

# **WORLD HEALTH ORGANIZATION**

## **WHO's Strategic Approach to Health Cooperation in the Horn of Africa**

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## **INTRODUCTION**

The Horn of Africa countries (Djibouti, Eritrea, Ethiopia, Kenya, Somalia, Sudan and Uganda) face common crises and vulnerabilities, including: drought, floods, environmental degradation, land pressure, armed conflicts, acute food shortages and mass displacements; not to mention chronic under-resourcing and lack of access to any health services for vast numbers of people.

Although the crises affect all areas, death from starvation and disease is most severe in border and remote areas because the majority of national and international resources are concentrated in the capitals and in central areas. The remoteness of many communities living near international borders and their prevalent pastoralist lifestyle make it difficult to provide primary health care, including preventative services. The social integrity, safety and “health security” of border communities and “border crossers” are widely neglected and relegated to a marginal position in the development agenda. Armed conflicts are commonplace in border areas and, in fact, no country in the Horn of Africa has escaped this fate.

The paper attempts to highlight the socio-demographic situation of the sub-region and the epidemiological profile of the common diseases to be focused on in the region, as well as the challenges in polio eradication in the Horn of Africa. It also highlights WHO approach in dealing with the Horn Region as one epidemiological block and summarizes recent interventions. Lastly, it will suggest areas of potential co-operation among the countries in the prevention and control of these diseases, as well as ways of strengthening the health information system in the sub-region, which will eventually contribute to confidence building and collaboration.

## **DEMOGRAPHIC AND SOCIO-ECONOMIC PROFILE OF THE HORN OF AFRICA**

The countries in the Horn of Africa share many common features, but there is also great diversity between them in terms of languages, ethnic groups, history and politics. They are among the poorest countries in the world with most falling under the category of the least developed countries. All the populations in the sub-region are adversely affected by man-made and natural disasters as well as conflicts within and across the national borders.

The sub-region has one of the highest population growth rates in the world (average 2.5% per annum) and is characterized by periodic, prolonged drought and desertification causing famine that creates massive humanitarian and stability problems within and across national borders. The natural and man-made disasters result in displacement of a large number of people within their own countries or to neighboring countries in the region. Of those displaced by famine or conflict, women, children, the elderly and the disabled are the most vulnerable.

## **MAJOR HEALTH PROBLEMS IN THE REGION**

The major causes of morbidity and mortality in the sub-region are those related to nutritional deficiencies and communicable diseases. Among the communicable diseases that contribute to the health burden and high mortality are HIV/AIDS, tuberculosis and malaria. The sub-region also contains two of the ten remaining countries in the world where poliovirus is still circulating.

### **HIV/AIDS**

With regard to HIV/AIDS burden, the sub-region is one of the heavily affected areas of Africa. In recent decades, the Horn of Africa has experienced several complex emergencies. HIV spreads faster during complex emergencies when conditions such as poverty, powerlessness, social instability and violence against women are most extreme. Psychosocial stress resulting from insecurity (physical, financial, and social) can cause coping mechanisms of individuals and communities to deteriorate. This results in high-risk sexual behavior and renders individuals powerless against sexual abuse. Moreover, in situations of war and civil strife, activities intended to control HIV/AIDS, whether undertaken by national governments or by other international and national entities, tend to disrupt or break down altogether. Thus, a large part of the population in the sub-region is vulnerable to HIV/AIDS.

In the areas of prevention and control, the countries exhibit varying levels of political commitment, technical implementation capacity, involvement of the private sector and NGOs and policy development. Little has been done to coordinate activities across borders.

### **Tuberculosis**

Countries in the Horn of Africa suffer from a severe burden of tuberculosis. For 1998, WHO estimated that 40% of the people in the region were infected with tuberculosis bacillus. It was also estimated that 450,000 people would develop active tuberculosis and that more than 100,000 in the sub-region die every year of the disease.

Somalia is a good example of TB control under complex emergencies, and WHO has been playing a key role in this regard. Standardized guidelines were developed, regular supply of drugs and laboratory materials are secured, and regular reporting of activities is taking place. Coordination among all partners is facilitated at the TB working group of the Somalia Aid Coordination Board with the help of WHO. In 2001, 6854 cases of TB were detected in Somalia, of which 4636 were in an infectious form (smear positive). Treatment success rate is more than 85%. The challenges include the volatile security situation in the country, particularly in the south, and anticipated increase of HIV epidemic. Due to these challenges, it is anticipated that the burden of TB will continue to increase in Somalia and continued efforts to control the disease are still much needed.

