

**MILLENNIUM PARTNERSHIP FOR THE RECOVERY OF AFRICA
PROGRAMME**

HUMAN DEVELOPMENT

HEALTH & COMMUNICABLE DISEASES

DEPARTMENT OF HEALTH, SOUTH AFRICA

**DRAFT FOR DISCUSSION AT THE PREPARATORY MEETING
IN ABUJA, NIGERIA, JUNE 2-4 2001**

EXECUTIVE SUMMARY

Africa's 784 million people continue to suffer from a **huge burden of potentially preventable and treatable disease**. It is estimated that 2.4 million people die from HIV/AIDS each year, 600 000 from Tuberculosis and more than one million from malaria.

The **reasons** for this disease burden are that:

- Poverty, marginalisation and displacement on the continent undermine health
- Disease control programmes fall short of the scale required to be effective
- Health services are too weak and under-funded to effectively support significant disease reduction
- The people of Africa are not sufficiently empowered to improve their own health.
- The benefits of development and health services tend to not equitably reach those with the greatest burden of disease

There are various major initiatives in place, which offer much towards reducing disease burden. However, if current trends continue it seems that, as was the case with their predecessors, they will not achieve their targets.

The MAP health programme tries to set Africa on a path towards ridding it of its burden of unnecessary death and ill health. It recognises that disease only focussed programmes are not sufficient for this. These must be twinned with achieving a secure and sustainable health system, and the eradication of poverty. So, MAP is committed to a composite, integrated approach, rather than a fragmented one. The MAP health programme is a medium term one, as sustainable programmes take time to become secure. The detailed strategies proposed draw on international best practice and continental experience, and tie in with major international initiatives.

The component elements of the MAP health programme are:

- To strengthen communicable disease programmes to reduce the burden of disease
 - To reduce HIV prevalence in young people by 25% by 2010
 - To reduce TB deaths and prevalence by 50% by 2010
 - To reduce malaria suffering and death by 50% by 2010
 - To reduce mortality rates for infants and children under 5 by $\frac{2}{3}$ by 2015
 - To enable effective prevention and appropriate care for other major burdens of disease

- To have a health system in place that meets needs and effectively supports disease control by 2010
 - To provide accessible facilities with the necessary infrastructure and services by 2010
 - To staff services with sufficient numbers of capable health workers by 2010
 - To have essential drugs and supplies in health facilities by 2005
 - To revitalize hospitals to function effectively as sources of referral by 2010
 - To achieve by 2010 management capability commensurate with running services efficiently
 - To fully harness the potential of the private sector in support of reduced burden of disease
 - To provide sufficient surveillance and monitoring to inform interventions by 2005

- To ensure the necessary support for sustainable development of an effective health system
 - Sufficient funding to build effective disease interventions and secure health services
 - To build institutional public health capacity on the continent within a sub-regional frame
 - To offset the 10:90 research gap by sufficient investment to make an evident impact by 2010
 - To bridge the digital divide in hospitals and clinics by 2010
 - To mobilize international support for commitments needed to achieve MAP health goals

- To achieve health literacy in Africa by 2005

- To impact successfully on the disease burden of the poorest people of Africa
 - To implement the MAP programme for the recovery of Africa
 - To achieve fairness in financing and equity in delivery by 2005

Projects that can make a difference now, but will also support medium-term developments are:

- A strong focus on the major communicable diseases
 - As per the immediate projects determined by the major initiatives
- Securing health systems
 - Initiate a secure health system process
 - Donor funding towards core service costs
 - Curtail permanent recruitment of Africa's health workers
 - Affordable drug prices
 - Competent drug distribution
 - Emergency transport fund
- Support for sectoral development
 - Sufficient funding to make a difference
 - Initial centres of excellence and networks
 - New drug and vaccine development
 - Communications infrastructure
- Public broadcasters for health literacy

What is different about the MAP health programme is that heads of state or government will themselves take responsibility. They will lay the ground for sustainable interventions and increase the allocation of their own funds to fight the scourge of disease in Africa. But, MAP recognises that although there is much that Africa can do for itself, success will require a partnership with developed countries and multi-lateral institutions. It also recognises that under-resourced efforts and health systems will not be able to match the challenging burden of disease, so it calls for increased levels of funding. As reducing the burden of communicable disease to targeted levels requires a decade long programme, support must be ready to stay the long road.

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HUMAN DEVELOPMENT PROGRAMME

HEALTH

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SECTION 1: THE HEALTH PROBLEMS FACING AFRICA

Africa's 784 million people continue to suffer from a **huge burden of potentially preventable and treatable disease**, which not only causes volumes of unnecessary death and suffering, but also stifles economic development and damages the continent's social fabric. Much of this burden is consequent on HIV/AIDS, tuberculosis, malaria and other communicable diseases. The burden is there in spite of the availability of many of the tools needed for prevention and treatment, and technological advances being within range, largely because the diseases are rooted in poverty and in weak health systems. The HIV/AIDS epidemic is turning back advances made in life expectancy over the past half century, with life expectancy in sub-Saharan Africa reduced by almost a third, from 60 years to 43. 2.4 million people die from AIDS each year, 600 000 from tuberculosis and more than 1 million from malaria. Communicable diseases of childhood also carry a heavy toll. 800 000 children in the African region die of diarrhoea before their fifth birthday, 1.2 million of pneumonia, 500 000 of measles and 600 000 of malaria. AIDS deaths are growing. Malnutrition is linked to more than 50% of all childhood deaths. In the face of these diseases, other important health problems can be overlooked, 272 000 women a year die in childbirth each year. Poorly cared for mental ill health and (much preventable) physical disability are widespread. Sleeping sickness is resurging, now affecting between 300 000 and 500 000 and non-communicable disease burden is growing.

