB and XDR-TB cases and the reduction of facility-based and community-based transmission of infection. Inadequate administrative controls and poor ventilation in crowded health care facilities coupled with general inadequacy of personal protection and other infection control measures increase the risk of nosocomial transmission of TB infection including drug-resistant TB.

Unlike first-line medicines, second-line medicines for the treatment of MDR-TB and XDRTB are not adequately available in the majority of countries in the Region. Second-line medicines are also not as effective as first-line medicines and tend to be associated with increased and severe adverse effects, making treatment compliance more difficult for patients. In addition, there is limited global supply of quality assured second-line medicines due to the limited number of international suppliers of these medicines. As a result, available country surveillance data indicate that a significant number of confirmed MDR-TB cases remain untreated. This is partly due to the high cost of second-line anti-TB medicines as well as lack of budget line items in TB control budgets for procurement of these medicines.

Even when second-line TB medicines are available for treatment of MDR-TB and XDRTB, the very lengthy duration of treatment (at least 24 months) and the need to treat patients near their families as much as possible pose major challenges. There is therefore need for operational research to determine how best to treat MDR-TB and XDR-TB in the communities.

**ACTIONS PROPOSED**

The aim and objectives for drug-resistant TB control in the region is to promote and support actions to prevent, identify and effectively treat drug-resistant TB through universal adoption and scale up of Programmatic Management of Drug-Resistant TB (PMDR-TB) in all Member States in the Region. Given that most of the issues and challenges associated with prevention and control of TB drug resistance revolve around the health system (e.g. limited access to general TB services, weak medicines procurement and supply management systems, weak TB laboratory infrastructure, inadequate funding, inadequate human resources for health, poor transport and communication systems, and weak strategic information and logistic systems) the actions proposed below are framed in the context of strengthening the overall health system.

**Preventing the generation of drug-resistant TB forms – actions to close the tap:** Countries should improve programme performance indicators for pan-susceptible TB, especially TB treatment success rates. This can be achieved by improving treatment compliance and completion rates through reducing patient default and transfer out rates and minimizing the proportion of patients not evaluated at the end of treatment. To this end, countries should identify and remove barriers to care for poor and other vulnerable communities and mobilize resources to support community-level partnerships and local initiatives.

**Developing and scaling up programmatic management of drug-resistant TB:** Countries should update their policies by adapting WHO guidelines for programmatic management of drug-resistant TB in DOTS programmes. Furthermore, national programmes should ensure uninterrupted supply of second-line anti-TB medicines, their rational use, pharmacovigilance, and establish or strengthen drug resistance monitoring systems and infection control. Countries should also
update their human resource plans to ensure adequate human resource capacity to combat MDR-TB and XDR-TB as well as addressing staffing, motivation, retention and support. PMDR-TB also entails training of teams of health care workers in order to build capacity for identification and management of confirmed cases. Collaboration with non-governmental structures, including the private sector, should be embraced to accelerate coverage and access to service points. In areas with high HIV prevalence, collaborative engagement of AIDS control programmes is essential to reduce the dual burdens of TB and HIV/AIDS. Likewise, systems for patient follow up and psychosocial support must be developed and monitored. These should include advocacy, communication and social mobilization strategies.

Establishing and sustaining national drug-resistant TB surveillance systems: Countries should establish routine laboratory-based surveillance of resistance to first- and second-line TB medicines among previously treated cases and other high risk TB patients and groups. They should also conduct regular periodic representative drug resistance surveys and establish standardized recording and reporting systems for drug-resistant TB as a logical extension of the regular TB recording and reporting system.

In order to strengthen cross-border surveillance, countries should work with partners and strive to set up electronic surveillance systems and incorporate TB programmes in International Health Regulation committees in countries to minimize transmission within and outside borders while ensuring that all cases of MDR-TB and XDR-TB are notified.

Strengthening procurement and supply management systems for second-line anti-TB medicines: Countries should review the essential drug list to include second-line anti-TB medicines and strengthen their procurement and supply chain management to ensure uninterrupted availability of good quality, affordable second-line medicines and related commodities. In this respect, countries are encouraged to apply for concessionary-priced, quality-assured second-line anti-TB medicines through the Global Drug Facility (GDF) system while accessing technical support from the evolving Regional Green Light Committee system (rGLC).

Developing and implementing TB infection control measures: National programmes should incorporate TB infection control strategies within existing national infection control policies.
and guidelines, and implement administrative, environmental and personal protection infection control measures for MDR-TB and XDR-TB in all health facilities. Infection control should be taken into account in the design of health facilities, especially in the context of HIV/AIDS to avoid cross-infections, especially in HIV high prevalent settings. The dangers of cross-infection between HIV and TB should be clearly elaborated and health staff concerned should be fully briefed on control measures. Furthermore, in collaboration with relevant government departments, TB programmes should support the development, implementation and monitoring of infection control plans in all health facilities.

**Mobilizing financial resources for supporting implementation of the recommended actions:**

In the context of overall health system strengthening, countries should allocate sufficient funds from the national budgets for control of TB including MDR-TB and XDR-TB. Countries should also mobilize additional resources from global and regional initiatives to complement their national resources. Under the new GLC framework, all countries can have access to low-priced second-line anti-TB medicines from the GDF which can be bought with resources from various global health initiatives. The use of such initiatives should go a long way to strengthen the overall health system.

**Expanding regional networks for diagnosis of MDR-TB and XDR-TB:** WHO and other technical partners should work with national governments to establish quality assured networks of TB laboratory services including evaluation and scale up of new rapid diagnostic technologies for pan-susceptible and drug-resistant TB such as the line probe assay and GeneXpert technology platform as they become available. National governments should also be supported to through strengthening of sub regional capacity to perform supranational TB reference laboratory functions including the establishment of additional regional laboratories capable of identifying strains resistant to second-line anti-TB medicines in order to identify XDR-TB among confirmed MDR-TB cases.

**Undertaking operational research:** The capacity to conduct clinical trials for new diagnostics and drugs should be improved in the Region. Countries with support of partners should perform operational research for example to determine how best to treat MDR/XDR-TB in the communities while taking appropriate infection control measures to reduce transmission.

---

**REFERENCES**

8. Cape Verde, Central African Republic, Chad, Comoros, Congo, Gabon, Guinea-Bissau, Liberia, Mali, Niger, Sao Tome and Principe and Sierra Leone
Strengthened institutional capacity for disaster preparedness and response (DPR) is of the utmost importance in the African Region — a region suffering from frequent conflicts and natural emergencies. A five-year strategy to improve emergency preparedness and response was initiated in 1997 and bolstered in 2005 by the Hyogo Framework for Action 2005–2015. Particular emphasis was given to building health systems and increasing community resilience. To this end the African Public Health Emergency Fund was established in 2009. In 2010, a survey of 46 countries in the African Region was undertaken to review the five-year strategy across health systems — 43 countries responded. Some modest improvements were noted; however, many challenges remain. This paper describes the new 10-year disaster risk management (DRM) strategy.
on Disaster Reduction in Hyogo, Japan, in 2005, adopted the Hyogo Framework for Action 2005–2015. It calls on all nations to support the creation and strengthening of multisectoral national platforms for coordinated action on disaster risk reduction. In addition, the International Health Regulations (2005) provide a framework for implementing alert and response activities to control international outbreaks and other public health risks and emergencies.

In 2005 a United Nations independent commission proposed reforms in the management of humanitarian response. These reforms were subsequently adopted in 2006 by the United Nations General Assembly. The reforms focus on three areas namely:

- building strong UN leadership at the field level;
- improving efficiency, accountability and coordination of interventions through sectoral working groups (humanitarian clusters) and;
- creating predictable sources of funding to facilitate effectiveness of humanitarian response.

In line with the Hyogo Framework for Action and the principles underpinning humanitarian reform, Member States adopted World Health Assembly Resolution WHA59.22 in 2006. The resolution requests Member States to further strengthen their national programmes with a special focus on building health systems and increasing community resilience. The establishment of the African Public Health Emergency Fund, as requested in Resolution AFR/RC59/R5 adopted in 2009 by the 59th session of the WHO Regional Committee for Africa, will further improve the funding of disaster preparedness and response.

In the past 13 years, Member States have made efforts to strengthen their institutional capacities for emergency preparedness and response with the support of partners. The level of implementation of the resolution, as reflected in the outcome of a survey conducted among the 46 countries in the Region in February 2010, is presented in Table 1. National emergency funds were available in 19 countries (41%). Twenty countries have conducted vulnerability assessments and risk mapping, the health component of which was adequately reflected in 12 of the countries. Early warning systems have been developed in countries for natural disasters (50%), communicable diseases (87%) and malnutrition (54%). Communities are involved in EPR in 67% of countries.

Although modest achievements in disaster preparedness have been recorded by Member States, several challenges remain. This report highlights key issues and challenges and proposes a way forward.

**ISSUES AND CHALLENGES**

Less than half of Member States in the Region have conducted vulnerability assessments and risk mapping. In this group, the health component was adequately reflected in only 12 countries. The plans developed by most countries are therefore not based on assessment of vulnerabilities and capacities, and mapping of risks, but usually target single hazards, mostly epidemic and pandemic diseases. Only 11 countries have national emergency preparedness plans that cover multiple hazards. Simulation tests, required in order to update plans, are conducted in only 19 countries.

In 15 countries, national health development plans do not incorporate emergency and humanitarian activities. Consequently many countries affected by emergencies have not developed a transitional strategy to boost health system recovery and ultimately link it to national health sector development. Where such health system recovery transitional strategies exist, implementation has been difficult because of shortage of funding as several priority programmes compete for the limited funds available.
Countries lack comprehensive disaster risk reduction and preparedness programmes containing the minimum WHO recommended elements regarding policy and legislation, capacity building, disaster risk analysis and mapping, and planning. Implementation of the Hyogo Framework calling on countries to assess the status and build the resilience and risk management capability of hospitals and other key health infrastructures has yet to commence.

The capacity to enforce international standards remains inadequate due to the absence of policies, procedures and coordination units. Fifteen countries do not have functional emergency units and, where they do exist, they are under-staffed and under-resourced. Yet these units are essential, given that several humanitarian actors have emerged in the field who follow different strategies and technical guidelines that, in many instances, are not in line with international standards.

Coordination is still a major challenge as national multisectoral committees lack the capacity and resources to coordinate the multiple components of DPR. Only 21 of the 46 Member States have established national platforms for disaster risk reduction. Observations made during monitoring visits showed that the participation of the health sector needs to be improved in most of the countries.

The health component of the early warning systems for natural disasters usually overseen by the multisectoral national platforms is weak. Half of the countries do not have health early warning systems for natural disasters, while 25 countries have reported that they have malnutrition early warning systems (see Table 1).

The critical mass of trained persons needed to support countries in DPR is not yet in place. Eighteen countries lack human resources with even the basic training to manage emergency responses. In countries where trained persons exist, they are limited in number ranging between 1 and 5. Exceptions can be made in only three countries where the Red Cross has conducted training in health emergencies in large populations (HELP) for significant numbers of its volunteers. This shortage of trained persons is due to the limited access to training courses most of which are run in institutions located outside the Region.

Member States action to empower communities in disaster risk reduction is mostly limited to sensitization activities and disease surveillance. Consequently, during most emergencies communities are inadequately equipped to cope with the effects, resulting in disasters.

