

FOCUS ISSUE 7: HEALTH

I. Overview of Commitments

Africa

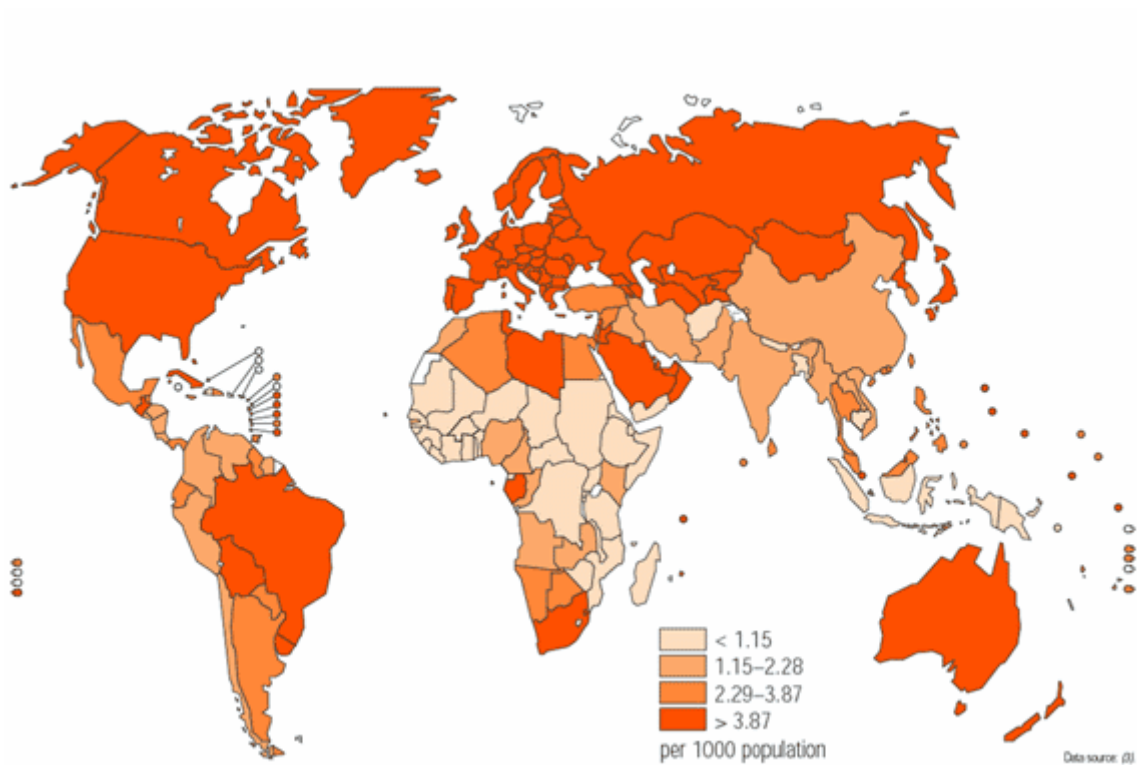
- ◆ All African countries are signatories to the **World Health Organization Alma-Ata Declaration of 1978**, wherein they committed themselves to achieve health for all by the year 2000. In 1998, African countries were part of the renewed global commitments made in the “World Health Declaration” of the World Health Assembly, wherein Member States affirmed the need to give effect to the “health-for-all policy for the twenty-first century” through relevant regional and national policies
- ◆ **Summit on Roll Back Malaria in Abuja in 2000** – the African Heads of State and Government committed themselves to halve the malaria mortality for Africa's people by 2010, through implementing the strategies and actions for Roll Back Malaria, agreed at the summit.
- ◆ The **New Partnership for Africa’s Development (NEPAD) 2001 declaration** committed to ensure food security for all people and increase the access of the poor to adequate food and nutrition.
- ◆ The **55th session of the Ministers of Health of the WHO African Region (2005)** declared tuberculosis (TB) an emergency in the region calling upon member states to implement urgent and extra-ordinary actions to rapidly improve tuberculosis case detection and treatment success-rates; and accelerate implementation of interventions to combat the TB/HIV (Human Immunodeficiency Virus) epidemic, including increased access to antiretrovirals (ARVs) by doubly-infected patients.
- ◆ In May 2006, the Heads of State and Government held another special summit on HIV/AIDS (Acquired Immunodeficiency Syndrome), TB and malaria, to review the status of implementation of their previous commitments on these diseases. They reviewed the continental status report on the implementation of the Abuja Plan of Action and called for accelerated action towards **Universal Access to HIV and AIDS, Tuberculosis and Malaria Services by a United Africa by 2010**. The Summit also reaffirmed previous global and regional targets for TB control.
- ◆ The **Africa Health Strategy 2007-2015** and the subsequent **Plan of Implementation of the Africa Health Strategy 2007-2015**, adopted by the Ministers of Health in April 2007 and May 2008 respectively, propose strengthening of health systems for equitable health outcomes, with the goal of reducing disease burden through improved resources, systems, policies and management. The Health Strategy reiterates that human resources for health (the health workforce) is a pillar for the provision of quality health care. The four-year implementation plan focuses on a comprehensive program of action to address all the elements of the health workforce crisis in Africa including advocating for the elaboration of national human resource plans of action; promotion of adoption of interventions that scale up production and retention of health workers; and implementation of mechanisms to tackle migration of health workers.
- ◆ Ministers of Health also adopted the **Maputo Plan of Action on Sexual and Reproductive Health in 2006**. The plan’s main focus is the integration of sexual and reproductive health services into primary healthcare.

