REPORT OF

JOINT CAMAS/OAU ROUND TABLE MEETING

MASERU, LESOTHO

18 AND 19 SEPTEMBER 1990

"HEALTH AND POLITICS IN AFRICA"

CONFEDERATION OF AFRICAN MEDICAL ASSOCIATIONS AND SOCIETIES (CAMAS)

CONFEDERATION DES ASSOCIATIONS ET SOCIETES MEDICALES D'AFRIQUE (CASMA)

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INTRODUCTION

With 10 years to go before the year 2000, it is increasingly clear that the goal of Health for All (HFA) may be unattainable by most African countries. For years, national medical associations and societies in Africa have through conferences, workshops and other means, expressed their concern to their national governments at the multiple constraints militating against improvement in health care on the Continent but with varying degrees of response. Undoubtedly, the African economic crises and global inflation are serious obstacles to achievement of Health For All by Year 2000 and the various structural adjustment programmes have led to less and less budgetary allocation to health and even much less to health development.

In the face of obvious continental pattern of declining health indices, poor standards in professional training centres and in the health care delivery systems, and brain drain of health workers, particularly physicians, the Confederation of African Medical Associations and Societies (CAMAS) had no option but to take up the challenge of exploring avenues through which the demands of people of Africa for better health can be achieved in spite of these numerous constraints.

Similarly, the Organisation of African Unity (OAU) is well aware of the role of health in the overall socio-economic development of its member states. In 1979, the Lagos Plan of Action (PLA) for the socio-economic development of Africa by year 2000 was adopted by the OAU Heads of States and Governments. The implementation of this blueprint has been hampered by multiple factors. In 1985, to speed up this socio-economic development, Africa's Priority Programme for Economic Recovery (APPER) between 1986 and 1990 was adopted. The awaited economic recovery is not yet evident but instead, the prices of Africa's exports have plummeted. The prices of Africa's import have soared steeply, the quantum of Africa's external debt has grown dramatically, and the Continent has sunk deeper in the quagmire of economic recession. This is the sombre background against which African leaders in 1987 issued the Declaration on "Health as Foundation for Development", and the backdrop against which plans are underway for the establishment of an African Economic Community.

PREAMBLE

In May 1990, the Secretariat of the Confederation of African Medical Associations and Societies in accordance with its objectives, approached the Secretariat of the Organisation of African Unity to jointly sponsor a round table meeting with a view to identifying constraints and find workable solutions to the unacceptable standard of health care delivery on the African Continent.

Upon acceptance of the idea in principle by the OAU, it was thought appropriate that the World Health Organisation (AFRO) and UNICEF should be invited to collaborate. Keynote papers were requested from selected persons on the following topics:

1. Health and Politics in Africa.
2. Health and Development in the Decade of the Nineties.
3. Health Development Strategies in Adverse Economic Climate.
4. Role of Politics in Health: Experiences from Francophone, Arab and Anglophone Africa.

All keynote papers as well as other papers delivered and the working group discussions will be published in the proceedings of the meeting.

THE ROUND TABLE MEETING

The meeting was declared open by the Minister of Health of the Kingdom of Lesotho, Mr F. L. Thoalane, who read the Opening Address. A welcome address was delivered by Dr M. Mokete, Past President (CAMAS) and President, Lesotho Medical Association. Keynote addresses and ordinary papers were presented by the following: HIS EXCELLENCY M.T. MAPURANGA — ASST. SECRETARY-GENERAL, O.A.U

Professor J. Namboze	—	*on behalf of WHO Regional Director (AFRO)*
Professor Mamdour Gabr	—	*Past President (CAMAS)*
Dr E. Tarimo	—	*Director, Division of Strengthening of Health Services WHO Geneva.*
Dr A. O. Adewunmi	—	*Nigeria*
Dr E. Kigonye	—	*Uganda*
Dr Nkandawarara	—	*Zimbabwe*
Dr J. Jagwe	—	*Uganda*
Professor Edemariam Tsega	—	*President (CAMAS) (Ethiopia)*
Professor Ope Adekunle	—	*Secretary General (CAMAS) (Nigeria)*

HIGHLIGHTS OF THE PRESENTATIONS:

A. HEALTH INDICES

Available data appears to suggest there has been some overall improvement in health in all countries as indicated by lower mortality rates over the last two decades and rising life expectancy. However, health development beyond the level of economic development is rare which in turn is affected by many adverse factors already enumerated. In fact there are countries whose level of health development falls short of their economic development. Such factors as education especially of women, nutrition, political systems and access to health services are important variables in determining health development vis a vis socio-economic development.

