POVERTY, INEQUITY AND PUBLIC HEALTH IN THE AFRICAN REGION

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Summary

Poverty is widespread in the African Region. The people living in this Region also face a heavy and wide-ranging burden of disease, which takes its toll on social and economic development and shortens life expectancy. The distribution of poverty or poor health is also not random. The Region exhibits determinants of poverty and health that may not be shared with other regions. Poverty, inequity and poor public health in the African Region can be tackled by sustained economic growth that is also geared to addressing inequities. The contributions of the health sector to poverty reduction include interventions both outside and within the health sector, mainly a strong advocacy platform targeting stakeholders and partners. It should also encompass doable orientations on the way other sectors incorporate health considerations into policies and practices that improve and protect public health. A concerted effort by countries of the African Region and their partners is gathering momentum for change and to help the Region to accelerate progress towards national and international health goals including those related with the Millennium Declaration. In order to succeed countries of the Region need to allocate a higher percentage of their national expenditure to health and their partners need to increase their assistance to these countries. However, increased aid can only lead to progress if recipient countries commit themselves to policies that aim at economic growth, more efficient management of health resources, addressing the social determinants of health, reducing poverty and bridging inequality gaps.

Introduction

The people living in the African Region[1] face a heavy and wide-ranging burden of disease, which takes its toll on social and economic development and shortens life expectancy. The HIV/AIDS epidemic, malaria as well as the resurgence of tuberculosis continues to

reduce life expectancy in some countries (WHO, 2003a). Progress in human development made by some African countries in the 1970s and 1980s has been sharply reversed by HIV/AIDS. In addition, countries in the Region continue to suffer from man-made emergencies, large-scale migration, famine, and economic decline. Other infectious diseases and –increasingly- non communicable conditions and complications of pregnancy and childbirth, are also a severe burden.

Poverty is widespread in the African Region. Among the basic indicators, the disparity in maternal mortality between the Region and other regions in the world gives a stark picture of the level of poverty in the African Region (Figure 1). The distribution of poverty or poor health is also not random (Nolen, Braveman, Dachs, Delgado, Gakidou, Moser, Rolfe, Vega & Zarowsky, 2005). There are unequal opportunities to be healthy associated with membership in less privileged social groups, such as women and rural residents. To decrease the magnitude of poverty, and to eliminate health disparities that are systematically associated with underlying social disadvantage, it is important to identify the determinants as well as manifestations of health disparities.

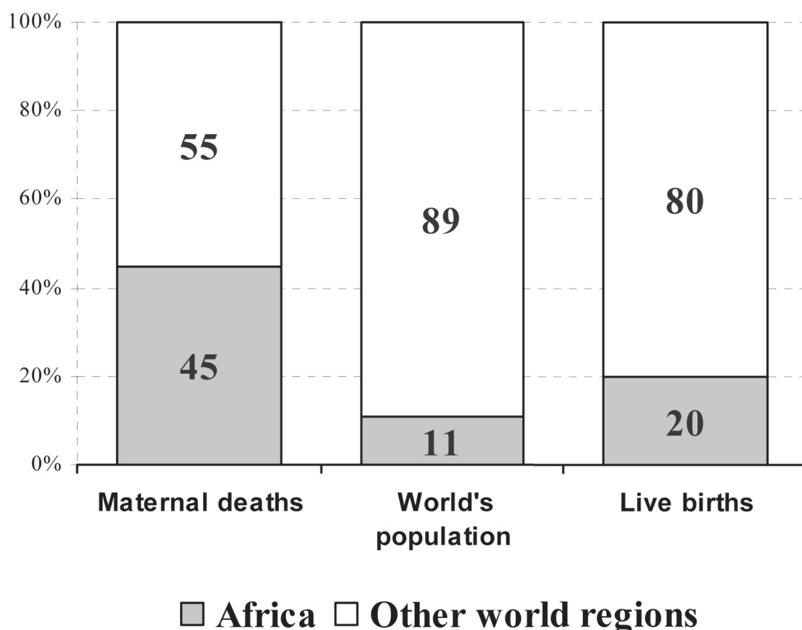


Figure 1. Source: World Health Organization

Discussions of poverty and public health should include the consideration of equity because it often influences the relationship

