Conclusion: what works?
Fishermen (Abdel Inoua)
7. Conclusion: what works?

It is a convenient untruth that there has been no progress in health in the Region. This report has used a wide range of data to show that, in the last decade, the overall health of the people living in the Region has improved considerably. Some of this has been due to demographic and economic change and improved political stability, leading to fewer conflicts. But much has also been due to sustained efforts to prevent illness and maintain good health, improve access to treatment when illness does occur, and to find ways to deliver a better level of health care in the African context.

Much more needs to be done. Mothers and their children need protection from the threats and diseases still harming and killing them in numbers far greater than in the rest of the world. The HIV epidemic has been curbed but is still killing too many young people.

Quality health care – that is care that is readily available, affordable, and provided by well-trained professionals equipped to identify the right problems and provide the best treatments – must be available to all, not just the wealthy living in towns and cities.

As health care improves and people survive their illnesses and injuries, disability and the consequences of living with chronic disease are becoming increasingly important threats to the health and well-being of people living in the Region. More attention needs to be paid to the health of older people. Mental health has long been neglected throughout the Region but is increasingly being recognized as essential to the health of not only individuals but also societies and nations.

Throughout this report we have looked at what has been shown to work to improve the health of the people in the Region. Some of these are things that have worked elsewhere – but to be effective all have been adapted to the African context. In this chapter we look at the strategies and approaches that are working to bring better health to the Region.
Good governance for health

Good governance is one of the elements of good leadership. Using evidence to form policy, good leadership for health demands accountability at all levels from the community upwards. Good governance is a key determinant of good health outcomes in countries. Within countries, between countries as well as at global levels, governance for health is manifested through policies and legislation in all areas having a direct or indirect bearing on the health of the people. Where leaders are actively engaged in promoting health interventions, demand for such interventions increases. One of the strengths of the polio eradication programme has been active engagement of national leaders, traditional leaders, religious leaders and “champions” to increase community acceptance of polio vaccination.

Health in all policies

Health in all policies is not a new concept but is more often talked about than acted upon. However, in the Region there is evidence that governments are now considering health when raising revenue or applying fines for breaches of the law. For instance, several countries are now using revenue gained by imposing taxes on tobacco products to finance their health services. Some countries are also using revenue from fines for environmental pollution or driving under the influence of alcohol to finance their health services. By doing this, these countries are achieving a “double win” – using taxes and fines to curb unhealthy behaviours known to increase usage of health services, while applying the revenues earned to provide better health services. Health in all policies goes beyond finance. It requires genuine partnership across all sectors. In the Region, infrastructure to support sanitation, provision of clean water, safe roads and transport is lagging behind economic growth. Action on any of these things would lower death and disability in the Region dramatically.
**Data-driven decision-making**

In the past decade the quality of data and the ability to collect, report and receive timely feedback has improved dramatically in the Region. This has been driven by the demand for quality data to inform the polio eradication programme but is now the platform upon which other real-time data collection and reporting is riding, for example for measles, yellow fever, rotavirus and child bacterial meningitis. It needs to be widened and strengthened to provide accurate data informing action on all the significant threats to human health in the Region, for instance the REACH dashboard described below.

Good data-driven decision-making is a success that generates success. As better, more real-time data provide decision-makers with information they can use to respond effectively to their population health needs, countries see the value of better data collection.

Find and fill the gaps

Unless gaps are identified early and accurately, simply providing a raft of general interventions will not meet the real health needs of the people of the Region. Better surveillance and a stronger laboratory system have led to early detection and rapid response to disease threats. When the pandemic influenza H1N1 emerged globally, countries in the Region strengthened their early-warning alert and response systems, leading to early detection of the first case of pandemic influenza (H1N1) in South Africa in June 2009, and subsequent cases in other countries in the Region.

REACH dashboards are tools used to assess data related to nutrition and apply it to provide an early-warning system. This enables countries to use data effectively to avert nutrition emergencies and improve nutrition overall. Countries adapt the dashboard to their specific population characteristics and needs but the aim is to portray indicators from all sectors relevant to nutrition. REACH dashboards have been drafted in Ethiopia, Ghana, Mozambique, Niger, Rwanda, Uganda and the United Republic of Tanzania.
**Staff properly paid**

The Region’s severe shortages of health workers are now being reversed in several countries where salaries have been increased and payment guaranteed. To ensure sustainability, these countries are in the process of institutionalizing this approach by increasing the percentage of general government spending on health. This is reflected in improved salaries and more posts, resulting in a better paid and more committed health workforce.

