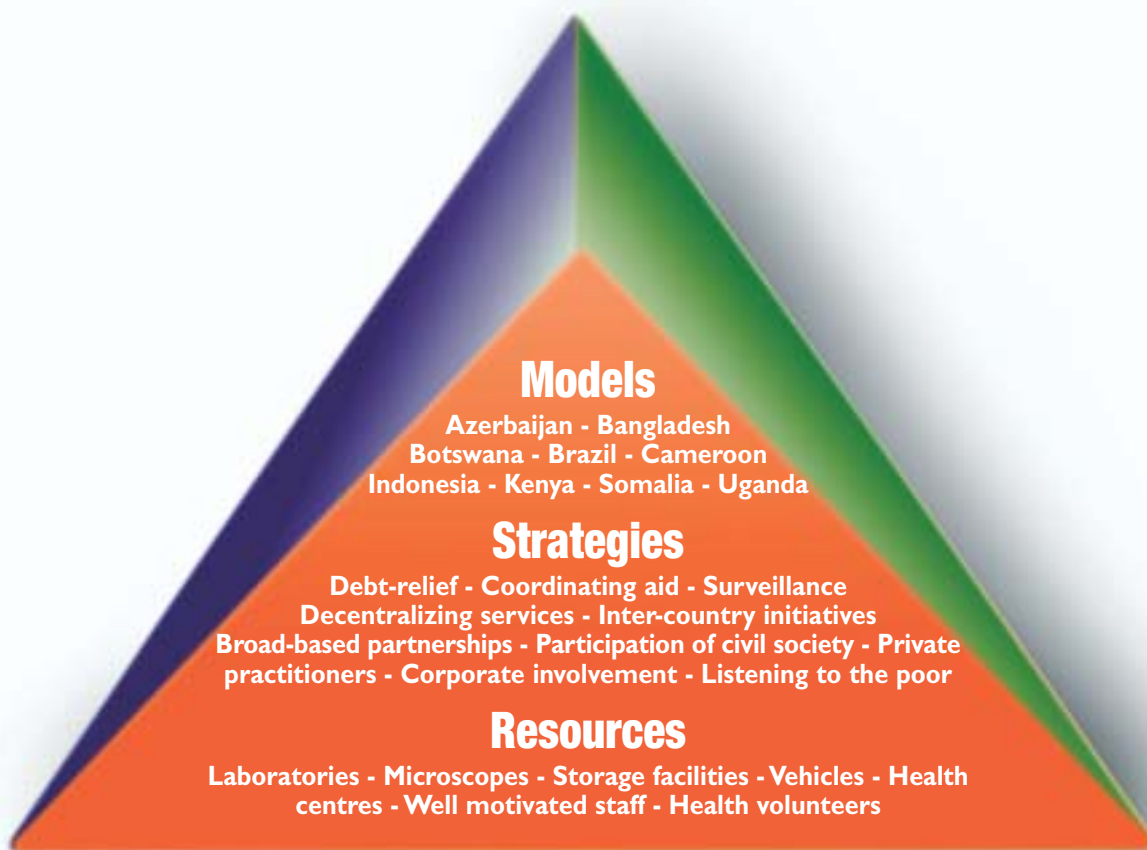


HEALTH SERVICES



In many developing countries, existing health services must be expanded, diversified and refocused to reach more people. New health services also have to be created where none currently exist.

Life-saving interventions must be delivered to those at greatest risk through health services. Health services provide the means for dispatching the tools and supporting the strategies needed to combat infectious diseases. These services are required to provide good-quality health care that is affordable, accessible, equitable and relevant to needs. If progress is to be made, vital components must include trained and well-motivated staff, laboratories and microscopes, health centres and facilities for storing medicines, and vehicles for visiting remote areas.

However, in most developing countries the public health system is poorly equipped to provide services that meet the main health needs of the population. Moreover, good quality private health care is often priced beyond the reach of the poor. The health systems of many developing countries are so weak that disease surveillance and reporting systems barely function, making it difficult to identify disease outbreaks and respond to the most urgent health needs.

RESOURCES FOR HEALTH SERVICES

Health services are frequently underfinanced in developing countries. The governments of some poor countries devote as little as US\$ 10 per capita to health. In many African countries, external assistance accounts for a large share of government health budgets. In the early 1990s, 40% of Uganda's health budget was provided through donor assistance; Gambia met 84% of its health costs with foreign aid. Throughout the developing world, far greater amounts of money are often devoted to other areas such as military spending and the construction of prestigious public facilities.

