THE AFRICAN HEALTH MONITOR

INCLUDING:
COMMUNICABLE DISEASES
EPIDEMIOLOGICAL REPORT

KEY DETERMINANTS FOR HEALTH IN THE AFRICAN REGION
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The African Health Monitor is a quarterly magazine of the World Health Organization Regional Office for Africa (WHOAFRO). 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 publishes articles that monitor health situations across the region, discuss trends and track progress toward the health-related Millennium Development Goals and other internationally agreed-upon goals. It disseminates relevant and scientifically rigorous public health information and interventions carried out in the Member States with the cooperation of AFRO technical programmes.

Comments on published articles and suggestions for new papers are welcome. Prospective authors should follow the Monitor style guidelines, which can be obtained by contacting the Editorial Office at AHM@afro.who.int or by using this intranet link http://intranet.afro.who.int/ guidelines/ahm.pdf
Editorial

Health inequities and key determinants of health in the African Region

The strategic directions of WHO-AFRO (2010–2015) are based on the recognition of the impact of key health determinants such as economic, social and environmental factors on health development and outcomes, as well as more proximal determinants such as behavioural risk factors. It underscores the need to address health determinants in the African Region where health inequalities are prominent and access to quality health services is limited.

A number of steps have been taken by AFRO for tackling health inequities through action on the determinants of health: a regional strategy was put in place and countries are being supported to develop health policies and strategies that enhance equity, are responsive to gender, and based on human rights. AFRO also provides normative and technical guidance to countries for strengthening food safety and nutrition programmes, including early warning systems, and nutrition and foodborne disease surveillance in line with the Regional Strategy on Food Safety and Health and the African Regional Nutritional Strategy 2005–2015.

This issue of the Monitor focuses on key determinants of health in the African Region and contains a number of papers describing the various facets of WHO’s work on these determinants.

The first article, “A strategy for addressing the key determinants of health in the African Region”, as reviewed and endorsed by the Regional Committee in 2010, proposes closing health gaps through priority interventions in line with the three overarching recommendations of the WHO Commission on the Social Determinants of Health: improving daily living conditions; tackling inequitable distribution of power, money and resources; and measuring and understanding the problem and assessing the impact of action.

Health promotion, discussed in a progress report on the implementation of the Regional Health Promotion Strategy (2001), is a cost-effective approach and a socially justifiable investment that can significantly help improve the health and well-being of individuals, families and communities.

Climate change has a direct effect on public health, but the majority of countries in the African Region are ill prepared to cope with its health impact, as discussed in an article on health considerations within national adaptation programmes of action for climate change in least developed countries and small island states.

Among infectious diseases, HIV/AIDS continues to be a strong risk factor in the Region, particularly among women. A report on progress in preventing mother-child transmission of HIV/AIDS in the last decade is included in this issue. Additionally, the issues and challenges of antimicrobial resistance in the African Region are discussed.

Recent decades have seen significant increases in noncommunicable diseases (NCD) in the Region, in addition to the long-standing burden of infectious disease. Alcohol abuse, together with drug abuse and tobacco use, is high on the list of critical health risk factors in the Region. An article discusses a strategy to reduce the harmful use of alcohol in the African Region.

This issue of the Monitor concludes with a look at the challenges facing the introduction of the WHO surgical safety checklist in African countries, the quarterly “Communicable Disease and Epidemiological Report” and a section on news and events.

I trust that staff of WHO and health workers throughout the Region will find it useful.

Luis Gomes Sambo, Regional Director
A strategy for addressing the key determinants of health in the African Region

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Health disparities exist within and between countries of the African Region and are widening in some cases. The strategy for closing the health equity gap through action on the key determinants of health evolve around the three overarching recommendations of the WHO Commission on the Social Determinants of Health, namely:

a) improving daily living conditions;
b) tackling the inequitable distribution of power, money and resources; and
c) measuring and understanding the problem and assessing the impact of action. They are divided into those that are within the immediate remit of the ministry of health, and those that come under other sectors or are cross-sectoral.

The proposed interventions recognize the widening health equity gap within and among Member States. The strategy places emphasis on addressing the structural causes of ill health, disabilities and premature death associated with access, affordability and availability, and addresses issues even beyond the risk factors. Member States are called upon to reduce the health equity gap through action on the social determinants of health. The prerequisite for success is political commitment to provide an enabling environment for all to contribute to reducing health inequities through action on the social determinants of health including measures to improve living conditions, tackle uneven distribution of power, money and resources, and undertake routine monitoring of the health equity gap.

This article outlines a strategy for reducing health inequities through action on the social determinants of health.

Situation analysis and justification

Situation analysis

In the 1980s and 1990s, most parts of sub-Saharan Africa witnessed increasing economic deprivation and poverty, diminishing food security, devastation due to the HIV/AIDS pandemic, environmental destruction, increasing unemployment and general reversal of human development indicators. Extreme poverty increased from 47% in 1990 to 50% in 2009. Women, the elderly and displaced populations were the worst affected groups. The African Region lags behind most other WHO regions in its overall health attainments. Life expectancy at birth was estimated at only 52 years in 2007. This contrasts with 64 and 65 years in the WHO regions of the Eastern Mediterranean and South-East Asia, respectively and with the global average of 68 years. Improvements in child survival in many countries in the Region have not resulted in higher life expectancy because these have been eroded by higher levels of adult mortality due to HIV/AIDS and conflict.

Progress towards achieving the Millennium Development Goals (MDGs) in the Region has been slow but perceptible. Although reliable data on income poverty are lacking, available information suggests that progress towards reducing poverty is slow. The Region made very little progress towards reducing under-five mortality with the vast majority of countries making only negligible improvements by about 2% between 1990 and 2005. There was only a marginal improvement in infant mortality rates (from 110 to 99 per 1000 live births) between 1990 and 2005. However, Malawi
and Mauritius recorded improvements exceeding 5%.

Most countries are likely to achieve gender parity in education by 2015. Ten countries achieved gender parity in primary education in 2005.7

Despite the progress noted in some of the MDG indicators, most MDG targets are not likely to be met. Even in those countries that are making some progress, the situation of the poor and vulnerable groups is not likely to change. Consequently, there is need to address the social determinants of health in countries in order to ensure that the poor are not left behind.

Widespread health inequalities exist in areas such as infant and child mortality, maternal mortality and stunting, and in accessing health services.8 The health system, itself a determinant of health, is not adequately prepared to address the “causes of the causes” as regards the major communicable diseases, maternal and child health problems and the increasing prevalence of chronic diseases. There are wide inequities, within and between countries, in health services coverage, safe water supply and sanitation, and health outcomes.9 In the majority of countries some common patterns are observed as regards urban/rural location, education and gender. These patterns are: urban dwellers generally live longer than rural inhabitants; higher education results in higher life expectancy; and females live longer than males. In some countries, there are major disparities in health status between the rich and the poor while for others the difference is insignificant. Disparities across households are also increasing.

Globalization, trade, urbanization, climate change, information technology and civil conflicts are among the major external drivers that have an impact on social, cultural and behavioural practices and ultimately on health outcomes across population groups. These factors, which are structural and intermediate, are beyond the remit of the health sector apart from environmental issues related to water supply and sanitation traditionally linked with public health. However, they have a huge cumulative impact on health due to their influence on lifestyle-related factors such as food consumption, use of tobacco, alcohol, drugs and other psychoactive substances, physical activity, violence, sanitation and hygiene, unsafe sex, health information seeking and high-risk behaviours, among others.

Climate change is threatening to erode the gains made in economic growth and poverty reduction. Sub-Saharan Africa suffers from natural fragility, with two thirds of its surface area being desert or arid land. In addition, it is exposed to spells of drought and flooding predicted to intensify due to climate change. Malaria, one of the major killer diseases in the Region, is spreading to previously non-endemic areas usually of high altitude.

In addition, the global economic crisis threatens to worsen the current health situation if the limited resources available are diverted from health to other areas accorded greater priority.

**Justification**

The responsibility for tackling many of the key determinants of health rests also with other ministries and not only the ministry of health. The challenge therefore is how the ministry of health can influence the actions of other ministries. WHO and Member States are already addressing these challenges through various initiatives.10 However, there is urgent need for a more coherent approach which strongly reaffirms the values and principles of primary health care (PHC) namely equity, solidarity, social justice, universal access and community participation.

**The regional strategy**

**Aim and objective**

The aim of this strategy is to assist Member States to promote actions to reduce health inequities through
intersectoral policies and plans in order to effectively address the key determinants of health. The objective is to provide Member States with a structured approach to implementing the CSDH recommendations in line with World Health Assembly Resolution 62.14\(^ {11} \) and to promote their uptake in countries. The overall goal is to ensure that all countries in the Region address the social determinants of health using a “whole-of-government” approach.

**Guiding principles**

In this regard, there is a need to adhere to the following general guiding principles:\(^ {12} \)

a) levelling up – health equity policies should strive to raise the health status of individuals and groups at the bottom of the ladder;

b) equity for all – the health system should be built on principles of fairness;

c) universal participation – all voices, including those of marginal groups should be heard;

d) partnerships – implementation should be based on partnership between the country and all development partners;

e) multisectorality – implementation should be the responsibility of all sectors; and

f) ownership – there should be a sense of ownership by country and relevant stakeholders.

**Priority interventions**

The priority interventions presented below emanate from the overarching recommendations of the CSDH:

a) improve day-to-day living conditions by improving the circumstances in which people are born, grow, live and age;

b) address the inequitable distribution of power, money and resources; and

c) measure and understand the problem and assess the impact of action.

The proposed interventions are grouped into two broad categories, namely: interventions specific to the health sector; and interventions in sectors other than health including cross-sectoral actions.

**Roles and responsibilities of Member States, WHO and partners**

**Member States**

In addition to the actions requested of Member States in World Health Assembly Resolution WHA62.14, countries should:

a) In the short term:

i) strengthen the stewardship role of the ministry of health to coordinate and advocate for intersectoral action to reduce health inequities through action on social determinants of health;

ii) institutionalize mechanisms for advocacy, evidence gathering and dissemination in order to act on socially determined health inequities both within and outside the health sector;

iii) cooperate with training and research institutions in order to document the situation with respect to the distribution of the key determinants of health. This analysis would further consolidate the evidence base on the impact of SDH in order to inform policymaking and establish a baseline for evaluation of the outcomes of these policies;

iv) build national capacity to advocate for reducing the health equity gap through addressing SDH in all priority public health concerns such as HIV/AIDS, NCD, mental illness and tuberculosis; and

v) adapt a “whole-of-government” approach to health promotion through multisectoral and multidisciplinary collaboration by establishing a Social Determinants of Health Task Force to, among others, identify and build support for health in all policies, at all levels of government and across all sectors.

b) In the long term:

i) ensure that health policies, plans and programmes are oriented to

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<tr>
<th>INTERVENTIONS SPECIFIC TO THE HEALTH SECTOR</th>
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<td><strong>Strengthen the stewardship and leadership role of the ministry of health</strong> to coordinate and advocate for multisectoral and multidisciplinary interventions to reduce the health equity gap through addressing social determinants of health (SDH). The responsibility for action on health and health equity should itself be assigned to the highest level of government.</td>
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<td><strong>Build capacity for policy development, leadership and advocacy to address SDH.</strong> There is need to build the capacity of the staff of the ministry of health to provide leadership in developing policies and programmes for improving health literacy, knowledge transfer and research on social determinants of health using multisectoral and multidisciplinary approaches.</td>
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<tr>
<td><strong>Advocate for legislations and regulations to ensure a high level of protection of the general population from harm and from the impact of some social and economic determinants of health e.g., globalization, commercialization, urbanization.</strong></td>
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<td><strong>Create health systems based on universal and quality health care.</strong> Health systems in the Region should be built on the basis of the principles of equity, disease prevention and health promotion. Quality health care services should be aimed at universal coverage of primary health care. Leadership of the public sector in equitable health care should be strengthened. The health workforce should be developed or strengthened and their capabilities to act on SDH should be strengthened.</td>
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<td><strong>Enhance fairness in health financing and resource allocation.</strong> The role of the ministry of health should be to advocate for fair allocation of financial and technical resources. Countries should strengthen or mobilize public finance for action on SDH by building capacity for progressive taxation. They should consider establishing mechanisms to finance cross-government actions on SDH and allocate funds fairly between geographical regions and social groups.</td>
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**Interventions in Sectors Other Than Health Including Cross-Sectoral Actions**

**Ensure social protection throughout the life course.** Countries should establish and strengthen comprehensive universal social protection policies that support a level of income sufficient for a healthy living for all.

**Develop or promote policies for healthy places and healthy people.** Health equity between rural and urban areas should be promoted. There is need for investment in rural development and for addressing the exclusionary policies and processes that lead to rural poverty, landlessness and displacement of people from their habitats. For urban areas, there is need to place health and health equity at the heart of urban governance and planning. There is need also to ensure economic and social policy responses to climate change and environmental degradation, taking into account health equity. Countries will need to take measures for increased resilience and for protection against adverse changes in the climate.

**Ensure health equity in all policies.** Countries should place the responsibility for action on health and health equity at the highest level of government and ensure its coherent consideration across all policies. Health and health equity should be the corporate business of the entire government, supported by the head of state and should be a marker of government performance.

**Assess and mitigate the adverse effects of international trade and globalization.** Countries should institutionalize health impact assessments of major global, regional and bilateral trade agreements and ensure and strengthen the representation of public health in domestic and international economic policy negotiations.

**Enhance good governance for health and health equity.** Countries and development partners including civil society should make health equity a shared developmental goal as part of ensuring social corporate responsibility e.g., in the areas of trade, urbanization and climate change, among others. There is need for a framework with appropriate indicators for monitoring progress, taking into consideration country contexts.

**Invest in early childhood development to ensure equity from the start.** Countries should commit themselves to implementing a comprehensive approach to early life, building on existing child survival programmes and expanding interventions in early life to include social, emotional, language and cognitive development. Depending on the availability of resources, quality compulsory primary and secondary education should be provided for all children.

**Promote fair employment and decent work.** Full and fair employment and decent work should be a central goal of national social and economic policy-making. Decent work should be a shared objective of national institutions and a central part of national policy agendas and development strategies with strengthened representation of workers in the creation of policy, legislation and programmes relating to employment and work including occupational health.

**Mainstream health promotion.** Priority should be given to mainstreaming health promotion in all policies and programmes to reduce the equity gap through community empowerment. Priority actions should be implemented within the primary health care approach to advocate for health; invest in sustainable policies and infrastructure; build capacity for policy development and leadership; ensure high level protection from harm through adequate regulation and legislation; and build partnerships with various players to create sustainable intersectoral action.

**Mainstream and promote gender equity.** Countries should address gender biases in the structure of society: gender-based cultural and social biases; biases in national and local government laws and their enforcement; biases in the way organizations are run; how interventions are designed; and how economic performance is measured. Policies and programmes aimed at bridging the gaps in education and skills and supporting female economic participation need to be developed and adequately financed. There is need to expand investments in sexual and reproductive health services and programmes geared towards universal coverage and respect for human rights.

**Address social exclusion and discrimination.** Addressing social exclusion, promoting social inclusion and respecting diversity should be key public policy priorities. Public service delivery should be equitable, culturally sensitive, appropriate to diverse needs and accessible to people with disabilities and other vulnerable groups and communities. If appropriate, information about health and welfare entitlements and public services should be made available in a broad range of formats and languages. Data collection strategies should ensure that adequate information about the social and geographical patterns of health of the population is routinely available.

**Enhance political empowerment.** All groups in society should be empowered through fair representation in decision-making about how society operates, particularly in relation to its effect on health equity and the creation and maintenance of a socially inclusive framework for policy-making. Civil society should be empowered to organize and act in a manner that promotes and realizes the political and social rights in regard to health equity.

**Protect/improve SDH in conflicts.** Countries need to improve SDH and promote human rights through building health care systems that promote health equity and community participation in conflict situations.

**Ensure routine monitoring, research and training.** There is urgent need:  

a) to ensure that routine monitoring systems for health equity and SDH are in place and to strengthen vital statistics and health equity surveillance systems to collect routine data on SDH and health equity;  
b) to conduct social, cultural and behavioural studies applying social science research methodologies to determine social factors likely to hinder or promote the bridging of the equity gap through action on social determinants of health that have an impact on priority public health issues such as control of communicable and noncommunicable diseases. This will complement the action of countries in implementing and monitoring the Algiers Declaration, the Libreville Declaration and the Ouagadougou Declaration; and  
c) to provide training on the social determinants of health for policy actors, stakeholders and practitioners, and invest in raising public awareness.
addressing the key SDH;

ii) review health and other training curricula to ensure that linkages between health and SDH are included in all training and in research funding criteria;

iii) provide the financial resources required to support activities for implementing these actions; and
iv) advocate for good governance and corporate social responsibility at local and global levels since the widening health equity gap results from structural forces such as globalization, trade and urbanization.

World Health Organization and partners

In addition to the actions requested of WHO in Resolution WHA62.14, WHO and partners should:

a) hold consultations and discussions on priorities and add them to already identified areas of collaboration;

b) establish a mechanism for annual monitoring of the progress that countries are making in addressing SDH and reducing health inequities; and

c) ensure greater coordination within WHO in order to provide the necessary technical support and guidance to countries in reducing the health equity gap through action on SDH.

Monitoring and evaluation

Three elements of monitoring and evaluation are crucial to the implementation of this strategy:

a) monitoring the overall implementation of the strategy over the next three to five years;

b) monitoring country progress in implementing the recommendations; and

c) tracking and documenting health equity trends for intercountry comparisons.

Resource implications

Implementing this strategy will require new and additional resources. Countries, WHO and partners are called upon to mobilize resources for implementation of this strategy.

Conclusion

This regional strategy proposes interventions for addressing SDH. The priority interventions outlined fall into three key areas of action:

a) improving the conditions of people’s daily life;

b) tackling the inequitable distribution of power, money and resources – the structural drivers of the conditions of daily life; and

c) measuring and understanding the problem.

The strategic interventions are grouped into two areas:

a) those that are specific to, or driven by, the health sector; and

b) those that are driven by sectors other than health including cross-sectoral actions.

Reducing health inequities through action on SDH requires committed leadership and bold action at all levels and strong partnerships between Member States, WHO and other development partners, communities and individuals.

Member States are encouraged to implement the proposed interventions, integrate SDH across sectors and settings, and provide an enabling environment for all stakeholders to contribute to the reduction of health inequities.

Education, specifically girls’ education, is a key determinant of health outcomes.

References


3. People living on less than US$1.25/day are said to be in extreme poverty. See World Bank MDGs website (http://web.worldbank.org/WBSITE/EXTERNAL/EXTABOUTUS/0,c0,00-1,2587-en.html).


7. These include Gabon, Gambia, Lesotho, Malawi, Mauritania, Mauritius, Namibia, Rwanda, Seychelles and Uganda.


10. For example, through work emanating from the Ouagadougou Declaration on Primary Health Care and Health Systems in Africa: Achieving Better Health for Africa in the New Millennium, the Libreville Declaration on Health and Environment, and the Algiers Declaration on Health Research for Health in the African Region, the Regional Strategy on Poverty and Health, and “Agenda 2020” on Health for All in the African Region by the Year 2020.


13. Evidence from the final report of the WHO-CSDH Knowledge Network on priority public health conditions can help inform this process.
Progress report on the implementation of the 2001 Regional Health Promotion Strategy

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The aims of the strategy detailed in Resolution AFR/RC51/R4 are:

a) to advocate for increased awareness of and support for the use of health promotion across sectors;
b) to develop national strategies incorporating policy frameworks and actions plans;
c) to plan, implement and evaluate health promotion actions for intervening in disease-specific issues, population groups or settings; and
d) to mobilize resources by engaging new players such as civil society and public and private sectors.

Later World Health Assembly Resolutions, WHA42.44, WHA51.12 and WHA57.16 also called on Member States and WHO to give priority to strengthening health promotion actions. The Seventh Global Conference on Health Promotion was held in Nairobi, Kenya from 29–31 October, 2009. This conference adopted the Nairobi Call to Action that identifies key strategies and commitments urgently required for closing the implementation gap in health and development through health promotion.

In 2011, during the Sixty-first Session of the Regional Committee in Yamoussoukro, Côte d’Ivoire, the African Region deliberated on the progress report regarding the implementation of the Regional Health Promotion Strategy in the African Region. The committee recommended updating of the existing strategy and to present it to the Sixty-second Session of the Regional Committee in 2012. The updated strategy was endorsed and a resulting resolution adopted advocating the need for a multisectoral approach involving individuals, families and communities, in successful health promotion strategies.