Resource allocation for emergencies by Member States remains inadequate. Only 19 countries in the Region have established a national emergency fund 12 years after the adoption of Regional Committee Resolution AFR/RC47/R1 calling for its establishment. Most countries depend mainly on donor funding usually earmarked for acute response. Disaster prevention and preparedness and post-disaster health system recovery remain

Table 1. Level of implementation of Regional Committee Resolution AFR/RC47/R1 by country, February 2010

<table>
<thead>
<tr>
<th>Action</th>
<th>Number of countries</th>
<th>Percentage of countries in the Region</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have persons trained in public health pre-deployment (PHPD) or in health emergencies in large populations (HELP)</td>
<td>28</td>
<td>60.8</td>
</tr>
<tr>
<td>Established Early Warning System</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Communicable diseases</td>
<td>40</td>
<td>86.9</td>
</tr>
<tr>
<td>Malnutrition</td>
<td>25</td>
<td>54.3</td>
</tr>
<tr>
<td>Natural disasters</td>
<td>23</td>
<td>50.0</td>
</tr>
<tr>
<td>Established national emergency funds</td>
<td>19</td>
<td>41.3</td>
</tr>
<tr>
<td>Integrated DPR into national health plans</td>
<td>31</td>
<td>67.4</td>
</tr>
<tr>
<td>Involve communities in DPR</td>
<td>28</td>
<td>60.9</td>
</tr>
<tr>
<td>Promptly declare</td>
<td>35</td>
<td>76.1</td>
</tr>
<tr>
<td>Conducted vulnerability assessment and mapping</td>
<td>25</td>
<td>54.3</td>
</tr>
<tr>
<td>Vulnerability assessment covers health component</td>
<td>12</td>
<td>26.1</td>
</tr>
<tr>
<td>Set up multisectoral emergency committees</td>
<td>39</td>
<td>84.6</td>
</tr>
<tr>
<td>Cooperate with and support neighbouring countries in emergency issues</td>
<td>31</td>
<td>67.4</td>
</tr>
</tbody>
</table>

Survey sample: 46 African countries; response: 43 countries.
under-funded; these components are weak in several countries.

The existing regional strategy needs to be updated to incorporate new global approaches and resolutions. The non-updating of the strategy limits the efforts of Member States to consolidate the gains made in EPR and poses a challenge to aligning the various regional initiatives and declarations that have an impact on readiness and response.14

**ACTIONS PROPOSED**

In view of the continuing threat posed by emergencies to socioeconomic development, there is a need to strengthen emergency preparedness and response. The new disaster risk management strategy developed by WHO comprises a minimum set of required priority interventions for each country which will assist in establishing the necessary enabling environment and capacities to manage disaster risks.

These priority interventions are guided by the following principles:

- **a)** Gender and human rights principles that ensure incorporation of gender equity and human rights perspectives into policies and programmes as well as neutrality and impartiality in humanitarian response;

- **b)** Equity in access to services, with special focus on highly vulnerable population groups including migrant populations and people living in Small Island Developing States;

- **c)** Country ownership, with governments coordinating and ensuring that all interventions by partners are in line with relevant national guidelines;

- **d)** Participation, with the involvement of communities and civil society;

- **e)** Strengthening partnerships within the health sector, using the humanitarian reform principles; and

- **f)** Fostering sustainable intersectoral collaboration at local and regional levels.

The strategic approach is to consider all potential hazards and all potential contributing factors that may affect health, including health determinants; climate change adaptation interventions; and action involving all ministry of health departments. The strategy may not require the development of new documents and structures, but an updating and strengthening of what exists. The following are the proposed interventions, the prioritization of which would depend on country context and specificities.

**Update national health policies, strategies and regulations** in order to incorporate provisions on prevention, preparedness and readiness, as well as response to the health impact of all potential hazards. The revisions should be congruent with national multisectoral legislation, policies and plans on DRM. The policy should cover all hazards and be based on all likely health risks (whole-health approach); this implies that all actors "manage the risks, not the crisis". This approach was reinforced in 2011 by the 64th World Health Assembly in its Resolution WHA64.10.

**Build the capacities of existing units in the ministries of health** for risk management in order to coordinate multidisciplinary health action and facilitate the integration of health with multisectoral actors; including the national platform on disaster risk reduction and the development of networks and communities of practice on DRM.

**Develop education and training programmes in line with DRM.** This is important at undergraduate and graduate levels as well as continuing professional education to develop and maintain the knowledge, skills and performance of the health emergency management community. The training should be aligned with the regional standard package on emergency training and appropriate financial resources should be made available.
Assess hazards, vulnerabilities, risks and capacities from a health sector perspective. This should include assessment of the safety of health facilities and related infrastructure. The results of the assessment should be mapped to serve as the basis for programme development and health contingency, response and recovery planning that follows a process of engagement with stakeholders. The plans need to be updated regularly following simulation exercises and post-operation evaluations.

Build health facilities and community resilience interventions. This involves designing the structural, nonstructural and functional requirements of new health facilities to enable them to withstand the impact of hazards, and be functional in emergencies. Existing health facilities should be retro-fitted. Health facility disaster plans should be developed and tested. Community leaders and health workers should be engaged in risk assessment, planning and preparedness to build on local knowledge, experience and capacity. Community members should also play decisive roles in the execution, monitoring and evaluation of DRM intervention at community level.

Prepare and provide timely and adequate response to emergencies. Preparedness should be strengthened by developing, evaluating and revising response plans based on comprehensive risk analysis, taking into account all prevalent hazards. The plans should involve identifying rapid response teams at local and national levels including sources of surge support; pre-positioning medical supplies and other logistics; designating isolation units and safe areas; and organizing mass casualty management services. Procedures should be regularly tested. Standard operating procedures (SOPs) for health response and recovery operations should be developed to determine what needs to be done, by whom and how, before, during and after emergencies and disasters. Post-disaster needs assessment should be conducted to foster continuity of service, and rebuild public health services.

Improve funding for disaster prevention, emergency preparedness and post-emergency health system recovery. Existing resource mobilization mechanisms should be explored. The creation of a national emergency fund in line with Resolution AFR/RC47/R1 constitutes an additional funding opportunity.

Strengthen early warning for the health components of natural disasters and food crises. Information on the projected and actual health consequences of disasters including event-based surveillance should be generated and monitored, using appropriate indicators, through the national surveillance system. This will provide early warning and guide preparedness and health response. At the community level, actions should be taken to help the community identify risks and develop the predictive capacity towards the consequences of the disaster.

REFERENCES
9. Algeria, Benin, Burundi, Chad, Democratic Republic of the Congo, Guinea, Sao Tome and Principe, Togo and Zimbabwe.
12. In addition to WHO guidelines, there are several others developed or in process of development by the Inter-Agency Standing Committee (IASC), International Committee of the Red Cross and Red Crescent (ICRC), Médecins Sans Frontières (MSF) among others.
In recognition of the inadequate resources available to Member States to combat epidemics and other public health emergencies in the African Region, the Fifty-ninth session of the WHO Regional Committee for Africa adopted Resolution AFR/RC59/RS entitled "Strengthening outbreak preparedness and response in the African Region in the context of the current influenza pandemic". The resolution requested the Regional Director to facilitate the creation of an African Public Health Emergency Fund (APHEF) to support the investigation of and response to epidemics and other public health emergencies. A technical working group, comprising representatives of ministries of health and ministries of finance from 17 Member States, the African Development Bank, the Coordinating Organization for the fight against Endemic Diseases in Central Africa (OCEAC), and the WHO Secretariat, met in Johannesburg, South Africa, in 2011, to deliberate on this initiative. This paper sets out the framework for the establishment of the APHEF, based on the recommendations of the technical working group.
Public health emergencies continue to be a major concern in Member States of the African Region. Epidemics and pandemic-prone diseases continue to wreak havoc on Africa's impoverished populations already grappling with a heavy burden of diseases and major health concerns such as HIV/AIDS, tuberculosis, malaria and maternal mortality among others.

In 2009, countries of the African Region were significantly affected by pandemic influenza A (H1N1), meningitis, cholera and dengue fever. Furthermore, the frequency and magnitude of emergencies in Africa are increasing. Natural disasters and social unrest continue to cause population displacements in many countries. In 2009 alone, over 6.9 million people were displaced including 4.9 million internally displaced persons (IDPs) and about 2 million refugees. West Africa is witnessing an increase in natural disasters in addition to conflicts and outbreaks of communicable diseases. Over 10 million people were affected by drought due to a poor rainy season in the Sahel in 2009–2010, causing food crises and malnutrition. At the same time, floods affected 1.45 million people in the Region. Floods and cyclones from El Niño cause destruction in Southern Africa annually. By the end of the rainy season in 2010, floods had affected over 368 000 people in Southern African countries, displaced about 29 000 people and destroyed two medical facilities in Angola, damaged 34 in Madagascar and made four inaccessible in Namibia. As at 31 March 2011, about 150 000 persons have been affected by floods and cyclones, causing 238 deaths and destroying farmland, houses and social infrastructure including health facilities in nine countries of Southern Africa.

Some of the major epidemics witnessed in Africa, notably meningitis and cholera, occur seasonally and are often associated with high rates of morbidity and mortality. For example, between 2004 and 2009, 84% of the cholera cases reported to WHO (i.e. 833 213 out of 992 145 cases) worldwide and 93% of reported cholera deaths globally (i.e. 21 852 out of 23 533 deaths) were from countries in Africa. Gaps have been noted in the provision of timely and appropriate case management in some African countries, contributing to the more than 10% of ensuing mortality. Over the same six-year period, 259 126 meningitis cases and 23 469 related deaths (representing a case fatality ratio of 9.1%) were reported from Africa.

These conditions put a huge burden on the economies of countries of the African Region. For example, a recent study estimated that the 110 837 cases of cholera notified by countries of the African Region in 2007 resulted in an economic loss of US$ 43.3 million, US$ 60 million and US$ 72.7 million, if life expectancy is assumed to be 40, 53 or 73 years respectively.

In order to address these public health emergencies, WHO has been working vigorously with Member States to strengthen their national health and emergency management systems in order to prepare for and respond to major pandemic and epidemic diseases and other public health emergencies. However, there is a huge gap in resources needed to provide adequate response because governments of most of the Member States allocate insufficient resources to public health emergency preparedness and response, leading to over-reliance on unpredictable donor funding.

In 2009, countries of the African Region were significantly affected by pandemic influenza A (H1N1), meningitis, cholera and dengue fever. Furthermore, the frequency and magnitude of emergencies in Africa are increasing. Natural disasters and social unrest continue to cause population displacements in many countries. In 2009 alone, over 6.9 million people were displaced including 4.9 million internally displaced persons (IDPs) and about 2 million refugees. West Africa is witnessing an increase in natural disasters in addition to conflicts and outbreaks of communicable diseases. Over 10 million people were affected by drought due to a poor rainy season in the Sahel in 2009–2010, causing food crises and malnutrition. At the same time, floods affected 1.45 million people in the Region. Floods and cyclones from El Niño cause destruction in Southern Africa annually. By the end of the rainy season in 2010, floods had affected over 368 000 people in Southern African countries, displaced about 29 000 people and destroyed two medical facilities in Angola, damaged 34 in Madagascar and made four inaccessible in Namibia. As at 31 March 2011, about 150 000 persons have been affected by floods and cyclones, causing 238 deaths and destroying farmland, houses and social infrastructure including health facilities in nine countries of Southern Africa.

Some of the major epidemics witnessed in Africa, notably meningitis and cholera, occur seasonally and are often associated with high rates of morbidity and mortality. For example, between 2004 and 2009, 84% of the cholera cases reported to WHO (i.e. 833 213 out of 992 145 cases) worldwide and 93% of reported cholera deaths globally (i.e. 21 852 out of 23 533 deaths) were from countries in Africa. Gaps have been noted in the provision of timely and appropriate case management in some African countries, contributing to the more than 10% of ensuing mortality. Over the same six-year period, 259 126 meningitis cases and 23 469 related deaths (representing a case fatality ratio of 9.1%) were reported from Africa.

These conditions put a huge burden on the economies of countries of the African Region. For example, a recent study estimated that the 110 837 cases of cholera notified by countries of the African Region in 2007 resulted in an economic loss of US$ 43.3 million, US$ 60 million and US$ 72.7 million, if life expectancy is assumed to be 40, 53 or 73 years respectively.

In order to address these public health emergencies, WHO has been working vigorously with Member States to strengthen their national health and emergency management systems in order to prepare for and respond to major pandemic and epidemic diseases and other public health emergencies. However, there is a huge gap in resources needed to provide adequate response because governments of most of the Member States allocate insufficient resources to public health emergency preparedness and response, leading to over-reliance on unpredictable donor funding.

Article 50(f) of the WHO Constitution states that one of the functions of the Regional Committee shall be
“to recommend additional regional appropriations by the governments of countries of the respective regions if the proportion of the central budget of the Organization allotted to the region is insufficient for carrying out regional functions”.

In this respect, the Fifty-ninth session of the WHO Regional Committee for Africa adopted Resolution AFR/RC59/R5 entitled “Strengthening outbreak preparedness and response in the African Region in the context of the current influenza pandemic” and requested that an African Public Health Emergency Fund be established.

