NEW PARTNERSHIP FOR AFRICA'S DEVELOPMENT
HUMAN DEVELOPMENT PROGRAMME

HEALTH

THINK GLOBALLY: BUILD LOCALLY

WORKING DOCUMENT 04/02

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SECTION 1: THE HEALTH PROBLEMS FACING AFRICA

Human development has been one of the most serious casualties of the poverty, social exclusion and marginalisation of and lack of sustainable development in Africa. The health problems facing Africa are rooted in this context, as are the potential health benefits of a broad human development strategy.

1.1 A HUGE BURDEN OF PREVENTABLE DISEASE AND DEATH

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 the most severely affected countries in sub-Saharan Africa reduced by almost a third, from 60 years to 43. However, its impact is not the same in all countries. HIV prevalence in adults ranges from below 5% to above 20%. Approximately 2.4 million people die from AIDS each year, 600 000 from tuberculosis and 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. 272 000 women a year die in childbirth.

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In the face of these statistics, other important health problems can but should not be overlooked. 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. Although the levels in Africa for some non-communicable disease deaths and morbidity are not yet at levels reached elsewhere, the fact that 77% of deaths from non-communicable disease worldwide occur in developing countries means that action on existing problems (e.g. injuries, violence, mental ill-health, disability and occupational disease) and emerging diseases of lifestyle (for example due to unhealthy diets, physical inactivity, tobacco and alcohol use) must not be neglected.

1.2 TARGETS FOR REDUCTION OF BURDEN OF DISEASE

A number of targets have been set for reduction of the disease burden in Africa, notably the Okinawa Goals, the International Development Targets, the Abuja Declarations and targets set in Africa's Health-for-All Policy. Yet, **if current trends continue** it seems that **the major international initiatives** against HIV/AIDS, TB, malaria and childhood and maternal death, as was the case with their predecessors, **will not achieve their targets**. Quite simply, the scale of programmes and of their financial / and human resources is insufficient. However, success is possible, especially if a comprehensive approach is used to deal with the reasons behind the burden of disease and appropriate and innovative strategies are used. There are many positive examples in Africa from which lessons can be drawn. Even though they are not spelt out in this report, they offer invaluable guidance for the future. The situation differs from country to country, so it is important to assess the feasibility and trends of these goals for each country and to redefine and refine resource requirements to achieve feasible country targets.

The Okinawa Goals
A 25% reduction in HIV/AIDS prevalence in all young people by 2010
(Also a UN Special General Assembly goal)
A 50% reduction in TB deaths and prevalence 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.

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1.3 THE REASONS BEHIND THE BURDEN OF DISEASE

The reasons why Africa is not on track to achieve these targets is not because they are impossible, but rather because:

- Continuing 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

The contribution of specific elements of the broad reasons for the burden of disease vary from country to country, but a broad assessment can be made:

- **Poverty, marginalisation and displacement**

Improved health is not simply a product of health service interventions, it is a consequence of many complementary factors. 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 in conflict areas. The effects are felt beyond the war zone, as the toll of war on the people and the 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. Lack of household food security is a consequence of more than poverty and underdevelopment and its impact on disease burden beyond malnutrition.

- Education, and in particular women's education, has many spin offs for health. Literate people are better able to 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.

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- The digital divide prevents Africa from fully exploiting the many uses technological advances offer for improving health.

- Governance and institutional weaknesses, although not uniform, influence health both indirectly and directly. Governments are faced with an array of pressures and health and health services are not necessarily afforded the priority required to meet disease burden targets. Quality of governance also impacts on economies and public services, and through this, on health.

- **Disease control programmes do not match scale of the problem**

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, rapid treatment 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, because the overall effort to reduce disease burden has been insufficient.

In consequence, national, African and international strategies and efforts to reduce the burden of disease have been strengthening over the past few years. These include the International Partnership Against Aids in Africa, Stop TB, Roll Back Malaria, the Integrated Management of Childhood Illnesses and the Making Pregnancy Safer Programme. The Framework Convention on Tobacco Control, Vision 2020 - The Right to Sight and the Global Campaign against Epilepsy are examples of programmes aimed at non-communicable disease burden. There is wide consensus on and regular updating of the strategies they employ - the key challenge is to scale up to the point of real impact. The specific situation on the individual major communicable diseases and other important health problems is presented in **Boxes 1-6** (see end).

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Although the specific mode of transmission and incubation periods for communicable diseases or the epidemiology of non-communicable diseases vary, as do the complexity and effectiveness of measures required for their prevention and control, there are common requirements for success beyond focussing on the disease. Countries also require a solid health care system, capacity for strategic support, effectively mobilizing personal action and addressing underlying poverty and underdevelopment. In turn, disease programmes, if developed effectively have the potential to enable broader improvements in health systems. There is also much potential for technological development to advance disease control. The increased international focus on disease burden, including new research initiatives are certainly welcome.

- **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 can become like a house without a foundation - they stay up for a while and look good, but are prone to later collapse. At the same time, systematic efforts to scale up disease control programmes, if developed appropriately, have the potential to strengthen health services, including into the periphery. This can then be built on to address a wider range of health problems.

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 need to 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 for a women in obstructed labour. Adherence to therapy for chronic diseases, such as tuberculosis, is particularly difficult in a weak health system, 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 benefit from effective health systems.

Central to any effective system is sufficient numbers of capable and committed health workers, particularly so in more remote and unstable areas. Negative attitudes displayed by health workers towards their patients have all too often been a complaint, while the inability to retain staff threatens the system. Retaining health workers requires decent conditions of service and a positive work environment. Yet, the reality is often the opposite. Salary scales in a number of countries are extremely poor, even though much of the health budget goes into remuneration of staff. In addition, workers also face adverse work environments and poor living conditions for their families, which chip away at the morale of even the most committed. This profoundly affects auxiliary level workers, who are commonly the backbone of more remote services. Under these conditions, the ongoing brain drain into the private sector and out of the country becomes understandable, if not desirable. Brain drain affects the capacity for training, supervision and management; and for staffing of first referral level hospitals.

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For many diseases, cheap generic drugs are still what is required. Yet, systems to ensure that drugs are always on the shelf are too often found wanting, with supply chains compromised at multiple points. Adding to the difficulty is the high cost of some drugs. In earlier days of antimicrobrial therapy, penicillin for gonorrhoea and chloroquine for malaria provided cheap and effective treatments, but resistance is an increasing problem. The cost of the alternatives to these drugs and of other newer needed therapies, including drugs used for AIDS, is beyond the means of even the better economies of Africa. The pricing practices of the pharmaceutical industry play a significant role in keeping costs high.

Governance and management weaknesses, the impact of which should not be underestimated, continue to undermine the system. A lack of effective systems for community oversight adds to management limitations. But, however judiciously available money is spent, current funding levels are inadequate to allow for viable health systems in Africa. If one has only 30 litres of fuel to travel the 1000km 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. In the least developed countries total health expenditure is of the order of $15 per capita.