Progress made

Between 2007 and 2010, ten countries\(^3\) developed national health promotion strategic action plans and 10 countries\(^4\) received technical support in developing national health promotion policies. These policies and strategies are available for use by both health and non-health professionals, including civil society groups.

Implementation of health promotion activities in various settings was strengthened through the development of tools and guidelines. Several generic implementation guidelines for application in school health promotion and other community settings were developed in collaboration with regional experts. The main guidelines include focusing on health promotion planning, implementation and capacity building.\(^5\) Tools containing key strategies, principles and values for integrating health promotion actions were developed for maternal and child health and HIV/AIDS prevention and control.

Capacity building workshops on the use of health promotion strategies and tools for noncommunicable diseases prevention and control were held in Ouidah, Benin, in 2007 and 2008 for 40 participants from 15 countries;\(^6\) in Entebbe, Uganda, in 2008 for 31 participants from eight countries; and in Harare, Zimbabwe, for 32 participants from 12 countries\(^7\) in 2010. The workshops imparted content and skills on the application of health promotion strategies and tools to address health risk factors and key determinants.

SUMMARY—Health promotion is considered a cost-effective approach and a socially justifiable investment that can significantly help improve the health and well-being of individuals, families and communities. With the increase in disease burden and premature deaths from preventable causes, Member States of the WHO African Region recognized the need to invest in health promotion. Consequently, in 2001, the Fifty-first Session of the WHO Regional Committee deliberated on and endorsed the Regional Health Promotion Strategy and adopted a related Resolution AFR/RC51/R4.\(^1\) Subsequent resolutions have called for the prioritization of health promotion including health education and the promotion of healthy lifestyles. The strategy advocates for integration of activities across sectors and encourages multisectoral collaboration. Ultimately, health promotion is a core function of public health which reduces the disease burden and mitigates the social and economic impact. This report summarizes the progress made in the implementation of the strategy and proposes the next steps.

Voir page 53 pour le résumé en version française.
Ver a página 53 para o sumário em versão portuguesa.
of NCDs. Furthermore, the capacity of three academic institutions offering health promotion courses was enhanced through joint curriculum reviews. A generic health promotion course was developed with technical support from regional experts.

Partnership, alliances and networks for health promotion advocacy, resource mobilization and evidence gathering were enhanced at regional and country levels. Education International (EI) provided funding for five years to secondary school teachers to advocate for HIV/AIDS prevention and control in 25 countries. UNICEF, UNFPA, Japan International Cooperation Agency (JICA), Ford Foundation and USAID provided resources to support health promotion activities in ten countries.9

To effectively support Member States to address disease risk factors and their determinants, the Regional Office established the Health Promotion Cluster in 2010 in line with the Strategic Directions for WHO AFRO 2010–2015 on “Achieving Sustainable Health Development in the African Region” to effectively support Member States.

The implementation of the regional health promotion strategy revealed several gaps and challenges. These are:

- **a)** weaknesses in leadership and the stewardship role of ministries of health in coordinating health promotion activities across sectors;
- **b)** low level of involvement of various players including civil society and communities in advocacy actions to regulate and legislate for good health governance;
- **c)** inadequate evidence regarding the effectiveness of health promotion;
- **d)** lack of a sustainable financing mechanism to support health promotion activities; and
- **e)** the need to build a critical mass of health promotion practitioners including at the community level.

**Next steps**

To effectively apply health promotion actions in response to the identified priority public health challenges facing countries of the WHO African Region, it is proposed to update the current regional strategy. Member States together with partners should:

- **a)** strengthen the leadership and stewardship role of the ministries of health to coordinate multisectoral actions within the primary health care context in order to address public health conditions existing outside the health sector;
- **b)** involve various players including civil society, private sector and communities to advocate for regulatory and legislative actions that seek to promote good health governance;
- **c)** monitor progress through evidence-based information and apply the findings to policies and programmes;
- **d)** establish innovative health promotion financing mechanisms e.g., dedicated taxes or special levies on tobacco or alcohol; and
- **e)** build a critical mass of health promotion practitioners at all levels through pre-service and in-service training, and continuing education.

The Regional Committee took note of this progress report and endorsed the proposed next steps.

In 2012, the Sixty-second session of the Regional Committee held in Luanda, Angola deliberated on the updated strategy. The strategy was endorsed and adopted. The updated strategy for health promotion in the WHO African Region places emphasis on the need for a multisectoral approach to address the risk factors and their determinants across priority public health conditions, and on the importance of participation of individuals, families and communities in the promotion of health.

**References**

2. WHA62.44: Health promotion, public information and education for health; WHA51.12: Health promotion; WHA57.16: Health promotion and healthy lifestyles.
4. Cape Verde, Ghana, Guinea-Bissau, Lesotho, Madagascar, Namibia, Nigeria, Sierra Leone and South Africa.
5. Guidelines for development of health promotion in countries of the WHO African Region. Guidelines for the implementation of the health promoting schools initiative (HPSI). Facilitator guides for regional orientation meetings for health promotion national focal persons and AFRO HPSIs.
9. Institut Régional de Santé Publique (IRSP), Benin; Ibadan University (Nigeria) and Ingrina PHC Institute (United Republic of Tanzania).
The state of health financing in the African Region

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Health is increasingly recognized as a key aspect of human and economic development in Africa and countries are increasing investment in actions and reforms to improve health outcomes and accelerate progress towards meeting the health Millennium Development Goals. The political will of national leaders to put health at the forefront of development has been reiterated at the continental level through actions such as the Abuja Declaration of 2001 on increasing government funding for health, the Addis Ababa Declaration of 2006 on community health in the African Region, the 2008 Ouagadougou Declaration on Primary Health Care and health systems in Africa and the 2012 Tunis Declaration on value for money, sustainability and accountability in the health sector. Health system financing is one of the key areas that offers important opportunities to translate these commitments and political will into results. Health financing is also the crucial element for moving countries towards the objective of universal health coverage (UHC) – a health system development goal for all countries that has been widely supported by the Member States of the WHO and of the United Nations (as endorsed by Resolution WHA64.9 at the Sixty-fourth World Health Assembly in 2011 and Resolution ResA/67/36 at the United Nations General Assembly in 2012).

The need to develop strong health financing systems is a common objective of all countries. Even the richest countries are finding it increasingly difficult to keep up with rising health care costs, and the current economic downturn is adding more pressure on health spending. In low- and middle-income countries, i.e. the vast majority of African countries, scarcity of funds for health is an even more acute problem. The average total health expenditure (THE) in African countries stood at US$ 135 per capita in 2010 – only a small fraction of the US$ 3 150 spent on health in an average high-income country. Insufficient investment in the health sector and in actions to tackle the environmental and social determinants of health is a serious obstacle to improving health outcomes in Africa, particularly considering that the continent bears the bulk of the global morbidity and mortality burden for maternal and infant mortality, HIV/AIDS and noncommunicable diseases.

In about half of African countries, 40% or more of THE is made up of out-of-pocket payments (OOPs), which is the most regressive way of funding health care. The reliance on OOPs creates financial barriers to access to health services and puts people at the risk of impoverishment. Furthermore, the current financial flows within the health systems are creating and exacerbating inefficiencies and inequities, for example through skewed allocation of funds to urban areas and specialized care. These weaknesses in the health financing systems have been identified as the main underlying reasons for the limited progress towards achieving the health MDGs in Africa.

The main objective of this paper is to provide information on the current state of health financing in the African Region in a manner that will support evidence-based policy discussions and policy-making. In this way it responds to the current challenge of measuring, observing, evaluating and analysing data on health financing.

Methodology

A data collection tool was developed and sent to countries to collect data on

SUMMARY—This paper provides information on the current state of health financing in the WHO African Region. It aims at responding to the current challenge of measuring, observing and analysing data on health financing and supporting evidence-based policy discussions and policy-making. A data collection tool on the health financing system parameters was sent to countries and where gaps existed, national health accounts data, collected annually by WHO and verified by the countries before finalization, were used. The analysis shows that the Member States of the WHO African Region are in general still far from meeting key health financing goals. However, while most countries in the Region have limited capacity to mobilize public revenue, many have succeeded in putting in place mechanisms to protect the poor and vulnerable population groups. The paper will also propose a number of actions that build on the observations and are consistent with those contained in other recent declarations and action plans developed in the African Region.

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the parameters of their health financing system and the health system in general. Where gaps existed in health expenditure data, national health accounts data, which are collected annually by WHO and verified by the countries before finalization, were used.

To assess the country rankings on various indicators, categorizations were used with point estimates set mostly at 2001, 2005 and 2010. These years were chosen because of their association with key milestones in health financing targets and availability of data. The milestones were the declaration made by Africa Union Member States to invest in health in Abuja (2001) and the World Health Assembly (WHA) Resolution 58.33 of 2005 that urged WHO Member States to adopt the goal of UHC and develop health systems and health financing systems to support this goal. The year 2005 was also the base year for the calculations included in the High Level Task Force for Innovative International Financing for Health systems (HLTF). The most recent internationally comparable health expenditure data available are for 2010.

**Results**

**Macroeconomics, government income and external funds**

According to the World Bank classification, 26 of the 45 countries assessed in the Region are categorized as low-income countries (see Figure 1).

**Total health expenditure**

Total health expenditure is an aggregate measure that reflects the total level of funds available for health from public, private and external sources and reflects the importance of health care in the overall economy.

In 22 of the 45 countries the level of funding for health is below the minimum level of US$ 44 per capita recommended for 2009 by the HLTF. Figure 2 shows the trends in THE for the African Region over a period of ten years.

Countries have been increasing expenditure on health although at a varying pace. For example, Rwanda more than doubled its (nominal) per capita expenditure on health over a period of ten years, with a large part of this increase attributed to external funds. On the other hand, six countries have remained below the expenditure level of US$ 20 per capita. Eleven countries have persistently spent over US$ 44 per capita over the same period.

**Domestic funds for health**

Many African countries have shown to have limited capacity to raise public revenue mainly because the informal nature of their economies makes tax collection difficult, including payroll tax collection for social health insurance. The performance, accountability and administration of the tax system are often an additional problem for many countries. Figure 3 gives an overview of
the public financial capacity in African Region countries

There is important variation among the countries in their capacity to mobilize public financial resources. Countries with high GDP in absolute per capita terms are able to spend more, even when their government expenditure as a share of the economy is low. This shows the macroeconomic constraints that limit the fiscal space in many countries and explains to a large extent why Gabon, for example, has a government expenditure of US$ 2,410 per capita while Malawi, with a similar share of GGE over GDP (28%), has an absolute GGE of only US$110 per capita.

The macroeconomic underpinnings differ between the countries. According to the International Monetary Fund (IMF), 20 of the 45 countries in sub-Saharan Africa can be viewed as significant exporters of natural resources. The situation of public finances in these countries is very different from that in the countries without or with limited revenue from natural resources and explains to a large extent the differences in fiscal space between these two categories of countries. But even in countries with large natural resource sectors the question of sufficiency and sustainability of public funds is crucial, if only because in only two of these 20 countries are revenues from natural resources projected to increase markedly during 2011 to 2016.7

External funds for health
In the majority of Member States of the WHO African Region, external sources account for less than 20% of THE. But some countries face special circumstances, such as Malawi, where donor funding consistently accounted for more than 40% of THE between 2001 and 2010.

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**Figure 2. Trends in total health expenditure (THE) per capita 2001, 2005 and 2010**

- **No. of countries (2010)**
- **No. of countries (2005)**
- **No. of countries (2001)**

<table>
<thead>
<tr>
<th>Category</th>
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<th>20</th>
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<td>20</td>
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<td>10</td>
<td>15</td>
<td>20</td>
<td>25</td>
<td>20</td>
</tr>
</tbody>
</table>

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**Figure 3. General government expenditure (GGE) as a share of GDP and GGE per capita (GGE/cap) in US$, 2010**

- **GGE/GDP**
- **GGE/cap**

---
Burundi and the United Republic of Tanzania registered significant increases in the relative importance of donor funding between 2005 and 2010 – in both countries external funding rose from about one third of THE to around 50% during this period.

Several issues have been raised regarding external sources in financing health services, including possible negative effects of donor funding on predictability of funds and/or on the fragmentation of health systems. Nonetheless, external funding for health will remain crucial in cutting the negative spiral of illness and poverty in the vulnerable countries. Increase in available international resources for health should be possible if the donor countries fulfil their promise to allocate 0.7% of their gross national income to official development assistance (ODA). In 2009 only five donor countries met this requirement.

**Extent of government prioritization of health**

There is scope for governments to allocate more money for health from domestic sources. In this regard, the 2001 Abuja Declaration urging African Union states to allocate “at least 15%” of national budgets to the health sector was a landmark. This commitment was further reaffirmed in the Maputo Declaration in 2003. Unfortunately this target had been achieved by only five countries by 2010 as shown in Table 1. During the same period 13 countries had reduced their relative government allocation to health while in four others the trend had not changed. The average amount allocated to the health sector by African Region countries stands at 9.8%. It is important to note, however, that allocations to the health sector as a percentage of total government budget ranged from 2% to 20% in 2010 in the African Region.

It is logical to consider the Abuja Declaration target together with the recommendation of the HLTF of reaching US$ 44 per capita THE. Over one third of the countries in the African
Region have not managed to raise health spending to the level of US$ 44. Only Botswana, Rwanda and Zambia have managed to meet both the Abuja and the HLTF targets as shown in Table 1.

### Financial risks and barriers to access to health services

Countries with a low level of public investment in health have high OOPs. In the African Region, 20 had a share of OOPs of over 40% of THE. Some studies have pointed out that where OOPs is below 15–20% of THE, catastrophic health expenditure drops to negligible levels.\(^{10}\) In 23 countries out of 45 that have reached the level of THE recommended by HLTF (US$ 44 per capita), in sixteen of them reliance on OOPs is still more than 20%. Countries that have reached the US$ 44 per capita mark but have a high level of OOPs have thus progressed relatively well in resource mobilization but need to focus also on developing and strengthening pooled prepayment mechanisms.

### Abolition of user fees or effective exemptions

Several countries have put in place mechanisms to protect the poor and vulnerable groups regarding OOPs. Voucher schemes for pregnant women, for example in Uganda and Kenya, and social grants for marginalized groups have been implemented, though largely on a pilot basis. Subsidies have been often extended also to private not-for-profit providers to enable them to provide free services to specific groups or for certain diseases or to provide services at highly subsidized fees to enable access by the larger population (Kenya, Lesotho, Malawi, Swaziland and Uganda). In some countries where fees exist, for example in the United Republic of Tanzania, there are

### Actions proposed

The following actions, in appropriate combination according to local context, may enable countries to improve health financing sector. The proposed actions are consistent with those contained in the framework for the implementation of the Ouagadougou Declaration on PHC and the Tunis Declaration on value for money, sustainability and accountability in the health sector.

- In the future, with Africa still on a projected path of economic growth,\(^{13}\) the focus should turn to how the economic expansion will affect availability of funds for health. Will health expenditure grow faster, slower or at the same pace as per capita income? The answer to this question will necessarily vary from country to country, but as there are most probably going to be “push” factors, such as the rise in noncommunicable diseases or in the ageing population, and “pull” factors, such as investment growth in high technology that will be similar to high income countries elsewhere, it is probable that many African countries will follow the same pattern of “excess growth” (health spending outpacing economic growth) that has been observed in high income countries. Looking at the very low levels of per capita spending and of total health expenditure as a share of GDP in most African countries this would be a welcome outcome in most countries, but it should not turn away focus on inefficiencies in utilization of resources.

<table>
<thead>
<tr>
<th>THE per capita</th>
<th>GGHE/GGE &gt; 15%</th>
<th>GGHE/GGE &lt; 15%</th>
</tr>
</thead>
<tbody>
<tr>
<td>&gt;US$ 44</td>
<td>Botswana, Rwanda, Zambia (3 countries)</td>
<td>Algeria, Angola, Cameroon, Cape Verde, Republic of Congo, Côte d’Ivoire, Equatorial Guinea, Gabon, Ghana, Guinea-Bissau, Lesotho, Mauritius, Namibia, Nigeria, Sao Tome and Principe, Senegal, Seychelles, South Africa, Swaziland, Uganda (20 countries)</td>
</tr>
<tr>
<td>&lt;US$ 44</td>
<td>Madagascar, Togo (2 countries)</td>
<td>Benin, Burkina Faso, Burundi, Central African Republic, Chad, Comoros, Democratic Republic of Congo, Eritrea, Ethiopia, Gabon, Guinea, Kenya, Liberia, Malawi, Mali, Mauritania, Mozambique, Niger, Sierra Leone, United Republic of Tanzania (20 countries)</td>
</tr>
</tbody>
</table>
External sources play a significant role and the focus should be on addressing challenges to their effective use. Improving predictability of donor funding and harmonization of donor funds with national priorities and mechanisms are among the issues that need to be addressed. A sector wide approach for better coordination and harmonization among the development partners themselves and between development partners and the countries is key. In this regard there exist useful tools such as the IHP+ Global Compact (International Health Partnership), signed by all parties. The health sector needs to develop a clear policy and a strategic plan as an investment framework for all available funding. In addition, the capacity of the ministries of health needs to be strengthened and collaboration between the ministries of health and finance should be improved to monitor donor aid for health.

Strengthening budget execution and demonstrating results from funding already provided to show return on investment. This calls for strengthening of monitoring mechanisms, and signals a need to institutionalize national health accounts (NHAs) and improve efficiency in health systems, including equitable access to skilled health workers and the introduction of measures such as results-based financing and incentives to enhance transparency and performance and reduce wastage.

Collaboration between the ministries of health and finance has to be improved and the misconception that health is an unproductive sector has to be demystified. This includes setting up inter-ministerial committees and strategic alliances for continued dialogue and information sharing; health sector participation in bilateral and multilateral engagements between government and partners; and finance ministry support for capacity building in financial management in the health sector. In addition, there is a need for finance ministries to participate fully in health financing processes right from agenda setting through to implementation and monitoring of interventions.

Every country will need to lay out a path towards universal health coverage, in particular countries need to develop strategies for reinforcing their health financing mechanisms so that they collect more and sustainable revenue, pool effectively financial risks among the population and ensure equitable and efficient use of resources.

Conclusion

This paper gives an overview of the health financing situation in the Member States of the WHO African Region. It shows that despite progress, many countries are still on average far from achieving their health financing goals such as the Abuja target of allocating 15% of government budgets to health or the goal of reducing the share of out-of-pocket expenditure in total health expenditure. For example, in 20 out of 45 countries out-of-pocket expenditures are still higher than 40% of the total health expenditure and in 22 countries the level of total health expenditure does not reach even the very minimal target of US$ 44. This cross-country analysis demonstrates that in general the health financing systems in Africa are weak and do not ensure sustainable progression and equity in the way funds are collected and pooled.

Several African countries have recently implemented successful health financing reforms. Countries in which health system financing has been improving and countries with more acute need for reforms and action, all need to constantly track progress in health financing in order to adapt to changing situations. This monitoring effort and the analysis derived from it will need to be translated to policy readjustments and/or into new actions and reforms so that countries stay on track to achieve the health financing goals that will support the objective of UHC.

The ministries of health cannot do this alone. The policy dialogue around the health financing strategy will need to engage all the key stakeholders. Particular focus should be given to the interaction between the ministries of health and finance in increasing health funding. Developing a health financing system that supports the objective of UHC will to a large extent depend on the overall government financial and fiscal position.

References

Optimizing global health initiatives to strengthen national health systems

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Health systems seek to achieve overall health improvement through provision of promotive, preventive, curative and rehabilitative health services. They encompass the population they serve and a set of six functions, namely: service delivery including interventions within specific disease control programmes; the health workforce; information; medical products, vaccines and technologies; financing; and leadership/governance. Health systems operate at and across national, district, community and individual levels. Governments are responsible for strengthening their health systems.

Health system strengthening is defined as building capacity in critical components of health systems to achieve more equitable and sustained improvements across health services and health outcomes. These include defining sector policies and strategies; clarifying roles and managing competing demands; ensuring fair and sustainable financing; creating an adequate and productive workforce; ensuring supply, maintenance and proper use of drugs and equipment; improving organization, management and quality of services; and ensuring availability and effective use of facility- or population-based information and monitoring systems. Building capacities may involve actions at one or more levels, from households to national and global levels.