The APHEF was approved at the Sixtieth session of the WHO Regional Committee for Africa through Resolution AFR/RC60/R5 in line with the principles set out in the framework document that was presented to the meeting. The resolution also requested the regional director:

• To convene a technical consultation among ministries of health and ministries of finance of Member States of the African Region, the African Union, the AfDB and regional economic communities, for the purpose of elaborating on the principles underlying financial contributions by countries, including the set criteria and the modalities and governance of the APHEF;

• To undertake advocacy among heads of state and governments, the African Union and regional economic communities to ensure sustained contributions to the APHEF;

• To report to the Sixty-first session of the Regional Committee for Africa, and on a regular basis thereafter, on the operations of the APHEF.

**JUSTIFICATION AND PURPOSE OF THE FUND**

The main justification for the establishment of the APHEF is the lack of adequate resources to respond to the frequent epidemics and public health emergencies in the African Region. Considering the common epidemics in the Region, it costs on average US$ 2.5 million per country to respond to an outbreak of cholera. With 30 countries in the Region experiencing an outbreak every year, that amounts to an estimated US$ 75 million required per year. For 24 countries in the meningitis belt, yearly outbreaks cost an average of US$ 5 million per country to provide adequate response (US$ 120 million). In respect to viral haemorrhagic fevers, to provide adequate response one outbreak costs as much as US$ 15 million. Based on an average of five outbreaks per year in the Region, this costs an estimated at US$ 75 million per annum.

Between 2006 and 2010, WHO raised US$ 165 million to support countries in the Region to respond to emergencies and humanitarian crises. This amount supplemented the resources provided by Member States.

The estimated total annual cost of responding to at least the three most important disease outbreaks and other public health emergencies in the Region is more than US$ 500 million. Though some countries can and do provide sufficient resources for preparedness and response, many others lack the requisite resources and often request external support when these outbreaks and emergencies occur.

It is proposed that the APHEF be set up as a trust dedicated to mobilizing additional resources to respond to disease outbreaks and other public health emergencies in line with Article 50 (f) of the WHO Constitution. The establishment of the APHEF will supplement existing efforts by governments and partners and promote solidarity among Member States in addressing public health emergencies.

The purpose of the APHEF is to mobilize, manage and disburse additional resources from Member States for responding rapidly
and effectively to public health emergencies of national and international concern including epidemic and pandemic-prone diseases, the health impact of natural and man-made disasters and humanitarian crises. This will ensure significant and sustainable contribution to the reduction of morbidity and mortality, thereby mitigating the socioeconomic impact of epidemic and pandemic-prone diseases in countries in need and contributing to poverty reduction as part of the Millennium Development Goals.

**GUIDING PRINCIPLES**

- The fund is strictly a financing instrument and not an implementing entity.
- The fund will mobilize financial resources and disburse them for interventions against priority disease outbreaks and other public health emergencies in Member States based on predetermined criteria and in line with agreed procedures and overseen by the APHEF Secretariat.
- The fund will establish simplified, effective and efficient processes that will ensure rapid disbursement of the required funding within the shortest possible time using existing WHO administrative and financial management structures and processes.
- Financial disbursements from the fund will be made in an equitable manner based on feedback from technical and administrative evaluations of requests and proposals received and the availability of funds.
- Based on an official request from a Member State for assistance, the fund will support investigation and response activities if at least one of the following conditions is fulfilled: (i) a formal declaration of an outbreak or a public health emergency by the responsible authorities of the Member State; and (ii) an appointment by the UN Secretary-General of a Humanitarian Coordinator for that particular emergency or outbreak.
- Requests and proposals will be evaluated on the basis of set criteria taking into account public health emergency priorities and the perceived effectiveness of interventions.
- The fund will be utilized to support requests received directly from Member States.
• Funding of investigation and response activities for each outbreak or emergency per country shall be limited to a maximum of US$ 2 million.

FINANCING

The APHEF will be financed from agreed appropriations and voluntary contributions from Member States in line with Article 50(f) of the WHO Constitution. In addition, mechanisms will be put in place to attract contributions from external donors. The four scenarios below are proposed for consideration by the Regional Committee in determining minimum yearly contributions by Member States.

SCENARIO 1: A United Nations adopted methodology that takes into consideration key factors such as population, debt burden, equity, level of poverty, and puts a limit on the maximum amount that a country can pay to the fund.

SCENARIO 2: The minimum yearly contribution of each Member State is determined as a percentage of the country’s GDP to the total GDP of countries of the African Region in the preceding year.

SCENARIO 3: Each Member State pays the same amount towards the fund.

SCENARIO 4: 50% plus 50%. For 50% of the total annual funding of APHEF, use the scenario 2 methodology to calculate the contributions of Member States. For the remaining 50% of the funding, use scenario 3 methodology. The minimum contributions of each Member State in each of the scenarios are shown in Table 1. Yearly contributions by Member States to the fund can be paid either as a lump sum or in agreed instalments.

WHO will be responsible for disbursements and reporting on the utilization of funds through its existing financial and administrative management systems. The AfDB is proposed as the trustee of the APHEF while a revolving fund with a limit of US$ 30 million will be set up at the WHO Regional Office. Replenishments will be made to the revolving fund by the AfDB based on agreed criteria and procedures. The AfDB will set up structures to ensure timely replenishment and will invest the cash balances of the fund in safe interest-yielding instruments. All interest earnings from the investments will be channelled back to the fund. This above arrangement is proposed for the following reasons:

• To draw on the experience and expertise of the AfDB in fundraising, financial management, and interaction with governments in the African Region as well as with international donors;
• To make a clear distinction between responsibilities for the management and disbursement of funds;
• To give the APHEF a broader outlook by involving other relevant partners in the African Region.

Alternatively, WHO, through its internal financial management systems, will manage the collection of contributions from Member States and other sources including managing investments. This arrangement will simplify the process of collection, disbursement of funds and place the funds closer to the level of implementation.

CORE STRUCTURES

In line with Regional Committee Resolution AFR/RC59/R5 a monitoring committee of the fund (MCF), composed of three sitting ministers of health (one from each WHO subregional groupings), three sitting ministers of finance (one from each WHO subregional groupings) or their representatives, with the chairperson of the AFRO Programme Subcommittee (AFRO/PSC) as an ex-officio member; will be created with a mandate to give necessary advice to the regional director and take decisions regarding the strategic
<table>
<thead>
<tr>
<th>Member State</th>
<th>UN methodology</th>
<th>GDP proportion</th>
<th>Flat rate</th>
<th>GDP + flat rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Algeria</td>
<td>19.74</td>
<td>19 736 367</td>
<td>13.64</td>
<td>13 639 893</td>
</tr>
<tr>
<td>Angola</td>
<td>3.50</td>
<td>3 501 180</td>
<td>7.36</td>
<td>7 382 517</td>
</tr>
<tr>
<td>Benin</td>
<td>0.81</td>
<td>812 195</td>
<td>0.56</td>
<td>557 200</td>
</tr>
<tr>
<td>Botswana</td>
<td>1.80</td>
<td>1 800 309</td>
<td>1.07</td>
<td>1 072 614</td>
</tr>
<tr>
<td>Burkina Faso</td>
<td>0.77</td>
<td>769 690</td>
<td>0.74</td>
<td>744 077</td>
</tr>
<tr>
<td>Burundi</td>
<td>0.01</td>
<td>10 000</td>
<td>0.13</td>
<td>126 043</td>
</tr>
<tr>
<td>Cameroon</td>
<td>3.23</td>
<td>3 232 323</td>
<td>1.88</td>
<td>1 877 524</td>
</tr>
<tr>
<td>Cape Verde</td>
<td>0.20</td>
<td>202 111</td>
<td>0.13</td>
<td>134 967</td>
</tr>
<tr>
<td>Central African Republic</td>
<td>0.16</td>
<td>164 963</td>
<td>0.18</td>
<td>181 300</td>
</tr>
<tr>
<td>Chad</td>
<td>0.37</td>
<td>367 110</td>
<td>0.65</td>
<td>651 410</td>
</tr>
<tr>
<td>Comoros</td>
<td>0.07</td>
<td>68 982</td>
<td>0.05</td>
<td>47 792</td>
</tr>
<tr>
<td>Congo</td>
<td>0.81</td>
<td>807 137</td>
<td>1.02</td>
<td>1 019 674</td>
</tr>
<tr>
<td>Côte d’Ivoire</td>
<td>3.09</td>
<td>3 085 794</td>
<td>1.92</td>
<td>1 920 597</td>
</tr>
<tr>
<td>Democratic Republic of the Congo</td>
<td>0.01</td>
<td>10 000</td>
<td>0.01</td>
<td>10 811</td>
</tr>
<tr>
<td>Equatorial Guinea</td>
<td>0.77</td>
<td>773 645</td>
<td>1.25</td>
<td>1 248 165</td>
</tr>
<tr>
<td>Eritrea</td>
<td>0.01</td>
<td>10 000</td>
<td>0.19</td>
<td>193 398</td>
</tr>
<tr>
<td>Ethiopia</td>
<td>0.01</td>
<td>10 000</td>
<td>2.65</td>
<td>2 654 807</td>
</tr>
<tr>
<td>Gabon</td>
<td>1.45</td>
<td>1 451 276</td>
<td>1.08</td>
<td>1 077 933</td>
</tr>
<tr>
<td>Gambia</td>
<td>0.07</td>
<td>70 344</td>
<td>0.01</td>
<td>892 23</td>
</tr>
<tr>
<td>Ghana</td>
<td>1.78</td>
<td>1 780 232</td>
<td>1.55</td>
<td>1 549 417</td>
</tr>
<tr>
<td>Guinea</td>
<td>0.42</td>
<td>422 661</td>
<td>0.37</td>
<td>372 725</td>
</tr>
<tr>
<td>Guinea-Bissau</td>
<td>0.01</td>
<td>10 000</td>
<td>0.07</td>
<td>70 767</td>
</tr>
<tr>
<td>Kenya</td>
<td>3.69</td>
<td>3 693 433</td>
<td>2.78</td>
<td>2 173 913</td>
</tr>
<tr>
<td>Lesotho</td>
<td>0.34</td>
<td>335 250</td>
<td>0.15</td>
<td>154 358</td>
</tr>
<tr>
<td>Liberia</td>
<td>0.01</td>
<td>10 000</td>
<td>0.08</td>
<td>83 629</td>
</tr>
<tr>
<td>Madagascar</td>
<td>0.63</td>
<td>634 632</td>
<td>0.07</td>
<td>71 473</td>
</tr>
<tr>
<td>Malawi</td>
<td>0.01</td>
<td>10 000</td>
<td>0.43</td>
<td>432 014</td>
</tr>
<tr>
<td>Mali</td>
<td>0.80</td>
<td>796 689</td>
<td>0.78</td>
<td>778 827</td>
</tr>
<tr>
<td>Mauritania</td>
<td>0.39</td>
<td>388 953</td>
<td>0.30</td>
<td>299 107</td>
</tr>
<tr>
<td>Mauritius</td>
<td>1.27</td>
<td>1 269 417</td>
<td>0.81</td>
<td>808 858</td>
</tr>
<tr>
<td>Mozambique</td>
<td>0.64</td>
<td>638 932</td>
<td>0.88</td>
<td>876 212</td>
</tr>
<tr>
<td>Namibia</td>
<td>1.44</td>
<td>1 442 462</td>
<td>0.98</td>
<td>982 521</td>
</tr>
<tr>
<td>Niger</td>
<td>0.01</td>
<td>10 000</td>
<td>0.48</td>
<td>490 750</td>
</tr>
<tr>
<td>Nigeria</td>
<td>22.00</td>
<td>22 000 000</td>
<td>17.73</td>
<td>17 732 230</td>
</tr>
<tr>
<td>Rwanda</td>
<td>0.01</td>
<td>10 000</td>
<td>0.49</td>
<td>488 472</td>
</tr>
<tr>
<td>Sao Tome and Principe</td>
<td>0.01</td>
<td>14 019</td>
<td>0.02</td>
<td>16 045</td>
</tr>
<tr>
<td>Senegal</td>
<td>1.72</td>
<td>1 721 227</td>
<td>1.09</td>
<td>1 085 999</td>
</tr>
<tr>
<td>Seychelles</td>
<td>0.17</td>
<td>165 999</td>
<td>0.08</td>
<td>78 852</td>
</tr>
<tr>
<td>Sierra Leone</td>
<td>0.01</td>
<td>10 000</td>
<td>0.16</td>
<td>163 110</td>
</tr>
<tr>
<td>South Africa</td>
<td>22.00</td>
<td>22 000 000</td>
<td>30.41</td>
<td>30 409 508</td>
</tr>
<tr>
<td>Swaziland</td>
<td>0.52</td>
<td>521 710</td>
<td>0.27</td>
<td>271 564</td>
</tr>
<tr>
<td>Togo</td>
<td>0.24</td>
<td>243 088</td>
<td>1.92</td>
<td>1 924 887</td>
</tr>
<tr>
<td>Uganda</td>
<td>1.30</td>
<td>1 296 150</td>
<td>0.26</td>
<td>263 756</td>
</tr>
<tr>
<td>United Republic of Tanzania</td>
<td>1.88</td>
<td>1 876 678</td>
<td>1.47</td>
<td>1 469 020</td>
</tr>
<tr>
<td>Zambia</td>
<td>1.26</td>
<td>1 261 035</td>
<td>1.35</td>
<td>1 346 323</td>
</tr>
<tr>
<td>Zimbabwe</td>
<td>0.56</td>
<td>557 007</td>
<td>0.48</td>
<td>478 262</td>
</tr>
</tbody>
</table>