between poverty and ill-health. Moreover, its consideration is necessary for effective intervention. For example, investments to improve the geographical and financial accessibility of preventive and curative health services may not improve the inequity in their use, without active support for the women, children, rural dwellers, and others most likely not to use these services (Braveman & Gruskin, 2003). Although the literature on poverty, inequities and health is fairly extensive, that dealing with the African Region is not. The African Region exhibits features that may not be shared with other regions, and that are important determinants of poverty and public health. Examination of these is an important first step to understanding the way forward.

This paper describes the poverty, inequity and public health situation in the African Region. It also presents the distribution of the major determinants of poverty and public health. Potential options for interventions are also described, as well as outlining what needs to be done by countries, the World Health Organization (WHO) and other partners to address the problem.

Poverty and Public Health in the African Region

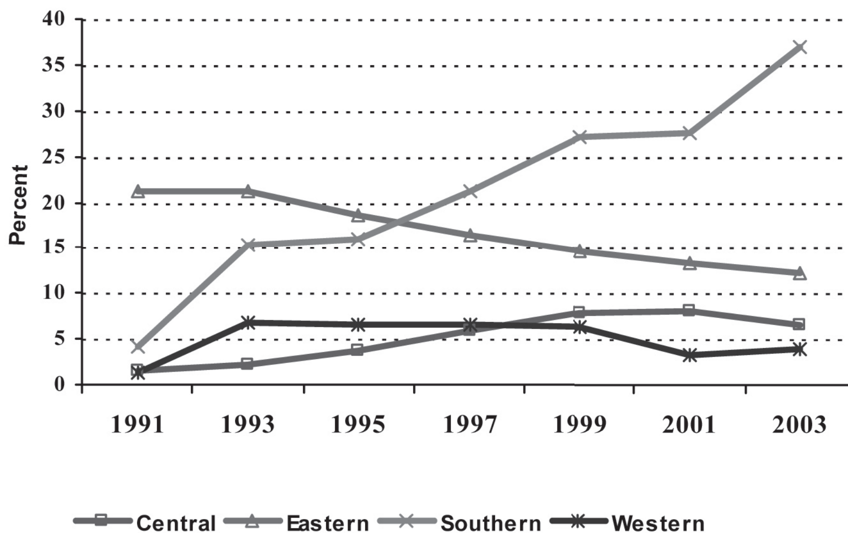
The concept of poverty is multidimensional and includes material deprivation and the multiple social disadvantages associated with it. Thus, it also connotes the inability of people to meet economic, social (including health) and other standards of well-being. However, for ease of monitoring and statistical analysis of the global poverty situation a narrower definition of poverty (based on income levels) is widely used (OECD, 2001: 41). A large proportion of the populations of the African Region live in poverty using this definition of poverty. Some 76% of the populations of the African Region live on less than US$2 a day, and 46.5% on less than US$1 a day. While poverty has declined in other parts of the world, such as East and South Asia, over the past 20 years, the trend in the African Region has been strongly in the opposite direction. Between 1981 and 2001 the GDP of countries of the Region decreased by 13% resulting in a doubling in the number of people in the Region living on less than US$1 a day from 164 million to 314 million (World Bank, 2005:4).

There is also a very strong relationship between the poverty situation described above and poor health in the Region. The most important public health problems are HIV/AIDS, TB, malaria, epidemic prone diseases, maternal and child health problems.

Non-communicable diseases, mental health problems and injuries are also emerging as important disease burdens.

Africa is the region of the world that is most affected by the HIV/AIDS pandemic. The Region has about 10% of the world's population and is home to more than 60% of all people living with HIV infection: about 25.4 million people. Without ready access to antiretroviral drugs, all of these people are likely to develop full-blown AIDS within the next ten years and will die if they do not get treatment. Some 17 million African people have already died from AIDS, and about 12 million children have lost at least one parent to AIDS. In 2004 alone, an estimated 3.1 million people became infected with HIV, while 2.3 million died of AIDS (UNAIDS/WHO, 2004). Despite efforts to prevent the infection and spread of disease, success on a large scale has been demonstrated in only a few countries where the rates of new HIV infections have stabilized or have been declining. Even in these places, the incidence of HIV infection remains unacceptably high. In the majority of African countries, new HIV infections are on the increase, indicating that preventive measures have not been effective enough (Figure 2).