A comparison of the situation in Africa with developed countries show glaring dissimilarities. Thus, in the least developed countries to which many African countries belong, the per capita gross domestic product is about US $250, compared with about US$12,000 in the developed countries. The amount spent on health per capita is often less than US$5, while it often exceeds US$2,000 in the developed countries. Life expectancy at birth is under 50 compared with 74 years in the developed countries.

Out of 1,000 babies born alive, some 120 die before they reach the age of one year, compared with 15 in the developed countries. Some 60% of the population in the least developed countries is illitrate compared with 3% in the developed countries. In addition, the population is growing by 2.7% a year, and is still increasing.

This fact alone could defeat any economic growth that may be achieved. In fact, statistics show that the per capita gross domestic product growth during the past decade was actually negative i.e. - 0.3% in these countries. In addition, the burden of AIDS (Acquired Immune-Deficiency Syndrome) which is closely linked to poverty and ignorance will add to the negative impact. Of the estimated 8 - 10 million cases of HIV infection globally, over 2 - 5 million are in the least developed countries. This means that about one in 80 adults in the least developed countries is HIV positive. For the least developed countries in Africa, the number is one in 40. The Global estimated cumulative number of cases of AIDS is about 800,000. Of these more than 575,000 are in developing countries of which over 350,000 are in least developed countries.

B. STATE OF HEALTH SERVICES AND INFRASTRUCTURES

Accurate statistical data are difficult to get on the quality and quantity of health services and health infrastructures in Africa. However, the following deficiencies have been identified in most African countries.

(1) Health Planning

Health Planning to ensure good programme management is lacking in most African countries.

(2) Medical supplies

In most parts of Africa, more than 50% of the local needs of drugs are imported. Importation tends to be erratic. Essential drug lists, proposed by WHO for the purpose of ascertaining continuity of supplies, protection of patients and minimising national cost, are only available in a limited number of African states.

(3) Equipment, Supplies, Repair and Maintenance

Like drugs, basic equipment are often imported. Such diagnostic and therapeutic equipment are obtained from different sources and become obsolete in a short time. Local expertise are not many. As a result, it is not uncommon to find a number of expensive and basic equipment stored away, waiting for spare parts and expertise.

(4) Specialised Services

Specialised services, like cardiac surgery, neurosurgery, etc. are not well developed in many African countries. As a result, only the privileged few can afford to go abroad for treatment. The economic implication is quite obvious.

(5) Health workers and health services

Compared to their counterparts outside the continent,health workers are poorly paid. In some countries there is no career structure to safe guard professional advancement. Collective bargaining is not tolerated by many governments. Yet, cost of living continues to soar. The results are:

(a) Loss of dedication and interest in government health services.

(b) "Brain drain", internally and externally

(c) Proliferation of private clinics with all its problems: i.e. it caters to the few, usually urban dwellers; it is often lucrative and poorly con trolled; it may weaken programme of training institutions.

(6) **Health Infrastructures**

Health institutions are not increasing in number commensurate with the rising population in many countries of Africa, while many of the existing ones are poorly maintained.

(7) **Inadequate funding**

Most African governments allocate a small proportion of their annual budget to health while devoting a lion share to defence.

C. **Working Groups**

The Round Table meeting deliberated on these issues from four major perspectives at two working group sessions.

1. Political structure and African Health Scenario.
2. Political Constraints in implementation of Health Programmes and how to overcome them.
3. Health Development Strategies in Adverse Economic Climate.
4. Individual Roles of CAMAS, OAU, WHO, UNICEF and other agencies reordering the political, social and economic order to assure Health attains its relevant role in development in Africa.

Conclusions And Recommendations

The keynote papers, other presentations and working group discussion were then considered by a Panel to produce the following Conclusions and Recommendations of the Round Table meeting.

1. **Political Structure and African Health Scenario.**

(a) The Round Table meeting notes the Declaration of the Heads of States and governments of member states of the Organisation of African Unity on the current political changes in Eastern Europe and their impact on Africa. It therefore recommends the encouragement of democratisation and popular participation of peoples of Africa in the processes of government and development, with extension of these processes to the health sector.

(b) The Round Table meeting notes the Declaration of OAU that health is the foundation for development. It therefore recommends the evolution of political structures which will among other things regard the Ministry of Health as a priority Ministry without surbodination to any other Ministry and be responsible for planning and implementation of health programmes including procurement of supplies.

(c) The Round Table meeting notes with concern the disruption in health services and attendant decline in health status as occurs during and after periods of intra country and inter country conflicts and during periods of political instability. It therefore recommends that the Organisation of African Unity reviews the policy of non-interference in internal affairs of member states and help establish peace when necessary in order to reduce the suffering of the people and ensure that their health is safe guarded.

