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.
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.”

“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”, says WHO Regional Director for Africa, Dr Luis Sambo.

**This burgeoning partnership between WHO, governments, partners and other stakeholders is helping countries to sustain political commitment to vaccination and lay a solid foundation for a participatory culture of prevention and health promotion in Member States”, Dr Sambo adds.**

Like the two previous editions of the AVW, in 2011 and 2012, the 2013 edition will also serve a number of purposes:

- Raise awareness on the life-saving value of immunization;
- Seek to increase vaccination coverage;
- Reach underserved and marginalized communities;
- Reinforce the medium and long-term benefits of immunization and other child survival interventions; and
- Help transform the lives of millions of children.

With the institutionalization of AVW the momentum on vaccination is growing – during the previous two editions of AVW, access to vaccines improved especially in hard-to-reach communities with more than 150 million people vaccinated with oral polio vaccine in 13 countries.

It is worth noting that Eritrea, which impressed the global health community with its recent successes in health development, tagged its 2012 campaign the “National Child Health, Nutrition and Vaccination Week” and listed as one of its objectives the vaccination of “at least 95% of children aged 9–47 months against measles.”

“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.
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.

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.
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 (CDSH) 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 entrainer 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 CDSH sont décrites dans cet article, tout en soulignant l’importance des interventions sectorielles.

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, incidindo nas recomendações da Comissão da OMS para os Determinantes Sociais da Saúde (CDSH). 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 azo a resultados desiguais em matéria de saúde. As pessoas que vivem na pobreza enfrentam um risco maior de resultados adversos na saúde do que aquelas 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 CDSH, destacando a importância das intervenções transsectoriais.

The state of health financing in the African Region

Résumé—La promotion de la santé est considérée comme une stratégie efficace et économique, et un investissement socialement justifiable permettant d’améliorer véritablement la santé et le bien-être des personnes, des familles et des communautés. Étant donné l’accroissement de la charge de la maladie et des décés prématurés dus à des causes évitables, les États Membres de la Région africaine de l’OMS ont reconnu la nécessité d’investir dans la promotion de la santé. En conséquence, la 51e Session du Comité régional de l’OMS tenue en 2001 a examiné et approuvé la Stratégie régionale de promotion de la Santé, et adopté la Résolution AFR/RC51/4 y afférente. Des résolutions ultérieures ont appelé la priorisation de la promotion de la santé, notamment l’éducation sanitaire et la promotion d’un style de vie sain. La stratégie prône l’intégration d’activités dans différents secteurs et encourage une collaboration multisectorielle. La promotion de la santé est, en définitive, une fonction essentielle de la santé publique qui réduit le fardeau des maladies et en atténue les incidences sociales et économiques. Le présent rapport résume les progrès réalisés dans la mise en œuvre de la stratégie et propose les étapes subséquentes.

Sumário—A promoção da saúde é considerada uma abordagem sazonalmente justificável, que pode ajudar a melhorar significativamente a saúde e bem-estar dos indivíduos, famílias e comunidades. Com o aumento do fardo das doenças e das mortes prematuras por causas evitáveis, os Estados-Membros da Região Africana da OMS reconheceram a necessidade de investir na promoção da saúde. Consequentemente, en 2001, a quainquagésima primeira sessão do Comité Regional da OMS deliberou e aprovou a Estratégia Regional de Promoção da Saúde, tendo adoptado uma resolução com ela relacionada, a Resolução AFR/RC51/4: Resoluções posteriores apelaram à atribuição de prioridade à promoção da saúde, nomeadamente à educação sanitária e à promoção dos estilos de vida saudáveis. A estratégia defende a integração das actividades nos diferentes sectores e incentiva a colaboração multisectorial. Em última instância, a promoção da saúde é uma função essencial da saúde pública, que reduz o fardo das doenças e atenua o impacto social e económico. O presente relatório resume os progressos feitos na implementação da Estratégia Regional de Promoção da Saúde e propõe os passos seguintes a tomar.