International Community

At Toyako in July 2008, the G8 reaffirmed its commitments to:

- ◆ Strengthen health systems, including social health protection, improvement of maternal and child health, scaling up of programmes to access essential medicines, vaccines and health related products.
- ◆ Work towards the goal of providing at least US\$ 60 million over 5 years to fight infectious diseases.
- ◆ Maintain or increase financial contributions to support the Global Polio Eradication Initiative.
- ◆ Expand access to long-lasting insecticide treated nets to counter malaria.
- ◆ Encourage the WHO to work on a voluntary code of practice regarding ethical recruitment of health workers and helping bring health workforce coverage towards the WHO threshold of 2.3 health workers per 1000 people.

Figure 1: World distribution of health workers



Source, WHO 2006 report

- G8 leaders have also made commitments to establish a Global HIV Vaccine Enterprise to accelerate HIV vaccine development and to get as close as possible to universal access to HIV treatment by 2010. They also agreed to improve access to health care, including to drugs and treatments at affordable prices.

II. What has been done to deliver on these commitments?

Africa

1. Five countries have met the 15% target of government budget allocation to health in 2005 and 18 countries were allocating between 10-15% of government expenditure to health.
2. The Millennium Project report suggests that in low-income countries, levels of expenditure on health should be at least US\$ 24 per capita in 2010 and US\$ 34 per capita by 2015 (UN Millennium project, 2005). In per capita terms, 16 African countries are allocating amounts greater than US\$ 24 per capita to health, up from 14 countries in 2000.
3. 22 countries in sub-Saharan Africa have developed national strategic plans and targets to achieve universal access to HIV and AIDS treatments.
4. Since TB was declared an emergency in the African region, 18 countries declared TB a national emergency/crisis and implemented special action plans to accelerate control (AUC and WHO, 2008a).
5. All countries in WHO's Africa region have established Roll Back Malaria coordinating bodies and also developed Malaria Strategic Plans (MSPs) in line with recommended WHO strategies since the 2000 Abuja Summit on Roll Back Malaria.
6. To increase access to malaria control interventions, 74% of countries have waived taxes on antimalarials, 64% have removed taxes or introduced waivers on insecticide treated nets (ITNs), while about half have waived taxes and tariffs on nets, netting materials and insecticides (AUC and WHO, 2008b).
7. Currently, 18 countries have developed second generation MSPs or are in the process of finalizing them (AUC and WHO, 2008b).
8. Since 2002, several countries have prioritized the rapid scale up of ITN use by targeting mainly young children and pregnant women with free or highly subsidized ITNs (AUC and WHO, 2008b).