Figure 2. Trend of HIV Prevalence among Pregnant Women in the WHO African Region, by sub-region, 1991 – 2003



Source: World Health Organization

In the African Region, approximately 2.4 million new TB cases and 500,000 TB related deaths occur each year. Nine of the 22 countries in the world responsible for 80% of all TB cases are in this Region, and 11 of 15 countries in the world with the highest incidence are also in the African Region. On average, 35% of TB patients reported in countries in the African Region are co-infected with HIV, and in most countries in Southern Africa, over two-thirds of children and adults with TB are co-infected with HIV. TB is also occurring more and more in younger economically productive members of society, especially girls and women closely resembling the trend of HIV prevalence (WHO, 2005a:10).

The African Region accounts for over 90% of an estimated 300-500 million clinical cases of malaria that occur across the globe every year. At the same time, children in the Region account for 90% of the nearly one million malaria related deaths that occur in children worldwide. Furthermore, malaria contributes significantly to anaemia in pregnant women and low birth weight in newborns. Estimates show that countries in Africa with endemic malaria have 1.3 percentage points less economic growth per annum compared to similar nonendemic countries, and that the annual cost of lost productivity and providing treatment for malaria in the Region is US$12 billion (WHO/UNICEF, 2003:17).

A woman in the African Region faces a 1 in 16 risk of dying due to pregnancy and childbirth during her lifetime compared with 1 in 2,800 in developed countries. For each maternal death, a further 30 women are affected by complications such as chronic anaemia, infertility and obstetric fistula (WHO, 2004a). Close to 4.4 million children die each year, 12,000 each day, from easily preventable or treatable illnesses and conditions. The chief causes are neonatal conditions, acute respiratory infections, malaria, diarrheal diseases, measles and HIV/AIDS. Close to 35% of deaths are due to the effect of under nutrition on diarrhoea, pneumonia, malaria and measles (Black, Morris & Bryce, 2003).

Major epidemics continue to occur in the Region. Thus, epidemics of meningitis, cholera, dysentery, and hemorrhagic fevers, to name a few, exact a very high toll of mortality and disability every year. In 2004 for example, the number of cases of meningitis in six countries affected by the epidemic totalled 31,520 with 4,294 deaths. During the same year, 27 countries reported 81,306 cases and 2,029 deaths due to cholera (WHO, 2004b). Currently, the Region is also threatened by a potential deadly pandemic of avian influenza. Other poverty-related diseases such as schistosomiasis, infection by soil-based helminths, sleeping sickness, visceral

leishmaniasis, lymphatic filariasis and Buruli ulcer are also taking their toll but are neglected by governments and partners. Progress has stalled on drug research and development to treat these diseases, but they still have a considerable negative impact on human development in the Region and have become worse while efforts have focused on other diseases (Roungou, Mubila, Dabira, Kinvi & Kabore, 2005; Meda, Rangou & Dabiré, 2004).

Health systems in the Region are straining under a double burden: a high mortality and morbidity due to communicable diseases coupled with increasing rates of noncommunicable diseases including mental illness and injury (WHO, 2000a). Road traffic deaths in the African Region are 50% higher than the world average. The death toll is only the tip of the iceberg with millions injured or disabled each year in road traffic crashes (Peden, Scurfield, Sleet, Mohan, Hyder & Jarawan, 2004). Those most at risk of injury and death are pedestrians and users of motorized two-wheelers, who tend to be from lower income groups. Armed conflicts are a frequent occurrence in African countries and may represent a major cause of ill-health, and even in countries that have not experienced armed conflicts there is a heavy toll from firearm injuries and other types of interpersonal violence, which can lead to physical disability (WHO, 2002a).