All health systems must be underpinned by clear and coherent national health and resource (e.g. drugs and human resource) policies and plans and legislative frameworks. The extent to which such policies and frameworks are in place varies across the continent. There should be mechanisms for the rapid review and registration of new technologies; a process that might be best performed through a regional centre, managed collectively by the countries.

Surveillance, monitoring and evaluation are central to early intervention in outbreaks and for improving health service delivery. It is the basis of evidence based policies and strategies and for assessing effectiveness of interventions. Systems for surveillance, monitoring and evaluation in Africa, with exceptions, are generally too weak to fulfil this role effectively, and their development is often inhibited by the more immediate pressures of dealing with patient loads and fiscal constraints. Mortality data is often questionable.

- **Lack of support capacity for health system development**

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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, while those in place often lack the critical mass of staff and resources required to be effective. This institutional inadequacy leads to dependence on, rather than partnership with commercial consultants, donor staff and public health institutions of the developed world. Even the support role of multilateral agencies is compromised by the size of their country offices. Also, relationships between Ministries of Health and Universities and other centres of excellence are not always conducive to collaboration.

The 10:90 gap in health research is used to describe the fact that 90% of the worlds research goes into less than 10% percent of its health problems i.e. into those of the developed world. We still do not understand nearly 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 vaccines with any real efficacy against HIV TB and malaria remain some years away.

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, UNICEF and UNFPA) 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 the contributions of all these players are complementary; that they consider long term financing and that they work within an overall country strategic plan. This has not always been the case.

- **People not sufficiently empowered to improve their health**

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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 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 roles 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 individuals and communities 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.

Health services can only go so far; they need to be supplemented by efforts of communities and their structures. These efforts are diverse in nature, ranging from campaigns to care. They can be more general, but often tend to focus on a specific health problem e.g. AIDS or disability. They have the ability to achieve results and mobilise energy and voluntarism in a manner that is difficult for formal health services to match. Results of many efforts in Africa are nothing less than extraordinary and there are many examples to learn from. The efforts can be rooted in NGOs, CBOs, faith-based organisations, or as part of a more general development structure. These organisations play an invaluable role in the health systems of Africa and their efforts have been growing in many countries; but there are massive gaps to be filled and a lack of emergence or sustainability of indigenous organisations.

- **The benefits of development and health services tend to not equitably reach those with the greatest burden of disease**

The burden of disease is not evenly spread between and within countries of Africa. This is not chance - it is a product of inequity, inequity that results in benefits of development not being evenly shared, nor are health services evenly spread. The poorest and most remote people and those displaced by war and other emergencies are especially vulnerable and contribute disproportionately to the burden of disease. In consequence, if the aim is to massively reduce disease burden, then development, public services and health care should be skewed towards the poorest and most marginalised people. Yet, the inverse is generally true. The poor and marginalised not only face fewer clinics and health workers, but also the least fair financing. Co-payments are a greater proportion of (meagre) incomes and serious illness can impoverish families for many years, as they not only lose income and production, but also have to pay back moneys lent.

Displaced communities and those affected by war are even more vulnerable, yet receive even less health care. Even when peace prevails, capacity and resource limitations have not allowed health services to be rapidly scaled up.

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SECTION 2: THE NEPAD HEALTH STRATEGY

2.1 THE NEPAD HEALTH VISION

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

2.2 THE STRATEGY

Given that efforts at disease control will not match the targets if they continue on their current path, there are **two choices** and they are quite stark. They are to **abandon the targets** and accept that Africa will continue to be weighed down by disease, **or** to **put in place a plan that is of sufficient scale and breadth** to be genuinely capable of reducing the burden in line with the international goals. The worst thing would be to retain the goals, but only support programmes obviously well short of what is required - and then suggest that Africa has not been able to deliver. The NEPAD health programme has chosen the latter option – to offer a strategy that can truly impact on the impossible burden of disease that Africa's people carry; a burden that is choking its social and economic development.

The NEPAD health strategy derives from an understanding of the health problems facing Africa and the reasons for them. The strategies and actions draw on international and African best practice, continental experience, a multiplicity of analytic and strategic reports and the many African programmes that offer innovative ideas. A number of the strategies have been endorsed by African heads of state or government, or by their health ministers. The strategy is based on a view that piecemeal and under-resourced efforts do not offer the potential to match the challenging goals. The strategy is therefore to build **a comprehensive attack on the forces that drive the burden of** disease - a composite and integrated, rather than a fragmented **approach**. It therefore foresees a massive scaling up of commitment, effort and funding to give it a realistic chance of success.

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 NEPAD health strategy recognizes that **reduction in poverty** is a health intervention. The overall NEPAD programme is therefore supportive of health – its strategy is not duplicated here. However, as any development is not automatically positive for health, the health potential and impact of planned developments should be considered and health-promoting ones 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.

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Although reduction in poverty is necessary for achieving Africa's health goals, this needs to be paired with health interventions, many of which have a more immediate impact.

The strategy is committed to **a massive assault on the major burdens of disease**. It is committed to build on existing initiatives, including the International Partnership Against Aids in Africa (IPAA), Stop TB, Roll Back Malaria, the Integrated Management of Childhood Illnesses (IMCI) and Making Pregnancy Safer. It is also allied to the declarations of heads of state or government or health ministers, and the plans to achieve these. In view of their massive burden, there would be a strong initial focus on AIDS, TB and malaria, but the express intention is to rapidly widen the scope. It is also the intention to develop the disease programmes in a manner that enables broader improvements in health systems. NEPAD explicitly supports programmes to reduce the burden of non-communicable disease, such as The Framework Convention on Tobacco Control, Vision 2020 - The Right to Sight and the Global Campaign against Epilepsy.

Health services are not simply mitigators of the effect of illness; they are basis for interventions for disease prevention and control. This is why all the major disease burden programmes emphasise the importance of an effective health system to their success. The NEPAD 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** – a joint massive effort. The NEPAD health strategy recognises that there are common features that go into making a health system secure. However, it does not prescribe a single recipe for Africa, because of the uniqueness of each country situation. Rather, it starts with each country undertaking a review of what it needs to do to secure its health system – to scale it up in a sustainable way to the point at which it can truly support programmes for the reduction of burden of disease. Each strategy will recognise the multiplicity of players in the health sector and the role of communities, to which services need to become more responsive and accountable.

The NEPAD health strategy also offers a mechanism to build the **support capability** required by the strategy - public health capacity, relevant research including efforts to develop new drugs and vaccines, information and communication technology and calls for a more co-ordinated effort by international partners.

Improvement in health will not come without the full participation of families and communities. The NEPAD strategy recognises that **people must become empowered** to take action **to improve their own health**. This is built on increasing the levels of health literacy and community involvement in health issues. Community involvement will be diverse in the health problems tackled, in the activities undertaken and in the organisations involved. They will reach out to all sectors of society and have sustained social mobilisation at their core. The details of how best to achieve community involvement will vary from country to country. The principle is therefore part of the strategy, but the mechanism is not prescribed. Involvement of those with and affected by the health problem that is being addressed is critical, not the least because they are the ones who tend to be most passionate and committed in their efforts.

