Matching Health Outcomes with Human Development in Africa and the Least Developed Countries: ECOSOC, Geneva 8th July 2009.

Francis Omaswa,
Executive Director African Centre for global health and Social Transformation(ACHEST), Kampala.

Health is the highest ranked priority among the poor as evidenced by the results of Participatory Poverty Assessment Studies in many countries, where it is most frequently cited by the poor themselves as the cause and consequence of their poverty. Sometimes a healthy body is the only asset that a young man or woman may possess. Freeing people from the humiliations and indignities brought about by ill health and unmitigated disability. Freeing the time and energy lost through illness, caring for the sick and burying the dead is what human development is about. Such time can be used for economic productivity, educational opportunity, recreation and social activity that dignify the human condition and bond society and make life truly worth living.

The disease burden in Africa is incredibly high; both chronic and acute. For many years I was a member of a group of surgeons, ASEA who travelled to remote hospitals every three months in one of eight countries is East, Central and Southern Africa to hold surgical camps. We were always overwhelmed by hundreds and thousands of patients, some blind from cataract, others with bumps and lumps, women with fistula and huge uterine fibroids, young children with grotesque neglected birth defects … all so depressing and upsetting. Our people are living like animals in the wild! Among these populations, premature death is accepted as normal designated as fate or even as acts of God. At the frequent funerals, we make speeches; for a young woman who died in child birth, we say "well, it was her day" for a child who died of malaria we say "God gives and takes away. God has called him/her". Our very first step is to reject this. Every death should be regarded as a failure of the health system, the failure of those who are at the funeral. Collective actions should be taken to prevent a recurrence of similar deaths. This is what happens in better organized societies. God does not call Japanese children until they reach the age of 85, does God Africans more than Japanese? The answer is no; Japanese just take better care of their people.

Ladies and gentlemen. Africa like the rest of the world must also take this route.

I have seen an Africa that was full of hope and promise just before and after independence, followed by a demoralized Africa in decline and now an Africa with a new hope rising from the dictatorships, HIV/AIDS, seeing economic growth in a globalised world clamoring for social justice bringing in so many new players into global health, replete with knowledge and technology. Africa must grasp this opportunity.

Here are my suggestions for critical interventions, among others that hold strong potential at this point in time for better health outcomes and human development in Africa:

(i) We need to launch a vigorous advocacy campaign to reject rampant ill health and premature death and in support of strong and transformed pro poor health systems at the same level that we fought for a global response to HIV and Aids.

(ii) Government leadership and stewardship is critical in our journey. Without strong governments in Africa the change that we desire will not come. However, governments also need to be facilitated and supported to be strong stewards. We need to recruit heads of state and governments into this movement. We need to support and strengthen leadership and governance capacity of Ministers of Health and build institutions to support them in each country. The WHO Commission on Social Determinants of Health points out the need for health in all policies but assigns leadership for this to the minister of health. MOH need to be supported to be champions and stewards of all health resources in their countries. With support from the RF my organization and the NYAM have been interviewing current and former MoH, leaders who work closely with them in countries, the UN system and other multilaterals and the report will be published in a few months. Preliminary findings indicate the desire of MoH for development of personal skills and institutional capacity around them for knowledge gathering, analysis and use and for implementation capacity.

(iii) The health workforce needs very urgent attention in African countries. We need a critical mass of appropriately skilled cadres of health professionals in each and every country who are motivated to serve in rural areas. They also need to be facilitated to meet together regularly holding each other as peers to account, governments to account and providing technical and political support to governments and engaging in dialogue with their societies as change agents. We need to cultivate "can do" attitude among these professionals in countries. Flying in technical assistance to Africa is not the answer as there is sufficient raw material locally who can be provided with the needed skills. GHWA in March 2008 convened the 1st global forum on HRH and adopted KD AGA which provides tools for moving forward on this important area. PHC principles that involve the active participation of people as the owners and the beneficiaries of health programs instead of waiting for others to do things for them.

(iv) Lastly financing instruments for channeling money to health programs should support integrated delivery of both personal care and public health and across the board capacity for planning, Implementation and monitoring and evaluation. Countries should find innovative ways to raise local funds for priority health programs.