**Grand total**

<table>
<thead>
<tr>
<th>%</th>
<th>US$</th>
<th>%</th>
<th>US$</th>
<th>%</th>
<th>US$</th>
<th>%</th>
<th>US$</th>
<th>%</th>
<th>US$</th>
<th>%</th>
<th>US$</th>
<th>%</th>
<th>US$</th>
</tr>
</thead>
<tbody>
<tr>
<td>100</td>
<td>100 000 000</td>
<td>100</td>
<td>100 000 000</td>
<td>100</td>
<td>100 000 000</td>
<td>50 000 000</td>
<td>50 000 000</td>
<td>100</td>
<td>100 000 000</td>
<td>100</td>
<td>100 000 000</td>
<td>100</td>
<td>100 000 000</td>
</tr>
</tbody>
</table>

The regional director will set up a secretariat (APHEF-SEC) to be based at the Regional Office to manage the APHEF including screening of proposals and requests and issuing of instructions for financial disbursement to requesting countries. The APHEF-SEC will be responsible for executing the decisions of the MCF and the recommendations of the TRG; mobilizing resources; providing strategic, policy, financial and administrative support; and producing regular financial and technical reports on the activities of the APHEF for use by the MCF. The APHEF-SEC will be supported by the WHO country office network that will support Member States in drafting proposals and will monitor and evaluate the implementation of funded response activities.

To support effective administration of the APHEF, programme support cost will be charged on all funds received at a rate of 7%. No additional cost will be charged for administration of the fund except those costs directly related to the funding of approved requests and emergency interventions.

ACCOUNTABILITY

The APHEF will use the existing WHO internal administrative systems (mechanisms, rules and regulations) and financial management systems to receive, disburse, account for, audit and report on the utilization of funds. Reporting will be done at two levels, firstly on funds received and invested and, secondly, on funds disbursed to Member States and expended. A yearly technical and certified financial report on the operations of the fund will be presented to every meeting of the Regional Committee.

The MCF of the APHEF will be responsible for periodic review of the operations of the fund to ensure that all activities are in line with the mandate given by Member States. The annual report of the MCF will be included in the annual report of the APHEF.

REFERENCES

Recurring epidemics of cholera, malaria, meningitis, measles and zoonotic diseases such as viral haemorrhagic fevers, plague and dengue fever continue to affect many countries in the African Region resulting in high morbidity, mortality and significant impacts on health and economic development. Preparedness for and response to epidemics have improved but national surveillance systems remain inadequate. This article highlights the issues and challenges related to recurring epidemics and proposes concrete actions for improving national epidemic and pandemic preparedness and response capacity. Key actions suggested centre on early detection and characterization of epidemics, prevention, and the establishment of preparedness and response plans at national, provincial and district level.
awareness of prevailing health risks, and weak health systems with limited capacity for timely identification and response to epidemics all contribute to the frequency and severity of epidemics. The inextricable link between humans and animals can lead to a serious risk to public health given that the majority of emerging and re-emerging infectious diseases have originated from animals. Zoonoses such as Ebola, Marburg, lujo arenavirus, plague, yellow fever and H5N1 avian influenza are examples of diseases experienced in the African Region in recent years.

Epidemics associated with high morbidity and mortality often occur over large geographical areas. For instance, between 2004 and 2008, 13 countries reported a total of 170,927 meningitis cases, 44 countries reported a total of 749,713 measles cases and 41 countries reported a total of 691,290 cholera cases. Recurring epidemics of cholera, meningitis and measles were reported by numerous countries (see Table 1).

Case fatality ratios (CFRs) reached 5% or higher during some cholera outbreaks, 10% or higher during some meningitis epidemics, and 60% or higher during most Ebola and Marburg outbreaks.

In 2009, all 46 Member States in the Region reported at least one disease epidemic: 33 countries reported pandemic influenza A (H1N1), 20 countries reported cholera, seven countries reported meningitis, and Malawi and Mozambique reported typhoid. The meningitis belt stretches over 21 countries (see Figure 1.) with a total of 495 million inhabitants at high risk of epidemic during the meningitis season (October to May). During the meningitis 2009 season, 81,283 cases and 4,473 deaths (CFR = 5.5%) were reported by 14 countries in the meningitis belt.

The already weak health systems of countries experiencing recurring epidemics suffer when financial, human and logistical resources are further diverted to epidemic response. Routine health services are often affected during epidemics because the priority shifts to epidemic response activities. For example, during recent Ebola and Marburg epidemics, services in outpatient, antenatal, tuberculosis and HIV/AIDS clinics were suspended.

Epidemic preparedness and response have improved since 1993 when Member States were urged to strengthen epidemiological surveillance for communicable diseases at the district level. This was further strengthened by the adoption of the Integrated Disease Surveillance and Response Strategy (IDSR) in 1998 and the International Health Regulations (IHR 2005) which entered into force in June 2007. However, national surveillance systems remain inadequate to act as early warning systems for the timely identification of unusual health events with epidemic potential.

### Table 1. Recurring epidemics 2004–2008, African Region

<table>
<thead>
<tr>
<th>Epidemic</th>
<th>No. of countries</th>
<th>Countries</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cholera</td>
<td>11</td>
<td>Angola, Democratic Republic of the Congo, Ethiopia, Kenya, Liberia, Mozambique, Nigeria, Senegal, United Republic of Tanzania, Uganda, Zambia</td>
</tr>
<tr>
<td>Meningitis</td>
<td>10</td>
<td>Burkina Faso, Central African Republic, Chad, Côte d’Ivoire, Democratic Republic of Congo, Ethiopia, Ghana, Mali, Niger, Nigeria</td>
</tr>
<tr>
<td>Measles</td>
<td>10</td>
<td>Algeria, Chad, Democratic Republic of Congo, Guinea-Bissau, Mauritania, Mozambique, Niger, Nigeria, United Republic of Tanzania and Uganda</td>
</tr>
</tbody>
</table>
ISSUES AND CHALLENGES

Notable improvement in regional and national capacities for early detection, confirmation and characterization of epidemic and pandemic threats has been recorded after adoption of the IDSR Strategy and International Health Regulations (2005). However, most countries have not conducted comprehensive risk assessments to facilitate the identification of populations and geographic areas at risk of epidemics. To date, risk assessments have been conducted for yellow fever in 11 countries. Member States need to develop the technical capacity required to expedite risk assessment activities. Communities are not often aware of common local disease risks and their associated risk factors. Existing communication strategies are often inadequate for raising community awareness about risks to human health and behaviours that could reduce these health risks.

All 46 Member States of the WHO African Region have surveillance systems capable of detecting epidemics but are unable to function as early warning systems. The time between case detection and reporting for most epidemics is more than the recommended 24 hours. The reasons include inadequate community-based surveillance, low index of suspicion among health workers, inadequate laboratory equipment and referral networks at local level, and weak communication and disease notification systems.

Linkages and collaboration between human and animal health sectors necessary for a comprehensive approach to zoonoses remain weak both at the regional level and within Member States. Moreover, there is insufficient knowledge and understanding about the human-animal interface for the transmission of some emerging zoonotic diseases such as Ebola, Marburg and influenza. The H5N1 avian influenza threat revealed a lack of multisectoral coordination structures. National and district epidemic management committees do not usually incorporate technical experts from agriculture, wildlife, environment or veterinary sectors; in addition, there are no systems for sharing routine disease surveillance information or for joint preparedness and

Figure 1. The meningitis belt in the African Region

Select the regions affected by the meningitis belt.
response activities for animal and human health.

The exchange of epidemiological data across borders and responses to outbreaks improved after Member States with similar epidemiological profiles established intercountry protocols of collaboration. The WHO Regional Office for Africa supported implementation of the intercountry protocols of collaboration through the establishment of subregional technical support teams which provide assistance for epidemic preparedness and response. For instance, countries in the meningitis belt are now implementing enhanced surveillance for meningitis and share data on a weekly basis to monitor trends; intercountry meetings are conducted annually to share experiences, challenges and lessons learnt. However, intercountry coordinated approaches and comprehensive responses to all potential epidemics are still inadequate. For instance, cross-border meetings to plan joint activities are not provided for in national preparedness and response plans and are not held on a regular basis.

Timely response to epidemics requires sufficient resources and comprehensive plans. Although all of the 46 countries in the Region have pandemic influenza preparedness and response plans and 26 countries have one or more disease-specific plans, only 16 countries have consolidated epidemic preparedness and response plans covering multiple priority diseases. Less than 20% of the countries are able to maintain functional national epidemic rapid response teams and contingency stocks of supplies needed for epidemic response. Preparedness and response to epidemic-prone diseases at all levels are severely limited by lack of adequate financial resources.

Response capacity at health-care facilities and at community level has improved where there are ongoing activities to enhance community awareness and participation in safe behaviours related to personal and community hygiene. Similarly, response has improved where health-care workers, community health agents, volunteers and other partners in at-risk communities have been trained in recognition and case management of local epidemic-prone diseases. Nevertheless, response capacity is limited at local level in most countries because of lack of awareness and inadequate supplies.

Some of the underlying factors associated with recurring epidemics are general and outside the scope of the health sector. Ecological, environmental and socioeconomic changes tend to aggravate the predisposing
factors. Inadequate access to safe water and sanitation, prolonged rainy or dry seasons, and population displacements associated with natural and man-made disasters contribute to the frequency and severity of epidemics. Increasing financial investment to raise standards of living will ultimately reduce the occurrence of epidemics. Strong partnerships and community participation are critical for successful preventive actions.

**ACTIONS PROPOSED**

Member States are encouraged to consider the following proposed actions to improve epidemic preparedness and response capacity. Specific recommendations are proposed for improving the detection and confirmation of epidemic threats as well as preventing and controlling epidemics.

**EARLY DETECTION, CONFIRMATION AND CHARACTERIZATION OF EPIDEMIC AND PANDEMIC THREATS**

- Conduct risk assessments to identify the populations and geographic areas at risk of relevant epidemic-prone diseases. Multisectoral analyses should be conducted to characterize the specific risks (e.g., disease vectors, inadequate water and sanitation, risk behaviours) to facilitate planning for disease prevention and epidemic preparedness and response.

- Establish or strengthen early warning systems to detect epidemic-prone diseases. Early warning systems should be incorporated into national integrated disease surveillance activities at all levels. Community-based surveillance systems maintained by community health workers should be supported and linked to national surveillance and early warning systems. Member States urgently need to improve systems and processes for both immediate notification and weekly reporting of epidemic-prone disease, particularly at the local level through improved communication mechanisms (e.g. data transfer by mobile phone). They should ensure that all levels of national laboratory networks are functional and meet all reference standards.  

- Adopt the “one world, one health” approach to the prevention and control of zoonotic diseases. Specifically, national and district task forces should incorporate technical experts from animal health, agriculture, environment and human health disciplines to establish mechanisms for sharing routine disease surveillance information and for coordinating joint preparedness and response activities.