Inequities and Public Health

There are discrepancies in magnitude of poverty between and within countries across Africa. Findings from studies done in developing countries (including several from the African Region) show that people in the highest socioeconomic class of the population are more than twice (or more) likely to have access to health services than people in the lowest 40% (Davidson, Abbas & Victora, 2004).

According to the World Bank classification of countries in income groups, in terms of gross national income (GNI) per capita 37 of the 46 countries in the African Region were low income countries with US$735 or less annual per capita income in 2003. Four countries were in the lower middle income bracket of US$736 – 2,935. Four others were in the upper middle-income bracket of the US$2,936 – 9,075. None of the countries in the African Region were in the high income bracket of US$9,076 or more (UNDP, 2003:250). Using these categories, the distribution of health indicators (healthy life expectancy, life expectancy, probability of death, and maternal mortality ratio) seem to improve

as one moves from low income countries to upper middle income countries (Table 1). For example, the average life expectancy at birth in low income countries is 47.8 years compared with 60.8 years in upper middle income countries, a difference of 13 years. Thus, the populations living in relatively economically affluent countries can be expected to lead longer and healthier lives than their counterparts living in relatively low income countries. The inequalities in health outcome across countries reflect the underlying inequalities in the distribution of various health determinants. Access to improved water sources, sanitation, adult literacy rate, and the combined education enrolment ratio are lower among low income countries than among the lower and upper middle income countries.

TABLE 1: The Distribution of Health Outcomes (life expectancy) and Selective Social Determinants by Level of Income of Countries in the African Region, 2003

Source: UNDP 2003

Variable Mean values	Low income countries (n=37)	Low middle income countries (n=5)	Upper middle income countries (n=4)
Male healthy life expectancy (at birth)	40.3	47.6	51.0
Female healthy life expectancy (at birth)	42.0	49.8	54.4
Life expectancy (at birth)	47.8	55.7	60.8
Population with sustainable access to improved water source (%)	55.5	77.2	85.8
Population with sustainable access to improved sanitation (%)	50.9	69.2	74
Adult literacy rate (%)	56.3	78.2	81.2
Combined education enrolment ratio	43.5	76	77.3
Maternal mortality ratio	960.6	238	181.3

Determinants of Poverty, Inequity and Public Health

The determinants of poverty, inequity, and public health in the African Region can be categorized into three broad categories: factors that are due to immutable factors like climate, geography and history; potentially modifiable global factors such as international trade, peace and stability; and national or country-level factors, including the health system and the HIV/AIDS pandemic.

Climate, Geography, and History

The topography of most of Africa, which is a series of plateau surfaces, the escarpment of which form barriers of falls and rapids in the lower courses of rivers, is not suitable for use of these rivers as transportation routes into the interior. The Region's rugged terrain is also not conducive to overland transportation of goods to the exterior. Moreover, the Sahara desert is an important barrier of high-volume overland trade between sub-Saharan Africa and the coastal areas and trading partners in the north, including Europe. This geographic barrier to transportation of goods, and thus trade has had important negative impact on the Regions economic development. Most people live in areas with few rivers to provide irrigation and a rugged terrain that does not permit cheap irrigation. Erratic rainfall and a secular decline in rainfall across the continent during the past 30 years did not permit extensive agricultural development. The warm and wet tropical climate has also been a very conducive place for breeding of insects and other vectors of diseases that plague the continent, particularly malaria. These diseases have negatively impacted socio-economic development in the Region (UN Millennium Project, 2005a:146).

The period of European colonization of Africa that began in the 15th century continued until the conclusion of World War II after causing immense human misery as well as economic and social devastation. The post-independence era has also been marked by a rise in cross-border and civil wars in countries.

Global Influences

Environmental degradation has also contributed to poverty and poor health in the Region. The actions of both African and industrialized countries have contributed to the worsening of the situation. The major deforestation of the Region, for example, was partly caused by local demand for land, construction materials and fuel with increasing population growth. But it was also caused by

the international demand for timber and other forest products (UN Millennium Project, 2005b:3).