Global Health Initiatives are usually targeted at specific diseases and are intended to bring additional resources.
to the health efforts of countries. Since 2000, the number of GHIs has grown exponentially, reaching over 140. Three of the major GHIs are:

- the Global Alliance for Vaccines and Immunization (GAVI) – a global effort to strengthen childhood immunization programmes and bring a new generation of recently licensed vaccines into use in developing countries;
- the Global Fund to Fight AIDS, Tuberculosis and Malaria, which directly contributes to the achievement of Millennium Development Goals 4, 5, 6 and 8; and
- the United States GHI which seeks to achieve significant health improvements and foster sustainable effective, efficient and country-led public health programmes that deliver essential health care whose first principle is to focus on women, girls and gender equality.

The GAVI Alliance and the Global Fund have identified functional health systems as essential to achieving their objectives and established health systems strengthening funding windows to effectively scale up proven, high-impact interventions and help improve the sustainability of results. Since 2007, the GAVI Alliance has made available US$ 500 million for health systems strengthening in 54 countries, most of which are in the African Region. In addition, the Global Fund has dedicated US$ 1.6 billion to health systems strengthening in 27 countries in the Region since 2005. In the recent past the GAVI Alliance, the Global Fund and the World Bank have explored the possibility of creating a health systems funding platform to effectively support countries in line with the principles of the Paris Declaration on aid effectiveness.

The investment of GHI resources in health systems in an integrated manner is yielding positive results, as illustrated in the following examples:

a) In 2005, the Global Fund joined DFID and other partners in Malawi to strengthen human resources in order to optimize the implementation of interventions related to MDGs 4, 5 and 6. Between 2005 and 2009, the health worker density increased by 66% (0.87 to 1.44) and, using the Lives Saved Tool (LiST), an evaluation of four coverage indicators (antenatal care, skilled birth attendance, administration of nevirapine for preventing mother-to-child transmission and fully immunized children) showed that 13 187 additional lives were saved due to their increased coverage.

b) In Ethiopia, three GHIs and other partners have supported the recruitment and training of 30 000 extension health workers to rapidly roll out four packages of promotive and preventive services and management of diseases at the community level. Final dose diphtheria, pertussis and tetanus (DPT3) coverage increased from 69% in 2005 to 86% in 2010.

c) Similarly, the Government of Rwanda has developed an integrated approach to health delivery and built health system strengthening components into GHI grants, thus avoiding the creation of parallel systems and enabling the renovation and construction of at least 100 health facilities and salary support for doctors and nurses, to improve

Figure 1. The Global Fund funding by disease 2002–2011

Source: Figure 4.5 Cumulative approved funding from the Global Fund by disease, 2002–2011, page 65 from Strategic Investments for Impact: Global Fund Results Report 2012.
their retention even in rural areas. Based on the Rwanda Demographic and Health Survey 2010, under-five mortality declined substantially from 152 to 76 per 1000 live births between 2005 and 2010.

Despite these efforts, progress towards the health MDGs has been rather slow in many countries in the African Region. Only Equatorial Guinea and Eritrea are on track to achieve MDG5, and only eight out of the 46 countries in the Region are likely to achieve MDG 4 by 2015. Failure to increase the pace towards the achievement of the MDGs is largely blamed on weaknesses within national health systems. Optimizing GHI resources to strengthen national health systems in the Region is expected to reduce the main bottlenecks to reaching disease-specific national and international health goals and targets. These bottlenecks are found in all the six building blocks of the health system and in their interactions, necessitating a holistic approach with strong government leadership.

Challenges

Government stewardship in strengthening health systems is sometimes overwhelmed by multiple and parallel approaches that fragment resources such that holistic implementation of national health strategic plans is hampered. There is inadequate focus on identifying the system-wide bottlenecks and estimating the related resources needed to optimally implement the interventions supported by the GHIs. In addition, there is suboptimal participation of key national and international partners in the development of national health policies and strategic plans to ensure that they adequately reflect major health priorities, clarify the roles and responsibilities of different stakeholders and maximize the extent to which specific technical strategies and plans benefit from and fit into national health strategic plans.

All the GHIs make their resources available to eligible countries, subject to development and approval of proposals. The different calls for proposals cause difficulty in harmonizing interventions to strengthen a health system. In addition, the intensity and consistency of the dialogue on how best to address systemic bottlenecks in order to effectively scale up high impact interventions vary from country to country. As a result, the health system strengthening components of the proposals may not fully reflect the health systems strengthening priorities set out in the national health strategic plans.
Therefore, consistency with national health policies and strategic plans is often undermined.

The large increase in the number of GHIs has underscored the need to improve national capacity to oversee and coordinate a wide range of stakeholders in the health sector. Globally, the slow progress towards the realization of the health systems funding platform has highlighted the challenge in achieving coordination among the GHIs without a well-defined mechanism. The 2011 report on the assessment of the five principles of the Paris Declaration showed that, as at 2010, only one (strengthen capacity to coordinate support) out of the 13 targets had been met. For example, only 19% of donors’ missions to the field were jointly undertaken, which is far below the required 40%. However, progress has been significant among the remaining indicators where the responsibility for change lies primarily with governments of developing countries.

Adequate funding for health system strengthening through domestic resources remains a daunting challenge for many countries in the Region. In general, the opportunities offered by GHIs such as GAVI and the Global Fund for health system strengthening have been inadequately utilized, while most other GHIs do not provide such opportunities. This may require exploring the prospects of making better use of the existing health system funding windows and increasing their numbers among GHI-supported programmes.

Opportunities

Despite these challenges, the support from GHIs provides several opportunities. In addition to committing substantial resources, GHIs play effective roles in advocacy, coordination and technical support. With the support of GHIs, some countries have successfully implemented programme specific interventions that have led to the reduction or elimination of diseases. Most of the countries in the Region have presented documentation showing success in the polio eradication agenda, with only one country still endemic in the African Region. Eritrea, Rwanda and Swaziland took only four years to exclude malaria from the ten leading causes of morbidity, controlling it to a level where the disease has ceased to be of any public health significance. The Measles Partnership Initiative contributed to measles mortality reduction by 85% between 2000 and 2010. Furthermore, the introduction of performance-based funding approaches has contributed to increased accountability at country level.

All GHIs support and agree with the five principles of the 2005 Paris Declaration on aid effectiveness. Additionally, in 2011 the Fourth High Level Forum on Aid Effectiveness came up with the Busan Partnership for effective development cooperation. Earlier, in 2006, GAVI and WHO had developed Working Paper No. 4 on “Opportunities for Global Health Initiatives in the Health System Action Agenda” that was presented as a background document to the GAVI board. The paper outlined how GHIs could support health systems strengthening and in which specific areas. Given its relevance to all GHIs, that paper provides an opportunity to enhance the ability of GHIs to work together in synergy.

In May 2008, WHO launched a process to generate evidence-informed guidance through the Maximizing Positive Synergies (MPS) project and has engaged stakeholders in a collaborative effort to build new knowledge on how GHI-supported programmes are impacting national health systems, and to harness this evidence for policy and implementation. The first draft document in 2009 presented an initial compilation of findings from MPS research partners who have analysed GHI-health systems interactions in more than 20 countries. Furthermore, in the same year, through the Civil Society Consortium, evidence of the interactions between GHIs and the health systems and the role of the civil society was documented for Kenya, Malawi, Uganda and Zambia.

The Grand Challenges in Global Health is an initiative by the Bill and Melinda Gates Foundation to address an imbalance in which only a tiny fraction of the resources spent on research is focused on discovering and developing
new tools to fight the diseases that cause millions of deaths each year in developing countries. Grand Challenges in Global Health focuses on 16 major global health challenges with the aim of engaging creative minds across scientific disciplines to work on solutions that could lead to health system advances and breakthroughs in developing countries. Grand challenges 1–3 are:

- one vaccination dose at birth;
- no refrigeration needed vaccines; and
- needle-free vaccines.

All the three grand challenges have grant opportunities for research.

GHIs actively support policy directions at national level, especially with regard to the provision of services free of charge at the point of delivery. They thus promote pre-payment mechanisms and contribute to progression towards universal coverage. In addition, they promote accountability among beneficiaries.

### Actions proposed

There is need to strengthen country stewardship, management capacity and advocacy for estimation of all the resources required for implementation of interventions so that all the expected system-level needs across the six building blocks are taken into account to enhance allocation efficiency. Involvement of partners in the development of national health strategic plans, within government set guidelines, is of paramount importance to ensure common agreement and buy-in on priorities, financing and reporting mechanisms and to ensure also that the specific roles in implementing the strategic plans are clarified, and that GHI interventions fit into the national health strategic plan.

During proposal development, there is need to promote a holistic approach on how best to address systemic bottlenecks in order to effectively scale up high-impact interventions. Integration of the proposed interventions into national health strategic plans should be a prerequisite for successful implementation of the interventions.

To effectively finance national health strategic plans, revenues collected from different sources (income tax, foreign aid including from GHIs, health insurance and some of the innovative means promoted) should be pooled into an integrated health financing mechanism that allows transparent, rational and efficient allocation and use of the resources. This will reinforce country efforts to move towards universal coverage with the entire population having access to good quality health services without the financial hardships resulting from out-of-pocket payment for access to these services.

Countries should maximize the use of the existing health system funding windows by ensuring achievement of results in a timely, accountable and transparent manner. In order to sustain results, there is need for long-term investment in health systems strengthening.

It is most important to enhance coordination and communication among GHIs and other key players and to work collaboratively to improve efficiency and harmonization between themselves and with other partners, and alignment to country priorities. This may require the formation of a “collaborative mechanism” or a “platform” for coordination of the contributions of each partner to meet country-specific needs including for health systems strengthening. In addition, there is need to explore how best to expand the number of health system strengthening windows among the other GHI-supported programmes.

WHO and other UN agencies should encourage health systems research, taking advantage of the Grand Challenges in Global Health initiative and the MPS project. Using its convening role, WHO should facilitate the discussion of the proposed actions among GHIs and remain an active player in the process of harmonization through the already established Harmonization for Health in Africa (HHA) and International Health Partnership plus (IHP+).

### Conclusion

Strengthening health systems is fundamental to improving health outcomes and accelerating progress toward the health MDGs. The ability of GHIs to raise and disburse additional funds to support disease control and strengthen health systems provides a unique opportunity for many countries to fill critical funding gaps in addressing their health development priorities. By addressing the challenges and making good use of the opportunities stated above countries can make tangible progress towards achieving not only disease-specific targets but also long-term and sustainable health outcomes.

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Overview of health considerations within National Adaptation Programmes of Action for climate change in least developed countries and small island states

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In the context of the United Nations Framework Convention on Climate Change (UNFCCC), least developed countries and small island states have been targeted to receive specific support from developed countries to support their adaptation processes in relation to climate change. Since 2004, these countries have received, with the support of the Global Environment Facility, the United Nations Environment Programme, the United Nations Development Programme and other organizations, technical guidance and financial support to prepare National Adaptation Programmes of Action to address the impacts of climate change. These programmes have been prepared through a consultative process at the national level, followed by a prioritization exercise, with the aim of identifying the most immediate priority needs and developing projects to respond to them. As part of this process, a vulnerability assessment is undertaken, as a basis for project development. To date, 44 NAPAs have been prepared and made available in the public domain, through the UNFCCC website (http://www.unfccc.int).

Human health is a central concern in climate change. It is one of the key priorities areas of the UNFCCC. Beyond economic and social impacts, the well-being of the human population and the capacity of the human race to survive are at stake. For this reason, WHO has been advocating greater consideration of health matters in climate change discussions. The NAPAs reflect what is currently intended to take place on the ground to respond concretely to the challenges of climate change. A review of health considerations within these plans has therefore been undertaken with the objective of informing policy-makers, experts and the general public on the current state of planning and to help shape the way forward in order to better address health in the current climate change process.

Review process

In 2010, WHO undertook a review of health considerations in NAPAs. A total of 41 NAPAs were reviewed including 29 from Africa and 12 from other least developed countries and small island states. Three review forms were prepared to capture the health related information contained:

- identified health impacts;
- adaptation needs and proposed adaptation actions; and
- the implementation framework.

A number of criteria were assessed within each aspect.

**Identified health impacts**

- Percentage of NAPAs with health listed as one of the vulnerable sectors;

The total number of selected priority projects is 459 with just 50 (11%) projects focused on health. The total estimated cost of the priority projects is US$ 1 853 000 000 with only US$ 58 000 000 (3%) going to health projects. With few exceptions, the current consideration of public health interventions in NAPAs is unlikely to support the resilience processes and protect public health from the negative effects of climate change. The article ends with recommendations suggested to improve this situation.

Voir page 54 pour le résumé en version française.
Ver a página 54 para o resumo em versão portuguesa.
Table 1. NAPAs identifying diseases and proposing interventions

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<tr>
<td>Malaria</td>
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<td>Respiratory diseases</td>
<td>9/36</td>
<td>25</td>
</tr>
<tr>
<td>Vector-borne diseases other than malaria</td>
<td>7/36</td>
<td>19</td>
</tr>
<tr>
<td>Malnutrition</td>
<td>7/36</td>
<td>19</td>
</tr>
<tr>
<td>Other parasitic diseases</td>
<td>6/36</td>
<td>17</td>
</tr>
<tr>
<td>Meningitis</td>
<td>6/36</td>
<td>17</td>
</tr>
<tr>
<td>Occular diseases</td>
<td>4/36</td>
<td>11</td>
</tr>
<tr>
<td>Skin diseases</td>
<td>4/36</td>
<td>11</td>
</tr>
<tr>
<td>Noncommunicable diseases</td>
<td>4/36</td>
<td>11</td>
</tr>
<tr>
<td>Unspecified</td>
<td>3/39</td>
<td>8</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Interventions</th>
<th>Number</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health system strengthening</td>
<td>13/30</td>
<td>43</td>
</tr>
<tr>
<td>Sanitation</td>
<td>11/30</td>
<td>37</td>
</tr>
<tr>
<td>Treatment of drinking water</td>
<td>10/30</td>
<td>33</td>
</tr>
<tr>
<td>Vector control (general)</td>
<td>9/30</td>
<td>30</td>
</tr>
<tr>
<td>Malaria control</td>
<td>7/30</td>
<td>23</td>
</tr>
<tr>
<td>Improved access to drinking water</td>
<td>7/30</td>
<td>23</td>
</tr>
<tr>
<td>Disease surveillance</td>
<td>6/30</td>
<td>20</td>
</tr>
<tr>
<td>Preparedness and response to epidemics</td>
<td>6/30</td>
<td>20</td>
</tr>
<tr>
<td>Insecticide-treated nets</td>
<td>5/30</td>
<td>17</td>
</tr>
<tr>
<td>Improved nutrition</td>
<td>3/30</td>
<td>10</td>
</tr>
<tr>
<td>Immunization</td>
<td>2/30</td>
<td>7</td>
</tr>
</tbody>
</table>

- Percentage of NAPAs considered to be comprehensive in their health vulnerability assessment (considered comprehensive when a full range of potential health impacts was clearly specified);  
- Coverage of health aspects; and  
- Gaps in the vulnerability assessment.

Adaptation needs and proposed adaptation actions
- Percentage of NAPAs including health in a list of adaptation actions;  
- Proposed health interventions;  
- Percentage of interventions found to be adequate in relation to the assessment (considered adequate if they were perceived as being at least possibly effective as measures to respond to the identified climate impacts); and  
- Gaps in interventions.

Implementation framework
- Total number of project profiles;  
- Percentage of project profiles focused on health;  
- Health aspects covered by project profiles;  
- Total estimated budget for all projects;  
- Total budget for all health projects; and  
- Percentage of overall budget devoted to health projects.

Main findings

Identified health impacts
In 39 of 41 NAPAs (95%) health was considered one of the sectors on which climate change was seen as having an impact. However, only 23% (9/39) of the NAPAs were considered to be comprehensive in their health vulnerability assessment. Notable gaps in the vulnerability assessments included a lack of baseline epidemiological data for the diseases and medical conditions specified that would be affected by climate change, and a description of the trends anticipated in these diseases and conditions. Most importantly, the underlying reasons why, or the manner in which, climate change would affect the diseases mentioned was unclear in many of the NAPAs, as typically the analyses were limited to a few diseases only without clear justification.

In respect of coverage of health aspects, of the 39 NAPAs that include health in the vulnerability assessment, three did not specify any disease or medical condition. For the remaining 36 plans, the diseases most frequently listed were diarrheal disease (69%), malaria (59%), respiratory disease (25%), vector-borne disease other than malaria (19%) and malnutrition (19%). Other diseases and conditions mentioned include noncommunicable diseases, parasitic diseases, meningitis and ocular and skin diseases. See Table 1 for details.

Adaptation needs and proposed actions
In total, 73% (30/41) of the NAPAs included health interventions within adaptation needs and proposed actions. However, only 27% (8/30) of those interventions were considered to be adequate (as defined in the assessment criteria above). In most plans there were no specific health protection objectives or targets. The proposed interventions did not clearly articulate the public health strategy or national disease prevention and control programme under which they were to be implemented. In respect of gaps, important discrepancies were found between proposed interventions and identified potential impacts of climate change. The most frequently listed interventions were health systems strengthening, improved access to safe drinking water and sanitation, vector control, malaria control, disease surveillance, improved nutrition, immunization and preparedness for and response to epidemics.

Implementation framework
According to guidelines provided by the UNFCCC (http://unfccc.int/resource/docs/cop7/13a04.pdf#page=7) countries are required to select priority projects and to develop project profiles including a budget for each project. One country did not include costing in its project profiles. Of the 40 remaining, the total number of selected priority projects was 459. Only 50 (11%) represented projects focused on health. The health aspects covered were mostly malaria control, vector control,
access to drinking water and sanitation and to a lesser extent nutrition and health systems strengthening. The total estimated cost of the priority projects was US$ 1 852 726 528 with just US$ 57 777 770 (3%) going to health projects.

Discussion

The NAPAs were prepared through a consultative process by multidisciplinary teams. Health was identified in the vast majority of countries as a sector on which climate change will impact. However, the extent to which health will be affected appeared to be inadequately understood and addressed. Health issues in NAPAs were handled in a manner that would not meet standard public health requirements: typically, there was weak epidemiological analysis, lack of an evidence base, an absence of clear public health objectives, and unclear and fragmented strategies. In many instances, this resulted in incomprehensible vulnerability assessments and inadequate adaptation actions. The proposed health adaptation projects were, for the most part, insufficient in terms of scope, size and resources. The analysis not only showed that the number of projects focused on health was small (11% of the total), the resources proposed to be attached to them were even smaller (3% of the total). Most NAPAs were developed more than three years ago and all now need to be reviewed. This will provide an opportunity to strengthen their health components.

Conclusion

With few exceptions, the consideration of public health interventions in NAPAs needed to be strengthened to support the resilience processes and protect public health from the negative effects of climate change.

Recommendations

Considering the complexity of the health impacts of climate change, the highly-specialized public health skills that are required to manage them; and the need for further and continued research to better understand climate change health impacts; and taking into consideration the conclusion above, it is recommended:

a) For least developed countries and small island states:

- To establish, within ministries of health, specific task teams to undertake the required work on climate change health vulnerability assessments and adaptation planning;
- To undertake a complementary assessment of climate change vulnerability focusing on health and using standardized tools and methodologies; and
- To systematically include two additional project profiles within the NAPAs that will address specifically: i) integrated environment and health surveillance; and ii) strengthening of health systems.

b) For WHO:

- To finalize and roll out guidelines for health vulnerability assessments as well as guidelines for the development of health components of NAPA project profiles;
- To facilitate and coordinate the establishment of resilience and adaptation public health objectives and targets as the basis for public health country adaptation planning;
- To develop a climate change and health vulnerability assessment and adaptation capacity building programme; and
- To provide technical support to least developed countries for addressing climate change adaptation working with national multidisciplinary and multisectoral teams.

c) For the UNFCCC and its subsidiary bodies:

- To facilitate a process of review of the current NAPAs so as to accommodate health issues in a way that will support the country resilience processes; and
- To establish technical and financial assistance mechanisms that are specific to health in order to facilitate the achievement of resilience and adaptation public health objectives and targets.