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The strategy recognises that biggest return on investment will come from a **focus on the poorest and most marginalized**. People in deep rural areas, in 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 recognised that the pressures of limited budgets, of staffing rural services and of visible pressure for services in urban areas have skewed health services. The NEPAD health strategy makes a specific commitment to equity in health care.

There is **much that Africa can and will do for itself.** But, **success will require a partnership** between African leaders and their counterparts in the developed world and the support of international agencies. The strategy recognises this and calls for unprecedented levels of commitment from donor countries.

Much as 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 which is needed to deliver it.

The NEPAD health strategy seeks not only to secure recognition of what is required, but also to **mobilise the funds to achieve the massive scaling up**. If funding needs to be sufficient to build effective disease interventions and secure health services – to make a real difference - then an increase in the order of US$8 billion, or US$10 per capita per annum is the starting figure that should be rapidly reached. Much less will, when distributed, be spread too thin to make the impact required. The slow response to and deficit on the targets of the Global Fund are of great concern, recognising that the amount will need to grow over time to the order of US$20 billion or US$25 per capita. (There is still some debate on the amount needed to make a real impact, but it is magnitudes more than rolling out existing levels of support.)

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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 NEPAD programme, so will dependence on donors reduce for sustaining the health systems of Africa.

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 decades long programme, the strategy calls for donor support to be ready to stay the long road and not become fatigued early on 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 and need to be delivered on.

It is critical to recognise that it is not the intention of NEPAD to see money thrown at problems. NEPAD 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 NEPAD 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. Indeed, it is this combination of an African strategy and the support of African heads of state that are important added values of the NEPAD health strategy. It gives an African voice to the debates on the steps needed to improve health on the continent.

NEPAD also envisages that donor partners will respect the right of African countries to take responsibility for the plans and programmes of the strategy, rather than for them to be donor determined or driven, as this is what will engender the African ownership and commitment that is so crucial to sustaining efforts for reducing the burden of disease.

2.3 OBJECTIVES

The objectives of the NEPAD Health Strategy are:

- To strengthen 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 $^2/_3$ 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 broadly meets needs and effectively supports disease control in place by 2015
- To ensure the necessary support for sustainable development of an effective health system by 2010
- To achieve health literacy in Africa by 2010
- To impact successfully on the disease burden of the poorest people of Africa by 2015
- To mobilise sufficient sustainable funding to build effective disease interventions and secure health services by 2004

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SECTION 3: THE NEPAD HEALTH PROGRAMME

The NEPAD health programme follows a **comprehensive, integrated approach** to addressing the disease burden of Africa outlined in the strategy. It recognises the overall role of NEPAD in addressing the poverty, marginalisation and displacement on the continent that is undermining health. The health programme specifically seeks to:

- Strengthen disease control programmes so that they do not fall short of the scale required to be effective
- Secure health systems so that they are not too weak and under-funded to effectively support significant disease reduction
- Build the support capacity necessary for development of a sustainable health system
- Empower the people of Africa to take action to improve their own health through achieving health literacy and wider community involvement.
- Share the benefits of development and health services equitably, so as to reach those with the greatest burden of disease
- Mobilise sufficient funding to build effective disease interventions and secure health services

The programmes are outlined in more detail below and the priority goals and targets are spelt out in Table 1. Table 1 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. While elements of the programmes have the potential to make rapid gains, the full programme will take time to unfold and become secure. Some elements are best seen as a ten or more year investment.

While the NEPAD health programme offers a medium-term approach, there are concrete projects that will make a difference now. A set of immediate projects is outlined in Appendix 2, and is listed, with objectives and estimated costs, as a Table in Appendix 2. These projects should not be seen in isolation, nor as a replacement for the massive scaling-up and medium term strategy that is required. Rather, they have been selected as they are first steps on the longer road, or because, if not dealt with early on, they are likely to become rate limiting steps to achieving other elements of the strategy.

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3.1 Strengthen programmes to reduce the burden of disease

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, malaria, infections of childhood and deaths related to childbirth. Many of the NEPAD disease control proposals are aligned to existing international or continental initiatives. NEPAD is also committed to the action plans of the Abuja Declarations on Malaria and on HIV/AIDS, TB and Other Related Infections and to securing the funding needed for their implementation.

NEPAD envisages a massively scaled up AIDS prevention effort incorporating education, access to condoms, voluntary counselling and testing, treatment for sexually transmitted infections and prevention of mother to child transmission. Targeting of those at high risk, such as sex and migrant workers must be stepped up and youth programmes prioritised and appropriately pitched. Care includes home based care and care of orphans, improvements in quality of life, treatment and prophylaxis of opportunistic infections and use of anti-retrovirals. As with other diseases, effective care will require affordable drugs and strengthened health systems, including effective drug distribution, strengthened laboratory services and caring health staff. It also requires community action and empowered individuals and families.

Tuberculosis control is to be based on early presentation of chronic coughers, a high index of suspicion in HIV+ve people, case detection using microscopy and multiple drug treatment using the "directly observed treatment short course" or DOTS strategy.

Malaria efforts foresee increased use of insecticide treated materials and, where appropriate other vector control measures, rapid diagnosis and treatment of malaria, including home initiated care, chemoprophylaxis for pregnant women, and early detection and response to outbreaks.

The prevention and control of childhood infectious diseases is through consolidation of the "Integrated Management of Childhood Illnesses" (IMCI). In addition to HIV/AIDS, TB and malaria, early identification and treatment of pneumonia and prevention and rehydration for diarrhoea are critical. Immunisation coverage must be ensured. Exclusive breastfeeding for six months, adding oil to staple diets, vitamin A capsules, iodised salt and iron rich foods all supplement the core requirement of food security. Indeed, good nutrition and household food security have a critical role to play in reducing the burden of disease, both directly and indirectly.

Women and their newborns must have ready access to skilled assistance in childbirth and easy referral for further care, such as Caesarean sections.

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Strategies to address other important burdens of disease are recognised in the NEPAD programme. These include tackling other communicable diseases of importance in Africa, such as sleeping sickness and river blindness and the reduction of deaths and disability from non-communicable diseases, (NCDs) including those related to tobacco, mental ill-health, substance abuse, violence and injuries and work-related injury and disease as well as the emerging chronic diseases of lifestyle.

3.2 Build a secure health system

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 and more. Many parts will need to work in synchrony. There can be no single health system recipe, given the diversity of both country and health service situations in Africa. Also, each

country will have different priority areas for attention early on – in one country it may be drugs, in another human resources and in another communication. Thus, each NEPAD partner will need to prepare a country specific plan for securing its health system.