The **reasons** for this disease burden are that:

- Poverty, marginalisation and displacement on the continent undermine health
- Disease control programmes fall short of the scale required to be effective
- Health services are too weak and under-funded to effectively support significant disease reduction
- The people of Africa are not sufficiently empowered to improve their own health.
- The benefits of development and health services tend to not equitably reach those with the greatest burden of disease

If current trends continue it seems that **the major international initiatives**, as was the case with their predecessors, **will not achieve their targets**. Key targets are the Okinawa Goals, the International Development Targets and targets set in Africa's Health for All Policy

The Okinawa Goals

- A 25% reduction in HIV/AIDS prevalence in all young people by 2010
- A 50% reduction in TB deaths and prevalence by 50% by 2010
- Reduce malaria suffering and death by 50% by the year 2010.

The International Development Targets

- Reduce mortality rates for infants and children under-5 by 66% by 2015
- Reduce maternal mortality by 75% by 2015

Similar targets have been set in the WHO Afro "Health-for-All Policy in the African Region: Agenda 2020", but with 2020 target dates.

How then do various forces drive the burden of disease?

Poverty, marginalisation and displacement

Improved health is not simply a product of health service interventions. Improved health advances development, while development is a precondition, although not a guarantee for improved health. What makes the most difference is how developments are linked to factors that improve health and how well they reach the poorest, most marginalized and displaced people. The links between health and development are woven into every facet of life on the continent.

- While peace is a pre-condition for development, it is also essential for health. War and conflict on the continent have had catastrophic effects on health, disease control and disability. Maternal mortality, a sensitive indicator of health system performance increases fourfold. The effects are felt beyond the war zone, as the toll of war on the people and health system spreads throughout countries.
- Economic underdevelopment, including through reduced production and raw goods prices, and protective trade and market practices, have damaged health through a number of paths, including unemployment and low incomes.
- Shortfalls in agriculture and lack of land reform have had a direct effect on food security and hence on malnutrition.
- Education, and in particular women's education has many spin offs for health and enables people to better take action to improve their own health. Lack of

education has made it difficult for many to secure their basic needs, including nutrition, or to include health-promoting actions in their lives.

- The oppressed position of women has led to poorer health in many ways, including a weak position in ensuring safer sex practices.
- People living in informal settlements with poor infrastructure have been exposed to fire, health problems of social instability and communicable disease, especially from inadequate water supplies and sanitation and from air pollution.
- 500 million Africans live without access to safe water or sanitation, losing 24 billion work hours per annum through illness. 40 billion work hours per annum are spent collecting water.
- Lack of general infrastructure, such as good roads, transport and communications have impeded health services, especially the chances of care in an emergency.
- The digital divide prevents Africa from fully exploiting technological advances for improving health.

Inadequate disease control programmes

Although the specific activities for prevention and control of the major communicable diseases of Africa vary, their impact can be massively reduced by effective programmes. Influencing sexual behaviour to prevent HIV/AIDS, treatment completion for tuberculosis, mosquito control for malaria, reaching children to immunise them against measles, use of oral rehydration to prevent dehydration from diarrhoea and early identification and treatment of pneumonia are all within our grasp. Yet, success to date has been limited, however at the core is that the extent of the overall effort to reduce disease burden has been insufficient.

In consequence, National, African and international strategies and efforts to reduce the burden of communicable disease have been strengthening over the past few years. These include the International Partnership Against Aids in Africa, Stop TB and the Roll Back Malaria Campaign. There is wide consensus and regular updating of the strategies they employ - the key challenge is to scale up to the point of real impact. Also welcome is the increased international focus on these diseases, including new research initiatives. The specific situation on the individual major communicable diseases and some information on other health problems is presented in **Boxes 1-5** (see end).

Although the specific mode of transmission and incubation periods vary, as do the complexity and effectiveness of measures required for their prevention and control, there are common requirements for success beyond simply focussing on the disease. These are a solid health care system, capacity for strategic support, effectively mobilizing personal action and addressing underlying poverty and underdevelopment. There is also much potential for technological development to advance disease control.

Health services unable to effectively support disease reduction

All the major communicable disease programmes call for massive improvements in health systems as a key to the success of their efforts, as international experience has shown that programmes focusing on single diseases alone do not reach their potential. They become like a house without a foundation - they stay up for a while and look good, but are prone to later collapse.

Securing the health system is critical to combating major diseases. If a person is suffering from a genital discharge, a chronic cough, a high fever, or shortness of breath, they should be able to access a health facility. When they get there they should be able to consult with a health worker capable of diagnosing and treating their condition, and the essential drugs and supplies required for their care should be available. The reality is that many health systems are unable to provide this basic care, have breakdowns in the supply chain and are unable to effect referrals to hospital in emergencies, such as a women in obstructed labour. Adherence to therapy for chronic diseases, such as tuberculosis, is particularly difficult with weak health systems, rendering treatment ineffective and leading to drug resistance. The same could apply to the introduction of anti-retrovirals in a poor health system environment. Disease prevention and health promotion measures, such as immunization and contraception also require effective health systems.

Management weaknesses continue to undermine the system. However judiciously available money is spent, current funding levels are inadequate to allow for viable health systems in Africa. If one has only 20 litres of fuel to travel the 500km from Lagos to Abuja, adding another 2 or 3 will still leave you stranded, however well you drive. Health system funding in Africa is in this position. Per capita public expenditure on health services is below US\$50 in 38 of Africa's 53 countries. Even if one adds private payments total expenditure remains below US\$50 in 28 countries.

Adding to the difficulty is the high cost of drugs, putting certain therapies beyond the means of even the better economies of Africa. The stark reality is that millions are dying each year for lack of access to drugs, not in a small part because of the pricing practices of the pharmaceutical industry. In earlier days of antimicrobial therapy, penicillin for gonorrhoea and chloroquin for malaria provided cheap and effective treatments. Now the alternatives required are beyond what most health systems in Africa can afford. In addition, even though the bulk of available funds go into personnel, low salaries remain a central obstacle to retaining staff and enhancing performance.