In other parts of the world, globalisation and good economic governance may have resulted in higher living standards. Globalisation however did not have similar positive effect on the economy nor decreased poverty or improved public health of the African Region (UNDP, 1999). Greater liberalisation of trading and finance systems and the creation of global markets where Africa is increasingly failing to compete have exacerbated the poverty situation, including the inability to pay for health services. It has also led to outflow of skilled (including health) workers from Africa to the developed countries (Joint Learning Initiative, 2004:18). Foreign aid has generally been used to encourage the cultivation of cash crops such as cotton, cocoa and coffee in place of subsistence farming.

The African Region continues to struggle under the severest onslaught of man-made disasters and disasters associated with natural hazard. Parts of the Region continue to face food shortage due to droughts, increasing HIV/AIDS prevalence and armed conflicts, leading to complex humanitarian emergencies (Commission for Africa, 2005:34). The African Region is vastly rich in natural resources but struggle for control over diamonds, timber, gold, minerals and oil resources have been the cause of instability and wars with direct negative effect on social welfare and health.

National or Country-level Factors

Rapid population growth, and migration to urban areas which tends to be fastest in countries of the African Region, has exacerbated the problems associated with the global determinants outlined above. It seriously hinders the availability of farmland and increases environmental degradation (deforestation, soil degradation, fisheries depletion, reduced freshwater). Without safe water for drinking and for use in food preparation, populations are vulnerable to an array of waterborne diseases including cholera, typhoid and other diarrheal infections, as well as to parasites such as guinea worm and schistosomes. In 2002 the percentage of people in the African Region with access to safe water supply was 84% for urban and 45% for rural areas. Collecting water is also a time-consuming, physically stressful task that falls disproportionately on women and children. Only 58% of the urban and 28% of the rural population has access to adequate sanitation facilities (WHO, 2005b:42). Hundreds of thousands of people, particularly children,

die every year from diseases caused by micro organisms, chemicals in the water supply, or diseases caused by poor sanitation.

Air pollution is one of the most serious environmental problems in the African Region and a continuing threat to health, especially in urban areas. As cities grow, more vehicles, industries, homes and power stations are contributing to the pollution load. Urban air pollution contributes to illnesses, such as lung cancer, heart disease, asthma, and bronchitis. Indoor air pollution has also impacted on people's health. Most people living in rural areas, informal settlements and city slums in the Region continue to rely on traditional fuels such as crop residues and firewood for cooking and heating, and these low-quality fuels, combined with inefficient stoves and poor ventilation creates high levels of pollutants inside the home (WHO, 2002b). Chemical pollution is another problem. Exposure to certain chemicals can cause effects ranging from acute intoxication to birth defects and cancer. Hazardous practices in agriculture or public health use of certain chemicals have profound repercussions on health. The use of DDT is a particular problem. Banned in much of the world because of its fat solubility, persistence and ability to travel, this pesticide is used in some parts of Africa in the absence of cheaper alternatives and because of its effective role in vector control (Govere, Lyimo, Bagayoko, Faye, Ameneshewa, Guillet, Murugasampillay & Manga, 2004).

From being an overwhelmingly rural part of the world just 20 years ago, Africa is urbanizing rapidly. Currently 37% of its people live in cities, but by 2030 this proportion is expected to reach 53%. Rapidly expanding cities are often characterized by slum-dwelling, inadequate water and sanitation services and wastewater problems. Microbes flourish and infectious diseases become epidemic. The overcrowding that always accompanies rapid urbanization contributes to a host of social and behavioural problems including disintegration of families, homelessness, crime, violence, drug use and sexual abuse (WHO, 2003b:4).

Health related behaviours are also important determinants. Risky sexual behaviour contributes to the current high levels of sexually transmitted diseases and HIV/AIDS. Chronic diseases are linked to a few common and modifiable risk factors: high blood pressure, high cholesterol levels, high blood sugar levels, tobacco use, inadequate intake of fruits and vegetables, and being overweight, obese or physically inactive. These risk factors are increasing due to urbanization and globalisation (WHO, 2002c:7). As people move out of villages into towns and cities, a traditional

diet rich in fruits and vegetables is gradually being replaced by a diet rich in calories from animal fats and low in complex carbohydrates. This dietary change is combined with a decrease in physical activity as people move away from traditional farming into sedentary jobs. Global marketing of tobacco, alcohol, and fatty, sugary and salty foods has reached into all but the most remote parts of the Region.