In developing the country specific plans, the role of the various players must be recognised. In a generic strategy such as this one, because of country variations, one cannot make definitive statements about the specific roles of the public service, private sector, NGOs, CBOs and other players who make up the diverse group of health care providers. What one can say is that all need to work in a co-ordinated fashion towards achieving the country's health and health service goals. Also, each one has particular strengths, such as the national base of the public sector, the responsiveness of private providers and the unique ability of NGOs to reach high risk and often marginalised groups.

It is also not possible to define precisely which interventions will work best to improve health systems, in part because of insufficient health systems research and of course country variability. However, there are developments that appear to offer good returns and are likely to feature in all plans. These include:

- Strengthening peripheral health systems and in particular the circumstances of lower level health workers – low salaries and low morale included - as they are the vital ones in delivering care.
- Strengthening management at district level and decentralisation of decision making. Decentralisation will not be undertaken in a manner that constitutes dumping of responsibility on local health workers and communities without the resources to deliver care.
- More trained managers, who can effectively mobilise, motivate and innovate, as well as plan, organise and budget, and manage information.
- Greater local involvement in health facilities, including community oversight of health workers and greater accountability through service or performance agreements
- Regular supervision of health workers. This should be done in a manner that encourages and enables performance, rather than as a policing exercise. Health workers should look forward to supervisory visits as they would a visit from a friend from whom they except support and ideas on how to deal with challenges.

Draft

Although there may be no generic prescription, it is possible to identify common requirements of an effective health system. All countries will need to:

- Strengthen peripheral health services
- Provide accessible services by increasing the number of local clinics and ensuring the necessary infrastructure – energy, communication and safe water
- Staff services with sufficient numbers of capable health workers through more effective training, better conditions of service and reduced brain drain
- Ensure essential drugs and supplies through strengthened distribution systems and affordable prices

- Revitalize hospitals to function effectively as sources of referral
- Achieve management capability commensurate with running services efficiently at national, regional and local levels
- Fully harness the potential of the private (for profit and not-for-profit) sector, as appropriate to the country, in support of reduced burdens of disease.
- Have clear national health and resource (human, drugs) policies and legislative frameworks
- Provide sufficient surveillance, monitoring and evaluation to inform interventions
- Strengthen planning, managing and monitoring capacity within ministries of health.

Health is a labour intensive and dependent sector. Therefore central to any strategy for an effective health system is it human resources. All country strategies will therefore need to adopt a comprehensive approach to the range of factors influencing human resource availability and performance and prioritise their implementation.

3.3 Support for sustainable development of the health sector

Capacity to support development of the health system is not a "nice to have", it is essential to disease control and to building a secure health system. The support needed is diverse.

Institutional public health capacity and expert centres on the continent, within a sub-regional framework, must be developed, as must south-south co-operation and more effective and relevant links with the north, which will continue to play an important role. 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. Existing structures, such as that for Polio Surveillance could be readily expanded to serve a broader disease surveillance role.

Draft

Health systems, disease programme and operational research must become recognized as a necessity for improving health system performance and not a luxury. It must be budgeted for and structured into the system. Ways for its product to be able to influence health policy and practice should be established. Research capability is in need of a strong injection, as are some surveillance systems and the collection of routine mortality statistics.

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. NEPAD 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.

Successful implementation of the NEPAD health programme 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. 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 and in facilitating harmonisation of policies, bulk procurement and consistency in care. The capacity of the WHO Regional Office for Africa and the regional bodies (ECOWAS, SADC etc.) should be strengthened, commensurate with their expanded responsibility.

3.4 Enable personal action to improve health

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.

Draft

A package of health learning should be identified and 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 Heads of State and a high profile, concerted effort, there is no reason why health literacy cannot be rapidly improved.

The NEPAD health programme seeks to achieve a real scaling up of community involvement in a range of health issues, starting with the major burdens of disease. At the core is a commitment to mobilise energy and voluntarism in a manner that is difficult for

formal health services to match, and to achieve results in groups that formal services struggle to reach.

On the one hand, it is important that people do not simply wait for government to do things for them, yet on the other, organisations do not arise spontaneously in sufficient numbers. Health Ministries will therefore need to intervene to create an enabling environment for community involvement, facilitate the emergence of local NGOs and organisations and provide seed funding to get efforts off the ground in hitherto unserved areas. As situations vary from country to country, there is no single way of going about this. Each country should consider its own situation and incorporate a deliverable approach to community involvement in its country plan. The details may be different, but the aim is common to all countries - to reach all sectors of society, including the poorest and most marginalized, in a sustained programme of social mobilisation in support of health.

3.5 A focus on the poorest and most marginalized

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 NEPAD is a war on poverty and marginalisation, whose every success will contribute to health. A strong focus on the needs of the poor, including basic food security will provide significant health returns. Strengthening public services, impacts most on the poor as this is where they access social and other services.

Displaced communities and those affected by war need to receive services, however challenging the situation. This should include services for women and children, including immunisation. Special arrangements may need to be made to provide care. Health will need to adopt a neutral position, possibly delivering care through NGOs. Then, as soon as peace prevails, health services need to be rapidly scaled up. This is not only because of the burden of treatable disease that is likely to have built up, but because it is an effective way of starting the reconstruction of communities and societies and building their confidence in post-conflict government.

Draft

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 NEPAD 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, it also offers the best return on investment.

3.6 Mobilise sufficient funding

It is quite clear that the massive effort envisaged against the major burdens of disease and unnecessary death in Africa will require substantially increased funding. This will not only need to go into disease specific programmes but also into securing the vehicle that provides much of the specific prevention and care that has to be implemented - the health system.

The additional funds will come from 3 main sources, NEPAD countries committing more of their own resources to health in line with commitments made in the Abuja declarations, directing funds mobilised from debt cancellation preferentially to health and from the Global Health Fund being pioneered by the UN secretary general. NEPAD supports the global health fund because it holds the possibility of an increase in funding to the level required to make a difference. However, it is critical that the Global Fund and any response to the report of the Commission on Macroeconomics and Health brings in new money and is not just a shuffling of the pack or a drawing out of funds from other sectors needing support, otherwise there is a serious risk that other essential health efforts and institutions get undermined. It is also crucial that the Global Fund is targeted towards all the elements required to reduce disease burden i.e. securing health systems, ensuring support capacity and enabling health literacy and not only to programmes against the 3 major communicable diseases. At the same time, the disease programmes must receive enough funds to match the scaling up that is required of them. Also, more effective co-ordination of donor funding and assistance is needed, to ensure that essential links in the chain of reduction of disease burden and building of health systems do not occur.

Each country will show its commitment to this programme by setting explicit goals for domestic spending in the health sector. NEPAD is further committed to strengthening mechanisms in its member countries for accessing, allocating, distributing and managing additional sources of funding. NEPAD countries recognise well that funding flows are in no small part going to be linked to their ability to effectively use and account for funds. Ministries of Finance will pay particular attention to this and to capacity building.