Lack of support capacity for health system development

Ministries of health worldwide do not attempt to secure within their offices every skill necessary to ensure effective health system performance or disease control. They rely heavily on appropriate use of experts, often based in universities, research institutes or health NGO's, to support their programmes. In Africa, there is a dearth of such centres of excellence, which often lack the critical mass required to be effective. This

institutional inadequacy leads to dependence on, rather than partnership with, public health institutions of the developed world. Even the support role of multilateral agencies is compromised by the size of their country offices.

The 10:90 gap in health research was identified more than a decade ago, namely that more than 90% of the world's research goes into less than 10% percent of its health problems i.e. into those of the developed world. Little has changed and we still do not understand enough about health behaviour and about what health systems interventions are effective in Africa. Disease surveillance, and monitoring and evaluation of interventions, to identify trends early and to inform management are underdeveloped.

Although there are important new initiatives, the lack of development of vaccines and more effective drugs for the treatment of malaria, tuberculosis, trypanosomiasis (sleeping sickness) and other communicable diseases remains a blight on the record of international organisations and the pharmaceutical industry. Vaccines against the pneumococcus which causes pneumonia, the rotaviruses and shigella which cause diarrhoea and the meningococcus causing meningitis are all within reach, but are not seeing rapid progress because the commercial opportunity is not good enough. For the same reason a vaccine with any real efficacy against HIV is at least 5 years away and against TB and malaria more than 10.

If advances in information and communication technology are a major driver of the global revolution, then the lack of such technology in the health systems of Africa is a major inhibitor. Few hospitals, let alone clinics are connected to the benefits of the web and many suffer from a lack of telephone or radio communication.

A number of UN bodies (UNDP, UNAIDS and UNICEF) focus on health, with the World Health Organisation (WHO) dedicated to it. The bulk of Africa falls under the WHO regional office, temporarily situated in Harare, (its permanent base is in Brazzaville) while some of the northernmost countries fall under the Eastern Mediterranean region. WHO spearheads many international initiatives, but is not the only contributor. There are numerous international partnerships, agencies, philanthropic organisations and faith based initiatives also active in Africa, as is the World Bank. Individual countries also play a key role. It is essential that their contributions are complementary.

People not sufficiently empowered to improve their health

There is much that individuals and families can do to improve their own health. For example, a drop of chlorine in a litre of water can prevent diarrhoea while the early use of home made oral rehydration solutions can prevent death from dehydration. Use of insecticide-impregnated materials helps prevent malaria and use of condoms, AIDS. Lifestyle changes, including a return to the more healthy traditional diet of Africa could impact on disease, while seeking health care early for children with fast breathing, a cough and a hot body would reduce deaths from pneumonia.

The question is why the potential for reducing disease from such personal actions is not realised in Africa. The role of poverty and illiteracy are well recognized, but it goes deeper than this. People do not intentionally risk their health and lives. More needs to be done to empower people to take action to improve their own health and done in a manner that enhances dignity and consciousness. Approaches that, however subtly so, are patronising, condescending or humiliating, tend to alienate people from health enhancing actions. Exploitative advertising is a counter force, which not only needs to be controlled, but whose power to use the media needs to be emulated in pursuit of health.

SECTION 2: THE MAP HEALTH STRATEGY

THE MAP HEALTH VISION

An Africa rid of the burden of unnecessary death and ill health.

The goals and objectives of the MAP health programme derive from an understanding of the health problems facing Africa and the reasons for them.

As the disease profile of Africa is first and foremost one of poverty, such as from a lack of food, leading to malnutrition and diminished immune capacity to fight off disease, the MAP health strategy starts by recognizing that reduction in poverty is a health intervention. The overall MAP programme is therefore supportive of health.

Health services are not simply mitigators of the effect of illness, they are basis for interventions for disease prevention and control. The MAP health strategy thus twins a strong focus on the heavy burden of communicable disease in Africa with a commitment to achieving a secure and sustainable health system. The strategy against communicable diseases is tied to the existing initiatives, including the International Partnership Against Aids in Africa (IPAA), Stop TB and Roll Back Malaria, and to the declarations of heads of state or government or health ministers, and the plans to achieve these. These programmes have drawn on international best practice and on experience in Africa, and are under ongoing review. MAP offers them the support of heads of state, a framework to consider them collectively, and most important of all, the possibility of a secure health system in which to root their efforts.

All the communicable disease programmes recognise the critical importance of an effective health system to their success. The MAP health strategy begins to offer the mechanism to get there, and to build the institutional capacity to support it. It also focuses attention on efforts to develop new drugs and vaccines and to empower people to take action to improve their own health. It recognises the importance of sustainable development and eradication of poverty to the health of the continent and the need for health interventions to equitably focus on the needs of the poorest and most marginalized people to achieve the best health returns on investment.

While recognising the potential for development in other sectors to improve health, it should not be assumed that all development is automatically positive for health. Some economic developments have a direct negative effect on health, while others impact negatively on the environment and through this on health status. Thus, the health potential and impact of planned developments should be considered and health-promoting developments preferentially selected. There is no doubt that equitable

development that provides sustainable incomes and access to services for the poorest will have the greatest impact on health.

Similarly, if the aim is to improve health and reduce morbidity and mortality from communicable disease, then the biggest return on investment will come from a focus on the poorest and most marginalized. Those in deep rural areas, and urban fringes, and those displaced by conflict carry the greatest burden of preventable and treatable disease. Yet, for many reasons, health systems often reach them last. It is understandable that under the pressures of managing on limited budgets, it is easier to staff and supply services in urban areas. Also, this is where the greatest visible pressure for care will be placed on government. It is where the media are most likely to pick up their stories.

SECTION 3: THE MAP HEALTH PROGRAMME

THE MAP HEALTH PROGRAMME

The MAP health programme has the potential to make rapid gains, but the full programme will take time to unfold and become secure. Some elements should be seen as a ten-year investment. The strategies and actions draw on international best practice, continental experience and a multiplicity of analytic and strategic reports. It is a composite, and integrated rather than a fragmented approach. It has a realistic chance of success. It is based on a view that piecemeal and under-resourced efforts do not offer the potential to match challenging goals. A number of the strategies have been endorsed by African heads of state or government, or by their health ministers. There is much that Africa can do for itself, but full success requires a partnership between African leaders and their counterparts in the developed world and the support of international agencies. MAP also envisages that donor partners respect the right of countries to prepare health plans and programmes, rather than for them to be donor determined and driven. The latter will not engender the African ownership, commitment or sustainability that is so crucial to reducing the burden of disease.