Health Systems

The health system itself can be viewed as a determinant of poverty, inequity and public health. Persons who are in poor health less frequently move up and more frequently move down the social ladder than healthy persons. The role of the health system becomes particularly relevant through the issue of access to preventive and curative health services (Braveman et al., 2003). The health system can directly address inequities not only by improving equitable access to care, but also in the promotion of intersectoral action to improve health status. The health system is also capable of ensuring that health problems do not lead to a further deterioration of people's social status and of facilitating sick people's social reintegration.

Equitable and sustainable access to properly functioning health systems, however, has not been attained across the Region. There have always been geographical disparities and these have worsened over the last decade. Many people, particularly those in rural areas, often have to travel long distance to receive basic health care. Once they reach a hospital or a clinic, they may only receive health care if they pay for it. Inevitably, many people may forego treatment because they cannot afford it, while those who pay may find the cost ruinous and the quality of service limited. Rapid turnover of people in key positions, lack of continuity in policy, lack of resources, poor management of available resources and poor implementation are seen in many countries as major constraints for improving the health systems. Most countries in the Region inherited a colonial, European model of health care that was primarily intended for colonial administrators and expatriates, with separate or second-class provision made –if at all– for Africans (WHO, 2000b:14).

Most countries in the Region do not have a health information system capable of collecting, storing, analyzing and reporting data to inform policy and decision-making. Although the critical baseline for judging a population’s health is derived from the

registration of births and deaths, these events go unrecorded for most of the people in Africa. For example, less than 10% of deaths are registered in the Region. Even when deaths are registered, often the causes of death are not given or attributed reliably (Mathers, Ma Fat, Inoue, Rao & López, 2005).

In some parts of the Region, over half of the population do not have access to essential medicines and are thus unable to benefit from proven treatment of common diseases. In the absence of affordable and good quality medicines, some people in the Region unwittingly resort to poor quality or cheap counterfeit medicines. Only 10% of countries in the Region have comprehensive medicine regulatory capacity (WHO, 2005c:9).

Although the absolute numbers of health professionals has increased, the health professional-to-population ratio overall has fallen. There are many factors that have contributed to the growing shortage of health workers across the Region. These include high disease burden that has necessitated the need for more health workers to take care of the sick, large losses of health care workers due to migration and death (particularly due to AIDS), inadequate or lack of human resource policies and plans that have not matched with increasing demands of health service delivery, and a weak or stagnant health system infrastructure that has not matched with population growth (Awases, Gbary, Nyoni & Chatora, 2004).

In African countries, overall public and private sector expenditure on health is about 5% of gross domestic product (GDP). Out of the total expenditure on health, government contributes 51% (of which 20% comes from external sources), and private enterprises and household contribute about 49%. Almost 80% of the latter consists of out-of-pocket expenditures by household. Heads of states of African countries made a commitment in Abuja to allocate at least 15% of their annual budgets to the health sector. By end of 2002, only two countries had spent 15% and above of their budgets on health (Chatora, 2005).

The HIV/AIDS Pandemic

Not only is the epidemic contributing to high disease burden, it is also a major constraining factor for development. It destroys human capital; it wrecks the mechanisms that generate human capital formation; it makes investment less attractive; and it drains the human and institutional capacities that drive sustainable

development. For example, with the massive turnover resulting from AIDS, firms face heavy costs of re-assigning and re-training workers (WHO, 2001:47). Skilled workers have died or fled in large numbers, leaving countries without the technical or entrepreneurial leadership. Large numbers of orphans left by AIDS have strained the social support networks. The direct time and expense of the frequent funerals may have a significant adverse effect on the local economy. The disease is overwhelming health systems and their overstretched and shrinking workforces (WHO, 2004c:8).