WISN is a tool that permits planners to use data to determine their genuine staffing needs. This tool has been used in different parts of the world and in Africa as a means of establishing or reviewing staffing norms. For example, Cameroon used the WISN tool and revised its staffing norms for different levels of the system (see Chapter 6). The method was participative but based on evidence and enabled the Ministry of Health to use the results to advocate for more funds to pay for staff.

**Harnessing local technological capacity**

The rapid rise in use of cell phones has been one of the most dramatic changes in the Region. Surveillance systems, diagnostic support for remote health workers, training and support can all be provided by mobile phone. However, to be effective this requires identifying and dedicating people within the system to administer the system, respond to diagnostic images and data appropriately, support surveillance with data collection and feedback, and support community workers with regular training, evaluation and physical support. For example, Cameroon distributed mobile telephones to key personnel to enable them to communicate epidemiological information at no cost. As a result, coverage of the epidemic-prone disease surveillance network increased from 30% to 98%, thus improving the response to cholera, yellow fever, measles and polio epidemics (see Box 6.6).
Quality in all things

Using external accreditation with support from partner laboratories and organizations, reference laboratories for polio and measles in the Region have reached international standards. Benchmarking, accreditation, genuine supervision, evaluation and constructive feedback should be used to ensure all health work – from community level up – is performed at the highest world standards. For the past 12 years an external quality assessment programme covering diagnosis of infectious diseases (HIV, tuberculosis, malaria and plague) has been provided to 81 national public health laboratories in 45 countries. Proficiency is tested and results shared with the laboratories, allowing them to improve diagnostic performance.

Surgery is an essential area of health care in which complications are common (3–16%). A surgical safety checklist had been successfully used in hospitals in Botswana, Mali, Namibia, Rwanda, Swaziland, Uganda and Zambia. The checklist has been successful where its use has been mandatory, where there has been strong support for it from hospital senior management, and where group discussions and regular meetings address issues arising from its use.

Performance-based health management

Performance-based management means taking responsibility for use of resources and delivering on promises. In health, these promises can be a matter of life and death for communities that health workers are serving. While linking outcomes to performance is a powerful way to make health workers accountable, equally, health workers need to be able to hold their managers and systems accountable. If vaccines, essential medicines, diagnostic tests, functioning equipment, regular training and logistical support are not readily available, those responsible for failing to deliver should also be held accountable. Burundi introduced a national results-based financing scheme in 2010 to overcome poor provision of services after pilot studies showed an average improvement of 50–60% for every indicator linked to finance (see Box 6.1).
Community-based intervention

Imposing interventions on communities is difficult and often not sustained because there is no genuine demand for them. Where communities are the planners, decision-makers and are responsible for supporting an intervention, it has more chance of succeeding. In Rwanda, when mutual health organizations are set up, it is community members who decide who should pay what. A strategy was devised to determine mutual health organization contributions, subsidizations and exemptions. This approach is based on traditional values aimed at rallying the people around shared efforts to improve social conditions. In the past, people living in small villages would organize themselves to work on farms and build houses for the poorest people. Development partners saw an opportunity to build on this ethic and set up a system whereby the community identifies destitute people and determines the assistance they need. The Government of Rwanda and development partners then send aid to groups that have identified their own needs, as part of poverty alleviation activities.

Understanding who communities trust for health advice and interventions (e.g. 80% use traditional healers) and why, and including those people in the health system, increases opportunities for bringing better health. Making it real – turning recommendations into implementable actions – requires genuine partnership with, and adaptation by, the communities affected.

Scaling up better

Scaling up, that is putting the theory proven by successful pilot programmes into widely used practice, is often difficult. New programmes tend to be imposed, rather than built up using existing capacity. The need to develop a strong surveillance and delivery system working well at all levels from community, through to district, provincial and national levels, all supported by high-quality laboratory services and a strong logistical system, has built capacity that is now being extended to other areas. Better support for immunization has strengthened community case-finding, diagnostics, reporting and detection of measles, yellow fever and other outbreaks, and malnutrition. This is an opportunity to build up better that should not be missed. The system is working, yielding results and should be widened further to capitalize on this home-grown platform.