The partnership will also require patience – turning around AIDS, TB and malaria is not going to happen overnight. They are not single action interventions. Like a bicycle, a number of parts need to work in unison and be well oiled, to move forward. Take away the wheels or the chain and you are stuck, without handlebars you lose direction and without a rider you will crash.

Given that building a health system is a decade long programme, donor support needs to be ready to stay the long road and not become fatigued early on. It is critical to recognise that it is not the intention of MAP to see money thrown at problems. Rather, the intention is to build sustainable systems. Therefore, one can't put funds in, expect concrete deliverables on medium term projects in 1 year and be disappointed when they are not there. At the same time, realistic interim targets will be set.

MAP countries are committed to showing that this investment will reap its rewards. To this end, leadership will come from Heads of State themselves. The nature of the proposed Millennium Partnership is premised on African countries achieving what they can from their own abilities and resources and creating an environment for sustainability and only then looking with confidence to donor countries to support the MAP health strategy. Confidence and trust returned, and an agreement on the challenges to be faced and the strategies to address them are at the core of a successful effort.

OBJECTIVES

The objectives of the MAP Health Strategy are:

- To strengthen communicable disease programmes to reduce the burden of disease
 - To reduce HIV prevalence in young people by 25% by 2010
 - To reduce TB deaths and prevalence by 50% by 2010
 - To reduce malaria suffering and death by 50% by 2010
 - To reduce mortality rates for infants and children under 5 by $\frac{2}{3}$ by 2015
 - To reduce maternal mortality by 75% by 2015
 - To enable effective prevention and care for other major burdens of disease
- To have a secure health system that meets needs and effectively supports disease control in place by 2015
- To ensure the necessary support for sustainable development of an effective health system
- To achieve health literacy in Africa by 2007
- To impact successfully on the disease burden of the poorest people of Africa

MAP PRIORITIES

The strategy and objectives of MAP lead one to the priority actions for addressing the burden of disease in Africa. **Table 1** spells out the priority goals and targets of the MAP health programme. It also identifies actions that African heads of state or government should take in support of the health strategy and the contribution of international partners to facilitate viable efforts to reach these goals. Without such personal commitment on the part of heads of state and without committed international partners, the strategy cannot succeed.

Although there is a need to address the full range of health problems affecting Africa, there is little doubt that the immediate priority must be to **reduce the burden of disease caused by AIDS, TB and malaria**. The programmes need to be multifaceted as described in boxes 1-3.

The process of **building a health system** that effectively meets needs and supports disease control has to take time, and will require sustained commitment over 10 years. It will also require strengthening of planning and monitoring capacity within ministries of health. Many parts will need to work in synchrony. The priorities are:

- To provide accessible services, in facilities with the necessary infrastructure – energy, communication and safe water
- To staff services with sufficient numbers of capable health workers through more effective training, better conditions of service and reduced brain drain
- To ensure essential drugs and supplies through strengthened distribution systems and affordable prices

- To revitalize hospitals to function effectively as sources of referral
- To achieve management capability commensurate with running services efficiently
- To fully harness the potential of the private sector as appropriate to a country, in support of reduced burdens of disease.
- To provide sufficient surveillance, monitoring and evaluation to inform interventions

In the MAP health strategy, **securing sufficient funding and capacity to support development** are prioritised.

Much like taking US\$10 into a supermarket in the developed world will not meet the nutritional needs of a family for a month, however judiciously the money is spent and low cost nutritional foods bought, so does much the same logic apply to health system funding in Africa. A decision has to be made if the aim is to offer a sheet of plastic to put on top of a shack to prevent it leaking, or to achieve funding for a modest house with basic amenities. Too often, costs are thought of in individual disease terms – x cents to do y, without recognising that it is not just the cost of the drug that resolves a health problem, but also the cost of the basic health system within which to deliver it.

Institutional public health capacity and expert centres on the continent, within a sub-regional framework, must be developed. They might be reference laboratories, Schools of Public Health or research institutes. Africa's experts should collaborate and network more with each other, be it on disease control or health service issues, and systems and organisations put in place to enable sharing of information.

Health systems, disease programme and operational research must become recognized as a necessity for improving health system performance and not a luxury, budgeted for and ways for its product to be able to influence health policy and practice. Research capability is in need of a strong injection.

Every support is offered to the major drive to put relevant vaccine and drug development onto a fast track, including through GAVI. The potential that these international public goods hold must not be allowed to slip through because of issues of ownership and markets.

The digital divide in hospitals and clinics is another capacity weakness undermining system development in Africa. MAP strategies in ICT hold real potential and clinics should be prioritised, costs kept affordable and mobile telephone and satellite technology exploited.

More and more international players are recognising that policies and strategies need to come from and be driven by Africa and not imposed on it, and that the role is a supportive one. They should continue to provide not only moral and material support, but also the unique expertise that they can mobilise. At the same time, they need to be realistic, and targets should not be set without recognising the necessary resource

requirements, lest Africa be labelled as failing to achieve something that was not possible in the first place. The role seen for the WHO Regional Office for Africa and for the regional bodies (ECOWAS, SADC etc.) means that their capacity should be strengthened commensurate with their expanded responsibility. Regionally they should facilitate harmonisation of policies, bulk procurement and consistency in care.