Reference

1. Africa: Benin, Burkina Faso, Burundi, Cape Verde, Central African Republic, Chad, Comoros, Democratic Republic of Congo, Eritrea, Ethiopia, Gambia, Guinea, Guinea-Bissau, Lesotho, Liberia, Madagascar, Malawi, Mali, Mauritania, Mozambique, Niger, Rwanda, Sao Tome and Principe, Senegal, Sierra Leone, Togo, Uganda, United Republic of Tanzania and Zambia. Other countries: Afghanistan, Bangladesh, Bhutan, Cambodia, Kiribati, Laos, Maldives, Samoa, Solomon Islands, Tuvalu, Vanuatu and Yemen. The NAPAs of Djibouti, Haiti and Sudan could not be downloaded at the time that the study was undertaken.
Prévention de la transmission mère-enfant du VIH/SIDA en Afrique Sub-saharienne

Isseu Diop Toure, Triphonie Nkurunziza, Charles Sagoe-Moses, Ghislaine Conombo et Tigest Ketsela
Auteur correspondant : Isseu Diop Toure e-mail : diopi@afro.who.int


Bien que la communauté internationale et les dirigeants africains se soient engagés à éliminer les nouvelles infections pédiatriques dues au VIH et à réduire la mortalité chez les femmes infectées d’ici 2015, 330 000 enfants étaient encore infectés par le VIH en 2011, dont plus de 90% en Afrique au sud du Sahara, et ce malgré une nette diminution des nouvelles infections pédiatriques de plus de 25% depuis 2009 dans 33 pays. Si l’on considère que la transmission de la mère à l’enfant du VIH a été pratiquement éliminée aux États-Unis et en Europe, cette situation n’est pas acceptable. Vingt et un des 22 pays où vivent la majorité des femmes infectées par le VIH ayant des besoins de services de prévention de la transmission mère-enfant du VIH (PTME) non couverts se trouvent en Afrique au sud du Sahara. Le rapport 2012 sur l’estimation de la mortalité maternelle montre que le VIH/SIDA est devenu la cause principale des décès chez les femmes pendant la grossesse et le post-partum dans les pays où la prévalence du VIH est élevée. Sur le nombre total des 19 000 cas de décès dus au VIH au niveau mondial 91% sont en Afrique Sub-saharienne.

Cet article a pour objectif de passer en revue les progrès réalisés par les pays de l’Afrique au sud du Sahara en matière de PTME, et par conséquent ceux de la Région africaine de l’OMS, en vue d’identifier les défis et les actions que les nations doivent entreprendre pour une génération sans VIH.

Méthodologie

Pour cette étude, nous avons exploité les publications et documents des agences impliquées dans la lutte contre le VIH/SIDA, notamment l’OMS, l’ONUSIDA et l’UNICEF, ainsi que des articles publiés en ligne. La base de données de l’OMS contenant les rapports annuels des pays de 2005 à 2011 a permis de suivre l’évolution des progrès réalisés dans le cadre de l’expansion des programmes de PTME. Les indicateurs de couverture des interventions essentielles en PTME, notamment les services de conseil et de dépistage, la prophylaxie aux antirétroviraux (ARV) pour la PTME, le traitement aux ARVs et la planification familiale ont été utilisés pour évaluer les performances.

Résultats

PTME reconnue comme un volet important de la lutte contre le VIH
La transmission mère-enfant du VIH (TME) est l’une des quatre voies reconnues pour la transmission du VIH.
Elle peut se produire pendant la grossesse, le travail, l’accouchement et l’allaitement.

En absence de toute intervention, ce risque est évalué à 15%–30% pendant la grossesse et l’accouchement, et à 10%–20% durant l’allaitement au sein. La prévention de la transmission mère-enfant du VIH, préconisée par l’OMS comme l’une des stratégies les plus efficaces dans la lutte contre le VIH/SIDA, fait l’objet d’une attention de plus en plus importante, aussi bien au niveau international, régional que national.


L’initiative pour l’élimination de la TME s’est concrétisée par l’adoption et le lancement en 2011 par les Nations Unies du Plan mondial pour l’élimination des nouvelles infections pédiatriques et le maintien de leurs mères en vie. Ce plan constitue un tournant important dans le cadre de l’accélération de la PTME en Afrique Sub-saharienne, et de l’accroissement des investissements de partenaires financiers tels le Fonds mondial de lutte contre le SIDA, la tuberculose et le paludisme et le gouvernement américain. L’OMS, en collaboration avec d’autres agences, a développé un cadre stratégique pour la Région africaine en vue de guider les pays sur les actions prioritaires à mener pour l’atteinte de cet objectif d’ici 2015.

**Utilisation continue des résultats de la recherche pour améliorer les interventions de PTME**

La recherche, partie intégrante de cette stratégie, a permis progressivement à l’OMS et à ses partenaires impliqués dans la PTME de promouvoir les moyens les plus efficaces de PTME. Corrélée aux avancées de la recherche, la PTME a connu de 1994 à 2003 une phase pilote, de 2004 à 2010 une phase de passage à l'échelle et depuis 2010 une phase d'accélération.

Suite à l’essai clinique PACTG 076/ANRS effectué aux États-Unis et en France et ayant démontré que la zidovudine (ZDV ou AZT) administrée par voie intraveineuse pendant le travail puis pendant six semaines au nourrisson non nourri au sein, réduit des deux tiers (67%) le risque de TME, la recherche a été poursuivie pour des protocoles ARV plus efficaces.


Les recommandations de l’OMS de 2011, en introduisant la prophylaxie ARV pendant l’allaitement maternel et une combinaison de trois ARVs chez les mères, devraient permettre de réduire la TME à moins de 2% sans et de 5% avec allaitement maternel et d’améliorer la survie des mères séropositives tout en réduisant le risque de résistance du VIH aux ARVs.

**Évolution de la couverture des interventions de PTME**

Le guide pour la mise à l’échelle au plan mondial de la PTME du VIH publié en 2006 préconise quatre volets : i) Prévention primaire de l’infection à VIH chez les femmes en âge de procréer ; ii) Prévention des grossesses non désirées chez les femmes vivant avec le VIH ; iii) Prévention de la transmission du VIH des mères vivant avec le VIH à leurs enfants ; et iv) Fourniture d’un traitement, de soins et d’un soutien appropriés aux femmes vivant avec le VIH, à leurs enfants ainsi qu’à leur famille.

Des progrès notables ont été enregistrés ces dix dernières années en Afrique Sub-saharienne en matière de PTME. Cependant les niveaux de performance varient selon la sous-région et le volet de la stratégie considérés.

**Accès aux services de conseils et de dépistage grâce à des stratégies novatrices et à une approche multisectorielle**

L’accès aux services de conseils et de dépistage du VIH a été accru grâce à l’expansion, la décentralisation, la systématisation de l’offre de services, l’organisation de campagnes de masse et la mise en œuvre d’activités à base communautaire.

La proportion de femmes enceintes ayant bénéficié d’un test de dépistage du VIH a progressé d’une moyenne de 9% en 2005 à 42% en 2010 en Afrique au sud du Sahara. Les pays de l’Afrique orientale et australe ont enregistré des progrès plus important, avec un taux de couverture qui est passé de 16% en 2005 à 61% en
2010, alors que les pays de l’Afrique centrale et occidentale connaissaient un accroissement plus modéré allant de 3% en 2005 à 25% en 2010 (Figure 1). Huit pays (Botswana, Kenya, Mozambique, Namibie, Swaziland, Tanzanie, Zambie et Zimbabwe) de la Région africaine de l’OMS ont atteint l’objectif de couverture universelle de 80% que les États s’étaient fixé depuis Abuja en 2005.

**Prophylaxie ARV pour la PTME**

La provision de produits ARV à visée prophylactique pour la PTME chez les femmes enceintes séropositives a connu un essor en Afrique au sud du Sahara avec un taux moyen de couverture qui est passé de 15% en 2005, à 45% en 2008, 54% en 2009 et 60% en 2010.12

Le pourcentage de femmes enceintes séropositives ayant reçu des ARV pour la PTME est estimé à 68% pour les pays de l’Afrique orientale et australe et à 21% pour les pays de l’Afrique de l’ouest et du centre (Figure 2). En 2011, 14 pays ont atteint des taux de couvertures de 50% à 74% et 6 pays des taux de 75% à 100%.

**Besoins non couverts en planification familiale**

Les pays d’Afrique Sub-saharienne ont connu de faibles performances, ce qui est dû à des goulots d’étranglements de plusieurs ordres. Cette situation est due à des goulots d’étranglements de plusieurs ordres auxquels les États doivent faire face.15

**Figure 1. Évolution du pourcentage de femmes enceintes ayant reçu un test VIH en Afrique Sub-saharienne de 2005 à 2010**

<table>
<thead>
<tr>
<th>Année</th>
<th>Afrique de l’est et australe</th>
<th>Afrique Sub-Saharienne</th>
<th>Afrique de l’ouest et du centre</th>
</tr>
</thead>
<tbody>
<tr>
<td>2005</td>
<td>10</td>
<td>20</td>
<td>50</td>
</tr>
<tr>
<td>2008</td>
<td>30</td>
<td>40</td>
<td>60</td>
</tr>
<tr>
<td>2009</td>
<td>50</td>
<td>50</td>
<td>70</td>
</tr>
<tr>
<td>2010</td>
<td>70</td>
<td>70</td>
<td>80</td>
</tr>
</tbody>
</table>


**Figure 2. Évolution du pourcentage de femmes enceintes séropositives ayant reçu des ARVs pour PTME en Afrique Sub-saharienne de 2005 à 2010**

<table>
<thead>
<tr>
<th>Année</th>
<th>Afrique de l’est et australe</th>
<th>Afrique Sub-Saharienne</th>
<th>Afrique de l’ouest et du centre</th>
</tr>
</thead>
<tbody>
<tr>
<td>2005</td>
<td>0,2%</td>
<td>10%</td>
<td>20%</td>
</tr>
<tr>
<td>2008</td>
<td>20%</td>
<td>30%</td>
<td>40%</td>
</tr>
<tr>
<td>2009</td>
<td>40%</td>
<td>40%</td>
<td>40%</td>
</tr>
<tr>
<td>2010</td>
<td>60%</td>
<td>60%</td>
<td>60%</td>
</tr>
</tbody>
</table>


**Discussion**

La mise en œuvre de la PTME a connu des avancées notables, mais la question de savoir si les pays de l’Afrique au sud du Sahara peuvent atteindre les objectifs ciblés d’ici 2015 continue de se poser.

La recherche a joué au fil des ans un rôle prépondérant dans la définition des politiques et des stratégies d’intervention en PTME. Les résultats ont permis de développer le savoir et de savoir-faire et de doter les acteurs d’interventions ayant fait la preuve de leur efficacité. Néanmoins, leur mise en œuvre et leur passage à l’échelle tardent à être effectifs. Il est donc important que la recherche s’intéresse aux obstacles qui empêchent les États, malgré leur engagement, à assurer la disponibilité et l’accès universel aux interventions de PTME.

Comme en témoignent les indicateurs de couverture, les progrès enregistrés sont loin d’être uniformes d’un volet à l’autre et d’une zone géographique à une autre. Les pays de l’Afrique centrale et occidentale ont par exemple connu des performances plus faibles que les pays de l’Afrique orientale et australe. L’offre de services pendant la grossesse, l’accouchement et le post-partum pour prévenir la transmission du VIH chez les femmes séropositives à leurs enfants a bénéficié d’une plus grande attention avec de meilleurs résultats. La prévention primaire de l’infection à VIH chez les femmes en âge de procréer, la prévention des grossesses non désirées chez les femmes vivant avec le VIH et les soins aux enfants vivant avec le VIH ont connu des faibles performances, ce qui amène Nicolas Méda à parler d’échec-programmatique.

Cette situation est due à des goulots d’étranglements de plusieurs ordres auxquels les États doivent faire face.

**Goulots d’étranglement empêchant l’expansion des services de PTME**

Le premier est social, avec ses lourdeurs et ses lourdeurs et croyances socioculturelles – mariages précoces et violences de jeunes...
filles vierges, par exemple – qui augmentent les risques d’exposition au VIH, la stigmatisation et la crainte de violences conjugales, et le faible statut social des femmes qui poussent ces dernières à cacher leur statut lorsqu’elles sont infectées. Cette situation favorise la propagation de l’épidémie, surtout au sein de la population féminine, et constitue un obstacle à l’utilisation appropriée des services de santé de la mère, du nouveau-né et de l’enfant, et les pratiques d’allaitement et d’alimentation appropriées des nourrissons et des jeunes enfants dans le contexte du VIH.

La seconde difficulté est d’ordre institutionnel, avec des services de santé dont l’accès et l’utilisation limités ne permettent pas de répondre aux besoins des populations, surtout en zones rurales. L’absence de dispositions politiques et réglementaires rendant les services de PTME systématiques dans certains pays, notamment en Afrique occidentale et centrale, peut aussi être une des raisons de la faible performance observée. Le mode de gestion et l’organisation de l’offre de service ne permettent pas aux structures de soin de santé maternelle, néo-natale et infantile (SMNI) et de santé de la reproduction de fournir un paquet de services de qualité intégrant la PTME. La PTME reste victime de l’approche verticale utilisée durant les premières années de son introduction. L’absence de ressources humaines qualifiées peut aussi être évoquée comme obstacle à la décentralisation des services de PTME. La faible attention accordée à la qualité des services offerts ne permet pas d’assurer une prise en charge continue des femmes et des enfants, d’où une perte importante le long de la cascade de prise en charge.

L’insuffisance des ressources financières, qui proviennent essentiellement de l’aide extérieure, ne permet pas aux populations de bénéficier de services de qualité au moment opportun. Il en résulte une faible utilisation des services de SMNI, et une multiplication des occasions manquées.

Actions requises pour offrir l’accès universel aux services de PTME et permettre l’élimination de la TME

L’ambition d’éliminer les nouvelles infections pédiatriques à VIH d’ici 2015 requiert les actions suivantes :

- La mise au point de méthodes innovantes pour encourager la participation des communautés, et l’implication des partenaires masculin et des familles en vue de promouvoir un environnement social et culturel favorable à l’expression de la demande de services par toutes les populations qui en ont besoin, la réduction de la stigmatisation et de la discrimination, et l’accroissement de l’utilisation des services de SMNI et de PTME.

- L’offre d’un paquet complet de services de SMNI et de santé de reproduction de qualité, basé sur une approche axée sur le client, qui intègre systématiquement toutes les composantes de la PTME afin de rendre les services de PTME disponibles et accessibles à toutes les femmes, à leurs partenaires et aux enfants à tous les niveaux du système de santé.

- La promotion des approches de délégation et de partage des tâches pour combler le déficit en ressources humaines et décentraliser les services.

- La poursuite de la recherche pour l’identification de solutions aux obstacles à la mise en œuvre effective et à l’accès universel aux interventions de PTME les plus efficaces, avec un bon équilibre entre les effets bénéfiques, le coût, la toxicité et la possibilité de développement de résistance.

- La traduction de l’engagement politique en actions concrètes, telles que l’augmentation du financement des interventions de SMNI en général et de PTME en particulier, et la prise de mesures institutionnelles effectives pour rendre le système de santé fonctionnel.

Conclusion

Des progrès ont certes été réalisés dans le cadre de la PTME en Afrique Sub-saharienne, mais il restent encore insuffisants pour réduire à 5% le taux de transmission de la mère à l’enfant du VIH en 2015. Les résultats enregistrés dans certains pays et l’engagement de la communauté internationale sont cependant des facteurs d’espoir. Une intensification de la prévention primaire de l’infection à VIH chez les futurs parents, une plus grande utilisation des services de planification familiale pour toutes les femmes en général, et les femmes infectées en particulier, la disponibilité, l’accès et l’utilisation appropriées d’un paquet de services de soins de santé maternelle et infantile de qualité intégrant le conseil et le dépistage, la prophylaxie et le traitement aux ARV pendant la grossesse, ainsi que la période périnatale et l’allaitement maternel, constituent les voies à suivre dans la marche des pays de l’Afrique Sub-saharienne pour l’atteinte des objectifs ciblés.

References

Antimicrobial resistance in the African Region: Issues, challenges and actions proposed

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Antibiotics play a critical role in reducing the burden of communicable diseases all over the world. However, the curative power of infectious disease by drugs or drug efficacy is not infinite. Antimicrobial resistance threatens the effectiveness of successful treatment of infections and is a public health issue with national and global dimensions. In low-income countries, AMR frequently occurs in microorganisms that are likely to be transmitted in the community such as organisms causing pneumonia, diarrheal diseases, tuberculosis (TB), sexually transmitted diseases and malaria. Drug resistance has dramatically increased the costs of fighting TB and malaria, and slowed gains against childhood dysentery and pneumonia. It also threatens the push to treat people living with HIV/AIDS effectively.1 While appearance of drug resistance is a continuous phenomenon in microorganisms, its amplification and spread is through the improper utilization of antimicrobial agents, the use of fake and counterfeit medicines, poor prescribing habits and non-compliance to prescribed treatments.2

Detection of resistance and monitoring its spread requires appropriate laboratory-based surveillance. Thus, to maintain the useful life of antimicrobial agents in African countries there needs to be improved access to diagnostic laboratories, improved surveillance of the emergence of resistance, better regulation and better education of the public, clinicians/prescribers and veterinarians in the appropriate use of antibiotics.3

Drug resistance is a major public health problem that requires a range of interventions and multidisciplinary teams approach. The purpose of this paper is to

SUMMARY—The use of antimicrobial agents plays a critical role in reducing the morbidity and mortality due to communicable diseases. However, the emergence and spread of resistance to many of these agents are negating their effectiveness. In the African Region the understanding of issues related to antimicrobial resistance (AMR) and its magnitude are hampered by surveillance of drug resistance being limited to a few countries resulting in incomplete and inadequate data on the true extent of the problem. Despite limited laboratory capacity to monitor AMR, available data suggest that the African Region shares the worldwide trend of increasing drug resistance. This paper aims to highlight the current status and importance of this public health problem in the African Region in order to raise awareness of the need to strengthen AMR surveillance and propose actions for containing the AMR phenomenon.

Voir page 54 pour le résumé en version française.
Ver a página 55 para o sumário em versão portuguese.
share the current status of this public health problem in the African Region, raise awareness on the need to strengthen AMR surveillance and propose key actions for monitoring this phenomenon.

**Current situation of AMR in the WHO African Region**

The understanding of issues related to antimicrobial resistance and its magnitude are hampered by inadequate data as surveillance of drug resistance is limited to a few countries resulting in incomplete data on the true extent of this problem.\(^5\) This situation leads to scarcity of accurate and reliable data on AMR in the African Region, especially for meningitis pathogens whose appropriate AMR testing methods are complex and not correctly applied in many countries.\(^5\)

Despite limited laboratory capacity to monitor AMR, available data suggest that the African Region shares the worldwide trend of increasing drug resistance. Significant resistance has, for example, been reported for diseases such as cholera, dysentery, typhoid, meningitis, gonorrhea, TB, malaria and AIDS.

During cholera epidemics the bacterium has the ability to develop increasing resistance, usually by acquisition of plasmids. Between 2008 and 2011 important resistance of *Vibrio cholerae* against cotrimoxazole was reported from affected countries. These pathogens remained highly sensitive to cyclines and quinolones.\(^5\)

Between 2008 and 2009, of the 451 isolates of the *Shigella* bacterium responsible for bloody diarrhea identified by 18 countries, 78% were resistant to the primary drug used to treat this condition.\(^4\) This has led to the use of new medicines that are expensive.

Infection with *Neisseria meningitidis* causes large outbreaks of meningitis in sub-Saharan Africa. The antibiotic susceptibilities of a 137 isolates of *Neisseria meningitidis* recovered between 2000 and 2006 from 18 countries were susceptible to ceftriaxone and chloramphenicol. Only 2% of isolates displayed reduced susceptibility to penicillin G.\(^7\) Susceptibility testing for 37 invasive meningococcal disease patients under 15 years was performed in Mozambique. *N. meningitidis* remained highly susceptible to all antibiotics used for treatment in the country, although the presence of isolates presenting intermediate susceptibility to penicillin advocates for continued surveillance of this pathogen.\(^8\)

The Group for Enteric, Respiratory and Meningitis Disease Surveillance in South Africa (GERMS-SA) has documented emerging antimicrobial resistance in several pathogens.\(^9\) After years of easy susceptibility of *Neisseria gonorrhoeae* to penicillin and other antibiotics, there is a worrying trend of antimicrobial resistance to the commonly prescribed antibiotics for gonococcal disease such as quinolones and emerging resistance to cephalosporin.\(^10\) Data on antiretroviral therapy (ART) resistance patterns in African countries are extremely sparse. Recent assessments show that rates of transmitted HIV drug resistance remain limited in low and middle-income countries.\(^10\) Surveys conducted at sentinel clinics providing ART in several countries in the African Region estimated that HIV resistance to all drug classes is less than 5%.\(^11,12,13,14\) This is likely to increase as more patients are placed on antiretrovirals.