The state of health financing in the African Region

Résumé—Cet article fournit des informations sur la situation actuelle du financement de la santé dans la Région africaine de l’OMS. Il vise à répondre au défi que représentent l’évaluation, l’observation et l’analyse des données relatives au financement de la santé, ainsi que l’appui à apporter au débat factuel sur les politiques et à la prise de décision. Un outil destiné à la collecte des données sur les paramètres des systèmes de financement de la santé a été envoyé aux pays, et là où des lacunes existaient, les données sur les comptes nationaux de la santé, collectées chaque année par l’OMS et vérifiées par les pays avant leur finalisation, ont été utilisées. L’analyse montre que les États Membres de la Région africaine de l’OMS sont encore, en moyenne, loin d’atteindre les principaux objectifs en termes de financement de la santé. Alors que la plupart des pays de la Région sont limités dans leur capacité de mobilisation des recettes publiques, plusieurs autres ont réussi à mettre en place des mécanismes de protection des groupes de populations pauvres et vulnérables. Le présent article proposera également un certain nombre de mesures inspirées des observations, et compatibles avec celles qui sont préconisées dans d’autres déclarations et plans d’actions élaborés dans la Région africaine.

Sumário—O presente documento fornece informação sobre a actual situação do financiamento da saúde na Região Africana da OMS. Pretende dar resposta ao actual desafio de medir, observar e analisar os dados sobre o financiamento da saúde, bem como de apoiar o debate sobre políticas de base factual e a respectiva formulação. Enviou-se aos países um instrumento de recolha de dados sobre os parâmetros do sistema de financiamento da saúde e, onde existiam lacunas, usaram-se os dados das contas nacionais de saúde, anualmente coligidos pela OMS e verificados pelos países, antes da finalização. A análise mostra que os Estados-Membros da Região Africana da OMS estão, em média, ainda longe de atingir as principais metas do financiamento da saúde. Embora a maioria dos países da Região tenha capacidades limitadas para mobilizar a receita pública, muitos conseguiram instalar mecanismos de proteção aos pobres e aos grupos populacionais vulneráveis. O documento propõe igualmente algumas acções que se baseiam nas observações efectuadas e são consistentes com as acções contidas em outras recentes declarações e planos de acção formulados na Região Africana.

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...
SUMÁRIO — Os sistemas de saúde procuram conseguir uma melhoria global da saúde, através da prestação de serviços de saúde promocionais, preventivos, curativos e reabilitadores. Os sistemas de saúde operam aos níveis nacional, distrital, comunitário e individual e entre eles. Os governos têm a responsabilidade de reforçar os seus próprios sistemas de saúde. O reforço dos sistemas de saúde é definido como a formação de capacidades em componentes essenciais dos sistemas de saúde, para se obterem melhorias mais equitativas e sustentáveis em todos os serviços e resultados da saúde. As iniciativas Mundiais de Saúde (IMS) são, tipicamente, programas orientados para doenças específicas e destinam-se a constituir recursos adicionais para os esforços dos países na área da saúde. A finalidade do presente artigo é realçar as oportunidades que existem para optimizar eficazmente os recursos das IMS, de modo a reforçar os sistemas nacionais de saúde e as acções que podem tirar partido destas oportunidades.

Overview of health considerations within National Adaptation Programmes of Action for climate change in least developed countries and small island states. ............ 20

SUMMARY — The health systems aim to achieve greater global health, through the provision of promotive, preventive, curative and rehabilitation services. Health systems operate at national, district, community and individual levels as well as between them. National governments have the responsibility to reinforce their own national health systems. Reinforcement of health systems is defined as the formation of capacities in essential components of health systems in order to achieve more equitable and sustainable improvements in all health services and results. The initiatives of the United Nations International Health Conferences (minis) are, typically, programs oriented to specific diseases and are intended to constitute additional resources in addition to the efforts of the countries in the area of health. The aim of this present article is to underline the opportunities that exist for optimizing effectively the resources of the minis, in order to reinforce the national health systems and the actions that can be taken to make the most of these opportunities.