Even when more money is forthcoming, resources alone are not sufficient. Governments must use these resources effectively and target them towards meeting the needs of the poor. In some countries, 60% or more of government health spending is devoted to urban hospitals serving just 10% of the population. In Ghana for example, the more affluent population account for three times more public

health spending than the poor. In 10 developing countries, between 1992 and 1997, only 41% of poor people suffering from acute respiratory disorders – including tuberculosis – were treated in a health facility compared with nearly 60% of the affluent. In the same period, only 22% of births among the poorest 20% of people were attended by medically-trained staff, compared with 76% among the richest 20%.

Economic constraints – many of them imposed externally – often dictate difficult national budgetary decisions. Because of its burden of debt, Nigeria made cuts in recurrent expenditures such as payment for health-staff salaries and supply of essential drugs, in both urban and rural areas. Niger spends more than twice as much servicing debt as it does on primary health care. Adjustment policies designed to compensate for inadequate resources, inequality and poverty resulted in deep cuts in government spending on health and infrastructure and left Niger's poor and marginalized people with virtually no access to medical care.

The combined impact of AIDS, TB and malaria has further stretched health services beyond their limits. During the late 1980s and the 1990s, the AIDS epidemic spread rapidly in Africa. In addition to AIDS, TB and malaria added a massive socioeconomic burden on already-struggling public health systems. Countries with very high rates of AIDS were simply overwhelmed, while health professionals were dying faster from AIDS than they could be trained. In one Zambian hospital, for example, deaths among health care workers increased 13-fold in the past decade as a result of AIDS.

When the public sector fails to meet the health needs of the population, those living in poverty must often opt for more expensive private medical services. Out-of-pocket payments to private medical services and traditional healers can exceed public expenditure and can cost a small fortune compared to the patient's earnings. Up to 90% of household expenditure on health in India is spent on private-sector health care, with the poor paying proportionally far



more than the rich. Much of this goes on drugs and treatments that are not medically justifiable or effective.

A shortage of health professionals and supplies

Health systems depend on people – professionals and support staff with the necessary education, training, skills and motivation to do their jobs effectively. However, there is often a mismatch: an oversupply of qualified staff with an undersupply of infrastructure, equipment and drugs – or vice versa.



Limited training and low pay for qualified health workers in many developing countries cause severe problems in service delivery. In Cameroon, the ratio of health professionals per acre is 1: 400 in urban areas and 1: 4000 in rural locations, requiring people to travel great distances to find health care in rural areas. This kind of imbalance is just as severe in rural areas of Cambodia, where 85% of the population lives, but where only 13% of health workers are based; and in Angola, where 65% of the population live in rural areas but only 15% of health workers, the vast majority of these having opted for better-paid jobs in urban areas.

In some countries, even where trained health staff are in place, primary care centres and district hospitals lack adequate facilities to diagnose infections and repeatedly run out of medical supplies and drugs. For example in Zambia, where the number of TB cases increased sixfold between 1992 and 1998, proper treatment was hindered because health facilities kept running out of TB drugs.

It is now widely recognized that protecting a community's health requires support beyond the responsibilities of doctors, nurses and professional medical staff. Health services can often be extended or diversified by using networks of volunteer health care providers. Religious organizations, other organizations (such as Rotary International, Zonta International and the Lions Club) and community organizations provide extensive networks of volunteers. They can be

trained to offer basic services such as the observation of TB treatment, distribution of insecticide-treated nets and education on how to prevent infection from HIV. Businesses and factories can integrate the provision of health services into the work week of their employees. Schools offer an obvious forum for educating future generations on how to protect themselves and their families from deadly diseases. Yet these vast networks of human resources are often untapped by national health systems.

Poor access to services

In many developing countries groups that are marginalized because of their ethnic background, geographical location or gender are at higher risk of levels of infectious disease. For example, in north-eastern and south-eastern Brazil, (poor regions with large ethnic minorities) the death rate among children under-five for the poorest 20% of the population is now three times that for the richest 20% in the rest of the country.