International Community

9. Aid for health from DAC countries rose from US\$1.7 billion in 2001 to US\$ 4.34 billion in 2007. Figures for reproductive health increased in the same period from US\$1.1 billion to US\$ 5.6 billion (OECD Stats).
10. The Global Fund for AIDS, TB and Malaria (GFATM) raised US\$ 9.7 billion for expanded activities for the period 2008-2010 at its Second Voluntary Replenishment Conference in Berlin in 2007.
11. A number of innovative financing mechanisms have been launched, including: UNITAID (an international drug purchasing facility) established in 2006, the Advance Market Commitment pilot on pneumococcal vaccine established in 2007, the International Financing Facility for Immunisation (IFFIm) in 2005, and the Affordable Medicines Facility for malaria (AMFm) established to bring down the cost of artemisinin-based combination therapy (ACT).
12. An International Health Partnership was launched in September 2007 and aims to improve the way that international agencies, donors and poor countries work together to develop and implement health plans, creating and improving health services for poor people.
13. US\$ 829 million has been provided to the Global Polio Eradication Initiative between 2006 and 2008.
14. Between 2003 and 2007, UNICEF provided around 69 million insecticide-treated bednets, of which around 80% in Africa.

15. WTO members agreed on 6 December 2005 to make permanent a decision adopted in 2003 to make it easier for poorer countries to obtain cheaper generic versions of patented medicines by setting aside a provision of the TRIPS Agreement.

16. WHO is developing a Voluntary Code on Ethical Recruitment of Health workers, due for completion in spring 2009.

III. What are the results?

17. Through extensive and targeted prevention programmes, several African countries have significantly cut their AIDS prevalence rate. The adult HIV prevalence rate in sub-Saharan Africa has declined from 5.8% in 2001 or 5.7% in 2006 to 5.0% in 2007. In most countries, the HIV prevalence rate has either stabilized or is showing signs of decline (UNAIDS, 2007). Four countries have experienced decreases in their national prevalence rates.

18. Thanks to declining prices for antiretroviral drugs, out of 4.6 million Africans living with the virus and requiring antiretrovirals, nearly a third are undergoing treatment. The number of people who received antiretroviral treatment in Central, East, South and West Africa, as a whole, increased from 100 000 in 2003 to 1.3 million in 2006 and to 2.1 million in 2007 (UNAIDS, 2007, AUC and WHO, 2008c). The corresponding coverage of people who received treatment improved from 2% in 2003 to 28% in 2006. Three African countries have already achieved the goal of treating at least 50% of the people living with the virus.

19. In 2007, over 470 000 HIV positive pregnant women were reported to have received ARVs for prevention of mother to child transmission (PMTCT) purposes, an increase of over 50% from the 2006 figure.

20. TB detection rates rose by 23% to roughly 50% between 1995 and 2005. By the end of 2006, 10 countries had halted and started to reverse overall and smear positive TB incidence as specified in the core MDG targets (WHO, 2008a).

21. Coverage of key malaria control interventions has increased in several countries. Two-thirds of African countries have adopted policies that include the use of drugs which are effective against malaria. By the end of 2007, 25 countries were implementing an artemisinin-based combination therapy (ACT) treatment policy with 20 of them implementing countrywide – a policy change from chloroquine.

22. The use of insecticide-treated bed nets by children under five in malaria risk areas in sub-Saharan Africa is reported to have improved from 2.1% in 2001 to 5% in 2005 and 8% in 2007.

23. The proportion of one-year-olds immunized against measles in Central, East, South and West Africa increased from 56% in 1990 to 64% in 2005 (ECA, 2008). This improvement has resulted in a dramatic decline of measles deaths in Africa which fell by 91% between 2000 and 2006, from an estimated 396,000 to 36,000 (AUC and WHO, 2008d).

24. Polio is closer to eradication than ever before. Cases dropped from 350,000 in 1988 to 2000 in 2007. Only seven African countries continue to report active transmission of polio.

But significant challenges remain

25. Public resources allocated to health are still insufficient to support scale-up towards universal access. The target of allocating 15% of national budgets to the improvement of the health sector as stated in the 2001 declaration has only been achieved by a limited number of countries.