Résumé — Les pays les moins développés et les petits États insulaires requièrent le soutien des pays développés pour préparer des programmes d’action nationaux d’adaptation (PAPA) destinés à faire face aux effets du changement climatique. La plupart de ces programmes remontent à environ 2010. Les questions de santé contenues dans ces plans ont fait l’objet d’une étude qui a porté sur trois aspects principaux : l’identification des conséquences sur la santé ; les besoins en termes d’adaptation et les mesures proposées à cet effet ; et le cadre de mise en œuvre des plans. Il est à noter que 39 des 41 PAPA analysés (soit 95%) montrent que la santé est l’un des secteurs touchés par les changements climatiques. Cependant, 23% seulement (soit 9 sur 39) de ces plans sont à la hauteur lorsqu’il s’agit de leur évaluation sur la vulnérabilité en termes de santé. Au total, 73% (soit 30 sur 41) de ces plans comprennent des interventions sanitaires dans le cadre des besoins d’adaptation et des mesures proposées, mais 27% seulement (soit 8 sur 30) de ces interventions sont jugées adéquates. Le nombre total des projets prioritaires choisis est de 45, mais 50 projets seulement (soit 11%) sont centrés sur la santé. Le coût estimatif total des projets prioritaires est de 1 853 000 000 dollars, avec seulement 58 000 000 (3%) destinés à des projets de santé. Concluons que, avec certaines exceptions, il y a des défis de santé dans les plans de santé qui consacrent des efforts sur les processus de résilience et de protection de la santé publique contre les effets négatifs des perturbations climatiques. 

Résumé — Les pays les moins développés et les petits États insulaires requièrent le soutien des pays développés pour préparer des programmes d’action nationaux d’adaptation (PAPA) destinés à faire face aux effets du changement climatique. La plupart de ces programmes remontent à environ 2010. Les questions de santé contenues dans ces plans ont fait l’objet d’une étude qui a porté sur trois aspects principaux : l’identification des conséquences sur la santé ; les besoins en termes d’adaptation et les mesures proposées à cet effet ; et le cadre de mise en œuvre des plans. Il est à noter que 39 des 41 PAPA analysés (soit 95%) montrent que la santé est l’un des secteurs touchés par les changements climatiques. Cependant, 23% seulement (soit 9 sur 39) de ces plans sont à la hauteur lorsqu’il s’agit de leur évaluation sur la vulnérabilité en termes de santé. Au total, 73% (soit 30 sur 41) de ces plans comprennent des interventions sanitaires dans le cadre des besoins d’adaptation et des mesures proposées, mais 27% seulement (soit 8 sur 30) de ces interventions sont jugées adéquates. Le nombre total des projets prioritaires choisis est de 45, mais 50 projets seulement (soit 11%) sont centrés sur la santé. Le coût estimatif total des projets prioritaires est de 1 853 000 000 dollars, avec seulement 58 000 000 (3%) destinés à des projets de santé. Concluons que, avec certaines exceptions, il y a des défis de santé dans les plans de santé qui consacrent des efforts sur les processus de résilience et de protection de la santé publique contre les effets négatifs des perturbations climatiques.

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 PTMCT 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.

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...
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 de uma Médica. Malgrê as capacidades limitadas dos laboratórios a controlar a resistência aos antimicrobianos, as doenças disponíveis indiquem que a Région africana partage a tendência mundial que no século da Région africana, a freguesia de a vigilância da AMR e propor acções de visant à endiguer este fenómeno.

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 infeciosas, 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 dos padrões prejudiciais 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. Este artigo analisa a situação regional e fornece um quadro de acção para os Estados-Membros e para a Região, que visa contribuir para a prevenção e redução do uso nocivo do álcool e dos problemas com ele relacionados na Região.