Since 2006, the African Region has witnessed the increasing emergence of multidrug-resistant TB (MDR-TB) and extensively drug-resistant TB (XDR-TB) which is a severer form of drug resistant TB. Between January 2004 and December 2011, a total of 53 798 MDR-TB cases were reported by 42 countries in the Region. At the same time, 3 231 XDR-TB cases were reported from eight countries.\(^15\) South Africa alone accounted for 84% of MDR-TB and 96.8% of XDR-TB cases.\(^16\) A recent survey (2007–2010) on anti-tuberculosis drug resistance found that in South Africa more that 10% of the cases of MDR-TB were extensively drug-resistant.\(^17\) Only 28 of the countries reporting MDR-TB and XDR-TB have structured drug resistant treatment programmes in place.\(^18\) Most African countries lack the laboratory capacity to confirm drug-resistant TB and so the true burden is not well known. 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.\(^8\)

With regard to malaria, in the early 1990s, widespread resistance to chloroquine had been detected in the Region. This led to changes in the malaria treatment policies to new combination antimalarial medicines. The Global Plan for Artemisinin Resistance Containment developed in response to confirmation of resistance in Cambodia and Thailand defined three areas.\(^19\) The three are: tier I where there is credible evidence of resistance; tier II – significant inflow from tier I; and tier III, including Africa, with limited contact with tier I areas and no evidence of artemisinin resistance.\(^20\) There are increasing reports of poor quality antimalarials in Africa.\(^21\) The 2011 World Health Assembly Resolution on malaria urged Members States to halt the use of oral artemisinin-based monotherapies and substandard medicines not meeting WHO prequalification standards or strict national regulatory authority standards.\(^22\)

Thus, although progress and efforts are being made by countries and WHO to address AMR issues, key issues and challenges still remain.

**Issues and challenges**

Although progress has been made in gathering and using AMR data in TB,
HIV/AIDS and malaria, challenges remain. Major challenges include lack of a comprehensive policy and plan to address AMR; weak medicines regulatory capacity and circulation of substandard/counterfeit antimicrobials; lack of AMR surveillance strategies; weak laboratory capacity on AMR testing and reporting; lack of essential laboratory reagents and consumables; and limited quality assurance and control protocols.

The medicines supply and distribution systems in most countries of the Region are fragmented and weak. This situation increases the opportunities for infiltration of substandard/counterfeit medicines into the supply chain. Inadequate access to basic health services coupled with shortages and frequent stock-out of essential medicines including antimicrobials in public health facilities could lead patients to look for other sources usually through illicit sources of supply, which usually deal with substandard/counterfeit medicines.

In the African Region, many countries struggle to protect their populations from unsafe and substandard/counterfeit medicines due to limited resources and the challenge of monitoring medicine supply systems within and from outside their borders. For example, several African countries have not enforced the ban on use of oral artemisinin monotherapies for treatment of uncomplicated malaria. This represents a major risk for development of resistance to artemisinin-based combination therapies (ACTs). The WHO Global Strategy for Containment of Antibiotic Resistance23 recognized laboratory-based surveillance of antibiotic resistance as a “fundamental priority” for the development of strategies to contain antibiotic resistance and for assessment of the impact of interventions. However, laboratories are perhaps the most neglected of all health system components in developing countries and have been termed the “Achilles’ heel” of global efforts to combat infectious diseases.24 Thus, a recently published article by WHO and the National Institute for Communicable Diseases (NICD) in South Africa on external quality assessment of national public health laboratories in Africa has revealed weakness in many countries for antimicrobial susceptibility testing.5

Faced with the above mentioned dimensions of antibiotic resistance as a threat to public health, some countries have established national and regional surveillance collaborations, others have not. Furthermore, there is no formal framework for collaboration among surveillance programmes region-wide. This lack of a regional framework for collaborative surveillance of antibiotic resistance seriously hampers efforts to track emerging resistance challenges; to identify, characterize and contain new antibiotic threats; and to systematically compare and evaluate the value of national resistance containment activities.

**Actions proposed**

In order to prevent and combat AMR, comprehensive national AMR policies, strategies and plans should be developed and implemented involving policy-makers, partners and stakeholders in public health. Targeted capacity building activities in various domains including AMR surveillance, laboratory services, quality control of test reagents and protocols, effective medicines regulation and rational use of medicines are urgently needed. Furthermore, establishment of national and/or regional policy platforms for management of antibiotic resistance could play crucial role. WHO has developed a policy package to combat AMR which can be found at: [http://www.who.int/bulletin/volumes/89/5/11-088435/en/](http://www.who.int/bulletin/volumes/89/5/11-088435/en/)

**Develop comprehensive national policies and plans to prevent and combat AMR**

Within the context of national health and medicine policies, governments should develop and implement comprehensive AMR policies and strategies that take into consideration the AMR threat to public health so as to limit the emergence and spread of resistant germs.

**Establish national and/or regional policy platforms for management of antibiotic resistance in countries**

Countries and health systems differ and the various barriers must be tackled in a contextualized manner. In establishing a multi-disease drug resistance surveillance network, the regional health community can build on a range of existing efforts.26

In order to initiate change, a detailed national/regional analysis of the situation on the ground by a multidisciplinary group including the agriculture and animal sectors is required.

**Build clinical laboratory capacity**

Understandably, the majority of surveillance programmes are laboratory based. Strategies for ensuring and maintaining the quality of laboratory test results are critical to the value of surveillance initiatives. All facilities should have procedures for ongoing assessment of the quality of test reagents and test performance by clinical laboratory technicians. In addition to internal quality control practices, laboratories should also participate in national and/or external quality assurance (EQA) programmes. Building clinical laboratory capacity will enable the generation of adequate and reliable AMR data that can guide policy actions to combat AMR.

**Improve antimicrobial surveillance systems by collecting and sharing information on AMR across networks of laboratories**

Surveillance is the primary strategy for tracking emerging drug resistance in the population, and thus allowing for early and appropriate action. Countries should therefore strengthen their capacity for early detection and identification of resistant germs that cause diseases of public health importance. Antimicrobial resistance surveillance data help monitor the susceptibility patterns of microorganisms to antimicrobial agents. The regular dissemination of data can be utilized by public health policy-makers to revise the national AMR policy.

**Regional framework for collaborative surveillance of antibiotic resistance**

The regional framework collaborative surveillance of AMR provides a standardized overview of the prevalence of AMR in many countries in a given region. The lack of this regional framework for collaborative surveillance of AMR is a key problem hindering information sharing for decision-making both at country and regional level. An efficient surveillance system for AMR, which is
part of integrated diseases surveillance and response (IDSR) implementation and health system strengthening, is necessary to reduce mortality and morbidity due to infectious diseases. In particular, antimicrobial resistance surveillance is crucial to demonstrate efficacy when treating communities during outbreaks. It is important for detecting the emergence of novel resistance patterns and for monitoring the impact of interventions aimed at minimizing the spread and burden of AMR.

AMR surveillance could be integrated in the existing AFRO integrated disease surveillance. Making drug-resistance surveillance routine across all societies and for all significant infectious diseases offers substantial benefits. Timely information about pathogen susceptibility will enable better management of patients and infection control in clinical settings. Aggregating the data to the population level will allow for more informed policy-making and action at national, regional and global levels and in all the public health areas.

The laboratory-based surveillance system requires the following components:

- Prioritization of organisms that should be monitored taking into account the burden of disease in the country;
- Selection of antibiotics to be tested for each isolate taking into account the list of essential medicines and treatment guidelines;
- Development or updating of standard operating procedures for the isolation, identification and antimicrobial susceptibility testing for selected pathogens using standardized methods;
- Establishing or strengthening laboratory quality systems; and
- Setting up a database for collating and sharing information with stakeholders through existing mechanisms such as IDSR.

**Strengthen national medicines regulatory capacities in the African Region**

While the weaknesses of a single national agency create health and safety risks for people in its particular country, poor regulatory capacity becomes an even larger problem when viewed in a regional context. A country’s policies and actions – or inactions – to regulate its drug supply have implications for other countries, even those well beyond its immediate borders, because of disease transmission and international trade in medicine.

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. The quality of medicines circulating within the national pharmaceutical markets should be monitored in order to prevent smuggling and use of substandard/counterfeit antimicrobials that may contribute to increasing AMR.

**Conclusion**

Left unchecked, the uncontrolled rise in resistant germs threatens lives and wastes limited resources. Urgent and coordinated action is required at all levels to ensure the preservation of these life-saving drugs for future generations. Governments should develop and implement medicine policies and strategies that take into consideration the threat of drug resistance so as to limit the evolution and possible spread of resistant germs.

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Reduction of the harmful use of alcohol: a strategy for the WHO African Region

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Public health problems related to alcohol consumption are substantial and have a significant adverse impact on the whole of society. Intoxication and the chronic effects of alcohol consumption can lead to permanent health damage (e.g. fetal alcohol syndrome, delirium tremens), neuropsychiatric and other disorders with short- and long-term consequences, social problems (e.g. unemployment and violence) and trauma or even death (e.g. road traffic accidents). There is also increasing evidence linking alcohol consumption with high-risk sexual behaviour and infectious diseases such as tuberculosis and HIV.

The alcohol-attributable burden of disease is increasing in the African Region, with an estimated total of deaths attributable to harmful use of alcohol of 2.1% in 2000, rising to 2.4% in 2004. However, with new evidence suggesting a relationship between heavy drinking and infectious diseases, alcohol-attributable deaths in the African Region could be even higher. No other product so widely available for consumer use accounts for so much premature death and disability. Alcohol-related problems and their adverse impact result not only from the quantities of alcohol consumed but also from the detrimental patterns of use. Effective and adequate policy measures and interventions, surveillance mechanisms and public awareness need to be developed or enforced in the Region.

In 2007, at the Fifty-seventh session of the WHO Regional Committee for Africa, Member States expressed concern about the impact of harmful use of alcohol on public health and emphasized the need to strengthen response in the Region. At the Fifty-eighth session of the Regional Committee, a set of evidence-based actions that would serve as a basis for developing national policies was adopted and countries called for a Regional Strategy.

At the global level in 2010 at the Sixty-third World Health Assembly, recalling the 2008 resolution WHA61.4 on strategies to reduce the harmful effects of alcohol use, Member States requested the submission of a global strategy to reduce harmful use of alcohol. In the process of collaboration to develop the draft global strategy, the WHO African Region has gathered information from Member States about existing evidence-based strategies and their applicability globally and in the Region, taking into account local needs and various national, religious and cultural contexts including national public health problems, needs and priorities, and differences in the resources, capacities and capabilities of Member States.

This article analyses the situation in the African Region and proposes a strategy for appropriate action. The strategy builds on existing World Health Assembly resolutions and on discussions at regional
and global levels, proposing a set of public health interventions aimed at reducing the harmful use of alcohol.

**Situation analysis**

Although alcohol constitutes an important source of income and its use is part of social and cultural practices and norms in many countries of the Region, alcohol-related health and social costs cannot be ignored. No other product so widely available for consumer use accounts for so much premature death and disability as alcohol. Alcohol-related problems and their adverse impact result not only from the quantities of alcohol consumed but also from the detrimental patterns of use. Public awareness, especially of specific types of harm, is low in many of the countries.

Recent studies and surveillance data provide an insight into harmful use of alcohol in the Region. The two main characteristics that describe alcohol consumption patterns in the Region are the high level of abstention in some countries and the high volume of consumption by drinkers, with severe health and social consequences. Overall, the adult per capita consumption of alcohol in the WHO African Region in 2004 was estimated at 6.2 litres of pure alcohol.

In 2008/2009, countries collaborated in the WHO Global Survey on Alcohol and Health. This process showed that out of the 46 countries in the Region, only ten had recent alcohol policies and 16 had advertising regulation. In many countries regular and systematic surveillance and monitoring systems with appropriate financial and human resources are still non-existent; basic indicators are not defined; and even when data are available they are often scattered among different departments and therefore difficult to collect. Data collected in the 2011/2012 survey has shown that progress in implementing these strategies has been slow in countries. In fact, despite all efforts made to improve areas of alcohol policies many countries seem not to be moving forward.

Adequate policies are few and coordination with relevant sectors and within government is lacking. Multisectoral approaches involving the private sector, professional associations, civil society, the informal sector, traditional healers, political and community leaders are not developed. At the community level there is a low level of awareness and non-governmental organizations are not engaged in addressing the problem. In 2012, out of 46 countries only ten have set in policy coordination mechanisms aiming at bringing together intervening agencies, organizations and stakeholders and although several countries designated the supervision of the all process to a specific unit in the Ministry of Health, specific resources for implementation have only been allocated in two countries. At the same time, only 12 countries developed national and regional consultation processes involving the community while developing alcohol policies.

Within the health system, alcohol problems are often not recognized, tend to be minimized or are not properly addressed due to lack of appropriate skills, knowledge, adequate resources or lack of coordination and integration among different health programmes. Although alcohol and illicit drugs share common neurobiological, psychological and behavioural characteristics, their related health hazards are often seen and treated separately, thus increasing the resources needed to address substance abuse in general. In the Region there is a lack of integrated approaches to dealing with substance use disorders. The absence or misplacement (in psychiatric hospitals) of effective and adequate interventions, ranging from brief interventions in primary care to more intensive treatment in specialized settings is a reality in the African Region. Access to prevention, screening and treatment services and psychosocial care for patients and families are severely hampered by low or non-existent budgetary allocations, general weakness of health systems and lack of public health infrastructure.

Interventions such as enactment of drinking and driving laws, taxation, restrictions on advertising and community information are already being used in the Region. Even so, they are used in an ad hoc, informal and fragmented manner, and frequently lack adequate control and enforcement systems.

It is estimated that unrecorded consumption accounts for about 50% of the overall consumption of alcohol in African countries. Despite concerns about the potential health hazards arising from unregulated or illicit production, there is little information on the problem and the issue is often overlooked or not given the necessary consideration in policy development.

**Justification**

Reduction of the public health problems caused by the harmful use of alcohol and of the required interventions by governments to control alcohol-related harm are essential in improving the health of the populations in the Region. Important and effective alcohol control measures are available. Therefore, the development and implementation of a regional strategy in the African Region is a timely and needed response. At the Fifty-eighth session of the WHO Regional Committee, in 2008, Member States requested WHO to support the development, implementation and evaluation of national policies and plans to combat the harmful use of alcohol and, to this end, submit a Regional Strategy to the Committee.

The magnitude and nature of alcohol-related harm clearly underscore the need for concerted action not only at national level, but also at regional and global levels. Strengthening national and region-wide capacities will enhance the capacity to respond effectively to the magnitude of the problem.

**The regional strategy**

**Aim and objectives**

The aim of the strategy is to contribute to the prevention or at least reduction of harmful use of alcohol and related problems in the African Region. The specific objectives are:

1. To provide a platform for advocacy for increased resource allocation, strengthening of action and intersectoral and international collaboration in responding to the problem;
2. To provide guidance to Member States for the development and...
implementation of effective alcohol control policies based on public health interests;
c) to address low awareness on alcohol related harm in the community;
d) to promote the provision of adequate health-care interventions for preventing harmful use of alcohol and managing the attendant ill-health and conditions; and
e) to encourage the creation of systems of systematic surveillance and monitoring of alcohol production, consumption and harm in countries.

Guiding principles

The strategy is based on five key principles which should guide policy development at all levels in countries.

● Policies should be based on best available evidence and be sensitive to national contexts.

● Citizens, especially those at risk, should be protected from alcohol-related harm, particularly harm from other people’s act of drinking, and from pressures to drink.

● Strong political commitment, leadership and appropriate funding will ensure that effective approaches to alcohol problems are formulated, taking into account public health principles.

● Actions should be undertaken in a coordinated, strategic and integrated manner jointly with key agencies and with appropriate involvement of all partners and stakeholders at all stages of decision-making, planning, implementation and evaluation.

● Equitable and non-stigmatized access to effective prevention and care services should be given to all individuals and families; human rights should be respected.

Priority interventions

Alcohol control policies, legislation and regulations should be developed and implemented – based on clear public health goals and best available evidence and should reflect national consensus regarding their implementation at country level. The policies require strong leadership and political commitment and are necessary to ensure transparency, continuity and sustainability of the measures adopted by all the relevant partners. Policy options can be grouped into the following areas:

Leadership, coordination and partners’ mobilization. Coherent, consistent and strong action with relevant actors, such as producers, retailers, health workers and communities, is fundamental for effective implementation and reinforcement of national policies and action plans. It is necessary to clearly define partners’ contributions, their roles in implementation, their responsibilities and mandates and the relevance of their support in line with national priorities. An appropriate coordination mechanism is therefore important to bring together all intervening agencies, organizations and stakeholders. The capacities of local authorities and the role of NGOs in this drive should be strengthened.

Awareness and community action. Provision of information for decision-makers and communities should be strengthened in order to increase commitment to public health protection, recognition of alcohol-related harm in the community and active participation in policy measures and in implementation. A dedicated day or week annually should be established to increase community and political awareness.

Information-based public education. Providing alcohol education and information to the public, and religious and community leaders is fundamental to support alcohol control policy measures and to increase community participation in their implementation. Efforts are needed to improve its quality and keep it under the responsibility of public bodies. The harmful use of alcohol should be integrated in the school curriculum. Community action programmes should be usefully combined with interventions in schools and other settings such as work places to mobilize public opinion to address local determinants of the increasing alcohol consumption and related problems. Local community action should be based on rapid assessment and involve the community and young people in problem identification, planning and policy implementation.

Improvement of health sector response. Efforts are needed to improve health sector response through adequate training, infrastructure and funding and by strengthening integrated approaches to alcohol problems at different levels of the health system, and in both urban and rural areas. Early detection and management of alcohol-related harm at primary care level and effective treatment of people with drinking-
related disorders are vital. Health professionals have an essential role to play in educating the community and mobilizing and involving players within and outside the health sector.

**Strategic information, surveillance and research.** Surveillance and monitoring, research and knowledge management play pivotal roles in alcohol control. Countries should establish information systems to monitor alcohol production, consumption and related health, social and economic indicators as well as the application of existing laws and regulations and their effect on the general population. Alcohol indicators with direct relevance to national policy priorities need to be identified and opportunities to integrate alcohol indicators into other surveillance systems should be adequately utilized. New partnerships with research entities should be explored and operational research should be promoted as an integral part of alcohol control in order to map unrecorded drinking patterns and document effective alcohol policy interventions.

**Enforcing drink-driving legislation and countermeasures.** Drink-driving countermeasures, including setting and enforcing a maximum limit of 0.5 g/l for blood alcohol concentration, frequent random-breath testing by the police and sobriety check-points should be a high-priority intervention. The visibility of such measures, rigorous and sustained enforcement of existing legislation accompanied by regular public awareness and information campaigns have a sustained effect on drink-driving.

**Regulating alcohol marketing.** There is a need to regulate the content and scale of alcohol marketing and the promotion of alcoholic beverages, in particular sponsorship, product placement, as well as internet and promotional merchandising strategies. Public agencies or independent bodies should closely monitor the marketing of alcoholic products. Effective systems of deterrence should be put in place and enforced.

**Addressing accessibility, availability and affordability of alcohol.** Commercial licensing systems that regulate the production, importation and sale (wholesale and retail) of alcoholic beverages should be put in place. Stricter regulation of the formal and informal sector and licensing of traditional outlets is crucial to ensure that beverages meet safety requirements and that they are controlled in order to protect most vulnerable groups such as adolescents and the low income population. There is a need to enact and enforce legislation on the minimum age at which alcohol drinking and purchasing is authorized and to restrict the times and places of sale. At the point of sale in supermarkets, alcoholic beverages should not be displayed together with water and other non-alcoholic drinks. Taxation should be increased with regular review of prices, based on the inflation rate, income levels and alcohol contents. To that end, adequate enforcement mechanisms should be established.

**Addressing illegal and informal production of alcohol.** The illegal and informal production of alcoholic beverages is seen as a major impediment to the adoption of effective policies. Nevertheless, this situation impacts on health and on tax revenues and reduces the ability to control production. This needs to be addressed and included in the national policy response. Some measure of quality control is needed including licensing and training of producers and introduction of appropriate enforcement measures. In addition, it is important to raise awareness among the general population and consumers about the dangers inherent in the consumption of certain forms of alcoholic beverages and to find funding to assist local informal producers to establish alternative income-generating business.

**Resource mobilization, appropriate allocation and integrated approach.** Resources are crucial to the implementation of the measures needed to reduce alcohol-related problems. These resources, to be mobilized by governments, from individuals, the private sector and international partners, should be available on sustainable basis and distributed among the different levels of the health system according to relative needs. There is a need to include harmful use of alcohol as a priority in the health development plans of countries. The development of an integrated approach to prevention and treatment can facilitate the use of existing resources in other areas or programmes for implementing the necessary interventions.