Attaining the basic knowledge and skills to enhance ones health in a manner that favourably influences attitudes and behaviour can be termed health literacy. In much the same way as literacy enables people to read and experience all the benefits associated with it, so **achieving health literacy** would allow people to experience the benefits of better health. The approach should be comprehensive and developmental. Too often, single disease programmes provide a burst of information in a manner that tells people what to do, rather than contextualising their learning. A whole package of health learning should be identified, linked to its target audience. The resources of the state, including public broadcasters, should be optimally used to spread health messages. Packaging learning in interesting formats, such as radio dramas and linking it to real life make the greatest impact. Community structures and community-based organisations are potentially very valuable routes for health promotion, while use of national figures, such as musicians, and peer education are also influential means of learning. If there is leadership from the Heads of State and a high profile, concerted effort, there is no reason that health literacy cannot be rapidly improved.

Successfully impacting on the disease burden of the poorest people of Africa requires economic recovery, pursued in a manner where real benefits reach those in greatest need. A central feature of MAP is a war on poverty and marginalisation, whose every success will contribute to health.

What must also reach the poor for their health to improve, are health services. In many countries the cost of health care to poor families is catastrophic and MAP envisages changes in health financing systems to achieve greater fairness. Each country will need to apply this principle to its own financing system. Equity in health systems is not only of moral value, but also offers the best return on investment.

IMMEDIATE PROJECTS

The MAP health priorities and strategies outlined above offer a medium term drive for an effective and sustainable programme to reduce the huge burden of communicable diseases and to set Africa on a path towards achieving Okinawa and other goals. But, the fire is burning: so what are the concrete projects that will make a difference now and also support medium term developments? A list of immediate projects with objectives is presented in **Table 2**.

A strong focus on the major communicable diseases

The projects for immediate funding in the major communicable disease programmes have been identified by them. The intention here is not to restate the case for bednets,

condoms, micronutrients for children and so on, but rather to indicate that the MAP health program supports the identified cost-effective interventions and best practices. The suggestions below are intended to put in place measures that will complement them

Securing the health system

- **Initiate a “secure health system” process**

A secure health system is so central to disease control that it must receive the same urgency as HIV, TB and malaria. The MAP programme has identified seven key areas for development. As each country has its own areas of strengths and weaknesses one cannot prepare a plan centrally. Each MAP country should prepare a secure health system plan whose frame of reference is not “how can I do best with what I have or a bit more”, but rather, “what needs to be done to reach a health system that will truly impact on the burden of disease”. The funding gap and obstacles can then be identified.

As there have been many different experiences with health sector development and reform, it is recommended that a process of reviewing what has worked best around the continent is undertaken. This will lead to a broad support document that countries can use to inform their planning.

- **Donor funding towards core service costs**

There has been an understandable tendency for donor countries to put their funds into specific programmes and to avoid recurrent costs, including salaries. But, as the programmes have to be largely delivered through the health services that remain weak and staff that are demoralised, they have not been able to achieve their potential. Unless core system costs are supported and meaningful salaries offered, this situation will continue. This does not mean that African countries will then withdraw funding from the health sector or abandon their responsibilities for core funding. The MAP health programme envisages increase funding for the health sector from own sources.

- **Curtail recruitment of Africa’s health workers and improve conditions of service**

African countries invest in the education of their countries health workers, starting with their primary school education. Then, they have to watch helplessly as they emigrate to the developed world and its opportunities of higher incomes and better lifestyles. One cannot lay the blame on Africans for being tempted. Rather, it lies with the countries that tempt them. Inadequate production of health professionals has not become an acceptable reason to poach health workers from poor countries. Structured interaction and skills development should of course continue. The loss of health workers then becomes self-perpetuating, as those who remain face increased pressure and are more likely to move on. At the same time as curtailing recruitment, salaries and conditions of service will need to be improved, otherwise this will come to little. The conditions under which many health staff work are untenable.

- **Affordable drug prices**

The problems for Africa arising from high drug prices has been highlighted by the costs of drugs against opportunistic infections in HIV and anti-retrovirals. But, this is only the tip of the iceberg, or in African terms, the head of the hippopotamus. There are many other conditions causing major burdens of disease for which the cost is beyond the means of Africa. Chloroquin is still widely used for malaria, even though resistance is reaching 80% in some areas. The pharmaceutical industry continues to return high profits year after year. It is in a position to show greater commitment to an international dispensation on equity pricing. It is recommended that a list is prepared of the drugs that Africa needs to make a real impact on disease, but which are unaffordable.

- **Drug selection and distribution**

Affordable drugs and new drugs come to nought if they do not reach those who need them, and there are indeed many weak links in the chain between manufacturer and patient. The first step is to review and update existing essential drug lists. Then, Africa is committed to put in place measures to control leakage from the system. Steps to secure distribution include effective stock control systems and transport. As even refrigerated goods reach village stores in good order, the possibility of contracting in private distributors should be considered. The drug needs of a clinic would hardly add to the load in their vehicles. Such contracts may be less vulnerable to the sort of problems that have been experienced with other forms of private contracting in the developing world.

- **Emergency transport fund**

Ambulance services are a medium term development that will not be there for some time. Yet, for a child with severe pneumonia, a person with severe malaria, or a woman with a post partum bleed, emergency transport is critical. The need is not as much for a trained paramedic as it is for the patient to reach a referral facility rapidly. How does one achieve this when the health service doesn't have vehicles – and may not even have the communication to call for help? The answer must lie in locally available transport, such as the local taxi. But, the cost of “night specials” is beyond the means of people in villages and informal settlements. They face a stark choice – watch desperately as your child or wife dies, or incur a debt that will impoverish you for some time, worsening your families health. Where proper controls can be put in place, an emergency transport fund might be established and a contract signed with local public transporters.

Support for sectoral development

- **Sufficient funding to make a difference**

The US\$10 billion annual target of the global AIDS and Health Fund launched by the UN Secretary General gives a sense of the scale of what could make a difference. The funds should not be used solely on disease programmes; a large slice should be applied to the

longer-term programme of building a sustainable health system, for sustainable reduction in disease burden. African countries will also show their commitment by increasing own source funding to the health sector, by strengthening management of public health finances and by distributing available resources more equitably. The funds should not be deployed to keep the costs of drugs high.