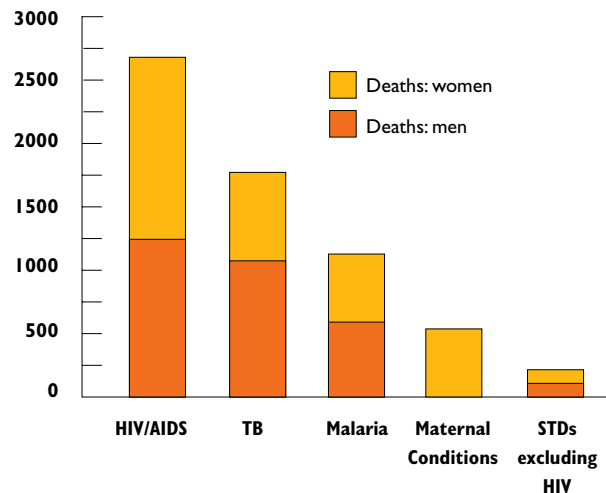
A long history of gender discrimination also leads to inequalities that perpetuate women's lack of access to resources and services for themselves and their children. Almost 70% of the 1.2 billion people living in extreme poverty are women who experience more illness and are less likely to receive medical treatment before the illness is well advanced. In many cultures, the lower value assigned to women translates into higher levels of suffering, with nearly 33% of all causes of death among women being due to infectious diseases.

TEN STRATEGIC FACTORS FOR DELIVERING AND STRENGTHENING HEALTH SERVICES

In many developing countries, existing health services must be expanded, diversified and refocused to reach more people. New health services also have to be created where none currently exist. Where public health services are inad-

The death toll among women

Womens' deaths from infectious diseases & other life threatening conditions ('000)



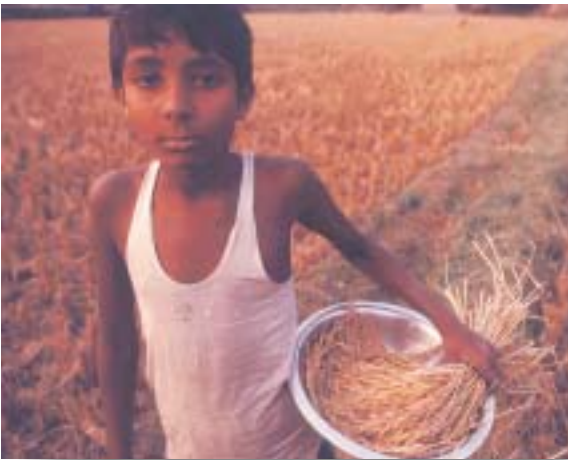
Source: World Health Report, 2000

equates, they can be substantially expanded with services from the private and voluntary sectors. These sectors can also help develop innovative ways of diversifying services under government stewardship which will protect the interests of the poor and ensure that best public health practices are adopted. The following 10 strategies have been used by some countries to strengthen, extend and diversify their health services.

Debt-relief

A serious problem in the poorest developing countries is that public resources are too often diverted to debt repayment, leaving little to cover the health or other needs of the population. In Africa, more than one-third of national budgets are poured into debt repayments while less than one-tenth are spent on social services, including health. Help with this problem is increasingly being provided by the World Bank and the International Monetary Fund through the enhanced Highly Indebted Poor Countries (HIPC) initiative. The HIPC initiative focuses on 42 countries, 31 of which are also among the poorest in the world. The “enhanced HIPC initiative”, which was launched in 1999, is now gathering momentum. This process promises faster, deeper and broader debt-relief. In some sub-Saharan countries national poverty reduction and social strategies include specific actions to prioritize health issues such as the control of HIV/AIDS, TB and malaria.

By July 2001, 23 countries had qualified for debt-relief amounting to US\$ 34 billion from the World Bank. Taking into account debt cancellations by bilateral aid donors and reductions in commercial debt repayments, the overall debt-relief provided to these 23 countries amounts to US\$ 53 billion, compared with an initial debt stock of US\$ 74 billion. The debt service ratios of these countries will therefore be much lower than previously estimated. Equally important, the funds saved are being used for social and development spending, with the education sector (40%) and the health sector (25%) being the main beneficiaries.



Poverty Reduction Strategy Papers (PRSP) that countries prepare as part of the debt-relief process provide a framework and a process for linking policy discussions at the macro level, with health systems and community action to reach specific health outcomes. Several countries have selected infectious disease targets and indicators as PRSP core indicators, which will help in government financing of actions to scale up the response. For example, Cameroon have decided to increase the percentage of pregnant women sleeping under bednets.