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TABLE 1: THE NEPAD STRATEGY FOR HEALTH: GOALS, TARGETS AND ACTIONS

	Focus areas	Goals	Targets	African action	International action
1	**Strengthen disease control programmes**	To strengthen communicable disease programmes to reduce the burden of disease	Comprehensive programmes that meet international and continental plans by 2005	Leadership by heads of state, ensuring visibility for problems, support for strategies	Committed and unwavering support to reduce the magnitude of suffering and death
1.1	AIDS and other STDs	To halt and begin to reverse the spread of HIV/AIDS To reduce HIV prevalence in young people by 25% in the most affected countries by 2005 and globally by 2010	Increased access to HIV prevention interventions Reduce the proportion of infants infected with HIV by 20% by 2005 and by 50% by 2010 Appropriate support and care to those infected and affected, with special assistance to children orphaned by HIV/AIDS Expanded, resourced and decentralised responses, as per targets by 2005	Match commitments made in the Abuja declaration and at the UN Special General Assembly and in the Millennium Declaration To have national strategies in place to address the socio-economic factors that make individuals particularly vulnerable to HIV infection and for multi-sectoral action against HIV by 2005	As per the IPAA programme and Abuja declaration
1.2	TB	To reduce TB deaths and prevalence by 50% by 2010	Targeted detection of infectious cases by 2010 Improved operational effectiveness of the DOTS programme, as per key indicators, by 2005	Match commitments made in the Amsterdam and Abuja declarations	As per the Stop TB programme and Amsterdam declaration Special emphasis on TB programmes in high burden countries
1.3	Malaria	To reduce malaria suffering and death by 50% by 2010	Increase vector control and the population in malaria free zones as per targets by 2010 60% of pregnant women and children at risk have insecticide-treated nets, appropriate chemoprophylaxis and treatment within 24 hours by 2005	Match commitments made in the Abuja declaration	As per the Roll Back Malaria programme and Abuja declaration

	Focus areas	Goals	Targets	African action	International action
1.4	Communicable d of childhood	To reduce mortality rates for infants and children under 5 by $^{2}/_{3}$ by 2015	Effective implementation of the components of the IMCI and EPI plus programmes and the unfolding Global Agenda for Children Complete the eradication of polio	Mobilise communities around the rights of children Commit government to IMCI, EPI plus and polio eradication	As per the IMCI, EPI plus and polio eradication initiatives
1.5	Maternal health	Reduce maternal mortality by 75% by 2015	Skilled attendants at 80% of births by 2010 and strengthen provision of emergency care Reliable emergency referral for 70% of births by 2010	Support broad measures to address women's status Commit to Making Pregnancy Safer and prioritise measures to build capacity of health systems to meet women's needs	As per Making Pregnancy Safer
1.6	Non-communicable diseases	To reduce deaths and disability from non-communicable diseases, (NCDs) including those related to tobacco, mental ill-health, substance abuse, violence and injuries, chronic diseases of lifestyle, work-related injury and disease	Each country to implement effective international and locally specific programmes against their major non-communicable diseases Implement programmes to promote healthy lifestyles (physical activity, diet, reduced violence and substance abuse etc.) Implement innovative care to achieve adherence to therapy and capacity for mental health and disability in primary care facilities	Committed support for programmes to reduce the burden of non-communicable diseases e.g. Global Campaign against Epilepsy, Vision 2020 – the Right to Sight Commit to the actions of the emerging Mental Health Global Action Programme (mhGAP)	Conclude and implement the Framework Convention on Tobacco Control
2.	**Securing the health system**	To have a health system in place that broadly meets needs and effectively supports disease control by 2015	To have an established international secure health systems partnership by 2005, b based on locally developed secure health system plans	Recognise the value of a secure health system to health and to social & economic development by prioritising its development	Recognise the importance of health system development by partnering in this and providing funds towards core costs of services
2.1	Accessible facilities	To provide accessible facilities with the necessary infrastructure and services by 2010	Every household to be within reasonable reach of a functioning health care service by 2015 Each facility to be adequately funded to permit delivery of	Prioritise planning for and infrastructure in clinics	Support less visible service infrastructure development

	Focus areas	Goals	Targets	African action	International action
			essential health interventions by 2015 To have telecommunications and power in all fixed clinics by 2010		
2.2	Capable health workers	To staff services with sufficient numbers of capable health workers by 2010	To improve the work environment and conditions of service by 2005 To reduce internal and external brain drain by 33% by 2005 To achieve equitable distribution by 2010	Revue and address conditions of service and the work environment for all levels of staff	Support efforts to offset the brain drain, including a code of conduct on for international recruitment Direct funds to help retain skills in Africa
2.3	Essential drugs & supplies	To have essential drugs and supplies in health facilities by 2005	To strengthen distribution and control systems by 2005 To provide effective drugs at affordable prices by 2004	Build supply systems and explore the use of alternative delivery systems Tighten controls to prevent leakage and corruption	Support for essential drugs and vaccines to become affordable, including effective new drugs Support development of local manufacturing of essential drugs
2.4	Hospital revitalisation	To revitalize hospitals to function effectively as sources of referral by 2010	A functional first referral level by 2010	Emphasise first level referral hospitals, even if they seem less prestigious	
2.5	Management capacity	To achieve management capability to run services efficiently by 2010	80% of managers to have had job focused management training by 2010	To put in place effective decentralisation and other management strategies	Support management training and development on the continent
2.6	Private sector	To fully harness the potential of the private sector in support of reduced burden of disease	To be implemented as per the policies of individual countries within the NEPAD framework	To develop clear policy frameworks and regulatory environments	Encourage long term commitment, offset opportunism and build appropriate roles
2.7	Policy and legislative frameworks	To have clear health and resource policies and legislative frameworks by 2005	To strengthen Ministries of Health policy and strategic capacity by 2004 To strengthen indigenous capacity in and to support Ministries by 2005	Commitment to strengthen Ministries of Health	Provide technical support in a manner that empowers Africa
2.8	Surveillance, monitoring and	To develop systems to effectively monitor and evaluate	To have a set of health system indicators regularly monitored by	Emphasise the importance by receiving and responding to	Flexibility in the face of emergency needs and