**PREVENTION OF EPIDEMICS**

- Invest in environmental health to improve access to safe water and adequate sanitation, promote good community and personal hygiene, and implement vector control measures to advance the prevention and control of communicable diseases. Mechanisms for strong partnerships at national level should be enhanced.

- Expand health promotion activities for epidemic-prone diseases in collaboration with existing health promotion and hygiene education programmes. National, provincial and district levels should support communities to plan and implement practical risk reduction measures including improvement of environmental health, safe water and sanitation, food hygiene, vector control and personal hygiene.
Key messages on common epidemic threats should be included in the curricula of primary and secondary schools.

- Conduct research to identify environmental, ecological, climatic, socioeconomic and cultural factors which facilitate the emergence and transmission of epidemic-prone diseases. Explore host factors that affect the impact and spread of epidemics including immune suppression (e.g. HIV/AIDS, malnutrition) and antimicrobial resistance.

**EPIDEMIC PREPAREDNESS AND RESPONSE CAPACITY**

- Establish functional national multisectoral epidemic management committees with responsibilities to prepare for and coordinate epidemic responses. These committees should update national consolidated epidemic preparedness and response plans that include disease specific plans and standard operating procedures. Member States are encouraged to establish and support similar mechanisms at provincial and district levels. Partners should be incorporated in the epidemic management committees.

- Conduct training for health workers including refresher training in management of epidemic-prone diseases, and prevention and control of infection. Create and maintain epidemic rapid response teams at national, provincial and district levels and train the teams in outbreak investigation and response including use of simulation exercises. Member States should have administrative arrangements in place for rapid mobilization and support.

- Improve rapid response capacity by prepositioning contingency stocks of essential supplies, equipment, vaccines, and diagnostic and treatment supplies at national, provincial and local levels. Provide sufficient financial resources to support response activities.

- Organize regular intercountry meetings to discuss implementation of joint protocols of cooperation for epidemic control. Member States are encouraged to strengthen communications with neighbouring countries to improve the sharing of information on communicable diseases.

**REFERENCES**

4. WHO. The Global Health Atlas, (see http://apps.who.int/globalatlas);
5. WHO. The Global Health Atlas (see http://apps.who.int/globalatlas);
20. Ibid 16.
Progress has been made in promoting and strengthening community involvement in health development in the African Region. However, the interface between communities and the formal health-care delivery system remains weak. Communities need to participate in ensuring universal coverage, comprehensiveness, continuity and people-centred health services to improve health outcomes. This article considers the issues and challenges and proposes actions to improve health service delivery and community involvement. Among the actions proposed are strengthening leadership and management, empowering communities to act to promote their own health and institutionalizing the concept of primary care as the hub of coordination in district health service delivery.

Habib Somanje
Saidou Pathé Barry
Babacar Dramé
Chris Mwikisa-Ngenda

World Health Organization, Regional Office for Africa

Corresponding author
Habib Somanje
E-mail: somanjeh@afro.who.int

HEALTH SYSTEMS STRENGTHENING: IMPROVING DISTRICT HEALTH SERVICE DELIVERY AND COMMUNITY OWNERSHIP AND PARTICIPATION

Têm-se verificado progressos na promoção e no reforço do envolvimento das comunidades no desenvolvimento sanitário na Região Africana. Contudo, a interface entre comunidades e o sistema formal de prestação de cuidados de saúde permanece fraca. As comunidades necessitam de contribuir para a garantia da cobertura universal, abrangência, continuidade e serviços de saúde centrados nas pessoas, para melhorar os resultados de saúde. Este artigo aprecia os problemas e os desafios e propõe acções para melhorar a prestação dos serviços de saúde e o envolvimento comunitário. Entre as acções propostas menciona-se o reforço da liderança e da gestão, bem como capacitar as comunidades a actuarem no sentido de promoverem a sua própria saúde e institucionalizar o conceito de cuidados primários como o centro de coordenação da prestação de serviços de saúde ao nível distrital.

SUMÁRIO

he World Health Organization defines a health system as all organizations, people and actions whose primary intent is to promote, restore and maintain health.1 It has six interrelated building blocks, namely: service delivery; health workforce; information; medical products, vaccines and technologies including infrastructure; financing; and leadership or governance. Improvements in service delivery require simultaneous improvements in the other building blocks at all levels of implementation including the district.
A district is defined as “a clearly defined administrative area covering a population at which some form of local government or administration takes over many responsibilities from central government departments”.

It translates central government aspirations, policies, strategic directions and road maps into district-level action and forges a mutually accountable partnership between people and government. A health district is the part of local government that takes over the responsibilities of the central ministry of health. It is large enough to justify the investment and management costs and small enough to be familiar with the relevant demographic and socioeconomic factors. It is normally equal to the administrative district and serves approximately 50,000 to 300,000 people.

The effectiveness of the organization and management of service delivery in the district depends, among others, on the competence and number of members of the district health management team as well as relevant management teams in health centres, health posts and communities. These teams coordinate the planning, implementation, monitoring and evaluation of health service delivery.

The Ouagadougou Declaration on Primary Health Care and Health Systems in Africa, the Addis Ababa Declaration on Community Health, the World Health Report 2008 on Primary Health Care and other related documents outline the principles and approaches for strengthening health systems. They emphasize the role of communities and partners in health development.

Communities are defined as “social groups of any size, whose members reside in a specific locality, share government, and often have a common cultural and historical heritage”. Many countries have set up community structures to work with health workers especially at the first level of the formal health system. In some countries, such community structures determine how health services are organized and operated. Where communities are closely involved, service utilization rates are higher.

One successful example is the Onchocerciasis Control Programme’s community-directed treatment with ivermectin.

The African Region has made progress in promoting and strengthening community involvement in health development. However, there is still a weak interface between communities and the formal health-care delivery system. It is necessary to promote and protect community ownership and participation to enable communities to benefit from global advances in medical technology. Communities need to participate in ensuring universal coverage, comprehensiveness, continuity and people-centred health services to improve health outcomes including the health Millennium Development Goals (MDGs).

Progress towards achieving the MDGs is slower than expected. Only 13 countries are on track to achieve MDG4. While the average annual reduction rate needed to achieve MDG5 in the Region is at least 5.5%, it was only 2.6% annually between 1990 and 2010. The prevalence of noncommunicable diseases such as cancer, cardiovascular diseases and road traffic accidents is also rising.

This document highlights issues and challenges and proposes actions to improve health service delivery and community involvement.

**ISSUES AND CHALLENGES**

Districts are the hubs for the coordination and management of planning, implementation, monitoring and evaluation of central government policies. These actions require a district
health management team that is competent in leadership and governance. However, in most countries in the African Region, there is a paucity of competent teams at district level. There are no formal approaches to develop leadership and governance competencies or to improve the adequacy, qualitatively and quantitatively, of members of district management teams.

In the African Region, the coverage of essential health interventions is inequitable and not universally accessible. Less than 50% of people with common illnesses obtain the required treatment. For example, only 38% of those needing treatment for pneumonia and diarrhoea are actually treated. Only 40% of those with malaria are treated and, on average, only 3% use artemisinin-based combination therapy, with rates ranging from <1% to 13%^14 Only 29.5% of mothers exclusively breastfeed their babies in their first six months.\(^{15}\) In addition, resource allocation favours curative services at high cost while neglecting primary prevention and health promotion which could prevent up to 70% of the disease burden.\(^{16}\) This is due to ineffective priority setting mechanisms, poor integration and lack of harmonization and alignment to a single national strategic health plan.

Health services are expected to be people-centred, i.e. based, holistically, on people’s health needs, including physical, emotional and social concerns beyond disease categories. They should be comprehensive, including health promotion, prevention, diagnosis, treatment, referral, long-term care and social health services. They should also be continuous, applying coherent management until the problem is resolved or the risk factor has disappeared.\(^{17}\) In most districts, services are still not people-centred, continuous or comprehensive. There is no institutionalization of the concept of primary care as the hub for coordination of health services for well-defined communities within the district. In addition, there is no decentralization of financial and other resources for management by a primary care team at this level.

The organization of service delivery requires focused and coordinated efforts. Health services including referral systems in most countries of the Region are not organized in a manner ensuring the continuum of care, efficient utilization of resources and reduction of hospital visits. For example, there is insufficient coordination of the continuum of care regarding HIV testing and counselling; prevention of mother-to-child transmission of HIV; necessary additional HIV laboratory work; and treatment with antiretroviral medicines. This weak coordination makes it difficult to improve the quality and quantity of integrated supervision even among related services.

An estimated 63% of countries facing the human resources for health (HRH) crisis worldwide are in the African Region.\(^{18}\) The Region manages 24% of the total global disease burden using only 2.3% of the total global health workforce.\(^{19}\) There is inadequate scaling up of the production of health workers and insufficient incentives to recruit, retain, develop and appropriately and equitably deploy personnel to offset the impact of the HRH crisis.

If universal coverage of essential health services is to be achieved, health financing must be in the form of prepayment in order to eliminate barriers to access, social protection must be organized, and inequalities must be shown and the un-reached populations must be reached.\(^{20}\) Many countries are yet to institutionalize robust prepayment systems that eliminate impoverishment of families due to out-of-pocket expenditure at the point of service.

Health infrastructure, medicines and health technologies are vital in the provision of comprehensive and quality health services. The challenge is to develop and effectively manage an efficient...
procurement system; equitable distribution; and rational use of health infrastructure, medicines and other health technologies to improve the quality of services provided at district and lower levels.

At district level, it is very important to measure progress towards attainment of the MDGs and other national and international goals. The current measurements for these goals are mostly retrospective and are thus too late for districts to make any necessary corrections for improvement. For example, the 2008 *Countdown to 2015* UNICEF report on the attainment of MDGs by 2015 used 2005 maternal mortality data.\(^{21}\) There are inadequate mechanisms to strengthen health information management systems such that districts are unable to detect, during the first month of implementation, the level of progress towards the attainment of annual or longer term goals. In addition, there is inadequate data gathering and analysis for timely and effective decision-making.

The success of service delivery and improvement in district health systems are measured through the health status of the communities within the district. Communities have a dual role: ensuring that their health needs are met by local government, and contributing effectively towards health development by living responsible lives that emphasize family values for health promotion and disease prevention. Many communities do not have enabling environments; others are mainly passive partners in health development because they are detached from national development agendas.

Districts perform well when they are fully decentralized in the form of devolution. However, in many countries, districts do not have full financial autonomy and the responsibility for staff recruitment and development. In addition, the necessary technical, political and administrative conditions do not exist at the level to which authority is to be transferred.\(^{22}\) As a result, there is minimal benefit of decentralization at district level, such as participatory planning and organization; effective communication with communities; effective management and coordination of programmes and services at all levels; adequate intersectoral collaboration particularly with the agricultural, education, water supply and waste disposal sectors; and improved services in terms of relevance, quality, availability, accessibility and acceptance on the part of the users.

**ACTIONS PROPOSED**

All the actions proposed are meant to be implemented at district level with guidance and support from the central level and involvement of the local assembly. Each
The community should be a strong partner in visualizing, planning, implementing, monitoring and evaluating these actions.

**Strengthen the leadership of district health management teams.** There is need to ensure that district health systems have technically-competent health management teams that lead governance at the district health office, district hospitals, health centres, health posts and communities. District health management teams should provide outstanding leadership in service delivery, health financing, information, health technologies and HRH management. Teams should be developed using formal and sustainable capacity-building programmes.

**Implement a comprehensive package of essential health services.** The comprehensive health services package should be based on population health needs, barriers to equitable expansion of access to services and available resources. The package needs to be considered as the minimum that can be provided during a specified time frame. There is need to consider the complementary capacities of the different levels of care and the necessary balance among promotional, preventive, curative and rehabilitative services.

**Improve organization and management of health service delivery.** In order to ensure availability, quality and continuum of care and to reduce the frequency of hospital visits by patients, there is need to use effective service delivery models that promote efficient referral systems and integration of services, e.g. integrated management of childhood illness. There is need to improve the quality and quantity of integrated supervision to ensure continuity of quality health care.