Coordinating aid

In countries with widespread poverty, such as those in sub-Saharan Africa, too many health programmes continue to be “vertically” organized, without reference to local needs, and funded by individual donors. This burdens countries with sometimes inappropriate projects, advice and equipment – in addition to the administrative complexity of coordinating the contributions of multiple donors, with a variety of project cycles, procedures and special interests. Development assistance is nonetheless a vital resource in addressing the health needs of the poor, and must be put to optimal use. The Sector Wide Approach (SWAP) and other development frameworks, such as the World Bank’s Comprehensive Development Framework, are aimed at achieving the greatest possible impact on health and development from the resources available – both local and external. They do so by reducing transaction costs, duplication and fragmentation of policies and services while increasing the focus on the health sector as a whole.

Sector Wide Approaches can be seen as a coordination mechanism to accelerate the aid process. They work by encouraging dialogue to create stronger cross-sector plans, common financing and management arrangements, and help avoid redundant funding of development plans by donors. Government stewardship in this context implies a fundamental shift in the role of government – from direct provisioning of health services to indirect and far broader

Development assistance is a vital resource in addressing the health needs of the poor, and must be put to optimal use.

Decentralizing health services by devolving decision-making and funds to district or local authorities and strengthening their capacity can make services more responsive to public health needs and more accountable to the people they serve.

oversight, strategic purchasing, financial rule-setting, and expanding health care and service delivery.

Surveillance

For progress to be made in tackling infectious diseases, the collection and analysis of information about their prevalence is vital. This involves tracking outbreaks and infection rates of individual diseases in each country and feeding this information into global networks that can then plan responses. It also involves monitoring the strains of a disease which are occurring in a particular area, and evaluating the impact of interventions and any evidence of drug resistance.

Many nations already have monitoring systems. Additionally, specialized alert networks, focusing on geographical regions or a single disease, also exist. But these surveillance systems have operated independently until now. WHO is weaving these systems into a Global Outbreak Alert and Response Network. Where gaps exist, WHO is providing training and equipment to build new disease monitoring systems.

Decentralizing services

Decentralizing health services by devolving decision-making and funds to district or local authorities and strengthening their capacity can make services more responsive to public health needs. Such decentralized services are also more accountable to the people they serve, and yet are still linked to central government, which sets overall policies and monitors how authority is exercised and how public money is spent.

Recent decentralization efforts in the United Republic of Tanzania have handed over authority to 35 districts, allowing them to set their own priorities within overall national guidelines, allocate funds, manage a strong monitoring and evaluation system, and train, hire and transfer specialist staff. Likewise, in Indonesia and Uganda, district governments have recently been given the authority to plan their own

development and allocate funds accordingly. The limited expertise and experience of local government staff in policy formulation, planning, and monitoring and evaluation is a challenge to the success of decentralization. Higher levels of government and local universities, however, can help to strengthen local capacity in these areas.

Inter-country initiatives

Institutional partnerships in and between countries are playing a vital role in capacity building. Several WHO collaborating centres in the South-East Asia region are working together to offer public health training for young people. In Thailand, for example, the Ministry of Public Health has trained more than 90 graduates who now run the epidemiological services in Thailand, and this programme has now been extended to neighbouring countries in the Mekong delta. The Asian Collaborative Training Network for Malaria involves nine countries with rotating country directorship, and supports managerial capacity in malaria programmes with regional training courses. The World Health Organization's collaborating centre in Thailand is supporting capacity development in HIV/AIDS care by offering training courses on the management and care of HIV/AIDS patients. In New Delhi (India), the National Institute of Communicable Diseases organizes paramedical training and short courses in outbreak investigation and response and the All India Institute has a two-year epidemiology training programme in Chennai. Another collaborator, the South-East Asian Ministers of Education Organization (SEAMEO) is working with WHO on mapping of tropical diseases in the Mekong region. Also in India, the management of TB with DOTS and a course on leadership training are being offered by WHO collaborating centres.