**Roles and responsibilities**

Countries should:

a) develop and implement comprehensive alcohol policies that are evidence-based and focus on public health interest; to facilitate this task a coordination body such as a national alcohol council should be established;

b) mobilize and allocate resources for alcohol policies;

c) create public awareness on alcohol-related harm and mobilize communities to support the implementation of evidence-based policy;

d) adopt and enforce regulations and legislation aimed at reducing alcohol consumption and related harm and strengthen clinical practices;

e) promote and strengthen independent research in order to assess the situation
and monitor national trends and the impact of adopted policy measures; 
f) reinforce training and support for all those engaged in alcohol control policy activities in an attempt to increase knowledge and skills and facilitate policy implementation; and 
g) establish systems for monitoring and surveillance in order to capture the magnitude of alcohol consumption and related health, social and economic harms, provide information on existing laws and regulations and contribute to the exchange of alcohol surveillance information between regions and countries.

WHO and partners should support countries by:
a) developing and providing evidence-based tools and guidelines for policies, interventions and services; 
b) maintaining a regional information system and providing technical support to Member States in surveillance, monitoring and evaluation of alcohol consumption and related problems; 
c) providing technical support in the development and review of effective and comprehensive alcohol policies and strategies; 
d) facilitating the creation and capacity building of intercountry networking for exchange of experiences; and 
e) facilitating effective linkages, cooperation and collaboration among international agencies, partners and stakeholders.

Resource implications

Resources are required to support the implementation of this strategy, particularly for the implementation of surveillance and recording systems, policy monitoring including enforcement measures, research and early detection and treatment components. This will reduce costs in the long term. Furthermore, there is a need to ensure the availability not only of trained human resources at different levels of the health care system but also of treatment structures. In most countries in the Region part of the revenues gathered from alcohol taxes should be allocated to support the implementation of this strategy.

Monitoring and evaluation

Continuous monitoring and evaluation will be based on progress, outcome and impact measurements, formulated under a regional plan of action, and to be reported every two years to the Regional Committee. Progress monitoring indicators include:
a) the availability and effective implementation of policies to reduce alcohol consumption and related harm; 
b) the implementation of sustainable national monitoring systems capable of collecting, analysing and disseminating data for evidence-based policy decisions; 
c) the development and implementation of appropriate health care interventions at all levels of the health system, ranging from early interventions to adequate treatment.

Outcome and impact indicators will require the availability of data on trends and alcohol-related harm.

Conclusions

The African Region is faced with the growing burden of harmful alcohol consumption and lacks appropriate mechanisms to respond to this situation. The main challenge is to develop such mechanisms for effective implementation of national actions that will contribute to reducing harmful use of alcohol and strengthen global initiatives.

The strategy outlines actions needed to reduce alcohol-related harm and facilitate policy development and implementation at the country level. In order to reduce alcohol-related morbidity and mortality in countries, Member States are invited to take guidance from this document according to their specific needs and situation. This strategy will pave the way for action region-wide including stronger cooperation among Member States, stakeholders and partners. Strong advocacy and commitment at the highest political level are fundamental elements for its success.

The Regional Committee reviewed and endorsed this proposed strategy in 2010.18

References

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6. Estimated mean of 20.24 litres of pure alcohol per resident alcohol user aged 15 or over, higher than the global consumption rate estimated to 15.8 litres. In: Rehm J et al., Alcohol, social development and infectious disease, Ministry of Health and Social Affairs, Sweden, 2009.
9. Policies to reduce the harmful use of alcohol must reach beyond the health sector and engage such sectors as development, transport, justice, social welfare, fiscal policy, trade, agriculture, consumer policy, education and employment.
10. Over the years, the stipulated maximum level has been lowered. It is now as zero or 0.2 g/l in a number of countries, and 0.5 g/l or lower in most countries in Europe.
11. Several studies have found mean price elasticities of -0.46 for beer, -0.69 for wine, and -0.80 for liquor, meaning that if the price of beer is raised by 10%, beer consumption would fall by 6.9%; if the price of wine is raised by 10%, wine consumption would fall by 0.69%; if the price of spirits was increased by 10%, consumption of liquor would fall by 8.0%. Anderson P et al., “Effectiveness and cost-effectiveness of policies and programmes to reduce the harm caused by alcohol”, The Lancet; 373, 2009, 2234–46.
12. Illegally produced alcohol refers to alcoholic beverage not produced according to law or not authorized by law. Illegally produced alcohol means alcoholic beverages produced at home or locally by fermentation and distillation of fruits, grains, vegetables and the like, and often within the context of local cultural practices and traditions.
Challenges facing the introduction of the WHO surgical safety checklist: A short experience in African countries

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Surgery is an essential element of health care with an estimated 234 million surgical procedures performed each year in the world. Complications are common and occur in 3% to 16% of all surgical procedures. This may suggest that at least 1 million patients die and 7 million patients are injured due to surgical related complications annually. Hence, the operating room (OR) is one of the most complex work environments in health care. As part of its efforts to improve patient safety the WHO launched a world challenge in 2008, the WHO Safe Surgery Saves Lives programme. The aim of the programme is to harness political commitment and clinical will to address important patient safety issues, including inadequate anesthetic safety practice, avoidable surgical infection and poor communication among team members. These have proved to be common, deadly and preventable problems in all the countries and settings. From 2008, the programme has focused on the use of a safe surgery checklist in operating rooms – the use of which has become increasingly widespread as studies have shown its use linked to a reduction in the rate of postoperative complications and deaths by more than one third.

However, the introduction of the WHO SSCL into workflow patterns can be associated with some challenges. To support Member States in implementing the WHO safety checklist in surgery WHO AFRO organized two workshops in Harare in 2011 which brought together senior surgeons and anesthesiologists (from tertiary hospitals) from ten English-speaking and five French-speaking African countries to orient them on the tool and its implementation.

Country plans were developed during the workshop on how to implement the safety checklist. The workshop agreed on the following steps for the implementation process:

1. Reporting to local authorities on the workshop and planned activities;
2. Formation of a core team/task force at facility level to facilitate implementation;
3. Adaptation of the safety checklist;
4. Start implementation at facility level; and
5. Plan for national rollout/formation of national team/task force and integration of patient safety training in the medical curriculum.

SUMMARY—The concept of using a checklist in surgical care was energized by publication of the WHO in 2008 of the WHO surgical safety checklist (SSCL) An orientation workshop on the checklist was held in Harare for 15 African countries in 2011 and a survey conducted in 2012 with the aim of analysing the use and challenges/barriers to its use. Via a questionnaire the workshop participants were asked to explore their experience with the SSCL implementation, enabling factors as well as challenges encountered and methods used to overcome them. Of the 15 hospitals surveyed 10 (67%) had successfully implemented the checklist as by October 2012. Four out of ten hospitals (40%) adapted the SSCL to suit their local conditions while the other six (60%) used the generic WHO version. None of the implementing hospitals had completed implementation in all of the institution’s operating rooms (OR). The mean compliance rate use of the checklist was 48.5% while the mean duration of use was 9.2 months. The main barrier to use identified were staff resistance in 70% of the hospitals that implemented the checklist and in all hospitals the perception that the SSCL was not really a priority. The enabling factors identified were the presence of strong hospital leadership support, group discussions and regular meeting to address arising issues from the use of SSCL and, in one hospital, making the SSCL mandatory. In conclusion, the implementation of the SSCL checklist has been successfully achieved in ten out of the 15 hospitals oriented on the use. The main barriers relate to organizational and cultural reasons and need to be addressed through strong supportive leadership and a clear follow-up mechanism to review the status of implementation on a regular basis.

Voir page 55 pour le résumé en version française. Ver a página 55 para o sumário em versão portuguesa.
The overall aim of this article is to analyse the challenges or barriers and enabling factors identified by the implementing teams following the Harare workshop. The specific objectives of the study were: a) to assess the implementation process of the WHO surgical safety checklist; b) to identify challenges and barriers; and c) develop a strategy for effective and sustainable use.

### Methods

The survey was conducted from 15–31 October 2012. Data on implementation were collected using an electronic questionnaire sent to 15 participating hospitals from 15 countries which had sent representatives to the orientation workshop in Harare in 2011. The questionnaire targeted members of the hospital surgical team. All the hospitals targeted were tertiary hospitals. The questionnaire explored the extent of use of the checklist (completeness, compliance, proportion of beneficiaries among patients undergoing surgery, adaptation of the checklist or use of the original WHO version), the barriers and challenges arising and how they overcame them. “Complete implementation” was defined as achievement of thorough and consistent use of the checklist in all operating rooms and “incomplete implementation” as partial or inconsistent checklist use. The compliance rate was defined by the percentage of surgical patients who benefited from SSCL use during a surgical procedure.

### Results

Ten out of fifteen hospitals (67%) had successfully implemented the checklist by October 2012. Four out of ten hospitals (40%) had adapted it to suit their local conditions, while the other six (60%) used the generic WHO version. None of the implementing hospitals had completed the implementation in all ORs. The compliance rate is given in Table 1.

The mean duration of use of the SSCL was 9.2 months (varying from 4 to 15 months). The compliance rate varied from 10–90% (mean: 48.5%). All three parts of the checklist were consistently completed in six out of ten hospitals (60%). The checklist implementation started in one OR and was rolled out in other ORs in seven of the ten hospitals (70%); and three out of ten (30%) started in all ORs simultaneously. The use of the checklist was captured in the patient’s record in seven of ten implementing hospitals (70%).

Out of the ten hospitals who had implemented the checklist the enabling factors identified were: strong hospital leadership (60%); group discussions and regular meetings to address issues arising (60%); and a management decision to make using the checklist mandatory in one hospital (10%). Only 40% collected indicators to monitor the effectiveness of the checklist on the outcome of the patients. The following indicators were collected: mortality rate following surgery (40%) of hospitals; surgical site infection for (40%); and unplanned return to the OR for (40%). None of the countries surveyed had started the national rollout of the SSCL implementation as at the end of October 2012.
Ten of the 15 hospitals (67%) in the 15 countries which were trained on the use of the SSCL had successfully started implementing the checklist by the end of October 2012. The reasons why a third of the countries that were trained had not yet introduced the checklist was not looked into but should be investigated. All the hospitals targeted were tertiary hospitals. Indeed the Patient Safety Programme in AFRO assumed that implementing a new strategy in tertiary hospitals would facilitate the rollout in the country. However, since the mean compliance rate stands at 48.5%, more effort needs to be put in place to achieve full implementation for a meaningful risk reduction in surgical complications. This mean rate is low and suggests that the checklist is not routinely used and most of the patients operated in those hospitals may not benefit fully from the use of the SSCL. Moreover the compliance rate among the surveyed hospitals ranged from 10–90%. Vats et al. reported that compliance rates vary over time within a team and a hospital. In fact, the UK SSCL pilot study reported that compliance rate ranged from 42–79% during the first year of implementation.10

The use of the checklist was being documented in the patient’s record in 70% of hospitals. This is not theoretically an issue if the use of the checklist is systematic and all three parts of the checklist completed. Regarding the barriers to the implementation of the checklist, most related to or depended on organizational and cultural factors (as previously reported by Fourcade et al.11). The translation of a new concept into practice is always a big challenge and typically follows the theory of diffusion and innovation11 – individuals acquire knowledge about the innovation, are persuaded by utility, make a decision to adopt, determine the usefulness of innovation, and then decide to continue using the innovation to full effect. This implies that education and local champions are keys to success.

However, a different approach was used in the UK12 and France13 where the national regulatory bodies (the National Patient Safety Agency in United Kingdom in January 2009 and the Haute Autorité de la Santé in January 2010) issued a directive for the implementation of the WHO Surgical Safety Checklist to be adapted nationally and used for every patient undergoing a surgical procedure. This national decision resulted in successful implementation throughout the two countries. The implementation of the checklist in the African context has largely been a voluntary initiative led by professionals without any supportive policy from the national health authorities or regulatory bodies. The WHO played a catalyst and supportive role by initiating the orientation workshop with the cooperation of the national health authorities in the targeted countries. Nevertheless, in one hospital the management of the hospital (CHU Andrianavalona in Antananarivo) made the use of the checklist obligatory. The real challenge is to scale up the use of the SSCL to all operating theatre teams.14

This survey identified supportive leadership as one of the enabling factors for the successful implementation of the safety checklist. The other factor was regular team meetings to review implementation progress. Leadership is a critical factor in motivating operating teams to adopt new ideas.15 Vats et al.15 reported the following factors as critical for successful implementation:

- a) provide training and learning materials;
- b) organizational leadership – senior clinicians make the checklist a clinical governance goal;
- c) cultivate local champions;
- d) clarify the role of each professional group;
- e) organize regular audits;
- f) support essential local adaptations but discourage oversimplification and modification for the sake of it.

Our findings support these recommendations. Most hospitals (70%) that implemented the checklist started in one theatre and then expanded use to all theatres. Starting in one or a few ORs and rolling out is largely seen as a good way progress.16,17 However, this needs to be further investigated to assess the sustainability of the checklist use over time. In 30% of hospitals implementation was started in all theatres at the same time but the challenges they faced did not differ from the hospitals that used a phased approach. According to WHO guidelines,16,17 the implementing hospitals are encouraged to collect indicators to monitor the patient’s outcome of the checklist implementation. Only 4 out of the 10 hospitals have an outcome

### Table 1. Checklist compliance rate and duration of use by hospital surveyed

<table>
<thead>
<tr>
<th>Hospitals</th>
<th>Compliance rates</th>
<th>Duration of use</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kenyatta Hospital (Nairobi, Kenya)</td>
<td>90.0%</td>
<td>7 months</td>
</tr>
<tr>
<td>Princess Marina Hospital (Gaborene, Botswana)</td>
<td>23.0%</td>
<td>6 months</td>
</tr>
<tr>
<td>CHU Gabriel Touré (Bamako, Mali)</td>
<td>80.0%</td>
<td>10 months</td>
</tr>
<tr>
<td>UTH Lusaka (Zambia)</td>
<td>50.0%</td>
<td>16 months</td>
</tr>
<tr>
<td>Mulago Hospital (Kampala, Uganda)</td>
<td>10.0%</td>
<td>10 months</td>
</tr>
<tr>
<td>Mbabane Government Hospital (Swaziland)</td>
<td>60.0%</td>
<td>4 months</td>
</tr>
<tr>
<td>Windhoek central Hospital (Namibia)</td>
<td>10.0%</td>
<td>15 months</td>
</tr>
<tr>
<td>CHU Ravoahangy Andrianavalona (Madagascar)</td>
<td>37.5%</td>
<td>5 months</td>
</tr>
<tr>
<td>Centre Hospitalier de Moheli (Comoros)</td>
<td>50.0%</td>
<td>7 months</td>
</tr>
<tr>
<td>CHU Kigali (Rwanda)</td>
<td>70.0%</td>
<td>12 months</td>
</tr>
<tr>
<td>Mean</td>
<td>48.5%</td>
<td>9.2 months</td>
</tr>
</tbody>
</table>

### Table 2. Barriers to implementation

<table>
<thead>
<tr>
<th>Barriers identified</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of senior leadership in the hospital</td>
<td>4/10 (40%)</td>
</tr>
<tr>
<td>Staff resistance</td>
<td>7/10 (70%)</td>
</tr>
<tr>
<td>Insufficient time to use the checklist</td>
<td>4/10 (10%)</td>
</tr>
<tr>
<td>Use of the checklist not seen as a priority</td>
<td>10/10 (100%)</td>
</tr>
</tbody>
</table>

Discussion

The use of the checklist was not routinely used and most hospitals would facilitate the rollout in the country. However, since the mean compliance rate stands at 48.5%, more effort needs to be put in place to achieve full implementation for a meaningful risk reduction in surgical complications. This mean rate is low and suggests that the checklist is not routinely used and most of the patients operated in those hospitals may not benefit fully from the use of the SSCL. Moreover the compliance rate among the surveyed hospitals ranged from 10–90%. Vats et al. reported that compliance rates vary over time within a team and a hospital. In fact, the UK SSCL pilot study reported that compliance rate ranged from 42–79% during the first year of implementation.10

This national decision resulted in successful implementation throughout the two countries. The implementation of the checklist in the African context has largely been a voluntary initiative led by professionals without any supportive policy from the national health authorities or regulatory bodies. The WHO played a catalyst and supportive role by initiating the orientation workshop with the cooperation of the national health authorities in the targeted countries. Nevertheless, in one hospital the management of the hospital (CHU Andrianavalona in Antananarivo) made the use of the checklist obligatory. The real challenge is to scale up the use of the SSCL to all operating theatre teams.14

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collection tool. These indicators are regarded as reliable in assessing the effectiveness of a SSCL.1,18

Conclusion

The implementation of a SSCL is undoubtedly intended to improve the outcome of surgical care and thus the quality of care in general. However, its introduction and sustaining its use is not easy. Literature8 indicates that over time, compliance of surgical staff is good but needs follow up and sustained education sessions including meetings to review and address the barriers in a comprehensive and sustainable way. This preliminary assessment appeals for a more structured evaluation of the initiative to be undertaken in the near future. The impact of introducing the checklist to surgical outcomes also needs to be evaluated. 0

References

The African Health Observatory (AHO) is a web-based platform that serves three core functions:

- Storage and sharing of data and statistics for visualization and download;
- Production and sharing of evidence and knowledge through the analysis and synthesis of information;
- Support of networks and communities of practice for better learning and innovation.

The AHO data and statistics platform allows users to access metadata and produce their own graphs, maps or tables. Users can also download the metadata and raw data. The AHO contains many dynamic and interactive graphs and maps, as well as an extensive statistical health profile for each of the 46 Member States of the African Region. The Atlas of African Health Statistics is an annual publication that contains over 250 maps and graphs on a wide range of indicators on health status, health systems, specific programmes and diseases, key determinants and progress on the health Millennium Development Goals.

As a repository of extensive information and evidence on national health systems, the AHO plays a key role in the policy dialogue, monitoring the implementation and evaluation of national strategies and plans. Thematic or subject-based profiles as well as country profiles are prepared and shared through the various publications of the observatory.

Comprehensive and analytical country health profiles provide analysis and synthesis of regional and country health situation to inform policy and decision making. Areas covered include:

- Health status and trends (life expectancy, mortality and disabilities);
- Health systems (governance, partnerships, finance, human resources, products and infrastructure, community participation, information and evidence);
- Specific programmes and services (HIV/AIDS, TB, malaria, family and reproductive health); and
- Key determinants (social determinants, environment/climate and risk factors).

In addition, there are four sections that describe progress on internationally agreed goals and targets. As an example, the analytical profile for the Republic of Congo runs to 150 pages of text, figures and illustrations.

The third major function of the observatory is to serve as a platform for networking and communities of practice and a “one-stop-shop” for information and evidence. It offers IT-based networking facilities where members of communities can create and capture information, share, discuss and learn together to improve performance.

With WHO support, several countries have started work towards establishing their own national health observatories (NHOs) to strengthen their national health information system, while a number of others have expressed interest in doing so. NHOs serve as multi-stakeholder and collaborative platforms, allowing national and sub-national stakeholders to come together to address issues of common concern.
CDER Editorial

In this first edition of the year we review public health events, cholera and meningitis as reported in the Region in 2011 and 2012.

Although the number of public health events reported in the Region in 2012 has reduced compared with those reported in 2011, more than 85% of these events are still largely due to infectious diseases.

The number of reported cholera cases and deaths in 2012, although slightly lower than 2011, remains high. More than half of the countries in the Region reported cholera cases in both years.

There is an apparent shift in the predominant pathogen serogroups causing meningitis in the Region. Following the introduction of meningitis A conjugate vaccine in Burkina Faso, Mali and Niger, NmA is no longer the predominant serogroup.

We hope that you will find the contents of this bulletin useful.
Public health events reported in the WHO African Region in 2011 and 2012

Between January and December 2011, a total of 103 public health events were reported in the Region compared with 67 in the corresponding period of 2012, as shown in Figures 1 and 2. Moreover, 86% and 88% of public health events reported during this period were due to infectious diseases, with cholera and meningitis topping the list. The Democratic Republic of Congo, Uganda and Nigeria reported at least five events each in 2012.

Figure 1. Distribution of public health events in the WHO African Region, 2011

Source: Events Management System WHO/AFRO

Figure 2. Distribution of public health events in the WHO African Region, 2012

Source: Events Management System WHO/AFRO
Cholera continued to be a major public health problem in the region in 2011 and 2012, and was associated with high case fatality rates of above 1%. More than half of the countries in the African Region reported cholera cases and deaths in 2011 and 2012. Over the two years, the Democratic Republic of Congo and Ghana were among the countries reporting the highest numbers of cholera cases and deaths.

