Despite progress, the same problems persist

Dr Luis Sambo provides an overview of the historical contribution of WHO to health in Africa and the challenges still faced

The World Heath Organization (WHO) was created in 1948, after World War II, when the international community decided through the League of Nations to create an international health organisation to consolidate an idea that existed before World War I broke out. WHO was established with the mission of attainment by all people the highest possible level of health.

The first Regional Committee for Africa took place in Geneva in 1951, chaired by Liberia. The Regional Office for Africa was established in Brazzaville in August 1956 through an agreement between the French colonial government and the World Health Organization. The WHO's Dr Francisco Cambournac marked the event by announcing: 'Through WHO work we bring to the population of Africa the priceless blessings of health, freeing them from the terror of plague and incurability.'

The key health concerns at the time were yellow fever, small pox, sleeping sickness and some vector control activities for malaria, venereal diseases, treponematosis and leprosy. Tuberculosis was also a concern. Fortunately some TB medicines and vaccine were available and being used. Others were schistosomiasis and onchocerciasis.

The member states of the WHO African Region were Belgium representing the colonies, France, Ghana after 1957, Liberia, Portugal, United Kingdom and the Union of South Africa. The associate member states were the Federation of Nigeria, and of Rhodesia and Nyasaland.

Leaders and achievements

We will trace historical developments by recalling the leaders of the WHO Regional Office:

General **François Daubenton** (1952 to 1954), a Dutch military general and medical doctor, was the first non-elected Regional Director for Africa. He was followed by Dr **Francisco Cambournac** (1954-1964), who was to say in 1965 that 'The incidence of diseases such as malaria, schistosomiasis and tuberculosis are still so high in Africa, and the repercussions on economic and social conditions are undeniable.'

Dr **Alfred Quenum** (1964-1984) from Benin was the first African Regional Director. In 1974 he said 'It is a social injustice and inhuman, to expect the vast majority of Africans to continue to live in unhealthy housing while the minority lives in luxury. The craze for comfort has led some Africans to become the new colonialists in their own countries, untouched by the misery of those living in tenements and slums.'

During that period between 1965 and 1970, the annual rate of urban growth was 5.4% in Africa, twice what was going on in the world on average; and only about 15% of Africans were living in towns. He made progress in controlling some of the endemic and epidemic diseases. Governments started organising themselves to increase health coverage. Dr Quenum also launched health research in our region.

Dr **Gottlieb Monekosso** (1984-1994) was from Cameroon. On taking charge he said 'It is my hope and belief that African Health Development Scenario will contribute to healthy and strong Africa, liberated from ignorance, hunger and disease; and taking its rightful place in the community of nations.' This was also the time when the World Bank and IMF started Structural Adjustment Programmes with all the effects that we now know happened to the social sectors and to health in particular.

During that period, the AIDS pandemic hit our region, when we were ill-prepared to fight HIV. His key achievements included the organization of health services based on Primary Health Care, and he supported the elaboration of National Health policies and plans.

Dr **Ebrahim Samba** (1994-2004). When he was leaving the regional office he said, 'I am leaving the post of Regional Director when the scourge of HIV/AIDS is increasing and hitting Africa in particular. HIV/AIDS reversed some of the very important trends in terms of mortality and morbidity in our region. During this period it was difficult to manage the regional office because the hosting country, the Republic of Congo, went through a civil war in 1997 leading to evacuation and transfer of the Regional Office to Harare in Zimbabwe. We came back to Brazzaville in 2001 to re-establish the Regional Office.'

A key achievement of Dr Samba was the elimination of onchocerciasis in West African countries. We also increased partnerships and financing for WHO Regional programmes. The funding of the Expanded Programme of Immunisation in the African region increased from US$7 million in 1995 to $180 million in 2002. He also established important partnerships with DFID, USAID, UNICEF and UN Foundation for integrated management of childhood illnesses, which contributed to the reduction of infant mortality and child mortality in our region.

Next in office, myself, Dr **Luis Sambo** (2004-2014). My successes were earned with support of many, some of them present at this the consultation meeting: Dr Peter Eriki, Dr Okello, Dr Dumizimi, Dr Dovlo and others. The vast majority of people living in Africa were yet to benefit from the advances of medical research and public health, because of an immense burden of disease and death devastating the African societies. Therefore, Health systems strengthening were the key response to provide a range of essential health care.

Dr. Luis Sambo, Emeritus RD/WHO Africa Region

Luis Gomes Sambo, former WHO Regional Director for Africa at the Consultation in Kampala.

During my term I tried to improve WHO organisational efficiency and effectiveness and to improve quality of participation of country delegations in global health debates. I empowered staff through delegation of authority, and decentralisation of the programme budget.

This period was difficult for national health financing, characterised by fragmentation of financial partnerships; the donors were coming on their own with their own agenda to countries; fragmenting the national health systems and creating difficulties for the overall management of the national health services. The Harmonization for Health in Africa (HHA) was created as a forum for consultation with the key health partners to harmonise the way support is provided to countries. An investment case called the Programme for the Elimination of Neglected Diseases in Africa (PENDA) was created to replace the Onchocerciasis Control Programme. The African CDC was also launched.

My other successes included: the first African Regional Health Report in 2006, the report on Women's Health in Africa of 2012,the Ouagadougou Consultation on Primary Health Care and Health Systems in Africa, the 2012 Inter-Country Study on Community Perspectives and Perceptions of Health Systems in Africa. Before leaving the region, I generated the second African Health Report. *A Decade of WHO Action in the African Region* summarising my achievements as Regional Director was also published.

Dr **Tshidi Moeti** (2014-present) from Botswana took over from 2014. Immediately after election she said: 'We will start by providing support to the recovery of the health systems in Ebola-affected countries. However, I emphasise that most countries in African region need intensive and sustained support to strengthen their health systems. I am excited by the determination of the global health community to facilitate this long standing barrier.'

Dr Moeti took office during the Ebola crisis in West Africa. She also had to deal with the unfinished agenda of the MDGs, particularly the health MDGs, including the need to address maternal mortality, HIV and AIDS, Tuberculosis and Malaria.

Health progress

Some key progress has been made:

- Life expectancy: in the 1960s it was 36 years, by 2000, 49 years, and by 2015, 55 years.
- Under-5 mortality rate, 310 per 1000 in the 60s, down to 154 in 2000 and 83 in 2015. We have a target of 25 per 1,000 in 2030.
- Neonatal mortality rate: in 2000, 40 per 1,000, falling to 28 per 1,000 in 2015 and projected to be less than 12 per 1,000 in 2030.
- Maternal mortality ratio in 2000 was 846 per 100,000, falling to 546 per 100,000 in 2015 and projected to be 70 per 100,000 in 2030.

On the question of where people are living, more than 50% of poor people are living in sub-Saharan Africa and yet we are less than 10% of the world population.

Sustainable gains?

We are making some progress but can we sustain this progress? Unfortunately, the gains that have been realised now are not sustainable because of the weaknesses of our health systems. These gains can be reversed anytime. Furthermore, the global health initiatives and programmes which support our countries depend to a great extent on external partners. This situation is delicate as any withdrawal of these partners could spell doom to our countries. While the pre-occupation of the rest of the world is public health challenges of the 21st century, we in sub-Saharan Africa are still grappling with the public health concerns of the 19th and 20th century. And yet we don't have enough resources to deal with our problems, or we are not putting the resources in the right priorities.