Cultivating broad-based partnerships

Effectively addressing the immediate needs for improved and expanded health care means introducing changes and

diversifying at a pace appropriate to each country's capacity, while planning longer-term improvements to infrastructure, institutional arrangements and capacity. The stakeholders in this process should also include academics, research institutes, NGOs, the private-sector and civil society. This is already happening in more advanced developing countries in Asia, where academic institutions already play a prominent role. Through exchanges at the health, scientific, R&D and policy levels, their potential is applied specifically to resolving local challenges in infectious disease control.



NGO and civil society participation

NGOs and civil society contribute to health-related activities through their knowledge of people's needs and by organizing grassroots activities. Although the performance of NGOs varies widely, they are often more effective and innovative than governments in delivering services directly to the poor. NGOs and civil society can also support the development of better governance. Once people themselves – particularly women and ethnic minorities – become organized in civil society organizations, they can influence local and national policy by articulating their health needs and holding authorities accountable. At the same time, they can lessen the control of power and funds by local elites.

Throughout the developing world, such groups are becoming more active and powerful in providing an alternative health service. For example, in Zambia, village councils formed partnerships with health authorities to tackle malaria. Then, supported by a donor, they stocked up on insecticide-treated nets, diagnostics and antimalarials for the prevention, rapid diagnosis and treatment of malaria. Faith-based organizations have played prominent and effective roles in health care delivery in many countries. The Christian Health Association of Kenya, for example, is involved in government policy-making, technical assistance and health-staff training, and advocates the waiver of health-service user fees for the poor.

Private practitioners

Private doctors provide health services to a significant proportion of the population in many developing countries, and their services are often put to greater use than public health services. Private practitioners are a valuable resource, located close to, and often trusted by, the community. They represent major opportunities to tackle global public health problems. However, private health care often places a huge financial burden and often provides services that are not always appropriate to people's needs.

For example, evidence from India illustrates both the strengths and weaknesses of private practitioners in the case of TB control. Studies show how the positive aspects – such as their proximity to TB patients and acceptance of their services by these patients despite costs – are often countered by their inappropriate TB management practices. This is generally a result of their ignorance about sound public health practice. Yet, one example of a private hospital working with a local TB control programme in India to implement DOTS demonstrates that this collaboration can be very effective. Bold and sensitive initiatives for bringing private and public health care providers together for a common cause could go a long way toward controlling major infectious diseases.



Corporate involvement

The ExxonMobil Corporation is playing a vital role in Roll Back Malaria (RBM) initiatives in five African countries: Angola, Cameroon, Chad, Equatorial Guinea and Nigeria. Launched in 2001 and initially targeted at the company's employees and their families, the aim is to extend malaria services to the community to give all people in these malaria-endemic areas access to essential medicines and prevention measures.

Led by national health ministries, these initiatives have been undertaken in full cooperation with RBM partners, including



nongovernmental organizations and private foundations. Each programme has its own focus. In Angola, it is performing baseline studies on insecticide-treated nets (ITNs). In Cameroon, it is the development of comprehensive ITN programmes, ranging from insecticide-treatment techniques to staff education and training. In Chad and Equatorial Guinea, the focus is on education and training for doctors and nurses who diagnose and treat malaria. In Nigeria, plans are under way to launch 12 village-based health clinics, which will be equipped with staff and resources to handle medicine distribution; they will also provide training in malaria prevention and control for pharmacists and health workers, in addition to making insecticide-treated nets available. Broader awareness-raising campaigns are being conducted together with these country initiatives, which may be expanded in the future.

The Coca Cola company has also recently formed a partnership with the Joint United Nations Programme on HIV/AIDS (UNAIDS) to work on marketing and distribution of education and health materials. Coca Cola is using the results of decades of market research and advertising knowledge to help develop public awareness and information campaigns. The company is also providing the resources of its Africa-wide network of manufacturers and distributors to spread education and information materials, as well as HIV testing kits, across the continent.

Listening to the poor

It is often mistakenly assumed that external agents deliver the benefits while the poor are passive beneficiaries. However, many interventions can be provided more effectively when resources are allocated to support basic social services so that the poor are empowered to help themselves. For example, microcredit schemes provide an important source of income, especially when a family is impoverished due to chronic or debilitating illness. In Nepal, a poor country with a high burden of TB, microcredit schemes linking regular group meetings with distribution of anti-TB med-

icines have provided income-generating opportunities, while at the same time promoting better compliance with TB regimens.