In 2011, a total of 107,163 cases with 2,969 deaths (CFR = 2.8%) were reported by 25 countries in the Region, as shown in Table 1. Cameroon, Chad, the Democratic Republic of Congo, Ghana and Nigeria accounted for 86% cases and 87% deaths.

In 2012, a total of 94,553 cholera cases with 1,834 deaths (CFR = 1.9%) were reported by 25 countries in the Region in 2012, as shown in Table 1. The Democratic Republic of Congo, Ghana, Guinea, Sierra Leone and Uganda accounted for 85% of cases and 81% of deaths.

Although, there is a slight reduction in the number of reported cases in 2012 compared with 2011, the CFR in both years remained higher than the WHO threshold of 1%.

<table>
<thead>
<tr>
<th>Country</th>
<th>2011</th>
<th>2012</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Cases</td>
<td>Deaths</td>
</tr>
<tr>
<td>Angola</td>
<td>1,810</td>
<td>110</td>
</tr>
<tr>
<td>Benin</td>
<td>762</td>
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</tr>
<tr>
<td>Burkina Faso</td>
<td>20</td>
<td>2</td>
</tr>
<tr>
<td>Burundi</td>
<td>1,020</td>
<td>2</td>
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<tr>
<td>Cameroon</td>
<td>22,433</td>
<td>783</td>
</tr>
<tr>
<td>Central African Republic</td>
<td>117</td>
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<tr>
<td>Chad</td>
<td>17,267</td>
<td>458</td>
</tr>
<tr>
<td>Congo</td>
<td>762</td>
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</tr>
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<td>Côte d’Ivoire</td>
<td>1,261</td>
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</tr>
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<td>Democratic Republic of Congo</td>
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<td>Ghana</td>
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<td>Guinea</td>
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<td>Guinea-Bissau</td>
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<td>Kenya</td>
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<td>Liberia</td>
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<tr>
<td>Malawi</td>
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<tr>
<td>Mali</td>
<td>2,220</td>
<td>95</td>
</tr>
<tr>
<td>Mauritania</td>
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<td>Mozambique</td>
<td>1,279</td>
<td>5</td>
</tr>
<tr>
<td>Niger</td>
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<td>Nigeria</td>
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<td>Sierra Leone</td>
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<td>0</td>
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<tr>
<td>United Republic of Tanzania</td>
<td>942</td>
<td>11</td>
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<tr>
<td>Togo</td>
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<td>Uganda</td>
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<td>Zambia</td>
<td>330</td>
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</tr>
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<td>Zimbabwe</td>
<td>1,220</td>
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</tr>
<tr>
<td>Total</td>
<td>107,163</td>
<td>2,969</td>
</tr>
</tbody>
</table>

Source: WHO/AFRO Database
Figure 3. Countries reporting cholera cases in 2012

Source: WHO/AFRO Database

Number of reported cases
- 001–999
- 1000–9999
- 10000–

Non AFRO WHO countries or no data
Distribution of meningitis cases and deaths in the African Region in 2011 and 2012

There are recurrent meningitis epidemics in the Region mostly affecting countries in the so-called “meningitis belt” that stretches from Senegal to Ethiopia. During 2011 and 2012, other countries outside the “belt” also experienced meningitis outbreaks.

In 2011, 29 countries in the Region reported 23,394 meningitis cases with 2,099 deaths and a case fatality rate (CFR) of 8.97%. During this period, 45 districts in 8 countries crossed the epidemic threshold, as shown in Table 2. The majority (86%) of the districts that crossed the epidemic threshold (39/45) were in Chad, Cameroon and the Democratic Republic of Congo.

Table 2. Meningitis cases, 2011

<table>
<thead>
<tr>
<th>Country</th>
<th>Cases</th>
<th>Deaths</th>
<th>CFR (%)</th>
<th>Number of districts that experienced epidemics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benin</td>
<td>269</td>
<td>50</td>
<td>18.6</td>
<td>1</td>
</tr>
<tr>
<td>Burkina Faso</td>
<td>3,875</td>
<td>588</td>
<td>15.2</td>
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<td>Burundi</td>
<td>60</td>
<td>11</td>
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<tr>
<td>Cameroon</td>
<td>2,577</td>
<td>166</td>
<td>6.4</td>
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<td>Central African Republic</td>
<td>411</td>
<td>52</td>
<td>12.7</td>
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<tr>
<td>Chad</td>
<td>5,960</td>
<td>270</td>
<td>4.5</td>
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<td>Congo</td>
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<tr>
<td>Côte d’Ivoire</td>
<td>141</td>
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<td>Democratic Republic of Congo</td>
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<td>Eritrea</td>
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<td>Ethiopia</td>
<td>229</td>
<td>9</td>
<td>3.9</td>
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<tr>
<td>Gabon</td>
<td>14</td>
<td>4</td>
<td>28.6</td>
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<tr>
<td>Gambia</td>
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<td>0.0</td>
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<td>Ghana</td>
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<td>Mozambique</td>
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<td>Namibia</td>
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<td>0</td>
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<td>United Republic of Tanzania</td>
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<td>Togo</td>
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<td>Zambia</td>
<td>52</td>
<td>4</td>
<td>7.7</td>
<td>0</td>
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<tr>
<td>Total</td>
<td>23,394</td>
<td>2,099</td>
<td>8.97</td>
<td>45</td>
</tr>
</tbody>
</table>

Source: WHO/AFRO Database
In 2012, 18 countries in the Region reported 28,351 cases with 2,468 deaths and a CFR of 8.7%. During this period, 46 districts in 12 countries crossed the epidemic threshold, as shown in Table 3. The majority (76%) of the districts that crossed the epidemic threshold (35/46) were in Benin, Burkina Faso, Chad and Ghana.

Table 3. Meningitis cases, 2012

<table>
<thead>
<tr>
<th>Country</th>
<th>Cases</th>
<th>Deaths</th>
<th>CFR (%)</th>
<th>Number of districts that experienced epidemics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benin</td>
<td>1,165</td>
<td>112</td>
<td>9.6</td>
<td>6</td>
</tr>
<tr>
<td>Burkina Faso</td>
<td>6,957</td>
<td>709</td>
<td>10.2</td>
<td>13</td>
</tr>
<tr>
<td>Cameroon</td>
<td>542</td>
<td>64</td>
<td>11.8</td>
<td>2</td>
</tr>
<tr>
<td>Chad</td>
<td>3,674</td>
<td>163</td>
<td>4.2</td>
<td>12</td>
</tr>
<tr>
<td>Côte d’Ivoire</td>
<td>500</td>
<td>59</td>
<td>11.8</td>
<td>1</td>
</tr>
<tr>
<td>Central African Republic</td>
<td>286</td>
<td>31</td>
<td>11.7</td>
<td>1</td>
</tr>
<tr>
<td>Democratic Republic of Congo</td>
<td>10,141</td>
<td>1,011</td>
<td>10.0</td>
<td>0</td>
</tr>
<tr>
<td>Ethiopia</td>
<td>150</td>
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<td>0.0</td>
<td>1</td>
</tr>
<tr>
<td>Gambia</td>
<td>200</td>
<td>9</td>
<td>4.5</td>
<td>1</td>
</tr>
<tr>
<td>Ghana</td>
<td>739</td>
<td>75</td>
<td>10.1</td>
<td>4</td>
</tr>
<tr>
<td>Guinea</td>
<td>196</td>
<td>13</td>
<td>6.6</td>
<td>0</td>
</tr>
<tr>
<td>Mali</td>
<td>688</td>
<td>12</td>
<td>1.7</td>
<td>1</td>
</tr>
<tr>
<td>Niger</td>
<td>314</td>
<td>56</td>
<td>17.8</td>
<td>0</td>
</tr>
<tr>
<td>Nigeria</td>
<td>1,206</td>
<td>74</td>
<td>6.1</td>
<td>2</td>
</tr>
<tr>
<td>Senegal</td>
<td>894</td>
<td>28</td>
<td>3.1</td>
<td>0</td>
</tr>
<tr>
<td>Togo</td>
<td>408</td>
<td>35</td>
<td>8.6</td>
<td>0</td>
</tr>
<tr>
<td>Uganda</td>
<td>70</td>
<td>11</td>
<td>15.7</td>
<td>2</td>
</tr>
<tr>
<td>Mauritania</td>
<td>41</td>
<td>6</td>
<td>14.6</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>28,351</td>
<td>2,468</td>
<td><strong>8.7%</strong></td>
<td>46</td>
</tr>
</tbody>
</table>

Source: WHO/AFRO Database

Figure 4. Countries reporting meningitis cases in 2012

Source: WHO/AFRO Database
Countries in the meningitis belt have established an enhanced meningitis surveillance system that includes collecting and testing cerebrospinal fluid (CSF) samples during the meningitis transmission season.

Tables 4 and 5 and Figures 5 and 6 show the number of specimens processed, the distribution of pathogens and serogroups.

### Table 4. Pathogens identified using three methods – polymerase chain reaction (PCR), latex agglutination and culture testing, 2011

<table>
<thead>
<tr>
<th>Country</th>
<th>Number CSF</th>
<th>CSF negative</th>
<th>NmA</th>
<th>NmC</th>
<th>NmX</th>
<th>NmW135</th>
<th>Other Nm ind.</th>
<th>S. pneum</th>
<th>Hib</th>
<th>Other pathogens</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benin</td>
<td>83</td>
<td>35</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>43</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>Burkina Faso</td>
<td>3 125</td>
<td>1 502</td>
<td>4</td>
<td>0</td>
<td>153</td>
<td>99</td>
<td>1</td>
<td>713</td>
<td>40</td>
<td>3</td>
</tr>
<tr>
<td>Cameroon</td>
<td>280</td>
<td>173</td>
<td>86</td>
<td>0</td>
<td>0</td>
<td>6</td>
<td>0</td>
<td>13</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Chad</td>
<td>228</td>
<td>107</td>
<td>98</td>
<td>0</td>
<td>0</td>
<td>6</td>
<td>0</td>
<td>13</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>Ghana</td>
<td>89</td>
<td>51</td>
<td>1</td>
<td>5</td>
<td>0</td>
<td>3</td>
<td>1</td>
<td>15</td>
<td>1</td>
<td>12</td>
</tr>
<tr>
<td>Mali</td>
<td>357</td>
<td>284</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>29</td>
<td>0</td>
<td>8</td>
<td>3</td>
<td>11</td>
</tr>
<tr>
<td>Niger</td>
<td>883</td>
<td>436</td>
<td>4</td>
<td>0</td>
<td>1</td>
<td>388</td>
<td>3</td>
<td>59</td>
<td>1</td>
<td>9</td>
</tr>
<tr>
<td>Nigeria</td>
<td>16</td>
<td>12</td>
<td>4</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<tr>
<td>Togo</td>
<td>61</td>
<td>32</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>2</td>
<td>25</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>5 122</td>
<td>2 634</td>
<td>197</td>
<td>5</td>
<td>154</td>
<td>514</td>
<td>5</td>
<td>889</td>
<td>53</td>
<td>39</td>
</tr>
</tbody>
</table>

Source: WHO/AFRO Database

Laboratory data from nine countries that reported in 2011 are shown in Table 4. The most prevalent pathogens identified were *Neisseria meningitidis* (48%) and *Streptococcus pneumoniae* (49%). Out of the 875 confirmed *Neisseria meningitidis* samples, the most frequent serogroup was NmW135 (59%, n = 514) while NmA contributed only 22%, as shown in Figure 5. However in Burkina Faso, Mali and Niger, the three countries that introduced the meningitis A conjugate vaccine in 2011, very few cases of NmA were reported with majority of outbreaks attributed to NmW135.

### Figure 5. Meningitis pathogens as identified by PCR, latex and culture testing, 2011

Source: WHO/AFRO Database
Laboratory data from 14 countries that reported in 2012 show that the most prevalent pathogens identified were *Neisseria meningitidis* (69%) and *Streptococcus pneumoniae* (29%), as shown in Table 5 and Figure 6. Out of the 1,268 confirmed *Neisseria meningitidis* samples, the most frequent serogroup was NmW135 (79%, n = 1,007), while NmA, was only 7%, as shown in Figure 8. No cases of meningococcal meningitis due to serogroup A were detected in 2012 in Burkina Faso, Mali and Niger – the countries that introduced the meningitis A conjugate vaccine. Instead, NmW135 was the predominant Nm serogroup circulating.

The drop in prevalence of NmA in Burkina Faso, Mali and Niger can be attributed to the introduction of the meningitis A conjugate vaccine.

### Table 5. Pathogens identified using three methods – polymerase chain reaction (PCR), latex agglutination and culture testing, 2012

<table>
<thead>
<tr>
<th>Country</th>
<th>Number</th>
<th>CSF</th>
<th>CSF negative</th>
<th>NmA</th>
<th>NmC</th>
<th>NmX</th>
<th>NmW135</th>
<th>Other Nm ind.</th>
<th>S. pneum</th>
<th>Hib</th>
<th>Other pathogens</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benin</td>
<td>192</td>
<td>148</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>6</td>
<td>0</td>
<td>34</td>
<td>1</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Burkina Faso</td>
<td>3,297</td>
<td>1,248</td>
<td>0</td>
<td>0</td>
<td>138</td>
<td>704</td>
<td>3</td>
<td>236</td>
<td>20</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Cameroun</td>
<td>218</td>
<td>186</td>
<td>13</td>
<td>0</td>
<td>0</td>
<td>6</td>
<td>0</td>
<td>13</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Central African Republic</td>
<td>32</td>
<td>0</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>24</td>
<td>4</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Chad</td>
<td>157</td>
<td>104</td>
<td>44</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>0</td>
<td>6</td>
<td>0</td>
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<td></td>
</tr>
<tr>
<td>Côte d’Ivoire</td>
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<td>0</td>
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<td>0</td>
<td>53</td>
<td>4</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Gambia</td>
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<td>148</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>27</td>
<td>0</td>
<td>5</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Ghana</td>
<td>155</td>
<td>97</td>
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<td>2</td>
<td>0</td>
<td>29</td>
<td>0</td>
<td>26</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Mali</td>
<td>520</td>
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<td>0</td>
<td>0</td>
<td>0</td>
<td>94</td>
<td>1</td>
<td>27</td>
<td>3</td>
<td>6</td>
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<tr>
<td>Niger</td>
<td>271</td>
<td>210</td>
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<td>0</td>
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<td>22</td>
<td>2</td>
<td>29</td>
<td>2</td>
<td>6</td>
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</tr>
<tr>
<td>Nigeria</td>
<td>35</td>
<td>23</td>
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<td>0</td>
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<td>3</td>
<td>0</td>
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<td>2</td>
<td>4</td>
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<tr>
<td>Democratic Republic of Congo</td>
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<td>0</td>
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<td>0</td>
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</tr>
<tr>
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<td>0</td>
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<td>0</td>
<td>10</td>
<td>1</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Togo</td>
<td>254</td>
<td>143</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>6</td>
<td>23</td>
<td>71</td>
<td>8</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>6,778</td>
<td>3,906</td>
<td>88</td>
<td>4</td>
<td>138</td>
<td>1,007</td>
<td>31</td>
<td>539</td>
<td>45</td>
<td>25</td>
<td></td>
</tr>
</tbody>
</table>

Source: WHO/AFRO Database

The drop in prevalence of NmA in Burkina Faso, Mali and Niger can be attributed to the introduction of the meningitis A conjugate vaccine.

### Figure 6. Meningitis pathogens as identified by PCR, latex and culture testing, 2012

![Meningitis pathogens as identified by PCR, latex and culture testing, 2012](source: WHO/AFRO Database)

- **Neisseria meningitidis**
- **Streptococcus pneumoniae**
- **Hemophilus influenzae and other Nm**

Source: WHO/AFRO Database
Dr Sambo briefs members of the diplomatic corps on the health situation in the WHO African Region

On 15 February 2013, and for the fourth time, the WHO Regional Director for Africa, Dr Luis Sambo, briefed representatives of international organizations and members of the diplomatic community accredited to the Republic of Congo on the health situation in the WHO African Region. He had held similar meetings with the diplomats in 2006, 2011 and 2012.

During this recent briefing Dr Luis Sambo called on African governments, together with their health partners, to intensify action in addressing three of the major health threats facing the Region: communicable diseases, noncommunicable diseases and public health emergencies. Addressing the envoys, the Regional Director stressed the need for countries “to strengthen their health systems with a view to ensuring equitable access to health services.”

Dr Sambo outlined the major communicable diseases facing the Region as malaria, TB, HIV/AIDS, neglected tropical diseases, epidemic and pandemic-prone diseases and vaccine preventable diseases. He stated that the Region records 90% of all global episodes of malaria, 90% of deaths, and a very high rate of malaria-related deaths among children and pregnant women. However, ongoing efforts to address this problem have reduced malaria deaths by more than 50% in 12 countries. The percentage of homes using long-lasting insecticide-treated nets has also increased from 3% in 2000 to 53% in 2012.

TB remains a major public health problem in the African Region, with 500 000 deaths annually that account for over 26% of notified TB cases in the world. While 19 countries have been able to treat over 85% of those affected, the co-infection of TB and HIV as well as drug-resistant TB and multi-drug resistant TB continue to complicate treatment of the disease.

The Regional Director highlighted progress made in the prevention, control and treatment of HIV/AIDS but said that the 1.2 million deaths recorded in the Region in 2011 is a matter of concern. He also noted that progress was being made in tackling neglected tropical diseases. However, more needs to be done to control elephantiasis, river blindness, bilharzia, trachoma, soil transmitted infections such as hookworm, roundworm and whipworm among others.

Referring to noncommunicable diseases, the Regional Director pointed out that tobacco use, lack of exercise, unhealthy diets and harmful use of alcohol are responsible for the rising trend of heart diseases, cancer, diabetes, chronic respiratory diseases, mental health problems, violence and trauma. It is projected that by 2025, about 55% of deaths in the African Region will be caused by noncommunicable diseases.

“Strengthening the technical skills of health workers, especially doctors, nurses and managers of health services will help improve the performance of health services.”

Dr Sambo told the audience that the proposed African Public Health Emergency Fund (APHEF) was now ready to take off with the contribution of US$ 1.8 million by five countries – Angola, Eritrea, Ethiopia, the Democratic Republic of Congo and Rwanda.
The expected annual contribution to the Fund is US$ 50 million. He appealed to countries to pay up their outstanding contribution for 2012.

Drawing attention to the impact of climate change, he stressed that it was time for all to face the realities of its projected effects which include increasing the population at risk for malaria in the Africa Region to an estimated 170 million people between now and 2030.

In his remarks, the Minister of Health and Population of Congo, Mr François Ibovi, stated that his government had decided to prioritize disease prevention, improved access to quality medicines, hospital hygiene and quality health personnel in improving the country’s health system. “Strengthening the technical skills of health workers, especially doctors, nurses and managers of health services will help improve the performance of health services”, he said.

Speaking on behalf of the diplomatic community, the Dean of the Diplomatic Corps in Brazzaville, Mrs Marie Charlotte Fayanga, said she was confident that more countries will make their contribution to the APHEF. Mrs Fayanga, who is the Ambassador of the Central African Republic to Congo, also appealed to decision- and policy-makers in the health sector in the African Region to ensure that people in the rural areas also had access to impregnated bed nets and antiretroviral therapy.

The next meeting between Dr Sambo and the Diplomatic Corps accredited to Congo is expected to be held in February 2014.

Beyond 4 February: Raising awareness and dispelling myths about cancer

Brazzaville, 26 February 2013 — An anonymous cancer patient in Brazzaville, Congo, once declared during a treatment session, “given the fact that people know so little about cancer, we should be talking about this disease all the time, all year round, and not just in February”. He was referring to the urgent need to continually raise awareness of cancer and how to prevent, detect or treat the disease.

The theme of World Cancer Day this year, “Cancer – Did you know?”, focusing on target 5 of the World Cancer Declaration – Dispel damaging myths and misconceptions about cancer – provided a justification and an opportunity for all to undertake year-round cancer awareness-raising activities in the WHO African Region.

What is cancer? Cancer is a disease that occurs when abnormal cells within any part of the human body continuously grow out of control. The chances of developing most cancers are related to modifiable risk factors such as tobacco use, unhealthy diet, harmful use of alcohol, physical inactivity, overweight and some chronic infections. It is therefore advisable to live a healthy lifestyle to prevent the onset of the disease.

According to WHO, there is growing evidence that the African Region is facing a major public health challenge due to the rising burden of cancer. It is projected, for example, that by 2030, Africa will bear some 1.6 million new cancer cases with 1.2 million deaths. The most common cancers in the Region are cancers of the cervix, breast, liver, prostate, Kaposi’s sarcoma and non-Hodgkin’s lymphoma.