The Way Forward

Multisectoral Interventions

The Millennium Development Goals (MDGs) recognize the interdependence between poverty, inequities and public health. The MDG framework shows that without significant gains in poverty reduction, food security, education, women's empowerment and improved living conditions in slums, or sustainable environment many countries will not attain health targets. And without progress in health, other MDG objectives will also remain beyond reach. At current rates not all countries of the Region are growing fast enough to achieve the UN MDGs, particularly Goal 1: cutting poverty in half by 2015 (UNDP 2005:18).

Poverty, inequity, and poor public health in the African Region can be tackled by sustained economic growth, bolstered by more investments in infrastructure (electric power, roads, ports, and communications), environmental sustainability, and improving urban management. Governments in the African Region have the greatest role to play to make sure that economic growth does not lead to widening inequities and that poor people share in overall growth, with a focus on expanding their access to secure land tenure, making it easier for them to start small businesses, and broadening their access to microfinance. Increased public investment in education and public health is also important. It is the state authorities that should take the lead in emphasizing human rights and social equity to promote the well being of all people and to ensure that poor and marginalized people fully participate in decisions that affect their lives (UNDP, 2004:15). But striving for macroeconomic stability should not lead to marginalizing and cutting expenditures on the social sector. The challenge is to secure a level of spending consistent with macroeconomic stability and that best promotes health development and equity in health (World Bank, 2006:198).

Health Sector Interventions

Considering the multidimensional nature of poverty, the contribution of the health sector to poverty reduction should include interventions both outside and within the health sector. The health sector should collaborate with other sectors to influence most of the underlying conditions required for public health, including: clean water and sanitation; food and drug safety; tobacco control; access to health-related education and information; and standards for safe working, housing, transport and environmental conditions. At the very least it could contribute by setting and enforcing standards on these underlying conditions.

The health sector should develop and maintain a strong advocacy platform targeting stakeholders and partners operating outside the health sector in order to sensitise them on the contribution of health to poverty reduction, and to provide orientations on how other sectors (education, agriculture, transport, energy, water and environment, finance and planning, housing, sanitation, industry) should incorporate health considerations into policies and practices to improve health outcomes. A first step to do this is by generating evidence on the linkages between public health and environmental and socioeconomic determinants. The health sector should also undertake a routine assessment of potential health implications of development policies for different social groups. In order to do this, routinely collected data on health, health care and other health determinants should be disaggregated into groups by factors such as wealth, gender and race/ethnicity that reflect poverty and social disadvantage (Nolen et al., 2005).

At the health system policy level countries need to put in place reforms with a view to shifting the focus of health systems away from an overly curative approach to a more preventive and promotional pattern of health interventions, with a view to accelerating the improvement of the health status of the poor. Extending health coverage to underserved areas for the benefit of vulnerable populations; reinforcing immunization programmes against childhood illnesses through regular monitoring and mobilization of adequate funding; as well as improving the local production of vaccines, medicines, and diagnostics will also be needed (OECD/WHO, 2003: 53).

Development of a national health financing system that contributes to improved health outcomes in an equitable and efficient way and that protects populations against the impoverishing effects of

illness is important. Equitable financing would increase access to health care for the poor, improve people's health and thus their ability to earn a living, thereby indirectly reducing poverty. It could also reduce the prevalence and depth of poverty by protecting the poor and vulnerable from further impoverishment resulting from health care expenses (WHO, 2005d). This would require securing more sustainable funding for health systems, choosing and purchasing cost-effective interventions, setting appropriate financial incentives for service providers, and ensuring equitable access to quality health services.

Another important intervention option is strengthening health promotion initiatives, including healthy behaviour to improve health and prevent priority diseases, particularly those afflicting the poor. It is important to focus on promoting adequate nutrition, food safety, reduction of environmental and behavioural risk factors, especially those leading to HIV/AIDS and other sexually transmitted diseases, cardio-vascular diseases, diabetes, and cancer. Promoting multisectoral interventions aimed at mobilizing individuals, families and communities to participate more in health promotion and prevention interventions will also be needed (WHO, 2002c:101).