**Institutionalize the concept of primary care as the hub of coordination (see Figure 1).** People-centred (see Figure 1), comprehensive and continuous health services require a hub of coordination close to a well defined community. The hub comprises a primary care team that is responsible for all the health needs, including referral, of the community. Decentralization of necessary financial and other resources to this hub is a prerequisite for ensuring accountability for results and efficiency in resource allocation and use.23

**Improve the adequacy of HRH and introduce a team approach in performance assessment.** There is need to invest in the production, recruitment and retention of HRH and to use standards to distribute personnel equitably across the public, private and nongovernmental health facilities based on service needs while implementing an
incentive package especially for rural-based health workforce. A team approach in assessing performance should be one of the means to motivate staff and improve their competence, responsiveness and productivity. Development and implementation of algorithms, mentoring and supervision of HRH should be promoted and guided by a strong regulatory framework to ensure adherence to HRH norms and standards, good quality and continuum of service.

Develop prepayment mechanisms such as social health insurance and tax-based financing of health care. In order to ensure universal coverage, there is need to eliminate the impoverishment resulting from catastrophic out-of-pocket expenditure at the point of service by institutionalizing prepayment mechanisms. Funds should be pooled regardless of their sources. Financial management skills of staff should be strengthened by promoting transparency, accountability and accuracy.

Strengthen procurement, supply and distribution processes and minimize commodity wastage. Countries should use transparent procurement procedures to achieve value for money. There is need to institutionalize regular inventories and improve supply management procedures to ensure regular availability of essential medical products and to invest in infrastructure development and maintenance.
Clarify district responsibility in achieving national, international and millennium development goals. Annual national targets should be reflected in each district and community on a monthly basis taking into account the catchment population. This is especially helpful for assessing progress during the first month of implementation and taking corrective measures on time. In addition, data gathering and analysis should be improved to institutionalize evidence-based decision-making.

Empower communities (including women, the elderly, children and other disadvantaged groups) to take appropriate actions for the promotion of their own health. As a true partner in health, communities need to be involved in the planning, organization, management and implementation and monitoring of health service delivery. They should advocate for better health services from government including health information, skills and financial and other resources to ease their participation. The focus of community-based interventions should be at individual and family levels.

Create an enabling environment for devolution of health sector responsibilities to the districts. The local assembly and the “health districts” should have adequate capacity to ensure smooth transfer of central level responsibilities to the districts so that they can attain full financial autonomy and take up responsibility for staff recruitment and development. The political and administrative conditions should be strengthened to ensure effective institutionalization of participatory planning and organization; effective communication with communities; effective management and coordination of programmes, services and partners including the private sector at all levels; and coordination of intersectoral collaboration particularly with the agricultural, education, water supply and waste disposal sectors.

REFERENCES

2. WHO. Operational support for Primary Health Care: the role of the district level in accelerating health for all 2000 for all Africans, Brazzaville, World Health Organization, Regional Office for Africa, 1987, (AFR/R37/1D/1, AFR/HFA/2).
The illegitimate manufacture, distribution, widespread availability and indiscriminate use of substandard/spurious/falsely labelled/falsified/counterfeit medical products have serious consequences on public health. Such products are available widely in the African Region. Factors contributing to this situation include weak regulatory systems and lack of legislation against substandard and counterfeit medical products, and, where they do exist, there is ineffective enforcement. This article presents the current status, issues and challenges related to such products and proposes actions to prevent and control their manufacture, distribution and use in the African Region.
and/or source. The definition is applicable to both branded and generic products. Counterfeit medicines may include products with correct ingredients, with wrong ingredients, without active ingredients, with incorrect amounts of active ingredients or with fake packaging. Substandard medicines are products whose composition and ingredients do not meet the correct scientific specifications and are consequently ineffective and often dangerous to the patient. Substandard products may be the result of negligence, human error, insufficient human and financial resources or counterfeiting. All these factors may lead to medical products being ineffective and harmful.

The use of ineffective, poor quality medicines can result in therapeutic failure, exacerbation of disease and resistance to antimicrobials. The use of counterfeit medical products is a global public health problem causing death, disability and injury to adults and children. Illegitimate distribution and rampant use of counterfeit medicines lead to loss of confidence in health systems, health professionals, pharmaceutical manufacturers and distributors.

Considering the negative impact of substandard/spurious/falsely labelled/falsified/counterfeit medical products on public health, World Health Assembly Resolutions WHA41.16, 47.13, and 52.19 requested WHO to initiate programmes for the prevention and detection of the export, import and smuggling of such products. One of the core functions of WHO’s Essential Medicines Programme is to provide support to medicine regulatory authorities to ensure quality and safety standards of medical products. Consequently, guidelines to develop measures for combating counterfeit medicines were prepared. The guidelines provide an overview of the factors contributing to counterfeiting of medicines and include approaches to inspecting and testing suspected counterfeit medical products and providing staff training.

Furthermore, a global coalition of stakeholders, the International Medical Products Anti-Counterfeiting Taskforce (IMPACT), was established in 2006 with WHO as its Secretariat. The coalition has been active in forging international collaboration to seek solutions to this global challenge and in raising awareness of the dangers of counterfeit medical products.

The Sixty-third World Health Assembly, having considered the Secretariat’s report on counterfeit medical products, decided to establish a time-limited and result-oriented working group on substandard/spurious/falsely labelled/falsified/counterfeit medical products comprised of and open to all Member States. Following this decision of the Health Assembly, it is envisaged that a regional working group would be established to contribute to the global working group.

Meanwhile, the Regional Office has organized a consultative meeting involving medicines regulatory experts from Member States to review the current status, issues and challenges and propose actions to prevent and control substandard/spurious/falsely labelled, falsified/counterfeit medical products in the African Region.

This document presents the current status, issues and challenges related to substandard/spurious/falsely labelled/falsified/counterfeit medical products and proposes actions to prevent and control the manufacture, distribution and use of such products in the African Region.

**CURRENT STATUS**

Member States with weak or no regulatory systems are fertile grounds for production and circulation of substandard/spurious/falsely labelled/
falsified/counterfeit medical products. In 2004 WHO carried out a survey on the situation of medicine regulatory authorities in the African Region. Only 4% of the Member States had developed national regulatory capacity, 33% had moderate regulatory capacity (i.e. carry out most functions to varying degrees) and 24% had basic regulatory capacity (i.e. carry out minimum functions). However, 39% of the Member States had limited regulatory capacity and the inspection of manufacturing premises, distribution outlets and ports of entries in these Member States was found to be weak or lacking. Furthermore, over the last five years, 26 national medicines regulatory systems were assessed to identify gaps and were provided with need-based technical support. Apart from individual national regulatory authority assessments, two African medicines regulators’ conferences were organized to exchange experiences, identify gaps and priority areas, and discuss the challenges of regulating pharmaceutical markets including combating the manufacture, distribution, sale and use of substandard/spurious/falsely labelled/falsified/counterfeit medical products in the Region.

In 2007, WHO undertook an assessment of national medicines quality control laboratories in the Region and 20 countries responded to the assessment. The assessment report revealed that out of the 22 laboratories in 20 countries, 11 had the capacity to perform comprehensive tests. Five laboratories had moderate capacities and another five had limited capacities to perform relevant tests. The findings of this assessment showed the varying capacity of quality control laboratories in the Region. Some of the Member States with limited or no quality control laboratory occasionally send samples of medical products to neighbouring countries with better laboratory facilities. Furthermore, the WHO collaborating centres for quality of medical products in South Africa and Algeria provide support to Member States to test samples for quality as well as develop the capacities of the staff of national medicines regulatory authorities (NMRAs).

A study was carried out in Kenya in 2006 on the status of antimalarial medicines prior to nationwide deployment of anti-counterfeiting taskforces. The study found 187 different antimalarial products in the market, 42% of which were not registered in the country. Furthermore, out of 43 samples tested in the laboratory, 12% failed to meet quality specifications. In 2005, WHO carried out a quality survey of antiretrovirals in seven African countries in collaboration with the respective national medicines regulatory authorities. Of the 394 samples collected, the overall failure rate was 1.8% and none of the samples had any critical quality
deficiencies which would pose a serious risk to patients. Information on registration by the NMRAs was available for 285 samples, of which 84% were registered. Products not registered comprised 12% of the total samples and these had mostly been sampled from private sector facilities. This underscores the positive effects of common efforts between NMRAs, WHO and other organizations involved in prequalification and procurement policies for essential medicines that have contributed to secure supply chains for ARVs, thus minimizing the problem of substandard/spurious/falsely labelled/falsified/counterfeit products.

In October 2008, an interregional meeting on combating counterfeit medical products was convened in Abuja, Nigeria. Medicines regulatory authorities, police and customs authorities from 13 countries attended the meeting. Recommendations were made to amend and reinforce the implementation of the IMPACT’s legislative principles and to facilitate experience sharing using IMPACT assessment tools. A strategy was developed to improve collaboration among regulatory, police and customs authorities at the national and subregional levels in order to strengthen their capacity to combat counterfeit medical products. Moreover, the meeting recommended that IMPACT activities be included in existing medicines regulatory harmonization initiatives; IMPACT desks be established in all Member States; and assessments using the IMPACT tool be conducted in Member States.

Subsequently in 2009, 11 countries carried out assessments using IMPACT tools to examine the situation of counterfeit medicines. The findings of the assessments indicated that 10 countries had established cooperation between national medicines regulatory authorities (NMRAs), customs and police and five countries had conducted joint operations with police and/or customs. In addition, customs authorities in ten countries required NMRA authorization to clear medicines at customs. All countries indicated that they would welcome specific legislation to fight counterfeit medicines. Other outcomes of the assessment included the need for strengthened cooperation among national law enforcement agencies and establishment of single points of contact to enhance information sharing at the national, regional and international levels.

WHO and the International Criminal Police Organization (INTERPOL), under the auspices of IMPACT, organized a two-day regional conference in Johannesburg, South Africa, in November 2009. The conference brought together representatives of national medicines regulatory, police and customs authorities from 15 countries. An overview of the situation regarding counterfeit medicines across Southern Africa, particularly within countries of the Southern African Development Community (SADC) was presented and
discussed. The conference made recommendations to enhance cooperation and collaboration among the various agencies involved. Participants proposed to establish legal frameworks to support the prosecution of offenders; create national multiagency taskforces with links to IMPACT and expand concerted law enforcement efforts.

Between 2008 and 2009, the East African NMRAs and the INTERPOL in collaboration with other national law enforcement agencies such as police and customs authorities carried out two joint operations code-named Operation Mamba I and II to identify and confiscate counterfeit medical products. Some of the counterfeit medical products confiscated in the Region included antimalarial products. These operations resulted in strengthened cooperation and collaboration among law enforcement agencies at both national and regional levels and created awareness of the general public on the implications of the use of counterfeit medical products for public health.

The assessment of the status of counterfeit medical products in Member States of the Economic and Monetary Union of West Africa (UEMOA) highlighted concerns related to weaknesses of NMRAs. The West African Health Organization (WAHO) has made this issue a priority in its strategic plan which was adopted during the workshop held in Senegal from 28 to 29 June 2010.

Furthermore, SADC medicines regulators met in March 2010 in Johannesburg, South Africa, to develop a strategy and strengthen national and regional efforts to combat counterfeit medicines. The meeting stressed the need for amending national policies and regulations; strengthening medicines quality control laboratory capacities and collaboration among relevant national authorities; harmonizing medicines legislation; ensuring effective border controls; facilitating international collaboration; promoting multidisciplinary approach; and providing consumer education.

In October 2009, the Chirac Foundation organized a one-day campaign against counterfeit medicines in Cotonou, Benin. Cognizant of the growing danger that trafficking and consumption of counterfeit medicines pose to public health, the Heads of State,22 the former Presidents of France and Mauritania, the representatives of the United Nations, African Union, European Union and countries including Chile, France, Laos, Mali and Nigeria signed the Cotonou Declaration on International Campaign Against Production, Trade and Circulation of Counterfeit Medicines.23 The Declaration calls upon the signatories to (a) contain the production and sale of fake medicines; (b) support the public and private actors already engaged in the fight against fake medicines; and (c) create awareness of the risks posed by falsified medicines.

ISSUES AND CHALLENGES

Counterfeiting is primarily motivated by the potentially huge profits that can be made and is perpetrated by criminals who compromise peoples’ health for illegal profits. The illegal production, smuggling and use of falsified medical products are real public health problems and constitute financial losses for individuals, communities and Member States. Counterfeiters smuggle illegal goods including medical products through illicit channels or through lawful but poorly regulated supply systems.