**MYTHS AND MISCONCEPTIONS**

Unfortunately there are lots of myths and misconceptions about cancer and we need to know the truth to better protect ourselves. Myths, misconceptions and scientifically unsubstantiated claims about cancer and its risk factors in the African Region can lead to gross misinformation which can hurt rather than help efforts by individuals, families and communities to prevent, detect or effectively treat the disease.

Cancer is not caused by an injury, such as a bump or a bruise. Cancer is not contagious. Although infections by certain viruses or bacteria increase the risk of some types of cancer, no one can get cancer from another person.

**DISPELLING THE MYTHS**

Many people in the Region do not know that they have cancer until it is at an advanced stage due to the lack of awareness and the weakness of early diagnostic capacities in our countries. Evidence generated through research tells us that about 40% of all cancer deaths can be prevented if diagnosed early. Indeed a vast majority of patients survive the disease because of early diagnosis and available advanced treatment methods.

It is therefore important to provide people in the African Region with correct, evidence-based information to enable them make informed decisions which help to keep cancer at bay. According to WHO, about 40% of cancer deaths are due to five leading behavioural and dietary risks which can be summarized as: tobacco use, harmful use of alcohol, low fruit and vegetable intake, lack of physical activity and high body mass index or being overweight or obese.

The 2013 World Cancer Day campaign focused its messaging on four myths.

**MYTH 1: CANCER IS JUST A HEALTH ISSUE**

*The facts:* cancer is not just a health issue. It is a serious medical condition which has wide-reaching social, economic, development, and human rights implications. Cancer constitutes a major challenge to development, undermining social and economic advances in the African Region. Approximately 47% of cancer cases and 55% of cancer deaths occur in less developed regions of the world. The situation is predicted to get worse. By 2030, if current trends continue, cancer cases will increase by 81% in developing countries.

**MYTH 2: CANCER IS A DISEASE OF THE WEALTHY, ELDERLY AND DEVELOPED COUNTRIES**

*The facts:* wrong – cancer does not discriminate. It is a global epidemic, affecting all ages and socio-economic groups, with low- and middle-income countries bearing a disproportionate burden. In Africa as well as
elsewhere in the developing world, cancer is threatening further improvements in women’s health and gender equality. Just two cancers, cervical and breast, together account for over 750,000 deaths each year, with the large majority of deaths occurring in developing countries which are now facing a growing double burden of infectious diseases and noncommunicable diseases including cancer.

**MYTH 3: CANCER IS A DEATH SENTENCE**

**The facts:** many cancers that were once considered a death sentence can now be cured and for many more people their cancer can now be treated effectively. With few exceptions, early stage cancers are less lethal and more treatable than late stage cancers. Cost-effective strategies for cancer control such as breast and cervical cancer screening as well as early detection exist for all resource settings and can be tailored to population-based needs.

**MYTH 4: CANCER IS MY FATE**

**The facts:** again, wrong. With the right strategies, more than one in every three cancers can be prevented. Prevention is the most cost-effective and sustainable way of reducing the global cancer burden in the long term. Global, regional and national policies and programmes that promote healthy lifestyles can substantially reduce cancers that are caused by risk factors such as alcohol, unhealthy diet and physical inactivity. Improving diet, physical activity and maintaining a healthy body weight could prevent around a third of the most common cancers.

**CONCLUSION**

The truth is that, globally, about one third of the most common cancers could be prevented through sticking to a healthy diet, being physically active and managing our body weight. World Cancer Day 2013 provided people in the African Region an ideal opportunity to banish the myths and get the facts about cancer so that they can stop the disease before it starts. As Dr Hama Boureima-Sambo, an expert in NCDs at WHO says, “preventing cancer is better and cheaper than treating or curing it”.

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**Celebrating the third African Vaccination Week**

*Brazzaville, April 2013 —* From 22 to 28 April, African countries celebrated the third African Vaccination Week (AVW), an initiative led by the World Health Organization.

During the week, all Member States of WHO in the African Region – island states, landlocked countries and those in coastal regions – organized a range of activities including high-level immunization campaigns and public education and information-sharing events.

The regional launching ceremony was organized in Uganda, a country that is set to introduce the pneumococcal conjugate vaccine into its routine national immunization schedule to reduce infant and child deaths due to pneumonia.

The theme of this year’s African Vaccination Week celebration is “Save lives. Prevent disabilities. Vaccinate.”

“We are delighted with the high and growing profile of the African Vaccination Week which is yet another opportunity for us to underscore the proven life-saving power of vaccines, and to encourage vaccination of children, adolescents and adults against deadly diseases.”

“Both infants and senior citizen stand to benefit from immunization”, Tanzania’s Minister of Health and Social Welfare, Dr Hussein Mwinyi, told participants at the fourth meeting of the Annual Regional Conference on Immunization in December 2012. “Immunization is an important component of health systems and a key strategy to reducing child mortality, improve maternal health and combat diseases. It is for this reason that we need to work together as a region to reach all children with immunization services in Africa”, Dr Mwinyi added.
WHO convenes the first ever multi-stakeholder dialogue to address risk factors for NCDs in the WHO African Region

About 200 participants met from 18–20 March in Johannesburg, South Africa, for the first ever stakeholders’ dialogue to address risk factors for NCDs in the WHO African Region. The theme of the meeting was “Today’s risk factors are tomorrow’s diseases”. This unique forum saw the participation of the 46 countries of the Region, economic operators, non-governmental and consumer organizations, research institutions, regional intergovernmental organizations and partners. A number of government ministries other than the health sector were also represented at the meeting where discussions focused on how these different sectors can work together to address the growing NCD burden in the Region.

The main NCDs include cardiovascular diseases, diabetes, cancer, chronic respiratory diseases and the consequences of violence and unintentional injuries particularly road traffic injuries. The four main risk factors for NCDs that are modifiable include tobacco use, harmful use of alcohol, unhealthy diet and physical inactivity. The biological risk factors associated with the NCDs include overweight and obesity, and elevated blood pressure and high blood sugar level as well as fatty substances, including cholesterol, that are present in blood. All these risk factors for NCDs act alone or in combination to produce undesired health outcomes. Most of these factors are related to behaviour and lifestyle and are, to a large extent, preventable through measures taken at individual, community and government levels. At least 80% of cardiovascular diseases, diabetes, and chronic respiratory diseases and 40% of common cancers are preventable.

WHO African Region faces a rapidly increasing burden of NCDs along with the continuing threat from communicable diseases. In 2008, about 2.8 million deaths globally were attributed to NCDs and this figure is projected to increase by 27% over the next ten years, with low- to middle-income countries being affected the most if remedial action is not taken. About 33% of these NCD-related deaths occur in people under 60 years of age, and are therefore considered as premature deaths, and this has huge economic implications for countries.

Meeting on WHO-EU Policy Dialogue Programme held in Brazzaville

A meeting on the implementation of the WHO-European Union Health Policy Dialogue Programme was held from 25–27 February in Brazzaville, Congo. The programme supports selected countries in policy dialogue on national health policies, strategies and plans and universal coverage. The aim of the meeting was to discuss progress made and lessons learned during the initial year of implementation of the programme in the seven selected countries: Liberia, Moldova, Sierra Leone, Sudan, Togo, Tunisia and Viet Nam.

Over 60 participants, including EU officials, WHO staff, representatives from ministries of health from the selected countries attended the meeting. Speaking at the opening session, the Deputy Regional Director at the WHO Regional Office for Africa, Dr Matshidiso Moeti, noted that since it started in June 2012, the programme had recorded commendable achievements ranging from assisting in coordinating partners during the development of national health strategic plans as well as contributing to a new culture of stakeholder involvement in the work of health ministries in line with the principles of the Paris Declaration.

She told the participants, “it is important that your deliberations be strategic enough and focused to take into account the need to perform better during the next two years. All the bottlenecks at all levels and settings need to be analysed”. The Deputy Regional Director stressed the need to speak the same language regarding universal coverage, policy dialogue around national health policies, strategies and plans, primary health care and all the other relevant aspects that the current project is trying to address.

Dr Moeti also added that it was important that the first group of seven countries benefiting from the programme succeed so that the second group of countries performs even better using lessons learnt earlier.

The WHO-EU programme draws on WHO’s convening role, institutional capacity and experience to support countries and provide advice to facilitate national health policy dialogue across programmes, systems and sectors.

African Advisory Committee on Health Research and Development meets, adopts recommendations

Brazzaville, 15 January 2013 — The African Advisory Committee on Health Research and Development has concluded its 27th session in Brazzaville, Congo, with a range of recommendations aimed at improving health research in the Region.

The recommendations focused on building research health systems, coordination of research activities, innovative funding mechanisms, strengthening partnerships, research planning, production and translation, monitoring and evaluation of the implementation of research projects.

In a speech delivered on his behalf at the opening session, the WHO Regional Director for Africa, Dr Luis Sambo said, “The depth and breadth of research in health reflects the diversity of the causes of ill health, of the interventions that restore health and well-being, and of the measures that prevent people and populations from becoming ill in the first place”.

“Without research, there would be inferior versions – or none at all – of the blood tests, vaccines, medicines, technologies and other products that are used to keep us healthy and to diagnose, treat and cure us when we are sick”, Dr Sambo said in the message delivered by the Director of the Health Systems and services Cluster, Dr Bakar Toure.

The Regional Director pointed out that research should inform the laws and regulations that protect public health, the strategies to achieve health equity, and health services delivery. He called on countries in the Region to invest in research that adds value to addressing priority health problems and strengthen organization structures, as well as the much needed capacities to produce and use research.

Other issues discussed included plans for the first African Forum for Health Research as well as the report of the Consultative Expert Working Group (CEWG). The three-day meeting began on 15th January 2013 with the primary objective of providing input to the draft regional strategy for health research which responds to the health challenges of the Region. It is expected that all countries in the region will have a functional health research system during the course of the new strategy.
A strategy for addressing the key determinants of health in the African Region

RÉSUMÉ—Une attention accrue a été accordée au cours des dernières décennies à l’équité dans les politiques de soins de santé sous l’angle des déterminants sociaux de la santé et de leurs conséquences, axé sur les recommandations de la Commission des Déterminants Sociaux de la Santé (CSDH) de l’OMS. Les conditions sociales et économiques dans lesquelles chacun naît, grandit, vit, travaille et vieillit, et les systèmes de santé en place pour faire face à la maladie ont un impact sur les résultats sanitaires. Ces conditions contribuent à préserver ou à détruire la santé. Pour différents groupes sociaux, l’inégalité d’accès ou l’imposition de conditions sociales ou économiques peuvent entraîner des résultats inégaux en matière de santé. Les personnes vivant dans la pauvreté sont exposées à un risque plus élevé de résultats de santé néfastes que celles qui ont plus de moyens. Après un bref aperçu des lieux de la situation d’ensemble, les principes d’orientations et les principales recommandations de la CSDH sont décrites dans cet article, tout en soulignant l’importance des interventions intersectorielles.

SUMÁRIO—Assistiu-se nas últimas décadas a um interesse acrescido no compromisso por uma maior equidade no domínio da saúde através da acção sobre os determinantes sociais da saúde e as suas consequências, incidiendo nas recomendações da Comissão da OMS para os Determinantes Sociais da Saúde (CSDH). As condições socioeconómicas em que as pessoas nascem, crescem, vivem e envelhecem, e os sistemas instalados para tratar das doenças influenciam os resultados na saúde. Estas condições podem ajudar a preservar ou a destruir a saúde das pessoas. Para diferentes grupos sociais, o acesso ou a exposição desigual às condições sociais e económicas dão a razão aos resultados desiguais em matéria de saúde. As pessoas que vivem na pobreza enfrentam um risco maior de resultados adversos na saúde do que aqueles que têm melhores condições de vida. Após uma breve apresentação do panorama da situação, este artigo descreve em seguida as principais orientações e recomendações da CSDH, destacando a importância das intervenções transsectoriais.

Optimizing global health initiatives to strengthen national health systems

RÉSUMÉ—Les systèmes de santé ont pour objectif une amélioration générale de la santé par la fourniture de services de santé promotionnels, préventifs, curatifs et de rééducation. Les systèmes de santé fonctionnent au niveau national, des districts, des communautés, et au niveau individuel. Les gouvernements ont la responsabilité de renforcer leurs systèmes de santé. Le renforcement des systèmes de santé se définit comme le renforcement des capacités des composantes essentielles des systèmes de santé, afin d’arriver à une amélioration plus équitable et plus durable des services et des résultats en matière de santé. Les initiatives pour la santé mondiale sont des programmes types qui ciblent des maladies spécifiques et visent à apporter des ressources supplémentaires aux efforts consentis par les pays en matière de santé. Le but de cet article est de mettre en évidence les opportunités qui existent pour une optimisation effective des ressources destinées aux initiatives pour la santé mondiale, en vue du...
Overview of health considerations within National Adaptation Programs of Action for climate change in least developed countries and small island states

SUMMARY—O virus da imunodeficiência humana (VIH) constitui um dos principais problemas de saúde pública e do desenvolvimento com que se confrontam os países da África a sul do Sura. Em 2011, segundo dados da ONUSIDA, o continente conta ainda com 71% dos casos de novas infecções em adultos e crianças infectadas pelo VIH e 70% do total de óbitos devidos ao VIH. A estratégia de prevenção da transmissão vertical do VIH (PTVV), preconizada pela OMS, é uma das abordagens mais eficazes para a luta contra o VIH/SIDA. Apesar do compromisso da comunidade internacional e de líderes africanos, e embora as intervenções comprovadas sejam bem conhecidas, os Estados continuam a enfrentar condicionantes de ordem social e institucional que comprometem a consecução dos objectivos de eliminação das novas infecções pediátricas até 2015. Este artigo passa em revista os progressos realizados em matéria da PTVV na Região Africana da OMS e identifica os desafios e acções a emprender pelos países para honrarem os seus compromissos. Os progressos realizados por alguns países são exemplos que tendem a mostrar que é possível uma geração sem o VIH.

Prevention of the transmission mère-enfant du VIH/SIDA en Afrique Sub-saharienne

SUMMARY—Human immunodeficiency virus (HIV) is a major public health and development problem that countries of sub-Saharan Africa must face. According to UNAIDS, 71% of new infections of adults and children and 70% of HIV deaths in 2011 occurred in Africa. The strategy for prevention of mother-to-child transmission of HIV (PTMCT) recommended by WHO is one of the most effective approaches to HIV/AIDS prevention and control. Notwithstanding the commitment of the international community and African leaders, and although there is good knowledge of proven interventions, countries are facing social and institutional bottlenecks hampering the attainment of the goal of eliminating new paediatric infections by 2015. This article reviews the progress in prevention of PMTCT in the WHO African Region and identifies the challenges countries are facing and the actions they should take in order to meet their commitments. The examples of progress in some countries tend to show that an HIV-free generation is possible.

Antimicrobial resistance in the African Region: Issues, challenges and actions proposed

RÉSUMÉ—L’utilisation des agents antimicrobiens joue un rôle capital dans la réduction de la morbidité et de la mortalité dues aux maladies transmissibles. Cependant, l’apparition et l’extension de la résistance à bon nombre de ces agents ont une influence négative sur leur...
Reduced of the harmful use of alcohol: A strategy for the WHO African Region

SUMÁRIO—O uso de agentes antimicrobianos desempenha um papel fundamental na redução da morbidade e mortalidade devido às doenças transmissíveis. Contudo, a emergência e a disseminação da resistência a muitos desses agentes estão a contrariar a eficácia. Na Região Africana, a compreensão das questões relacionadas com a resistência antimicrobiana (AMR) e a sua magnitude é dificultada pelo facto de a vigilância da resistência aos medicamentos se limitar a alguns países, o que resulta em dados incompletos e inadequados sobre a verdadeira extensão do problema. Apesar da limitada capacidade laboratorial para monitorizar a AMR, os dados disponíveis sugerem que a Região Africana partilha a tendência mundial de um aumento cada vez maior da resistência aos medicamentos. O presente documento pretende partilhar a actual situação deste problema de importância para a saúde pública na Região Africana, com vista a aumentar a sensibilização para a necessidade de reforçar a vigilância da AMR e propor acções de contenção desse fenómeno.

Challenges facing the Introduction of the WHO surgical safety checklist: A short experience in African countries

RÉSUMÉ—Les problèmes de santé publique liés à la consommation de l'alcool sont importants et ont des conséquences négatives sérieuses sur les consommateurs d'alcool et sur la société. Dans la Région africaine, la charge de la maladie attribuée à l'alcool est en augmentation, avec un total de décès attribués à l'usage nocif de l'alcool estimé à 2,1% pour s'élever à 2,4% en 2004. Toutefois, de nouvelles données indiquant qu'il existe un rapport entre la forte consommation de l'alcool et les maladies infectieuses, le nombre de décès attribués à l'alcool dans la Région africaine pourrait même être plus élevé. Aucun autre produit largement utilisé par les consommateurs ne cause autant de décès prématurés et d'incapacités comme l'alcool. Les problèmes liés à l'alcool ainsi que leurs conséquences néfastes proviennent non seulement des quantités consommées, mais aussi des modes d'utilisation néfastes. La Région nécessite que soient mis en place ou renforcés des mesures et interventions efficaces et adéquates, ainsi que des mécanismes de surveillance et de sensibilisation du public. Cet article analyse la situation régionale, et offre un cadre d'action dans les États membres et pour la Région qui vise à contribuer à la prévention et à la réduction de l'usage nocif de l'alcool et des problèmes liés à l'alcool dans la Région.

SUMÁRIO—São consideráveis os problemas de saúde pública relacionados com o consumo do álcool, os quais exercem um significativo impacto adverso, não só sobre o consumidor como sobre a sociedade. Na Região Africana, o fardo das doenças atribuíveis ao álcool está a aumentar, com um total estimado de mortes atribuíveis ao uso nocivo do álcool de 2,1% em 2000, ascendendo a 2,4% em 2004. No entanto, com novas evidências que sugerem uma relação entre o uso abusivo do álcool e as doenças infectiosas, o número de óbitos atribuíveis ao álcool na Região Africana poderia ser ainda mais elevado. Não há nenhum outro produto tão facilmente disponível para consumo que seja responsável por tantas mortes prematuras e incapacidades como o álcool. Os problemas relacionados com o álcool e o seu impacto adverso resultam não apenas das quantidades de álcool consumido, mas também da adesão prejudicial do seu uso. É preciso criar ou aplicar na Região medidas e intervenções eficazes e adequadas, assim como mecanismos de vigilância e de sensibilização do público.

États membres et pour la Région qui vise à contribuer à la prévention et à la réduction de l'usage nocif de l'alcool et des problèmes liés à l'alcool dans la Région.

SUMÁRIO—La situation de la mise en œuvre de la liste de contrôle. Les principaux obstacles rencontrés sont liés à des raisons culturelles et organisationnelles, et il convient de s’y pencher dans le cadre d’initiatives d’appui et de mécanismes de suivi clairs visant à analyser régulièrement la situation de la mise en œuvre de la liste de contrôle. Les principaux obstacles rencontrés sont liés à des raisons culturelles et organisationnelles, et il convient de s’y pencher dans le cadre d’initiatives d’appui et de mécanismes de suivi clairs visant à analyser régulièrement la situation de la mise en œuvre de la liste de contrôle.
With over 730 million inhabitants in 46 countries, the African Region accounts for one seventh of the world’s population. This statistical atlas provides the health status and trends in the countries of the African Region, the various components of their health systems, coverage and access levels for specific programmes and services, the broader determinants of health in the Region, and the progress made on reaching the Millennium Development Goals.

Each indicator is described, as appropriate, in terms of place (WHO regions and countries in the African Region), person (age and sex) and time (various years) using a bar graph. The aim is to give a comprehensive overview of the health situation in the African Region and its 46 Member States.

The main source for the data is WHO-AFRO’s integrated database, based on the World Health Statistics 2012. Other UN agency databases have been used when necessary. All the data and figures in this atlas can be accessed through the African Health Observatory (AHO).
Forthcoming...

The next issue of the *African Health Monitor* — a special issue on *Health Financing*

The next issue of the *African Health Monitor* will be devoted to health financing. A wide range of topics and case studies will be featured covering developments in this field, including:

- the impact of mutual health organizations in Rwanda;
- Gabon’s national insurance scheme;
- the abolishment of user fees in Uganda; and
- the effect paying for essential healthcare has on deepening poverty – the experiences of Burkina Faso, Mauritania and Senegal.

The experiences of French-speaking countries will be highlighted, and the aim of developing health financing systems which support the promotion of universal health coverage in Africa will be explored via the case studies, analyses and lessons learned presented.

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