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

RéSUMÉ — L’idée d’utiliser une liste de contrôle dans les soins chirurgicaux a été relayée par la publication de la liste de contrôle de l’OMS pour la sécurité chirurgicale (SSCL) en 2008. Un atelier d’orientation organisé par le Bureau de l’OMS pour l’Afrique s’est tenu à Harare en 2011 à l’intention de 15 pays africains, et une étude a été menée en 2012 pour analyser les défis et les barrières qui font obstacle à son utilisation. Les participants aux ateliers ont été invités, à l’aide d’un questionnaire, à analyser leur expérience de la mise en œuvre de la SSCL, les facteurs favorables, les défis et les méthodes utilisées pour les surmonter. Sur les 15 hôpitaux sondés, 10 (soit 67%) avaient réussi à mettre en œuvre la SSCL à la date du 31 octobre 2012. Quatre sur dix (40%) avaient adapté la SSCL à leur situation locale, tandis que les six autres (60%) avaient utilisé la version générique de l’OMS. Aucun des hôpitaux n’avait acheté la mise en œuvre de la liste de contrôle dans la totalité de leurs salles d’opérations. Le taux moyen de conformité était de 48,5%, et la durée moyenne d’utilisation de 9,2 mois. Les principales barrières identifiées ont été la résistance du personnel dans 70% des hôpitaux qui ont mis en œuvre la liste de contrôle, ainsi que le sentiment que la SSCL n’était pas une priorité dans tous les hôpitaux. Les facteurs favorables étaient le soutien ferme des dirigeants des hôpitaux, les discussions de groupes et les rencontres régulières afin d’adresser les problèmes découlant de l’usage de la SSCL et, dans le cas d’un hôpital, le fait de rendre son usage obligatoire. En conclusion, la mise en œuvre de la SSCL a été bien menée dans dix des 15 hôpitaux qui ont bénéficié des ateliers d’orientation. Les principaux obstacles enregistrés 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 du suivi clairs visant à analyser régulièrement la situation de la mise en œuvre de la liste de contrôle.

RéSUMÉ — Etudier la mise en place de la SSCL dans les soins chirurgicaux d’urgence a été relayée par le lancement de la SSCL par l’OMS en 2008. Un atelier d’orientation organisé par le Bureau de l’OMS pour l’Afrique a été mené à Harare en 2011 avec la participation de 15 pays africains, et une étude a été menée en 2012 pour analyser les défis et les barrières qui font obstacle à son utilisation. Les participants aux ateliers ont été invités, à l’aide d’un questionnaire, à analyser leur expérience de la mise en œuvre de la SSCL, les facteurs favorables, les défis et les méthodes utilisées pour les surmonter. Sur les 15 hôpitaux sondés, 10 (soit 67%) avaient réussi à mettre en œuvre la SSCL à la date du 31 octobre 2012. Quatre sur dix (40%) avaient adapté la SSCL à leur situation locale, tandis que les six autres (60%) avaient utilisé la version générique de l’OMS. Aucun des hôpitaux n’avait acheté la mise en œuvre de la liste de contrôle dans la totalité de leurs salles d’opérations. Le taux moyen de conformité était de 48,5%, et la durée moyenne d’utilisation de 9,2 mois. Les principales barrières identifiées ont été la résistance du personnel dans 70% des hôpitaux qui ont mis en œuvre la liste de contrôle, ainsi que le sentiment que la SSCL n’était pas une priorité dans tous les hôpitaux. Les facteurs favorables étaient le soutien ferme des dirigeants des hôpitaux, les discussions de groupes et les rencontres régulières afin d’adresser les problèmes découlant de l’usage de la SSCL et, dans le cas d’un hôpital, le fait de rendre son usage obligatoire. En conclusion, la mise en œuvre de la SSCL a été bien menée...