Many factors contribute to the manufacture and distribution of substandard/spurious/falsely labelled/falsified/counterfeit medical products. They include (a) lack of harmonized definition of counterfeiting; (b) globalization; (c) the rapid expansion of the internet; (d) establishment of free trade zones; (e) porosity of borders;
(f) corruption; (g) conflicting interests; (h) poor governance; and (j) increasingly easier access to sophisticated printing and manufacturing technologies that considerably contribute to these illegal practices. National policies that fail to comprehensively direct trade issues as they relate to public health result in the importation, exportation and sale of medical products without adherence to good manufacturing and distribution practices.

In many Member States of the Region medicines regulatory authorities do not have adequate capacities for effective enforcement of legislations. In particular, legislations against substandard/spurious/falsely labelled/falsified/counterfeit medical products are not yet in place, and where they exist, they lack effective enforcement. Weak regulatory systems and lack of coordinated and strict measures result in the proliferation of such counterfeit medical products in national and international markets.

Adequately trained and sufficient numbers of staff are critical for the effective performance of medicines regulation functions. However, many NMRAs have limited financial and human resources. Inadequate number of staff, low staff morale and salaries, and lack of incentives contribute to high staff turnover which further weakens regulatory capacity.

A fragmented and weak supply and distribution system increases the opportunities for counterfeiters to infiltrate the supply chain with substandard/spurious/falsely labelled/falsified/counterfeit medical products. Inadequate access to basic health services coupled with chronic shortages and frequent stock out of essential medicines in public health facilities could lead to the purchase of counterfeit medicines by patients.

Illiteracy and poverty put the population at risk. In many countries in the Region, there are insufficient or no health insurance and social security schemes, leading to payment by households of exorbitant prices out of their pockets for their medical needs. These factors hinder access to quality medicines and predispose patients, especially the poor, to seek care through informal channels. Such situations provide an opportunity for counterfeiters to offer cheaper prices for substandard/spurious/falsely labelled/falsified/counterfeit medical products.

Timely, independent and objective information on substandard/spurious/falsely labelled/falsified/counterfeit medical products are vital for evidence-based regulatory decisions. In addition, interventions to combat such products can be effectively applied when the magnitude
and nature of the problem is fully understood. However, the extent of the problem is not well documented in most countries in the Region.

Cooperation and collaboration among the authorities concerned (e.g. regulatory authorities, trade officials, police, customs and the judiciary) within and across countries in the Region are generally weak.

**ACTIONS PROPOSED**

Given the diverse and complex nature of the issues and challenges related to substandard/spurious/falsely labelled/falsified/counterfeit medical products, a wide range of interventions are needed to effectively address them.

Member States should **reaffirm their commitment** to the fight against counterfeit medical products and engage in updating, developing, implementation and monitoring of national medicines policies.

Member States should **establish NMRAs that have adequate legal mandate, independence and institutional capacity** to ensure and strictly enforce compliance of medical products with standards of quality, safety and efficacy; and to effectively control the manufacture, export, import and distribution of substandard/spurious/falsely labelled/falsified/counterfeit medical products.

In order to address the problem of sufficient training and availability of qualified staff, Member States should **develop and implement a sustainable human resource strategy for the pharmaceutical sector** that ensures adequate human resource capacity including specialized training and retention of regulatory personnel. Continuing education and training programmes should be constituted into training curricula to enhance the knowledge and skills of health personnel to enable them to prevent, recognize and appropriately deal with cases of substandard/spurious/falsely labelled/falsified/counterfeit medical products.

Member States should **put in place reliable supply systems and the requisite financial resources** to ensure the availability of quality and affordable essential medical products in public health facilities. Comprehensive quality assurance systems for procurement and distribution should be strengthened for the public, private and other health care providers. Necessary measures to ensure access to affordable medical products that meet quality and safety standards should be incorporated and given due emphasis in national health policies and strategic plans. Government authorities should monitor and regulate the prices of medical products to ensure their availability and affordability.

Member States should **establish effective systems** to carry out specific studies and routine market surveillance to quantify the magnitude of the problem and to inform the development and implementation of appropriate policies and regulations. Based on the findings of the studies, Member States should develop information, education and communication strategies to increase awareness of policy makers, health workers and the general public about the dangers of using substandard/spurious/falsely labelled/falsified/counterfeit medical products. The strategy should involve all activities aimed at fighting illegal production, distribution and use of these medical products.

Member States should **establish effective national, regional and interregional cooperation and collaboration mechanisms** including reinforcing regulatory networks and exchange of information among public health, law enforcement, professional associations, NGOs and other relevant authorities to improve prevention, detection, investigation and prosecution.
of cases related to substandard/spurious/falsely labelled/falsified/counterfeit medical products.

WHO should (a) further develop tools and guidelines enabling Member States to adapt and implement policies and strategies; (b) continue to assess and strengthen NMRAs in order to ensure the quality, efficacy and safety of medical products; (c) support Member States to mobilize more resources for developing human resource capacity for the pharmaceutical sector; (d) continue to facilitate the exchange of objective and independent regulatory information among Member States; (e) intensify the promotion and implementation of good governance, accountability and transparency in Member States; (f) strengthen the conduct and dissemination of operational research on substandard/spurious/falsely labelled/falsified/counterfeit medical products and encourage Member States to use evidence for policy actions; and (g) strengthen monitoring and evaluation of programmes dedicated to combating the manufacture, distribution and use of substandard/spurious/falsely labelled/falsified/counterfeit medical products.

In line with the decision of the Sixty-third session of the World Health Assembly Member States should establish a time-limited and results-oriented Regional working group on substandard/spurious/falsely labelled/falsified/counterfeit medical products. The working group will examine, from a public health perspective, WHO’s role in (i) measures to ensure the availability of quality, safe, efficacious and affordable medical products; (ii) relationship with the International Medical Products Anti-Counterfeiting Taskforce and; (iii) the prevention and control of medical products of compromised quality, safety and efficacy such as substandard/spurious/falsely labelled/falsified/counterfeit medical products.

REFERENCES

1. Medical products include medicines, vaccines, pharmaceutical ingredients, medical devices and diagnostics.
2. Market in this context encompasses unauthorized outlets, shops, street peddlers, the open market, etc.
8. WHA63 (10) Decision.
15. US Pharmacopeia and USAID. Survey of the Quality of Selected Antimalarial Medicines Circulating in Madagascar, Senegal, and Uganda, November 2009.
23. www.fondationchirac.eu
24. WHA63 (10) Decision.
This edition of the Communicable Diseases Epidemiological Report compares the situation of influenza, cholera and meningitis in the WHO African Region at the end of March 2012 with the corresponding quarter in 2011.

Reported data from laboratories that routinely supply data on influenza to WHO indicate a consistent decline in the proportion of pandemic influenza A (H1N1).

The numbers of cholera cases and deaths reported are slightly lower than the corresponding quarter in 2011 although the case fatality rate is still above the acceptable threshold.

A shift in the Neisseria meningitidis serotypes that are circulating in the countries that are implementing enhanced meningitis surveillance has also continued to be observed. In this transmission season, the predominant pathogen has been Nm W135.

Dr J B Roungou
DIRECTOR, DPC Cluster

VIROLOGICAL SURVEILLANCE OF INFLUENZA IN THE AFRICAN REGION DURING THE FIRST QUARTER OF 2012

The African Influenza Laboratory Network is made up of 24 laboratories in 23 countries. These laboratories share data with WHO on a weekly basis using a standardized form. The total number of specimens collected during the first quarters of 2010, 2011 and 2012 were 11,965, 11,361 and 9,652 respectively, as shown in Table 1. Around 90% of the specimens received were tested for the various influenza subtypes.

Among those tested specimens in the first quarter, proportions of positive influenza specimens were 18%, 14% and 8% for 2010, 2011 and 2012, respectively. As shown in Table 1 and Figure 1a, in the first quarter of 2010, the predominant virus subtype detected was influenza A (H1N1) pdm09 virus at 63% and A (H3N2) at 14%. In the corresponding period of 2011, influenza A (H1N1) pdm09 virus and B were circulating in almost similar proportions (42% and 36% respectively) while A (H3N2) viruses had increased to 16%. There was only one laboratory-confirmed case of A (H1N1) during the period. See Table 1 and Figure 1b.

However, in 2012 A (H3N2) at 43% was the predominant pathogen while pandemic influenza A (H1N1) pdm09 virus (23%) and B (29%) co-circulated in almost similar proportions as shown in Table 1 and Figure 1c. There were no laboratory-confirmed cases of seasonal A (H1N1).

No A (H5) was detected in the first quarters of 2010, 2011 and 2012. The proportion of specimens positive for pandemic influenza A (H1N1) pdm09 virus subtype decreased from 63% in 2010 to 23% in 2012 as shown in Table 1.

These data indicate a changing pattern of circulating influenza subtypes with a marked reduction of influenza A (H1N1) pdm09 positive samples.
Table 1. Distribution of circulating influenza virus subtypes 2010–2012

<table>
<thead>
<tr>
<th>Year</th>
<th>First quarter</th>
<th>Specimens received</th>
<th>Specimens processed</th>
<th>Total influenza positive</th>
<th>A (H1)</th>
<th>Pandemic A (H1N1)</th>
<th>A (H3N2)</th>
<th>A (not sub-typed)</th>
<th>B</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>11 965</td>
<td>11 353</td>
<td>2018</td>
<td>18</td>
<td>48</td>
<td>2</td>
<td>278</td>
<td>14</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2011</td>
<td>11 361</td>
<td>10 607</td>
<td>1454</td>
<td>14</td>
<td>1</td>
<td>0</td>
<td>614</td>
<td>42</td>
<td>16</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2012</td>
<td>9652</td>
<td>8610</td>
<td>658</td>
<td>8</td>
<td>0</td>
<td>0</td>
<td>152</td>
<td>23</td>
<td>43</td>
</tr>
</tbody>
</table>

Source: AFR Influenza Laboratory Network.
By the end of March 2012, 14 countries in the African Region had reported a total of 15,261 cases with 268 deaths (CFR = 1.9%) compared with 15 countries that reported 20,982 cases with 436 deaths (CFR = 2.1%) in the corresponding period of 2011, as shown in Table 2. This represents a 27% and 39% decline in cholera cases and deaths respectively during the first quarter of 2012 compared with 2011, although the CFR is still unacceptably high.

Figure 2 shows the countries that reported cholera cases and deaths in 2012 with the size of the dot proportional to the caseload. Angola, the Democratic Republic of Congo, Niger and Sierra Leone reported more than 90% of the cases. Moreover, the Democratic Republic of Congo alone accounted for 69% cases and 63% of deaths (CFR = 1.6%) in the first quarter of 2012. Conversely, during the first quarter of 2011, Cameroon, the Democratic Republic of Congo, Ghana and Nigeria accounted for more than 80% cases and 84% deaths.

Although Guinea, Sierra Leone and Togo did not report any cases in the first quarter of 2011, they experienced outbreaks in 2012. On the other hand, Chad, Kenya, Malawi, Mozambique, Zambia and Zimbabwe did not report any cases in the first quarter of 2012 compared with the corresponding quarter of 2011.