MODELS FOR IMPROVING HEALTH SERVICE DELIVERY

Despite many obstacles, countries have managed to mobilize funds, skills, knowledge and action to reverse the impact of infectious diseases. These achievements usually originate in identifying and responding to the most urgent health needs and are a result of strong government commitment. They are also characterized by a commitment to removing barriers to health service access and making services equitable, accountable and supportive to the poor.

Azerbaijan

Although malaria had been virtually eliminated in Azerbaijan by the end of the 1960s, the later break-up of the former USSR, followed by conflicts in the district of Nagorno Karabakh and economic turbulence, brought a disturbing resurgence of the disease in the mid-1990s. In response, a partnership was formed between WHO, the International Federation of Red Cross and Red Crescent Societies (IFRC), Médecins sans frontières Belgium, UNICEF and other UN agencies.

Then in 1998, in the context of WHO's newly launched Roll Back Malaria partnership, Eni – an Italian multinational oil and gas company – also joined as a private-sector partner. Eni, which has set up a network of health facilities for its staff, families and local communities in some 70 countries throughout the world, recently contributed US\$ 767 000 to a three-year malaria control programme in Azerbaijan, which helped reduce malaria cases there by over 50% during the late 1990s.

The project built capacity for early malaria diagnosis and rapid treatment, improved surveillance and epidemic

In just two years, Azerbaijan was able to reduce malaria cases by half as a result of strong partnerships.

response, promoted cost-effective mosquito control and strengthened operational research capacity within the Azerbaijani Ministry of Health in collaboration with the ministries of agriculture and water management, as well as the private-sector. The campaign was impressive: during 1998 alone, some 400 000 at risk people received preventive medicines and case detection was improved. As a result, the number of malaria cases was halved in only two years, and dropped from its 1996 high of 13 000 cases to only 1 500 in 2001.



Bangladesh

One of the largest NGOs in the world is BRAC – the Bangladesh Rural Advancement Committee – which has successfully provided health, education and microfinancing services to the poor. Its capacity and efficiency have often exceeded that of the government. Although the emphasis of BRAC's work is at the community level, its success has been instructive for national and even global policy initiatives.

To ensure sustainability, all of BRAC's health activities are integrated within essential health care programmes. A network of local health specialists and workers provides services for child survival, family planning, women's health and TB in numerous fully-equipped facilities. The community-based TB control programme, covering a population of 13.4 million, has a cure rate of nearly 87%. In the course of its work, BRAC has been instrumental in mobilizing thousands of community health workers to care for TB patients; training health specialists; building facilities and equipping laboratories with diagnostic equipment and supplies.

BRAC's experience with TB treatment using the DOTS strategy has been copied regionally and internationally, with delegations from Japan and Nepal being sponsored by the Japanese International Cooperation Agency to observe and learn from BRAC's experience in instituting community-based DOTS. The success of BRAC's projects

has been instrumental in mobilizing additional funds to expand services and to gradually cover rural areas throughout the country. With the rise in HIV/AIDS, BRAC has developed the capacity to deliver disease-awareness campaigns and prevention strategies among the districts and communities it serves.

Botswana

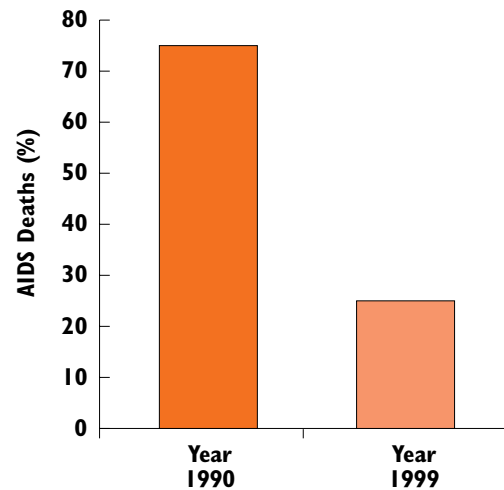
In areas such as franchising, social marketing and contracting, governments can learn from the private-sector. In Botswana, the diamond mining joint venture, Debswana, is active in the fight against AIDS. Although rich in mineral resources, Botswana currently has the highest HIV prevalence of any country in the world with nearly 40% of the adult population estimated to be HIV-positive. The tide is now beginning to turn however, with some much-needed support from the private-sector.