	Focus areas	Goals	Targets	African action	International action
	evaluation	interventions by 2005	2005 To have adequate disease surveillance systems for major health problems by 2005	key national level information	programme reorientation
3.	**Support for sectoral development**	To ensure the necessary support for sustainable development of an effective health system			
3.1	Capacity for public health	To build institutional public health capacity on the continent within a sub-regional framework	To have institutions in place to support major burden of disease & health system efforts by 2010	Personal support for the establishment of centres of expertise in Africa	Fund institutional capacity in Africa, in addition to own expertise
3.2	Research for development	To offset the 10:90 research gap by sufficient investment to make an evident impact by 2010	To build by 2010 appropriate systems, disease programme and operational research capability To scale up research for new drugs and vaccines to achieve GAVI and other targets	To display recognition of the value of research by setting aside 2% of budget for this To support ethical field trials and expedite registration of new drugs and vaccines	Support the proposed Global Health Fund Dedicated funding for research that focuses on the health problems in Africa Incentives and guarantees to stimulate the effort for new drugs & vaccines
3.3	Information technology	To bridge the digital divide in hospitals and clinics by 2010	To have telecommunication in 80% of clinics and e mail in 50% by 2005 To have tele-education capability in 80% of health professional learning institutions by 2007	Prioritise information technology in health facilities	Recognise the potential of enhanced information technology for health
3.4	International and regional agencies	To mobilize and provide the support, capacity and commitment needed to achieve NEPAD health goals	To provide increased technical support in and for Africa by 2005 and through collaborative efforts increase implementation capability of countries To reach capacity in regional health structures - WHO and Development Community level	To ensure that commitments made in international and other declarations are put into effect	To provide technical and resource support to enable international targets to be met
4.	**Enabling personal action to improve health**	Mobilise community energy and ability in support of health			
4.1	**Health literacy**	To achieve health literacy in	To ensure that by 2010 90% of	To personally and visibly	To increase resources for

	Focus areas	Goals	Targets	African action	International action
		Africa by 2010	the continent has knowledge of appropriate basic health prevention and care actions that they can take To increase research on and utilization of learning methods that influence behaviour by 2005	share and advocate the health literacy package	effective methods of conveying health information
4.2	**Community involvement**	To continuously scale up community involvement in all its forms	To have in place a clear programme to support health NGOs and increase their capacity and number by 2005 Implement a plan for social mobilisation	Create an enabling environment for community involvement and NGOs Support attempts at innovation in community health	Support social mobilisation in support of health
5.	**Focus on the poorest and most marginalized**	To reduce the disease burden of the poorest people of Africa	To increase the life expectancy of the poorest quarter of the population by 20% by 2010		
5.1	Enhance development and reduce poverty	To implement the NEPAD programme for the recovery of Africa	To give greater priority to those interventions that have the greatest impact on health To deliver focused development programmes to reach the poorest and most marginalized people	To provide personal leadership for the NEPAD programme	To how respect for Africa's own plan through fulfilling the partnership responsibilities
5.2	Recovery to reach the poor	To implement NEPAD programmes focussed on the poor	To achieve basic food security for 90% of Africans by 2010 To strengthen public services caring for the poor	To provide personal leadership for the NEPAD programme	To support NEPAD measures aimed at the poor, food security and public services
5.3	Reduce displacement and its effects	To implement NEPAD programmes for peace, security and good governance	To provide health services for displaced communities and those affected by war To rapidly scale up health services as soon as peace prevails	To provide personal leadership for African and NEPAD linked peace efforts	To use their influence to support peace, security and development of good governance
5.4	Equity in health systems	To achieve fairness in financing and equity in delivery by 2010	To design a fairness in financing and equity plan by 2003 System whereby the poor do not pay fees by 2005 To achieve equity in public or public funded primary health care	Personally lead the drive for equity	Steer support in favour of equity

	Focus areas	Goals	Targets	African action	International action
		To provide basic health services for the poorest and most marginalized by 2015	by 2010 To progressively scale up services for the poorest and most marginalized.		
6.1	**Sustainable financing**	Sufficient funding to build effective disease interventions and secure health services	To have increased funding secured by 2003, commensurate with that required to reach targets for reduction of disease burden Countries to set concrete targets for own spending on health services by end 2003. Strengthened systems for management of funds by 2003	To significantly scale up own spending by 2004	Match the US$10 billion global fund and respond positively to the report of the principles of the report of the Commission on Macroeconomics and Health

SECTION 4: 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 support for such a strategy and its specific projects. A key advantage is that African leaders themselves are committed to putting their and their governments full weight behind NEPAD health strategies that will advance economic and social development and reducing suffering.

APPENDIX 1: THE MAJOR DISEASES IN AFRICA

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. Life expectancy in the most severely affected countries in sub-Saharan Africa has been reduced by almost a third, from around 60 years to about 43. About 8.8% of adults aged 15-49 are living with the virus and about 4 million new infections are occurring annually, although HIV prevalence varies from <5% to >20% in different countries. It is estimated that there are around 11 million AIDS orphans now and that the number will reach 40 million in 2010.

AIDS is first, and foremost, a disease of poverty, underdevelopment and illiteracy. 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. A broad-based developmental strategy, including addressing the vulnerability of women, provides the base, and accelerated public health interventions, supported by inter-sectoral and community action, offer more immediate impact. Core measures for prevention, control and care are available and most effective when comprehensively applied, as they tend to complement one another – they work as two sides of the same coin. Voluntary counselling and testing allows people to make more informed choices; while improvements in quality of life, treatment and prophylaxis of opportunistic infections and use of anti-retrovirals reduce transmission through reducing viral loads. Treatment of STIs helps reduces infection, as the chances of transmitting the virus are increased manifold in the presence of a genital ulcer or a vaginal infection. The lack of effort for a vaccine and microbicide 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 International Partnership against AIDS in Africa (IPAA) with its focus on national partnerships, is the main example of many international efforts in support of the fight against AIDS. The Declaration of Commitment on HIV/AIDS of the special UN General Assembly (in June 2001) not only recognised the broad set of factors underpinning the HIV/AIDS epidemic, but also set out a comprehensive programme of action, whose targets NEPAD countries are committed to attaining. The Declaration again emphasises the global nature of the challenge posed by HIV/AIDS. Globally the resources, including financial, are available to match the challenge and to launch the full spectrum of responses required. The challenge is to mobilise them, a challenge which has the full support of NEPAD.

This rise in international focus and commitment is promising. However, the UN goal of a 25% reduction in prevalence by 2010 will not be met unless efforts are massively scaled up: education, access to condoms, voluntary and confidential counselling and testing, treatment for sexually transmitted infections and prevention of mother to child transmission. Targeting of those at high risk of acquiring and transmitting HIV must also be stepped up. This includes sex and migrant workers and those with sexually transmitted infections.

BOX 1: HIV/AIDS (CONTINUED)

The goals of a 25% reduction in HIV/AIDS prevalence in youth in most affected countries by 2005 (UN), and in all young people by 2010 (Okinawa) seem more modest and attainable - many of those now infected will no longer be young or will have died, and the new cohort of youth will have received more education and seen more of the effect of AIDS. Yet, it is not quite like that – youth programmes are neither sufficient nor effective enough. We are still not understanding, or influencing youth behaviour appropriately. 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.

Care goals will not be met unless drugs become available and affordable and health systems are strengthened. Extending family and community-based care is essential and should be integral to community mobilisation. A supportive environment and capacity to care for orphans must be built up. Improvements in quality of life, treatment and prophylaxis 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.