In time, it may become apparent that an effective strategy for health in Africa requires greater levels of funding than the currently proposed increases. However, as successful upscaling takes time, a phased approach is appropriate. As funds are optimally utilised and the limits to improvement that available funds can achieve becomes apparent, so the level of funding can be linked to the targeted reductions in burden of disease.

- **Initiate or secure initial centres of excellence and networks**

Building comprehensive institutional capacity for public health in Africa will take time. But, a start can be made by identifying the capacity most critically needed in the regions of Africa and by making a concerted effort to put it in place. Indeed, in many instances, the framework on which to build exists, but low funding prevents centres from making a full contribution. The centres need to offer proper contracts, have a sufficient critical mass and be able to make their contribution across countries. African experts also need to get more opportunities to share their expertise through the establishment of African networks in the different areas of public health, so that learning and ideas can be rapidly spread around the continent and expertise shared.

- **New drug and vaccine development**

So near and yet so far is the reality regarding new drugs and vaccines for the health problems of Africa, as lack of research funding and potential profit stifle efforts. There have been some very positive developments recently, especially from private benefactors. But, donor governments have a key part to play – if they were to guarantee a reasonable market for new drugs, for say sleeping sickness or leishmaniasis, let alone for malaria and tuberculosis, the pharmaceutical industry would find its focus. But, the industry must also play its part. They should set aside an agreed amount of their research budgets for health problems of Africa, on areas agreed to by mutual consent. If all the major companies made this commitment, none would be at a competitive disadvantage by “losing out” on their main focus.

- **Communications infrastructure**

One of the most alienating parts of being a rural health worker is the feeling of desperation when one cannot communicate for help or advice in an emergency. Another cause for despair is the inability to place orders for drugs by phone, fax or e-mail. In the modern telecommunications era there should be no need for slow movement of paper-based orders. Workers also feel isolated and are unable to share problems with their managers or colleagues, receive moral support and gain continuing education. Personal support visits to and from managers and educators will remain critical, but given the time,

cost, distance and transport involved, these will remain too infrequent to make an impact. A “communication for every clinic” project is a priority.

Public broadcasters for health literacy

Developing grassroots programmes for health empowerment and skilling health workers in effective learning pedagogies will take time. What can one add in the short term that will make a real difference? An answer seems to lie with public broadcasters, and with programmes that offer entertainment and encourage critical thinking and analysis. For example, radio (or television) dramas can be very effective. They can be followed up by phone-in programmes to discuss the show (and deepen the learning), or to other learning materials. Many public broadcasters have the capacity to do so, using core messages from existing disease control programmes located in a developmental context. It should enable people to maximise the health benefits within reach and the use of resources. The potential for this to impact on health literacy is significant, especially if the shows enjoy the support of heads of state or government.

IMPLEMENTATION

The nature of the proposed millennium partnership is premised on African countries being committed to achieving what they can from their own resources and creating the basis for sustainability, and then looking with confidence to donor countries to support the MAP health strategy. Donor countries will in turn feel confident that their funds will be put to good use. Mutual confidence and trust and an agreement on the challenges to be faced and the strategies to address them will be at the core of a successful partnership.

Building the health system and tackling the major communicable diseases should be seen as a decade long programme, but realistic interim targets should be set. Donor commitment to stay the long road and not become fatigued early on is required to reap the rewards that leadership from Heads of State themselves can offer.

The costs of these initial projects vary. Start up funds need to be sufficient to make a real difference, so an increase in the order of US\$10 billion, or US\$15 per capita per annum would be required. Much less will, when distributed, be spread too thin to make the impact required. Although there is some debate as to the amount needed to make a real impact, one will certainly require more than rolling out existing levels of support.

As evidence of their own commitment to this programme, Heads of State will lay the ground for sustainable interventions and increase the allocation of their own funds to fight the scourge of disease in Africa. For each country, the amount committed will be different, but will be such that no observer would question the country’s resolve to tackling its burden of disease. As economies grow with implementation of the overall MAP programme, so will dependence on donors reduce for sustaining the health systems of Africa.

Successful implementation of the MAP health programme and the immediate projects will require a range of partnerships. These will be between African countries, regional and continental networks and United Nations bodies (including UNDP, UNAIDS, UNICEF and WHO) multilateral agencies, regional structures e.g. the EU, philanthropic organisations, non-governmental organisations, universities and the private sector. Leadership will be vested in the heads of state, with responsibility for operational strategies and management delegated as appropriate. The World Health Organisation Regional Office for Africa, in collaboration with its Mediterranean counterpart, must certainly play a central role. Regional structures, such as ECOWAS and SADC also have a critical role to play in expanding regional initiatives and networks.

CONCLUSION

Africa's leaders are committed to addressing the poverty that is the root cause of much ill health in Africa and to replace it with sustainable development. They are also committed to reducing the heavy burden of communicable disease and to securing an effective health system. The Millennium Africa Programme provides an appropriate vehicle through which to drive such Programmes and specific projects. Its advantage is that African leaders themselves are committed to putting their full weight and that of their governments behind health strategies that will advance economic and social development and reducing suffering.

BOX 1: HIV/AIDS

Although an accurate picture is difficult to provide, because of weak information systems, it is estimated that 25.3 million (end 2000) Africans are living with HIV and currently 2.4 million are at an advanced stage of the disease. More than 14 million Africans have already died of AIDS, and life expectancy in sub-Saharan Africa has been reduced by almost a third, from around 60 years to about 43. 8.8% of adults aged 15-49 are living with the virus and 4 million new infections are occurring annually. It is estimated that there are 11 million AIDS orphans now and that the number will reach 40 million in 2010.

AIDS is first, and foremost, a disease of poverty. Poverty leads to migration, influences sexual behaviour and limits care and education. In turn, AIDS threatens efforts to revitalize economies and has devastating social impacts. But, as shown by countries, there is much that can be done, starting with a broad-based developmental strategy. AIDS prevention and care requires an inter-sectoral approach and a strong focus on youth. It also requires specific actions from the health system. Health services have been struggling to respond at scale. The lack of effort for a vaccine remains a hole in prevention efforts.