Control of tuberculosis has been of considerable concern to the health authorities in the Horn of Africa. Under the auspices of WHO, a series of meetings were organized for the health officers responsible for the tuberculosis control in the region leading to the formation of a Technical Co-coordinating Committee for the Control of Tuberculosis (HATCI).

## **Malaria**

Malaria is one of the most serious health problems in Africa, and by far the world's most important tropical parasitic disease. It is estimated that between 270 and 480 million clinical malaria cases occur every year in Africa, of which 1.4 to 2.6 million die of the disease. In the Horn of Africa, most of the countries are epidemic prone, with some significant endemic areas. The situation is further complicated by the increased resistance to antimalarial drugs in a region where conflicts and other factors induce mass movements of populations.

In Eritrea for example, malaria affects over 67% of the 3 million estimated population of the country, accounting for over 30% of outpatient cases in certain seasons of the year. *P. Falciparum* is increasing sharply and it is reported to account for more than 94% of the total recorded cases as compared to 60% in the 1970s.

*P. Vivax* and *P. Malariae* are also present, the latter being of little epidemiological significance.

In Ethiopia, malaria is unstable due to the topographical and climatic features of the country; hence the population at risk is exposed to frequent waves of epidemics. More than 40 million are at risk of being affected by malaria. The estimated number of clinical malaria cases is 1.5 million each year. All four species of *plasmodia* are present in Ethiopia; however, the two epidemiologically important species are *P. Falciparum* and *P. Vivax*.

## **Polio Eradication**

In 1988 the World Health Assembly adopted the resolution calling for the global eradication of poliomyelitis by the year 2000. In 1988-1989, countries of Africa joined this initiative and began the implementation of polio eradication strategies. In 2002, polio cases have been reported in Sudan and Somalia.

The routine immunization coverage in the region is very low. In order to supplement the low routine immunization, periodic vaccination campaigns are organized to ensure reaching the remote areas in the region. In spite of these efforts, some parts of the sub-regions are not yet covered because of poor infrastructure and security. WHO and its partners worked with the Ministries of Health in harmonizing the campaigns and coordinating activities.

## **HEALTH INFORMATION SYSTEM**

Each of the countries in the region has a different type of health information system (HIS). The HOA Ministerial Conference of 1996 and 1998 defines the HIS at sub-regional level as weak. Lack of co-ordination and co-operation in health programs of similar nature at border districts were pointed out. Apart from the routine and basic HIS at country level, there is no epidemiological surveillance system at regional or inter-country level that could support prompt decision making in case of emergencies.

There are several efforts and initiatives going on aimed at improving the information management and exchange in the region. WHO has taken forward the issue of HIS to IGAD, Horn of Africa Ministers of Health and other UN agencies dealing with development and communication improvement. Some of the issues raised were that the countries in the sub-region could co-operate in the free circulation of health information at all levels and by promoting a regional HIS that:

- covers the most marginal/vulnerable areas and groups;
- monitors the most prevalent hazards, the levels of risk, signs for early warning, health activities and resources;
- is supported by adequate communication technologies, and by reference centers and experts.

Geographic information system and mapping health facilities have been used in the region for monitoring some communicable diseases, such as malaria and other diseases determined for elimination and eradication. These techniques are becoming more common in the area of health and help to easily visualize the health situation.

## **WHO AND THE HORN OF AFRICA**

In order to tackle the health problems of the sub-region, WHO considers the Horn as one epidemiological block, in that unless health interventions are coordinated among the countries and partners, the desired impact will not be achieved. Therefore, WHO initiated collaboration, co-ordination, and innovative projects amongst the Horn countries and, in 1996, organized the First Conference on Public Health in the Horn of Africa to strengthen cooperation in the region; focusing on the vulnerable populations such as refugees, IDPs and pastoralists. By focusing on common problems and working on health-related issues in early warning, community emergency preparedness and response, food security, conflict mitigation and peace-building activities; WHO intended to offer substantial opportunities for shifting the focus of activities in these critical and post-conflict situations from emergency work to rehabilitation and development.