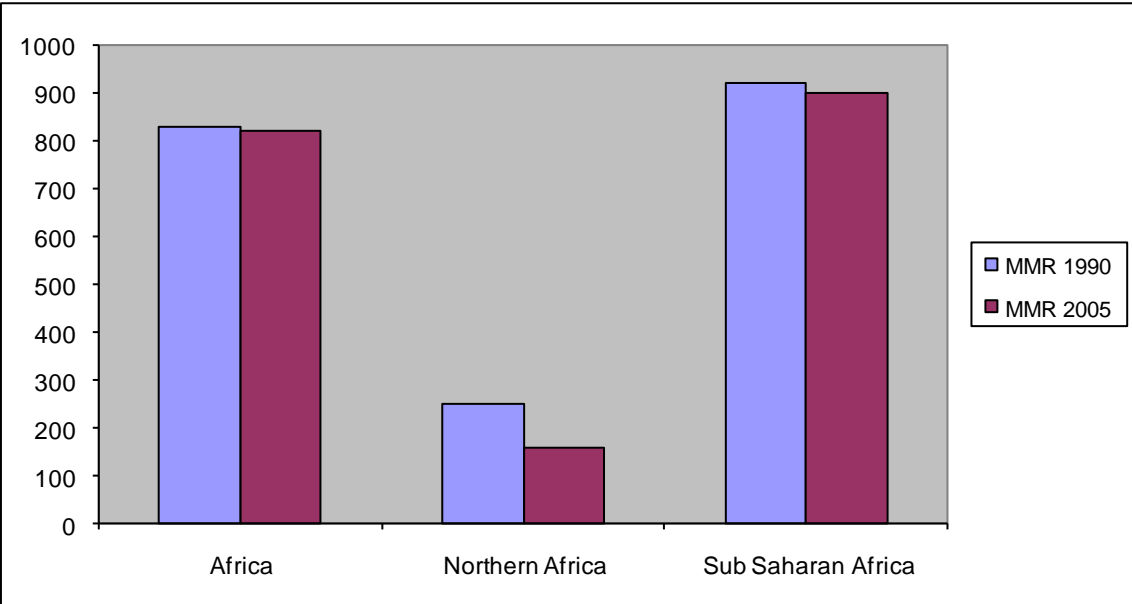
26. Improvements in under-five mortality rates have been low, with an average annual improvement of only 0.1% between 1990 and 2005 (ECA, 2008). This leaves most African countries significantly off track to achieving this goal.

27. The vast majority of African countries experienced a very negligible improvement in maternal mortality rate (MMR) of 1.8% between 1990 and 2005, which amounts for an annual average improvement of 0.1% (WHO, 2007). Thirteen countries in Africa still have an MMR of more than 1000 per 100.000 live births

28. Nutritional status of children remains a concern. In nine African countries with more than one available national survey between 1980 and 2000, there was a rising trend in stunting, and in another nine there was no change. The best progress in the region has occurred in North Africa

29. Many countries still face critical shortages of health workers, and the vertical nature of funding for health has not facilitated the strengthening of health systems. Moreover, there is still a large unmet need for family planning and other reproductive health services – for example, contraceptive prevalence in sub-Saharan Africa is low, at 23%, compared to global average of 61%.

Figure 2: Trends in maternal mortality ratios between 1990 and 2005



Source: WHO, 2007

30. Health systems remain weak, characterized by inadequate human resources (low numbers, poor motivation and low retention), lack of adequate equipment, weak laboratory capacity and poor infrastructure.

31. ‘Vertical’ funding from donors targeted at specific diseases undermines rather than reinforces health systems, as it can distort budget allocations, and divert scarce resources to particular diseases, rather than strengthening capacity to cope with very diverse health threats.

32. In sub-Saharan Africa, the estimated health workforce (including public health practitioners, doctors, nurses and allied health workers) is 3% of the world's health workforce; yet these health professionals are responsible for addressing 25% of the world's burden of disease (High Level Forum on the Health MDGs, 2004). The major factors responsible for the shortage of health-related human resources in Africa in general include: brain drain of medical staff leaving to go abroad; medical staff leaving the public sector for the private sector; and the impact of HIV/AIDS on health workers.

The Americas	Sub-Saharan Africa
14% of the world's population	11% of the world's population
10% of the global burden of disease	25% of the global burden of disease
42% of the world's health workers	3% of the world's health workers
>50% of global health expenditure	<1% of global health expenditure

33. At the country level there is generally weak utilisation of community-level participation and partnership with the private sector, NGOs and faith based organisations for health services and inputs.

34. Although access to antiretroviral treatment has significantly increased, the coverage rate is still very low and the unmet treatment gap is high. Almost two thirds of people in the region who are in need of antiretroviral therapy have no access yet (AUC and WHO, 2008c). The proportion of women infected by HIV is high and is increasing. As of December 2007, women constitute 61 % of infected people in sub-Saharan Africa, up from 57% at the end of 2003 (UNAIDS, 2007).