Africa and the world are taking the epidemic ever more seriously. The recent Abuja Declaration on HIV/AIDS by African Heads of State and Government and the HIV/AIDS strategy adopted by African Ministers of Health in Ouagadougou in 2000 reflect Africa's concern and strategies. The effort of the International Partnership against AIDS in Africa (IPAA) is the main example of many international efforts in support of the fight against AIDS. A special UN General Assembly has been called for June 2001.

The Secretary General of the United Nations is also at the front of efforts against AIDS. He has called for action in five key areas. These are:

- Containing the epidemic, through amongst other things large scale awareness and prevention campaigns and condom distribution
- Reducing vertical transmission from mothers to newborns through the use of short-term anti-retrovirals
- Accessible treatment, including cheaper drugs, as part of a comprehensive HIV care package which includes home based care and treatment of opportunistic infections.
- Advances in science and higher prioritisation to achieve a vaccine and a cure and
- Protection for the world's growing number of AIDS orphans, estimated now at more than 10 million in Africa

The recent rise in international focus and commitment is promising. Yet, at this stage, even though core measures for prevention and control are available, the attainment of the UN goal of 25% reduction in HIV/AIDS prevalence in 15-24 year olds by 2005 in most affected countries the Okinawa goal of a 25% reduction in all young people by 2010 seems a real challenge. In theory the Okinawa goal seems modest and attainable, given that many of those now infected will no longer be young or will have died by then. However, we are still not understanding, or influencing youth behaviour sufficiently. More emphasis needs to be placed on a holistic approach and on contextualising how AIDS can prevent youth from meeting their aspirations. Peer education is a vital tool.

Preventive efforts are also hampered by limited access to condoms, to voluntary counselling and testing and treatment for sexually transmitted infections. (The chances of transmitting the virus are increased manifold in the presence of a genital ulcer or a vaginal infection) At the same time, many of those living with HIV are denied care because drugs are too expensive, health systems too weak and support for home based care too limited. Improvements in quality of life, treatment of opportunistic infections and use of anti-retrovirals do not only improve the health of the individual, they also reduce transmission through reducing viral loads. In fact, in many ways, treatment and care are two sides of the same coin.

The lack of resources to scale up health system efforts, including NGO and CBO programmes, to address the epidemic has undoubtedly been damaging. The entire AIDS effort needs to be scaled up to an unprecedented level if we are to be successful. It needs visible leadership from African heads of state, who fully commit their country's resources to fight this condition; to be supported by a "full war chest" and affordable drug prices.

BOX 2: TUBERCULOSIS

Approximately 600 000 Africans die annually from tuberculosis, commonly 30-40 years prematurely. 34 of the 46 countries in the WHO African region have a tuberculosis burden in excess of 300 per 100 000 population. 1.6 million new active TB cases arise annually on the sub-continent from the 200 million people infected with dormant tubercle bacilli. This figure is growing due to weaknesses in control programmes and because lowered immunity in HIV+ve persons increases reactivation, resulting in more bacilli in the air and more new infections. (Poverty related stresses such as malnutrition have always been a cause of lowered immunity.) It is estimated that TB is increasing by 10% per annum as a result of HIV.

Tuberculosis control is based on early case detection, preferably through microscopic detection of tubercle bacilli in the sputum of infectious individuals, and multiple drug treatment. Effective treatment does exist and the STOP TB initiative, launched by the WHO in 1998, aims to raise global awareness of TB and to enhance its control and care through a variety of technical and service advances. Prior to this, the World Health Assembly had declared TB a global emergency in 1993 and African Health Ministers had adopted resolutions between 1991 and 1994 on tuberculosis. The latter resolutions called for the implementation of "directly observed treatment short course", or DOTS as it is commonly known. Short course treatment using Rifampicin in combination with other drugs has increased the cure rate in the field from 56% to 70%, while allowing treatment to be reduced from more than a year *to* 6 months. But, experience has shown that taking medication continuously for 6 months is no easy task. It is best achieved by having every dose observed by an independent "partner", often a health worker. Without treatment, not only will the person usually suffer terribly and die, but they will infect many more people.

The Amsterdam Declaration targets a 70% detection of TB by 2005 and Okinawa targets halving TB deaths and prevalence by 50% by 2010. To achieve this, the proposed African goals of smear positive case detection rates of at least 70% and treatment success rates of 85% would need to be met. These goals seem well out of reach, unless drastic measures are taken. At present, many cases are not identified, or are identified late, and many of those diagnosed are not successfully treated. The main obstacles are the weaknesses in health systems, the unavailability of Rifampicin and the absence of alternative cures for TB. Little of the world's research capability has gone into new drugs for TB. Health systems are short of capacity to make microscopic diagnoses of TB, of personnel to provide care and of systems for delivering essential drugs consistently for the duration of treatment. The emergence of multi-drug resistant TB is one of the consequences of interrupted or failed treatment. In sum, to tackle TB one needs to build up the health systems of Africa, make effective drugs readily available and empower people to become partners in their diagnosis and care. Early progress has been made through STOP TB, country efforts and the Okinawa commitments, but the significant challenges tuberculosis poses to the individual, the health system and countries development will only be met by a significant scaling up of effort.

BOX 3: MALARIA

Malaria, endemic in 45 of the 53 countries of the Africa kills around one million and infects 300 – 500 million Africans each year. In many areas and probably on the continent as a whole, malaria is still increasing rather than decreasing, driven forward, amongst other factors, by increasing drug and insecticide resistance. Most of the deaths occur in poor children and in the poorest nations. In some countries, 3 in 10 hospital beds are occupied by malaria patients; further stressing an already stretched health service. It has slowed economic growth in African countries by 1.3% per annum. Yet, malaria could be controlled for a small fraction of its annual \$12 billion economic cost.