Debswana, for example, agreed in May 2001 to cover 90% of the cost of treating its HIV-positive employees with life-prolonging antiretroviral drugs. As Debswana is also the country's largest private employer, it is hoped that this model will encourage other socially responsible businesses to follow suit. Such initiatives are receiving full political support from the government. Botswana's President is personally leading the crusade to save his people from the "threat of annihilation". This initiative has prompted the Government of Botswana to develop a policy that would lead to free ARV treatment in public hospitals for all who are suffering from AIDS.

Brazil

Drug-price reductions can be achieved through the production or importation of generic alternatives. For example, the Government of Brazil has a policy of universal access to antiretroviral drugs, which benefits nearly all AIDS patients in the country. From 1996 to 1999, thanks to antiretroviral therapy, the number of AIDS deaths was nearly halved in

Comprehensive HIV/AIDS prevention and treatment has reduced AIDS deaths in Brazil, 1999



Source: Government sources Brazil, 1999

Brazil and the incidence of opportunistic infections was cut by 60% - 80%. Without significant decreases in the cost of antiretrovirals, however, Brazil's universal access programme would not have been possible. The Government achieved these price reductions through the local manufacture of drugs that were not patent-protected, combined with bulk purchases of imported antiretrovirals and price negotiations with the producers. Between 1997 and 1999, many AIDS-related hospitalizations were averted, resulting in savings of nearly US\$ 290 million. During this period, condom sales also doubled.



Brazil allocates US\$ 450 million each year to providing free antiretroviral treatment. In Asia, Thailand's dramatic reduction in HIV infection rates is also largely due to government financing of most HIV/AIDS control programme activities. In 1997, the country's budget for these activities had reached US\$ 82 million – more than US\$ 1 per capita. Even this underestimates the magnitude of country-mobilized funds: as early as 1991, private businesses alone contributed an estimated US\$ 80 million towards fighting AIDS in Thailand.

Cameroon

In sub-Saharan countries, where public spending on health is low, increasing spending on health services in rural areas is an important element in poverty reduction. Most countries involved in poverty-reduction strategies are already channelling debt-relief funds into control of the main infectious diseases. In Cameroon, where more than 50% of people live below the poverty line, the control of HIV/AIDS has been identified by the Government as one of the primary means of reducing poverty. An estimated US\$ 2 billion in debt-relief funds will be directed to improving social services for supporting HIV/AIDS work, and also for increasing vaccinations, controlling malaria and completing a health map of the country. The Government of Cameroon has explicit policies and strategies for tackling HIV/AIDS, and is committed to preventing the further spread of the disease. It is offering finan-

cial incentives to health professionals as well as educating staff to treat people living with HIV/AIDS and STIs. Arrangements are being made to improve the procurement and overall delivery of drugs and supplies.

Cameroon's chance came during the early consultative stages of the World Bank, IMF HIPC process when local NGOs and donors were asked to contribute towards the HIV/AIDS strategy, opening the way for future collaboration. The private-sector was also involved in comanaging and cofinancing health services. For example, the Cameroon Development Cooperation (an agro-industrial business), and the Cameroon Aluminium Company have set up prevention and awareness-raising campaigns. In addition, closer links were forged with a number of partners, including bilateral donors, development banks and UN agencies. This process motivated the donor community to increase its resources for tackling other major infectious diseases through existing programmes such as Roll Back Malaria, Stop TB and the Global Alliance for Vaccines and Immunization (GAVI).

Indonesia

Some governments are introducing new human-resource development approaches, including combining staff with different skills, decentralized recruitment, financial incentives, performance-based pay and civil-service reforms. In Indonesia, a new system of financial incentives, which offers civil-service appointments to doctors willing to work in remote areas, has proved successful in attracting doctors from urban centres. A payment-for-performance system has also been introduced which rewards knowledge and professional performance and has boosted both transparency and motivation. The creation of semi-autonomous public hospitals has also had the effect of decentralizing control to the level of district and primary care centres. Working together with local NGOs and civil society organizations, these centres have been able to deliver services that better reflect the needs of the local population.



Kenya

Creating local markets, bringing new sources of income to local communities and linking these initiatives to improved health is critical as a supplement to government services. In Kenya, for example, the African Medical and Research Foundation (AMREF), together with the pharmaceutical company GlaxoSmithKline, has successfully promoted the use of insecticide-treated nets by linking it with the establishment of a local income-generating industry.