2. Political constraints in implementation of Health Programmes and how to overcome them.

The Round Table meeting recognised the following factors as the main political constraints in implementation of health programmes in most African countries.

(a) Political instability
(b) Absence of a health oriented development plan
(c) Absence of a national health policy
(d) Huge foreign debt with debt servicing
(e) Inappropriate political leadership
(f) Defective economic policy
(g) Lack of political culture of public accountability

It therefore recommends that:

(a) each member state should take measures to enhance popular participation, equality of opportunity and hence prevent internal conflict and political instability.

(b) each member state of the OAU should articulate its national health policy based on Primary Health Care and formulate strategies for its implementation which will not be adversely influenced by changes in political leadership.

(c) each member state of OAU should build into its political system measures that will promote public accountability.

(d) political appointments to professional posts in the health sector should be based on merit.

(e) member states of the OAU should encourage the participation of representatives of their professional medical associations in the development of their health policies and implementation of their health programmes.

3. **Health Development Strategies in Adverse Economic Climate.**

The Round Table meeting notes the adverse economic climate in Africa due to heavy debt burden, global inflationary trend, inter country conflicts, falling prices of export commodities and rising prices of import commodities resulting in Structural Adjustment Programmes.

It therefore recommends that:

(a) member states of OAU should adopt the ECA proposed Structural Adjustment Programme.

(b) member states of the OAU should adopt a collective bargaining position in negotiating for funds for health development programmes like Drug Revolving Fund, Health Systems Fund, Purchase of Equipment etc. to avoid unfavourable and exploitative terms built into bilateral negotiations.

(c) member states of the OAU should ensure that health programmes especially those of benefit to the poor are not affected by the Structural Adjustment Programmes.

(d) cost sharing schemes between the government and the community should be built into designated health services.

(e) member states should improve and upgrade health facilities for optimal utilisation by existing trained manpower and discourage resort to overseas medical treatment by privileged few.

(f) member states should consider collectively setting up regional centres of excellence to facilitate exchange of information, manpower training and referral for specialised care.

(g) member states should encourage management training by health professionals especially early in their career.

(h) member states should give priority to:

1. Implementation of appropriate remuneration structures for physicians.
2. Improvement of health care facilities in order to stop manpower loss through internal and external brain drain.

(i) the OAU should intensify its efforts to harmonise educational qualifications in African Health Institutions and also determine the relevance of foreign medical curricula to African needs.

4. Individual Roles of CAMAS, OAU, WHO, UNICEF.

The Round Table meeting recognised the individual and collective roles of these organisations and recommends as follows:

(a) **CAMAS**

(1) should continue to sensitise its member associations on the impact of politics on health.

(2) should encourage its member associations to enter into dialogue with their national governments, act as partners in progress and have strong ocacy for national health programmes.

(3) should continue to function in collaboration with OAU, WHO, UNICEF in health development at national and continental level:

(4) should encourage its member associations to persuade individual physicians to enter politics so as to act as catalysts for change from within.

(b) **WHO**

(1) should continue to fulfil its role in international health as stipulated in its charter.

(2) should provide directions and appropriate framework for attainment of Health for All by the year 2000.

(3) provide collaborative role with member states by providing technical assistance based on health priorities already identified and assist in mobilising human, material and other resources.

(4) foster cooperation among professional groups for example CAMAS and in so doing contribute to the advancement of health.

(5) collaborate with Sister United Nations agencies, other International organisations and N.G.Os to facilitate health programmes.

(6) work closely with OAU in the promotion of Health in Africa through WHO Liaison Office in Addis Ababa.

(c) **OAU**

(i) should strengthen Africa's cooperation with international agencies like WHO and UNICEF and others that deal with health in order to channel increased financial and manpower resources to the African Continent.

(2) encourage formation of and strengthening of existing medical associations and societies and to convince governments of member states to involve them in planning of national health systems and programmes.

(3) draw attention of OAU member states to the grave consequences of armed conflict on peoples' health and also the resultant plight of refugees and displaced persons.

(d) **UNICEF**

(1) should continue its advocacy at the highest level for equitable distribution of health services particularly to reach the poor.

(2) should continue to support institutional capacity building at all levels.

(3) should support measures to monitor the effects of adverse political changes on health.

(4) should cooperate with CAMAS and other agencies in advancement of health.

(5) should support mechanisms or structures established for the active involvement of communities.

The Round Table meeting resolved that this document be placed before the 3rd Ordinary Session of Organisation of African Unity Health Ministers Conference in April/May 1991.

PROFESSOR O. O. ADEKUNLE

Secretary General (CAMAS)

September 1990.