The Ministerial Conference identified constraints and issues of common concern for inter-country collaboration. The main needs and constraints identified were:

1. Prerequisites and resources for decentralization are not yet fully met
2. Weak national and regional health information system (HIS)
3. Lack of co-ordination and co-operation in health programs of similar nature at border districts
4. Inequity in distribution of health infrastructure and services
5. Haphazard delivery of health services in conflicts and natural or man-made emergency situations
6. Inadequate provision of health services to special population groups (e.g. nomads, returnees, internally displaced people and urban squatters and, in general, people living in border areas)
7. Poor scientific, technical and academic co-operation among countries of the sub-region in health, health related fields and training.

On the basis of the above-mentioned constraints and needs, the Conference resolved that the following actions should be undertaken:

- Countries of the sub-region should develop health agreements for co-operation to address the cross-border and other priority problems and to develop plans of action;
- periodical inter-country meetings should be held to review and monitor the implementation of the action plans;
- countries of the sub-region should establish health networks to enable free and timely exchange of health information;

In March 1998, the Health Ministers of the HOA countries signed a Protocol of Cooperation, which sought to address cross-border health problems, and WHO was asked to facilitate the implementation of the provisions of the Protocol. WHO established the Horn of Africa Initiative (HOAI) to implement the recommendations of Health Ministers. The Initiative collaborates with UN agencies and NGOs and has the following objectives:

- To consolidate capacities of Member Countries to elaborate inter-country strategies for control of major health problems at their borders;
- To increase capacities of Member Countries to implement inter-country strategies for control of major health problems at their borders;
- To develop appropriate capacity for integrated epidemiological surveillance and response for priority communicable diseases and malnutrition; and
- To promote peace building health activities in highly unstable border areas to facilitate transition from post conflict settings to rehabilitation and development.

Since 1996, WHO is in close contact with the Inter-governmental Authority for Development (IGAD) and both organizations have signed a protocol of co-operation of which the main goal is to technically assist IGAD to form a Health Desk.

## **ONGOING HEALTH COLLABORATION ACTIVITIES AMONG COUNTRIES**

For the implementation of cross border collaboration, sites were carefully selected. At each site, cross border health committees (CBHCs), which comprise health staff and other sectors, were established. Capacity building activities, including provision of equipment and instruments, training in management and control of communicable diseases, were implemented.

CBHCs and managers of communicable diseases control and polio eradication teams meet regularly. In the areas of malaria control, the issues discussed are standardization of treatment drug protocols at border areas to avoid

drug resistance. Moreover, they developed common strategies for distribution and pricing of insecticide treated nets (ITNs). This was deemed very important because it avoided leakage of ITNs from one side of the border to the other. They also collaborated in malariometric surveys and KAP study on ITN use at border districts.

With regard to TB control, national, regional and district managers met and discussed expansion and implementation of DOTS at border areas. A major problem identified was patients' movement across the border during the treatment course. The teams developed a transfer form that helped follow up on patients crossing the border. Moreover, joint trainings in case management were conducted for staff at border areas.

With reference to HIV/AIDS, the managers acknowledged that war, civil strife, droughts and a pastoralist life style contribute to mass movement of people across the porous borders, which in turn facilitates spread of HIV/AIDS. In the cross border meeting, HIV/AIDS was identified as a major public health problem that should be jointly tackled. Another problem is TB and HIV/AIDS co-infection that strains the already weak TB centers at border areas. In a recent meeting in Hargeisa, N.W. Somalia, attended by Djibouti, Ethiopia and Somalia, the managers came up with strong commitments to collaborate, and prepared a project proposal on HIV/AIDS prevention.

In the area of polio eradication, focus is given on synchronization of national immunization days (NIDs) and exchange of health teams and vaccines. The national managers and their UN partners regularly meet to synchronize the immunization days and exchange information on acute flaccid paralysis (AFP). The regional and district teams compare their NIDs micro-plans and identify gap areas for joint collaboration. They decide how to cover the gap areas and share responsibilities. A major area of collaboration is AFP tracing across the border.

### **HEALTH AS BRIDGE FOR PEACE**

As a WHO program, health as bridge for peace (HBP) started in August 1997 and was formally accepted by the 51<sup>st</sup> World Health Assembly in May 1998 as a feature of the 'Health for All in the 21<sup>st</sup> Century' Strategy. HBP is a multidimensional and dynamic concept aimed at providing a policy and planning framework to strengthen the returns of health sector investments in areas affected by conflict or undergoing a post-conflict transition. These returns cover a vast array of objectives going from the reduction of social violence to actual peacemaking. HBP integrates the delivery of health care with conflict management, social reconstruction, and sustainable community reconciliation.