The health sector should also scale up interventions against the major public health problems of the Region. For HIV/AIDS, the emphasis should be on prevention and control of infection, as well as care and support of people living with AIDS. Access to antiretroviral medicines and local production of generic medicines needs to be promoted. Increasing the coverage of access to a directly observed short course treatment should be pursued in the control of tuberculosis. Malaria will need to be tackled through the introduction of the artemisinin-based combination therapy in countries with evidence of resistance to chloroquine. Preventive treatment for pregnant women, vector control through the use of insecticide-treated materials and spraying of insecticides will also need to be promoted. Maternal health should be improved by increasing access to quality prenatal and postnatal care, including emergency obstetric care aimed at reducing maternal and newborn mortality. Child health services, especially immunization and the Integrated Management of Childhood Illnesses, will also need to be supported by strengthening primary health care services in health facilities and at the community level. The implementation of improved and expanded schemes for nutrition and infant and young child feeding, as well as disease surveillance and epidemic response strategies should also be pursued (WHO, 2003c:8).

Such health interventions will create new opportunities for poor people to enter the labour market with increased capacities and thus result in higher productivity. This, in turn, will help to reduce poverty insofar as it affects the individual, the family, the community and the nation. To undertake such interventions countries need to institute appropriate reforms; update national health policies and increase the budget allocated to the health sector in accordance with the Abuja Declaration of heads of states of the African Region (OAU, 2000), which commits countries to allocating 15% of their total budget to the health sector; advocate at the national and international levels for more resources to be allocated to the health sector; and to develop a transparent mechanism for managing, monitoring and evaluating the efficiency in use of such resources.

The Role of WHO and Partners

The Millennium Development Goals (MDGs), the health strategy of the New Partnership for African Development (NEPAD), World Health Assembly, African Union heads of state resolution on health, and country priorities should form the basis for current health priorities of WHO and other partners in the African Region. Partnership is a key element for the achievement of the MDGs. Closer collaboration will need to be forged between WHO and the African Union, UN Economic Commission for Africa and regional economic communities; as well as other United Nation agencies, the World Bank and International Monitary Fund, bilateral donors, government and nongovernmental sectors. Efforts should also be made to promote the involvement of civil society organizations, women, the private sector, and academic and research institutions in supporting health sector reform. Community views need to be considered so that national health systems are more responsive to people's expectations and needs; and communities increase their involvement in health promotion and prevention.

The current international consensus on the importance of health for socioeconomic development and poverty reduction, as reflected in the report of the UK Africa Commission and G8 resolution, as well as the Global Fund to Fight AIDS, Tuberculosis and Malaria, (GFATM), the (US) President's Emergency Plan for AIDS Relief (PEPFAR), and the Global Alliance for Vaccines and Immunization (GAVI), and the Making Pregnancy Safer (MPS) initiative provide unprecedented avenues for improved technical

cooperation of WHO and other partners with countries of the Region.

Conclusion

A concerted effort by countries of the African Region and their partners is gathering momentum for change and to help the Region come closer to achieving the MDGs. In order to succeed countries need to allocate a higher percentage of their national expenditure to health and their partners need to increase aid to the African Region to address the lack of financial resources. Governments and their partners also need to make sure they translated good policies into action.

Progress on achieving the MDGs is dependant on the effort of countries but also hinges on policy changes made by wealthy countries, such as debt forgiveness, commitment to increased aid and its effectiveness, and freeing of market restrictions. Some progress has been made in these areas. Donor countries have also agreed to harmonize aid and respect development priorities in recipient countries. However, several of the rich nations have not yet fulfilled their commitment to give 0.7 percent of their annual income in aid (UN, 2002). However, increased aid can only lead to progress if recipient countries commit themselves to policies that aim to reduce poverty and inequities, and that promote and protect public health.

NOTE

[1] This paper focuses on the 46 Member States of the African Region of the World Health Organization (WHO). The WHO African Region does not include all 54 countries on the African continent. Although the Region mostly consists of countries in Sub-Saharan Africa, it is not limited to Sub-Saharan Africa.

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