The lack of resources to massively increase health system efforts to address the epidemic, and for NGO and CBO programmes, undoubtedly remains very 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. There should be national targets, country specific programmes and periodic reviews. All sectors of society must be involved in a sustained programme of social mobilisation, critically people living with HIV/AIDS and civil society. There should be a specific focus on human rights and the elimination of discrimination and strategies to combat stigma and social exclusion. Special attention should be paid to gender equality and the empowerment of women.

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, they will also 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 in 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 $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 chloroquine resistance, AIDS and health system weaknesses. Pregnant women are also particularly vulnerable. Their newborns are also 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 as to 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

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. Chloroquine resistance is reaching 80% in places and resistance to sulphadoxine-pyramethamine, also cheap, develops rapidly. Artemisinin is likely to remain expensive because of high production costs, as will the cost of combination therapy. 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 childrens' deaths.

Improvements in quality and quantity of water, sanitary measures and breastfeeding 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 of 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: CHILDBIRTH

272 000 women 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 of the order of a 1 in 16 chance of dying in childbirth compared to around 1 in 4000 in Europe. In countries facing complex emergencies, maternal mortality is especially high.

Underpinning these deaths is lack of access to health care, exacerbated by poverty, illiteracy and the inequality of women. These causes were recognised at the Cairo Conference on Population and Development and the Beijing Conference on Women. The main cause of maternal death is post-partum haemorrhage, commonly associated with anaemia following on malnutrition or malaria. Puerperal sepsis, aggravated by poor hygiene during delivery or pre-existing untreated sexually transmitted infections, is the second most important cause of death. Other important causes are eclampsia following on untreated hypertension in pregnancy and obstructed labour. Pregnant adolescents face a higher risk of problems. Unsafe abortions with consequent sepsis, haemorrhage and uterine trauma are also a major cause of mortality. In neonates, the main causes of death are neonatal infections, birth asphyxia and trauma, and pre-term birth and low birth weight.

In spite of the Safe Motherhood Initiative, launched collectively in 1987 by the major multilaterals, maternal and neonatal deaths have remained high. The International Development target of reducing maternal mortality by 75% by 2015 will not be reached, unless there is a massive improvement in health systems. It is evident that the prevention and treatment of postpartum haemorrhage, puerperal sepsis, eclampsia and obstructed labour require a skilled birth attendant with a functioning referral system. Health systems, including those in the periphery must be able to monitor for and address risk during pregnancy and labour. This must include use of intravenous fluids and the ability to call for and get emergency transport during childbirth - both of which are not secure in the health systems of Africa. Similarly, women cannot be sure of the availability of antibiotics for sepsis. The “Making Pregnancy Safer” strategy provides the elements of an appropriate overall programme. Initially it was thought that training of traditional birth attendants would reduce maternal mortality, but it has now been shown that to address the causes of death one requires more skilled care. The importance of the health system is recognised in the goal of having a skilled attendant present at 80% of births by 2005.

BOX 6: 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 be protected by end 2002, but 25 million hectares of fertile riverine land will also become available for food production. Other filarial infections also cause much illness.

Programmes against river blindness are achieving notable success, and no effort should be spared in achieving its eradication. Sleeping sickness and other filarial infections do not receive similar levels of attention.

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. An epidemiological transition is already taking place associated with 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, traditional career relationships 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 and costly, as are work related injuries and disease.

Although not all of them are identifiable by easy to use names, there are a number of international programmes targeting prevention and/or care of major non-communicable diseases. The programmes are implemented to a lesser or greater degree in Africa, although some need major scaling up when disease burden is matched against disease effort.

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.

APPENDIX 2: IMMEDIATE PROJECTS

The NEPAD health programme outlined above offers a medium term approach to the development of 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, there are concrete projects that will make a difference now. A set of immediate projects is outlined in Appendix 2, and listed with objectives and estimated costs as a Table in Appendix 2. These projects should not be seen in isolation, nor as a replacement for the massive scaling-up and medium term strategy that are required. Rather, they have been selected as they are first steps on the longer road or because, if not dealt with early on, they will later become rate limiting steps to other elements of the strategy.

A strong focus on the major communicable diseases

The immediate projects for the major burden of disease are not specified as these are incorporated into the major international programmes and African initiatives. The intention here is not to restate the case for bed nets, condoms, micronutrients for children and so on, but rather to indicate that the NEPAD health program broadly supports the identified cost-effective interventions and best practices. It supports the strengthening of existing initiatives and the development of innovative programmes. However, the eradication of polio requires particular mention as an immediate project,

- **Eradication of polio**

The unique features pertaining to poliomyelitis including a simply administered effective vaccine, a stable virus and serious consequences make it a suitable target for worldwide eradication. The Global Polio Eradication Initiative and the Kick Polio out of Africa campaigns aim to do just this. Progress in the campaign means that poliovirus circulation is largely confined to West and Central Africa and to the Horn of Africa. The needs now are for supplementary immunisation, effective surveillances, political support and focussed funding, in addition to the strengthening of routine immunisation and of the health services to support this.
US$ 276.19 for 02/03

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 NEPAD 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 NEPAD country should undertake a rapid country health review and 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 is needed 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, leaving the core weak is a situation that will continue if core system costs are not supported and meaningful salaries offered. Donor support does not mean that African countries will then withdraw funding from the health sector or abandon their responsibilities for core funding. The NEPAD health programme is committed to increase funding for the health sector, from own sources as well. Goals for finance will be set after each country has undertaken its rapid review and resource assessment.

- **Retaining Africa's health workers**

African countries invest in the education of their countries health workers, starting with their primary school education. Then, they have to watch helplessly as doctors and nurses emigrate to the developed world and its opportunities of higher incomes and better lifestyles. Support is needed for efforts to offset the brain drain. This should include agreements to curtail the permanent recruitment of Africa's health workers - structured interaction and skills development should of course continue. Tied to this must be improvements in Africa in what in some situations are untenable salaries and conditions of service and a review of production of health professionals in developed countries. This effort must be paralleled by efforts to improve the conditions and capabilities of auxiliary and other health workers.

- **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 whose drug cost is beyond the means of Africa. For example, chloroquine is still widely used in areas where it is no longer suitable e.g. where resistance is beyond 50%, because of the cost of the alternatives. 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 envisaged that an updated list will be 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. Africa is committed to put in place measures to control leakage from the system and to secure distribution, including 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. A review and updating existing essential drug lists would ensure that the most appropriate drugs are available.

- **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? An answer could 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.

- **Surveillance and laboratory capacity**

Lack of disease and health system surveillance capacity continues to undermine disease control and health service development efforts. Country plans will specifically address improvements in this regard.

Communicable disease surveillance is in no small measure dependent on good laboratory capacity, starting with simple tests and backed up by national laboratories, and reference laboratories capable of evaluating quality, doing complex tests and testing for drug resistance. The building blocks are in place in Africa, but they need strengthening and cementing together into a regional network. Setting this up will require improvements in infrastructure e.g. electricity supply, equipment and communication. It was also require training mortality.