The Horn of Africa has several areas where war and civil strife are on-going. The HOAI attempted to do some health activities aimed at creating a bridge for peace. Some of the activities are summarized below.

- The war between Ethiopia and Eritrea started in 1998 and in 2001 the two countries signed a peace treaty to cease hostility. WHO wanted to seize this opportunity to organize initial joint health activities in polio eradication. Meetings were held with Rotary Clubs, in Addis Ababa and Asmara, that support polio

eradication programs and invitations to attend the first meeting at the border area were sent to the Clubs. The joint meetings have not yet taken place.

- Somalia has no central government and each part of the country has organized itself as an entity. Health professionals in the different entities have started organizing themselves and established their own health professionals associations. A meeting was held in Hargeisa, with the Officers In-Charge of WHO Sub-Offices, to assess how to link and harmonize the health professionals associations. It was also raised that the associations and health workers need capacity building in health emergency, ethics and humanitarian interventions.
- WHO organized a meeting for Somali health authorities in Cairo, 3-5 September 2002. The State Minister of Health of the Transitional National Government, the Minister of Health and Labor of *Somaliland*, and Director General for Health of *Puntland* attended the meeting. During the meeting, the health authorities discussed with the Egyptian Undersecretary for Ministry of Health and Population and Senior Officers from the Arab League on issues regarding assistance to Somalia in areas of health services delivery and strengthening training health professionals. During the tour, the health authorities worked together in harmony and committed themselves to collaborate among themselves and increase coordination.

## **NETWORKING AMONG HOA COUNTRIES IN TRAINING AND CAPACITY BUILDING**

WHO plays an important role in facilitating information sharing among the Horn countries. The ministries of health, through the HOAI Focal Persons, are informed about planned activities and training programs relevant to the HOAI focused diseases. When the countries show interest, the HOAI assists them to receive more information and to attend the training/workshop. Among the activities accomplished, the initiative facilitated and sponsored exchange of professionals participating in a training/workshop and a study tour.

## **CONCLUSIONS**

Since 1995, WHO has been working with HOA countries and has organized two ministerial meetings on public health perspectives in the Region. In both meetings, strong recommendations were made on the need to collaborate in communicable diseases control and polio eradication, focusing on vulnerable populations at remote border areas. Moreover, WHO, in close collaboration with IGAD, is placing health as a priority and prerequisite for development.

The HOAI was established to promote cross border collaboration in disease control and polio eradication. However, the border areas are weak in terms of service delivery and it is always difficult to attract qualified personnel to work in those remote areas. In spite of the weaknesses, these districts are obliged to host and provide health services to refugees, IDP and pastoralists that continuously cross the borders. Thus, strengthening

health services at border districts should be considered as a priority and prerequisite for collaboration among the countries.

Poor communication and information sharing are still major obstacles to health collaboration in the sub-region. Therefore, supporting border districts and regions in communication facilities is vital. The idea of establishing an inter-country early warning system should be operationalized to promote a joint surveillance system at sub-regional level.

The Horn is prone to conflict and strife; therefore, health interventions and collaboration can be translated as a bridge for peace. WHO had prepared HBP packages that consist of training in negotiation, conflict resolution, ethics and humanitarian action. These packages can be adapted and implemented for the health workers and policy-makers. Furthermore, consideration should be given to activities that can bring together communities from different countries. BDN programs implemented at both sides of the border can trigger communication, collaboration and exchange of experiences between communities.

The sub-region is also prone to prolonged droughts and shortage of food. Malnutrition and related diseases, especially in children, are common. Joint efforts and approaches to integrated management of child illnesses should be enhanced. Family and child health programs are weak; antenatal care and routine immunization are also very low. The most important challenge is to streamline all efforts at polio eradication in order not to miss the international deadlines. However, to maintain the achievements, strengthening family health programs and routine immunizations for childbearing women and under-fives are major challenges.

Joint research proposals need to be encouraged in order to foster collaboration among health professionals and researchers from different countries. WHO encouraged and supported nationals to propose operational research proposals. Some proposed topics are Pastoralists' Health and Drug Resistance at Border Areas. Another potential area of collaboration is human resources development, such as networking among medical and nursing schools and exchange of tutors and students.

In conclusion, the HOAI has proven to be an innovative framework for health collaboration in the HOA that has been functioning since 1998. It can be used as an umbrella for long-term health cooperation among the HOA countries. Strengthening health services, control of major communicable diseases and an inter-country early warning system network are considered priorities and prerequisites for long term cooperation in the sub-region.

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