Although the malaria parasite and the mosquitoes that transmit it have been growing resistant to drugs and insecticides, reasonably effective measures do exist. These are included in the Roll Back Malaria campaign launched by WHO in 1998, preceded by the African Initiative for Malaria and a 1997 OAU Harare Declaration on Malaria Prevention and Control. Roll Back Malaria, which is a multi-agency and country partnership, aims to scale up action and inter alia have in place evidence based decisions, rapid diagnosis and treatment and multiple prevention measures. These include insecticide-treated materials, new medicines and insecticides, vaccines, strengthened health services and a dynamic global network. Its strategies are based on extensive consultation. The Multilateral initiative on malaria (MIM) and the Medicines for Malaria Venture (MMV), a publicly underwritten capital venture fund are other projects.

In acute malaria, children can die within 24 hours if they are not effectively treated, making an effective health system paramount to reducing deaths. Mortality in infants and children is increasing because of chloroquin resistance, AIDS and health system weaknesses. Pregnant women are also particularly vulnerable. Their newborns are also put at risk from low birth weight.

The Roll Back Malaria target, repeated at Okinawa, is to reduce malaria suffering and death by 50% by the year 2010. Although there is an increased commitment by world bodies and African governments to malaria control, this target could yet join the list of wished for but never achieved goals, seemingly unless at least these things happen:

- Resources available for malaria control and care are dramatically increased
- Health services are strengthened so that they can activate control measures and provide care at scale
- People are effectively empowered and mobilised to take action.
- Efforts to find a vaccine and new drugs and ways of controlling mosquitoes are stepped up dramatically

Increased commitment by African government's, and more focused commitment and financial support from developed countries is needed. RBM is trying to ensure that 60% of young children and pregnant women at risk have access to protective measures, such as insecticide treated nets. At present only a fraction do, against an African target of 50% by 2005. Emerging country plans and commitments made at the G8 summit in Okinawa offer a positive start to the massive, continuing attack that is required. Further support will need to come from peace, stability and growth on the continent, as wars disturb control and care, while poverty stops it from getting off the ground.

The drug situation needs urgent attention. Chloroquin resistance is reaching 80% in places and resistance to Fansidar, the only other cheaper drug, develops rapidly. Artemesinin is likely to remain expensive because of high production costs as will the costs of combination therapy, which is clearly what is required. The only thing stopping this is affordability. Safer and more effective insecticides also need to be developed.

BOX 4: COMMUNICABLE DISEASES OF CHILDHOOD

161 out of every one thousand children born in Africa die before their fifth birthday, most of them from preventable or readily treatable communicable diseases. 800 000 die of diarrhoea, 1.2 million of pneumonia, 500 000 of measles and of course 600 000 from malaria. The AIDS burden is still growing. 30% of children in sub-Saharan suffer from malnutrition, which is the cause of, or contributes to more than half the children's deaths.

Improvements in quality and quantity of water and sanitary measures can help prevent diarrhoea, caused by a number of infectious agents, while the use of a simple home made sugar and salt solution can offset dehydration, the direct cause of death.

Pneumonia, most commonly caused by streptococcus pneumonia, generally remains sensitive to simple and cheap penicillin or amoxycillin. The key is to get access to diagnosis and drugs early in the disease.

Measles is completely preventable through immunization using a low cost vaccine. Indeed, measles could be wiped out of Africa. The key is a health care system that can sustain high levels of immunisation coverage. Severe disease and death from measles is more likely in malnourished children, especially those with vitamin A deficiency.

Although not comparable in mortality or morbidity, polio needs a special mention. Effective efforts have come close to freeing the world of this horrible disease. As the focus shifts elsewhere, the job should not be left unfinished.

The measures for the prevention and control of the main childhood infectious diseases have been captured in a programme called the "Integrated Management of Childhood Illnesses" (IMCI). Beyond its focused drive, the success of IMCI is closely tied to a secure health system, empowered parents and indirectly to measures to reduce poverty. Poverty weaves itself into child ill health in a number of ways, not the least of which is through malnutrition. Simple measures, such as exclusive breastfeeding for six months, adding oil to staple diets, vitamin A capsules, iodised salt and use iron rich foods would all go a long way to reducing impact. Vitamin A coverage is patchy and in some countries, less than 10% of the population are using iodised salt.

BOX 5: OTHER IMPORTANT HEALTH PROBLEMS

In the face of AIDS, TB, malaria and child deaths it is easy to lose sight of other causes of heavy burdens of disease in Africa.

Outbreaks of plague, meningitis and the feared hemorrhagic fevers are usually highlighted. Yet, more quietly, sleeping sickness (Trypanosomiasis), an endemic disease in parts of Africa causes much suffering. River blindness (onchocerciasis), like polio, should be wiped out and no effort should be spared in doing so. Not only will 40 million people will be protected by end 2002, but 25 million hectares of fertile riverine land will become available for food production. Other filarial infections also cause much illness.

As we recognize the ill health in children, so we cannot ignore the newborns and the 272 000 women who die in relation to childbirth annually. Probably more than any other condition, these unnecessary deaths reflect on the state of access to health services on the continent, as most of the deaths are preventable with skilled help. A woman in Africa has a 1 in 16 chance of dying in childbirth compared to 1 in 4000 in Europe.

Chronic diseases such as diabetes, cardiovascular disease, stroke, hypertension and epilepsy (an estimated 10 million sufferers, 80% of whom are not treated) may seem something for the future, but this is misleading. There is already a large burden of disease and this will continue to grow in consequence of the adoption of changed lifestyles. Indeed, there should be no let up in preventive efforts, such as anti-tobacco action to prevent chronic obstructive airways disease and other consequences of smoking. The care of these conditions is largely dependent on ongoing assessment and long-term drug therapy, care requiring a secure health system and funding for drugs. To enable long-term adherence, the basis of real benefit, patterns of care must be adapted to allow patients to become partners in their care.

When health systems come under pressure, those facing mental ill health or physical disability, including blindness, seem to lose out first – maybe because their illness is not acute and they don't die in large numbers, but the impact is enormous. More visible are the injuries arising from war, violence and accidents, the health, social and economic consequences of which are often long term.

For effective prevention and care of all these health problems, a functional health system is essential as is empowering people to take action to prevent ill health.