- **Health policy programme**

Enhancing skills in health policy formulation is commonly identified as a key learning need amongst health ministry staff. Given that the first step in the NEPAD health programme is country reviews and plans, which must be tied to policy development, it is important to strengthen health policy capability in Africa. Training will help to ensure the

most appropriate policies for the country's health system and for the various programmes. This is critical to cost-effective and ethical use of funds. Training will also facilitate use of best practices and international experience when formulating policies while well-considered policies will take into account the absorptive capacity of countries, to ensure that funds can be effectively applied.

Support for sectoral development

- **Sufficient funding to make a difference**

Africa's slice of 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 would make a difference. These 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.

Linked to the country reviews and secure health system plans, each country should assess their trends towards reaching the goals for reduction of disease, and the feasibility of getting there. Then, they should redefine and refine the resource requirements needed to achieve targets.

- **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 to staff, 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 many new drugs and vaccines for the health problems of Africa, as a lack of research funding and potential profit stifle effort. There

have been some very positive developments recently, especially from private benefactors, but these need to be built on. Donor governments could help to guarantee a reasonable market for new drugs, for say sleeping sickness or leishmaniasis, as well as malaria and tuberculosis. This and other forms of public funding are critical, but the pharmaceutical industry must play its part, making its own commitment clear.

- **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 could get a boost from an improved communications infrastructure. 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.

- **Capacity in regional structures**

Neither communicable diseases nor patients stop at country borders. This is one reason why regional collaboration is so critical for disease control. Other reasons include complementary policy formulation, shared institutions and bulk buying. But, to reap the fruits of regional collaboration, one needs to have sufficient health desk capacity in organisations like ECOWAS and SADC. This is not in place now.

The World Health Organisation and in particular its African Regional Office plays a critical role on the continent. However, WHO's country offices are too small to fulfil the mandates and programme support requirements expected of them. They need urgent strengthening and / or a review of their role.

- **Public broadcasters for health literacy**

Developing grassroots programmes for health empowerment and skilling health workers in effective learning pedagogies will take time. However, many public broadcasters have the capacity to rapidly develop radio (or television) programmes, such as dramas that offer entertainment, while impacting on health literacy and encouraging critical thinking and analysis. Programme content can come from the core messages of the disease control programmes, located in a developmental context. Learning materials to support the messages can be developed and learning can be deepened by discussion, in a variety of settings, of the issues that the show has raised. .

- **Support for NGOs**

There are many examples of excellent NGOs in Africa. However, many suffer from chronic financial shortages that continually undermine their efforts. An immediate project

would therefore be to provide health ministries with funding to strengthen credible NGOs where such a boost would make a real difference to their effectiveness. Alternatively, they could choose to use the funds to facilitate the emergence of new local NGOs and provide seed funding to get efforts off the ground in more remote areas or amongst marginalized groups. If this latter option is chosen, then support structures must be put in place, amongst other things to ensure proper management of finances. Such support could come from twinning the new effort with established organisations.

APPENDIX 2 TABLE: THE NEPAD STRATEGY FOR HEALTH: IMMEDIATE PROJECTS

Project areas	Objectives	Unit cost	Immediate cost US$ millions
A strong focus on the major communicable diseases	As per priorities determined for African initiatives and the major international programmes Country and region specific plans	As per the immediate projects of the major international and continental programmes of action	As per the individual programmes
Eradication of polio	As per the Global Polio Eradication Initiative and the Kick Polio out of Africa campaigns	US$ 276million required for the 2002/03 programme	276
Securing health systems			
Initiate the process for securing health systems	Rapid country health reviews by mid 2003 "Secure health system" country plans by mid 2004 Identify and share best practices on continent	US$ 0.5 million per country US$0.5 million	7.5 0.5
Donor funding towards core service costs	Agreement for allocations towards core costs by end 2001		-
Brain drain	Agreement on implementing a strategy to offset the brain drain by 2003, including ethical recruitment	US$ 0.5 million, including consensus meeting costs	0.5
Affordable drug prices	Affordable drugs for opportunistic infections by 2003 Commitment to affordable prices of other essential drugs by end 2003	US$ 0.5 million to support negotiations	0.5
Competent drug distribution	"Pilot competent drug distribution districts" by end 2002 Review essential drug list and identify those that are unaffordable	20 pilots @ US$ 0.2 million / pilot, including collaborative overheads US$ 0.5 million, including expert meeting costs	4.0 0.5
Emergency transport fund	Pilot clinics for emergency transport fund operational by mid 2003	20 pilots @ US$ 0.3 million / pilot	6.0
Laboratory capacity	Financial support for a training centre(s) for surveillance, data management and laboratory techniques by 2003 Initiate a programme by 2003 to extend the capacity of the 3 regional and 12 national laboratories for polio identification to cover broader disease surveillance Laboratory capacity for testing for drug resistance in the major communicable diseases Establish courier capability for conveyance of biological	US$ 2 million to create capacity US$ 2 million / regional and US$1 million per national lab. 50% for recurrent costs US$ 3 million / lab x 5 labs US$ 0.25 million for organisation	2.0 18.0 15.0 1.0

Project areas	Objectives	Unit cost	Immediate cost US$ millions
	materials for laboratory investigations by end 2002	and US$ 0.75m for courier costs	
Health policy programme	A programme for advanced learning in health policy formulation and development delivered by end 2002	US$ 0.5 million for curriculum development and 5 courses of 30 participants including travel costs	0.5
Support for sectoral development			
Sufficient funding to make a difference	Global fund of US$10 billion per annum secured by 2004	Global fund targets	$8b/annum committed to Africa
Initial centres of excellence and networks	Initiate or strengthen an initial group of centres of excellence by end 2002 Establish networks in priority areas by end 2002	Average US$ 1.0 million / identified centre / annum x 5 yrs x 10 centres US$ 0.25 million to launch. US 0.25 million / network / annum x 5 x 10	10.0 5.0
New drug and vaccine development	Programme commitments to scale for African burden new drugs and vaccines by mid 2002	As per GAVI and other initiatives US$ 0.5 million to strengthen Africa's capability to engage	As per GAVI and others 0.5
Communications infrastructure	Effective telecommunication for 60% of clinics by end 2002 Support feasibility planning for a continent-wide communications network using dedicated satellite technology.	Exact costs not determined. May change with new technologies US$ 2 million for feasibility	Estimate 40.0 2.0
Capacity in African regional structures	Strengthen capacity in regional structures (e.g. ECOWAS) Strengthen capacity of WHO NEPAD country offices	US$ 2 million / structure x 5 US$ 1 million / NEPAD partner	10.0 15.0
Public broadcasters for health literacy	Strategy for public broadcasters to strengthen their contribution to health literacy by end 2002 3 year production schedule by each country by mid 2003 First programmes broadcast by end 2003	US$ 2 million for strategy development and broadcaster strategic briefing US$ 1 million per NEPAD partner	2.0 15.0