35. Africa has inadequate and sometimes irregular supplies of medicines and commodities. Supplies of medicines are still inaccessible by many due to high cost (AUC and WHO, 2008b).

36. There remain weak linkages between the health sector and broader national development processes (national development plans, PRSPs etc.) across Africa, and limited use of multi-sectoral approaches to health. Achievement of positive health outcomes is dependent on other sectors besides health including agriculture, education, transport, water and sanitation etc.

37. Significant inequities exist regarding access to and utilization of health care resulting from income differences, rural-urban location and other factors. Most physical health facilities are concentrated in urban areas: consequently, the broad majority of people -- who reside in rural areas -- do not have equitable access to health facilities.

38. Monitoring, evaluation and reporting are weak, characterised by lack of complete and updated data that is critical for policy and decision-making and resource allocation.

IV. New emerging issues affecting the health sector

39. The direct health effects of **climate change** include those caused by projected high frequencies of natural disasters such as floods, droughts, dust and sand storms resulting in injury, illness and death. Increased water stress and flooding associated with droughts and floods can result in poor quality of drinking water, which in turn can lead to health disorders related to environmental and water contamination by bacteria, viruses, protozoa and parasites. The indirect health effects of climate change include increased transmission of infectious diseases such as malaria, dengue, cholera, West Nile fever, Chagas' disease and yellow fever, Rift Valley fever and onchocerciasis (UNFCCC, 2006, IGAD and ICPAC 2007). Increased food insecurity caused by droughts can lead to malnutrition and other famine-related health problems.

40. Other **emerging diseases** that are a threat in Africa include Ebola, Lassa fever and Marburg. These are viral haemorrhagic fevers that are transmitted by direct contact with infected people, rodents and contaminated materials. The number of reported outbreaks of the diseases on the continent has been increasing.

V. What are the key priorities?

African countries should:

- ◆ Securely embed health and health equity into the existing national development and planning frameworks (e.g. PRSs);
- ◆ Increase health budgets required for strengthening of the health delivery systems (such as human resources, infrastructure, information systems, pharmaceuticals and equipment, health financing); and improve the efficiency with which public resources are utilised;
- ◆ Have mechanisms put in place to ensure sufficient targeting of district and operational levels;
- ◆ Encourage community-level health service provision and stronger partnerships with the private sector, NGOs, faith based organisations, and other partners;
- ◆ Target vulnerable groups so as to promote equity in health;
- ◆ Bolster personnel management policies and address the challenge of shortage of health personnel through strategies that aim to intensify training, retention and sustain productivity of the health workforces;
- ◆ Strengthen procurement, production and supply of essential medicines and commodities including ARVs, ACTs, ITNs, and TB drugs;
- ◆ Take steps to tackle those areas where progress is lagging, such as infant and maternal mortality;
- ◆ Coordinate sectoral policies and ensure that the other sectors support the promotion of better health and achievement of equitable health outcomes, for example through improved basic education, hygiene education, food security, sanitation, clean water sources, gender equality, and poverty reduction :
- ◆ Strengthen the capacity for data collection and analysis as well as for overall monitoring and evaluation systems for better policy-making.

With regards to emerging diseases:

- ◆ African governments should evaluate the threat that climate change poses to health, assess the additional burden placed upon health systems and implement strategies for adaptation;
- ◆ African governments should establish warning systems against disasters and epidemics, and improve access of local communities to disease outbreak/weather/ climate-related information and to proven coping strategies;
- ◆ African governments should strengthen water supply and sanitation infrastructure.

The international community should:

- ◆ Continue to develop and support innovative financing mechanisms and work towards the goal of providing US\$ 60 billion over five years for health, referred to in the 2008 Hokkaido summit leaders declaration,;
- ◆ Support the strengthening of African national planning capabilities;
- ◆ Gradually move from vertical funding to budgetary support to the health sectors;
- ◆ Provide more predictable and sustainable funding;
- ◆ Increase access and effectiveness of health-related assistance through lowering the cost of treatments and continue to work for relaxation of WTO rules;

- ◆ Continue to develop WHO's code of practice on ethical recruitment and, through support for the Kampala declaration and agenda for global action, support Africa's efforts to strengthen its health workforce;
- ◆ Make available resources that can assist African governments to adopt adaptation and mitigation strategies that can help in the early detection and prevention of climate change-related diseases.

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