In this innovative project, community groups were trained to sew and sell ITNs. An extensive health-promotion campaign sponsored by GlaxoSmithKline got sales off to a good start, and over a four-year period more than 5 200 nets were produced. Coverage in the local communities of some 75 000 people expanded from 14% to 20%. Looking for a way to link community-based manufacturing to established local industry, AMREF held consultations with the local authorities, the Ministry of Health and local businesses, and then launched the Employer-Based Malaria Control in Coastal and Western Regions of Kenya project. Promotional activities were so successful that the initial demand for nets outstripped supplies.

Kenya is also modelling cost-effective methods for drug procurement. Bulk purchasing is now done through a local procurement and distribution agency. This method has produced a 40% saving on annual drug expenses. Regional cooperation has also proved effective in other parts of the world. For example, the Eastern Caribbean Drug Service representing six countries achieved a 44% average price reduction for the top 25 drugs in the region.

Somalia

Fourteen international NGOs and two local authorities, with the coordination and support of WHO, collaborated to provide a remarkable example of how health services

can be developed and a disease such as TB managed successfully even during complex emergencies.

Somalia has been suffering from ongoing civil strife. Establishing and delivering health services during complex emergencies of this nature is a challenge. Collaboration among international NGOs, local authorities and WHO made it possible to develop and deliver effective services to manage TB.

TB is highly endemic in Somalia and is one of the leading causes of morbidity and mortality. Aside from security, TB in Somalia is reported to be the greatest barrier to stability and economic development.

Through this partnership, TB diagnostic and treatment services were made available, and DOTS was introduced in 22 health facilities in 15 out of 18 regions. These services have enabled the detection of more than 23 000 cases of TB and cured more than 85% of them between 1996 and 2000. This shows how health services can be developed during complex emergencies and how a disease of poverty can be successfully managed.

Local NGOs and community groups play a central role in HIV/AIDS care, support and prevention activities.

Uganda

The process of developing sectorwide approaches has gathered momentum in several African nations where they are the preferred mechanism for strengthening district and primary health care services. Resources have been invested in their development and are bearing fruit in terms of improved strategic planning and financial control, wider political support and country ownership. In Uganda, the Government has demonstrated a commitment to building health-organization and management systems and to developing a sound legal and regulatory framework in health care. Minimum health care packages have been developed and access to services improved through construction and upgrading of primary health care centres. Funds channelled to primary health target “best buys” – cost-effective inter-

Prices for essential drugs can be lowered if governments reduce import duties, customs and taxes, and remove unduly restrictive regulations.

ventions which benefit the poor – have been used to increase immunization coverage, distribute insecticide-treated nets and antimalarials, expand awareness of HIV risks and increase condom use by vulnerable groups. The Government has also established HIV/AIDS coordination mechanisms at central and district levels that are reviewed quarterly by donors and civil-society organizations.

Key in reducing Uganda's high HIV infection rates has been a remarkably high level of political commitment – spear-headed by the President himself – to prevention and care, involving a wide range of partners across all sectors of society. A large number of local NGOs and community groups have taken up HIV/AIDS care, support and prevention activities, with people living with HIV playing a leading role. In addition, a creative social marketing scheme boosted condom distribution to over a million and condom use from 7% nationwide to 85% in urban areas within the short space of a decade. Another innovative scheme is a self-treatment kit for sexually transmitted infections (STIs). Shopkeepers who sell the kits over the counter at low, subsidized prices are also trained in STI management strategies. Yet another Ugandan innovation was the 1997 introduction of same-day voluntary counselling and HIV testing services. The combination of education and action has helped reduce the country's HIV infection rates even while the rates of neighbouring countries are still spiralling upwards.

Uganda has also taken significant steps to address malaria. Prices for essential drugs can be lowered if governments reduce import duties, customs and taxes, and remove unduly restrictive regulations. In a recent move to ensure malaria protection for millions of children and adults, Uganda and 12 other African countries – Cameroon, Côte d'Ivoire, Ghana, Kenya, Mali, Mozambique, Namibia, Nigeria, Sudan, the United Republic of Tanzania, Zambia and Zimbabwe – reduced or abolished taxes on insecticide-treated nets to make them more affordable. Previously, tariffs constituted 30% - 40% of the retail prices of nets.