The case fatality rate has remained above the 1% acceptable threshold implying the need to scale up country preparedness and response to minimize cholera deaths.
Figure 2. Countries reporting cholera cases in the first quarter 2012
**Table 2. Distribution of cholera cases and deaths in the first quarters 2011 and 2012**

<table>
<thead>
<tr>
<th>Country</th>
<th>First quarter 2011</th>
<th>First quarter 2012</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Cases</td>
<td>Deaths</td>
</tr>
<tr>
<td>Angola</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Benin</td>
<td>11</td>
<td>1</td>
</tr>
<tr>
<td>Burundi</td>
<td>180</td>
<td>0</td>
</tr>
<tr>
<td>Cameroon</td>
<td>2919</td>
<td>120</td>
</tr>
<tr>
<td>Chad</td>
<td>265</td>
<td>22</td>
</tr>
<tr>
<td>Côte d’Ivoire</td>
<td>523</td>
<td>12</td>
</tr>
<tr>
<td>Democratic Republic of Congo</td>
<td>3823</td>
<td>67</td>
</tr>
<tr>
<td>Ghana</td>
<td>6007</td>
<td>62</td>
</tr>
<tr>
<td>Guinea</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Kenya</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Liberia</td>
<td>370</td>
<td>0</td>
</tr>
<tr>
<td>Malawi</td>
<td>15</td>
<td>4</td>
</tr>
<tr>
<td>Mozambique</td>
<td>1062</td>
<td>2</td>
</tr>
<tr>
<td>Niger</td>
<td>96</td>
<td>10</td>
</tr>
<tr>
<td>Nigeria</td>
<td>4268</td>
<td>119</td>
</tr>
<tr>
<td>Sierra Leone</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>United Republic of Tanzania</td>
<td>532</td>
<td>8</td>
</tr>
<tr>
<td>Togo</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Zambia</td>
<td>273</td>
<td>7</td>
</tr>
<tr>
<td>Zimbabwe</td>
<td>637</td>
<td>2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>20 982</td>
<td>436</td>
</tr>
</tbody>
</table>

Source: Member States.
**DISTRIBUTION OF CEREBROSPINAL MENINGITIS IN THE FIRST QUARTERS OF 2011 AND 2012 IN THE AFRICAN REGION**

The number of cases of, and deaths from, cerebrospinal meningitis reported during the first quarters of 2012 and 2011 are listed in Table 3. A total of 21 countries reported cases of cerebrospinal meningitis in the first quarter of 2012, as shown in Table 3 and Figure 3, compared with 22 countries during the corresponding period in 2011.

A total of 12,095 cases and 1,100 deaths, with a CFR of 9.1%, were reported in the first quarter of 2012 compared with 8,536 cases and 879 deaths, with a CFR of 10.1%, in the corresponding quarter of 2011, as shown in Table 3. Overall, the number of reported cases and deaths increased by 41% and 25% respectively, between 2011 and 2012. Nearly 80% of meningitis cases were reported by Burkina Faso, Chad, the Democratic Republic of Congo, Ghana and Nigeria in the first quarter of 2012.

Table 3. Distribution of cerebrospinal meningitis cases and deaths first quarters 2011 and 2012

<table>
<thead>
<tr>
<th>Country</th>
<th>First quarter 2011</th>
<th>First quarter 2012</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Cases</td>
<td>Deaths</td>
</tr>
<tr>
<td>Angola</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Benin</td>
<td>112</td>
<td>24</td>
</tr>
<tr>
<td>Burkina Faso</td>
<td>1,983</td>
<td>340</td>
</tr>
<tr>
<td>Burundi</td>
<td>16</td>
<td>1</td>
</tr>
<tr>
<td>Cameroon</td>
<td>526</td>
<td>47</td>
</tr>
<tr>
<td>Central African Republic</td>
<td>199</td>
<td>26</td>
</tr>
<tr>
<td>Chad</td>
<td>3,542</td>
<td>175</td>
</tr>
<tr>
<td>Côte d’Ivoire</td>
<td>55</td>
<td>19</td>
</tr>
<tr>
<td>Democratic Republic of Congo</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Eritrea</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Gabon</td>
<td>11</td>
<td>3</td>
</tr>
<tr>
<td>Gambia</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Ghana</td>
<td>434</td>
<td>69</td>
</tr>
<tr>
<td>Guinea</td>
<td>110</td>
<td>7</td>
</tr>
<tr>
<td>Kenya</td>
<td>16</td>
<td>1</td>
</tr>
<tr>
<td>Liberia</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Mali</td>
<td>153</td>
<td>7</td>
</tr>
<tr>
<td>Mauritania</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Mozambique</td>
<td>128</td>
<td>25</td>
</tr>
<tr>
<td>Namibia</td>
<td>6</td>
<td>1</td>
</tr>
<tr>
<td>Niger</td>
<td>629</td>
<td>71</td>
</tr>
<tr>
<td>Nigeria</td>
<td>421</td>
<td>23</td>
</tr>
<tr>
<td>Senegal</td>
<td>19</td>
<td>2</td>
</tr>
<tr>
<td>Sierra Leone</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>South Africa</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>United Republic of Tanzania</td>
<td>23</td>
<td>6</td>
</tr>
<tr>
<td>Togo</td>
<td>226</td>
<td>32</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>8,536</strong></td>
<td><strong>879</strong></td>
</tr>
</tbody>
</table>

Source: Member States.
Cerebrospinal fluid (CSF) samples are collected, tested and reported in countries with enhanced surveillance namely: Benin, Burkina Faso, Cameroon, Chad, Côte d’Ivoire, Ghana, Mali, Niger and Togo.

During the corresponding quarter of 2011, of the 1950 CSF samples tested, 978 (50.2%) were positive. The most prevalent pathogens were *Neisseria meningitidis* 379 (38.7%) and *Streptococcus pneumoniae* 382 (39.2%). Among the *Neisseria meningitidis* serogroups, NmW135 accounted for 227 (23.2%) and NmA 109 (11.1%) of the positive samples, as shown in Table 4.

During the first quarter of 2012, of the 1860 CSF samples tested, 937 (50.4%) were positive. The most prevalent pathogens in the positive samples were *Neisseria meningitidis* 388 (41.4%), *Streptococcus pneumoniae* 177 (18.9%) and Hib 9 (1%). Among the *Neisseria meningitidis* serogroups, NmW135 accounted for 303 (32.3%) and NmA 45 (4.8%) of the positive samples, as shown in Table 5.

Figure 3. Countries reporting cerebrospinal meningitis cases in first quarter 2012
Furthermore, 40 districts from countries within the meningitis belt, namely Benin, Burkina Faso, Chad, Côte d’Ivoire, Central African Republic, Ethiopia, Ghana, Mali and Nigeria, crossed the epidemic threshold in the first quarter of 2012. For those countries with enhanced meningitis surveillance, the predominant serotype was NmW135 except in Benin and Chad where the predominant pathogens and serotypes were Streptococcus pneumoniae and NmA respectively, as shown in Table 5.

Table 5. Pathogens identified using three methods – polymerase chain reaction (PCR), latex agglutination and culture testing – reported in the first quarter 2012

<table>
<thead>
<tr>
<th>Country</th>
<th>No. of CSF Results</th>
<th>Number of CSF positive by serogroup/serotype</th>
<th>Proportions (%) of pathogens</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Neg Pos</td>
<td>Nm A</td>
<td>Nm X</td>
</tr>
<tr>
<td>Benin</td>
<td>52 19</td>
<td>33</td>
<td>0</td>
</tr>
<tr>
<td>Burkina Faso</td>
<td>857 341</td>
<td>516</td>
<td>2</td>
</tr>
<tr>
<td>Cameroon</td>
<td>147 124</td>
<td>23</td>
<td>6</td>
</tr>
<tr>
<td>Chad</td>
<td>228 107</td>
<td>121</td>
<td>98</td>
</tr>
<tr>
<td>Mali</td>
<td>121 101</td>
<td>20</td>
<td>0</td>
</tr>
<tr>
<td>Niger</td>
<td>464 248</td>
<td>236</td>
<td>3</td>
</tr>
<tr>
<td>Togo</td>
<td>61 32</td>
<td>29</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>1950 972</td>
<td>978</td>
<td>109</td>
</tr>
</tbody>
</table>

1 Nm B, Nm C, Nm Y and other unknown pathogens were also screened for.

The data demonstrate a further decline in the predominance of Neisseria meningitidis A in 2012 with the predominant serotype reported now being NmW135. This is probably due to the introduction of meningitis A conjugate vaccine in Burkina Faso, Mali and Niger. The findings highlight the importance of laboratory confirmation in ensuring the appropriate formulation and deployment of the correct vaccine whether for routine or reactive meningitis vaccination programmes.
Since the end of the Cold War, state and non-state actors – including WHO – have come to rely on health diplomacy, in its various forms, to advocate for the improvement of the health status of populations including those in the African Region.

In the history of health diplomacy, 10 February 2006, 11 February 2011 and 10 February 2012 have symbolic and practical significance for the African Region of WHO. On these dates, WHO, under the leadership of its Regional Director for Africa Dr Luis Sambo, organized information and sensitization sessions for diplomats accredited to the Republic of Congo and based in Brazzaville where the Africa Regional Office of WHO has been hosted since 1952.

Rationale for engaging the diplomatic community

“The central aim of these encounters has been to engage and influence foreign policy and development actors and processes that impact on the broad area of development cooperation, and to facilitate action to promote and protect the health of the people of Africa”, says Dr Matshidiso Moeti, Deputy Regional Director at the WHO Regional Office for Africa.

“Around the world, health, increasingly a part of foreign policy agendas, is included in national security, trade, diplomacy and other discussions, leading to an outpouring of health assistance and to a variety of new financing mechanisms. Our instituting this annual meeting with the diplomatic community accredited to our host country reflects our recognition of the broad determinants of health, and the need to engage people and structures in policy arenas beyond the health sector,” she added.

Little wonder then that the three briefings organized so far were attended not only by heads of African and non-African missions accredited to the Republic of Congo, but also representatives of bilateral development institutions as well as non-governmental and inter-governmental organizations. Participants in this year’s briefing were joined, for the first time, by health attachés and health desk officers of 15 African diplomatic missions accredited to the United Nations in Geneva – headquarters of the WHO.

In steering the 10 February 2012 meeting, Dr Sambo, once again, highlighted the health situation in Africa and made concrete proposals for action by suggesting proven, evidence-based, and high impact interventions to address the health challenges facing the Region. He clearly outlined the strategic directions that guide WHO’s current work in Africa (2010–2015) and gave the audience an insight into on-going reforms. He left his audience with some very clear, unambiguous key messages. These can be summarized as follows:

- The global financial crisis has adversely impacted WHO; therefore, national governments and the international community should rally around WHO to ensure minimum disruption of its work in Africa.

Response of the diplomatic community

“We shall do our job by relaying the information you have provided us to our home governments”, said the Mrs Marie Charlotte Fayanga, Dean of the Diplomatic Corps in Brazzaville and Ambassador of the Central African Republic to Congo.

Mrs Fayanga was joined by the Congolese Health Minister, Professor Georges Moyen, in lauding the initiative to set up the African Public Health Emergency Fund which, Dr Sambo had hinted, was already receiving contributions from some Member States.

... continued over.
WHO RELEASES FIRST EVER NORMATIVE GUIDANCE ON DIAGNOSIS, PREVENTION AND MANAGEMENT OF A MAJOR CAUSE OF DEATH OF PEOPLE LIVING WITH HIV/AIDS CRYPTOCOCCAL DISEASE

On 7 December 2011, WHO released the first ever normative guidance document on the prevention, diagnosis and management of cryptococcal disease which ranks among the top causes of death among people living with HIV/AIDS. Cryptococcal disease, a little known but one of most important opportunistic infections in humans, is believed to account for between 13% and 44% of deaths in HIV-infected cohorts in resource-limited settings.

The WHO publication, officially launched in March 2012, is entitled *Rapid advice: Diagnosis, prevention and management of cryptococcal disease in HIV-infected adults, adolescents and children.*

Rapid advice was released during a side event at the Sixteenth International Conference on HIV/AIDS and Sexually Transmitted Diseases held from 4 to 6 December 2011 in Addis Ababa. The document outlines standards for high quality care of persons living with HIV infection and cryptococcal disease, by providing evidence-based recommendations that consider the risks and benefits, acceptability, feasibility, cost and other resource implications.

Rapid advice recommends six broad areas of intervention including, early diagnosis and treatment; prevention of the disease by initiating early antiretroviral therapy (ART); and the induction, consolidation and maintenance of treatment regimens. Other broad action areas of intervention include adhering to a minimal package of toxicity prevention; monitoring and management of amphotericin B (a medicine used for the treatment of cryptococcal disease); and optimal timing of ART initiation or provider-initiated HIV testing and counselling and referral for HIV care services in order to facilitate early HIV diagnosis and uptake of ART. The sixth general area of intervention is the discontinuation of treatment in adults and adolescents with successfully treated cryptococcal disease. However, this recommendation also advises the continuation of treatment in children less than two years old. In sub-Saharan Africa alone, where more than 500 000 deaths occur each year due to cryptococcal meningitis, the commonest presentation of HIV-related cryptococcal disease is in adults.

To download Rapid advice go to: [http://www.who.int/hiv/pub/cryptococcal_disease2011/en/]