iAHO Knowledge Generation Capacity Building Workshops

August & September 2022

iAHO
Integrated African Health Observatory

World Health Organization
REGIONAL OFFICE FOR Africa

REPORT BY

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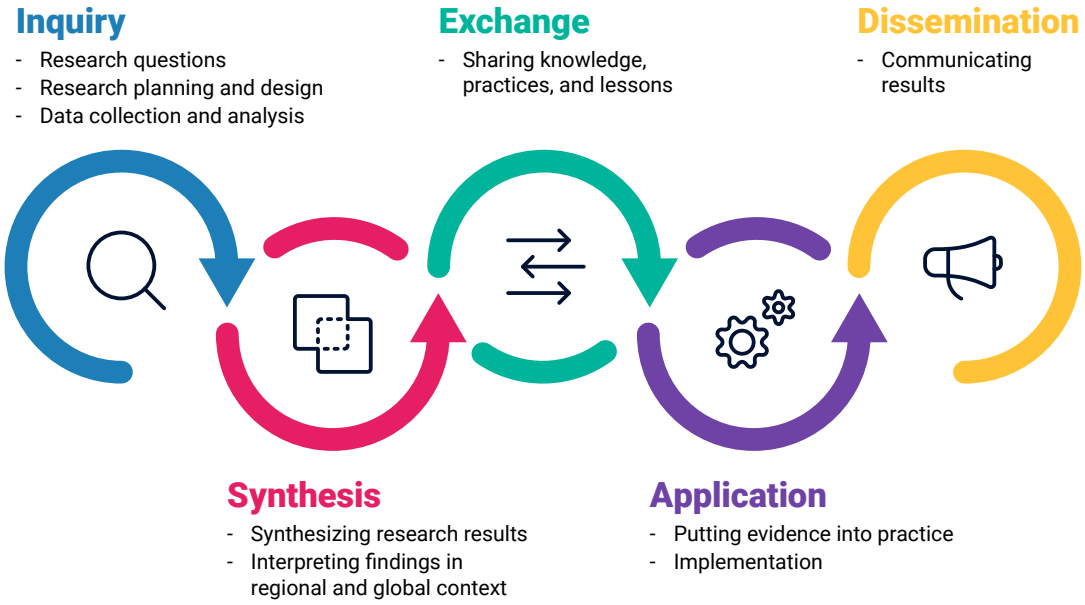
Background

With WHO/AFRO support, several countries are developing their national health observatories (NHOs) as "one-stop shops" within the integrated African Health Observatory (iAHO) to strengthen their national health information systems. Part of the support is to support countries in knowledge generation as they are sitting in a lot of data and information that is not use for the right purpose. In fact, in 2022, the iAHO team agreed to produce strategic knowledge outputs to develop a robust regional evidence base for decision making. This involves building the capacity of Member States to generate targeted policy-relevant knowledge products. These products are to be developed and channelled across the knowledge translation chain.

Figure 1: Knowledge Translation chain



Not only will the production of this knowledge increase the visibility of AFRO's work (cf. GPW13) and improve the understanding of universal health coverage, health security and healthier populations, it will also drive traffic to the integrated African Health Observatory (iAHO). The iAHO is WHO's "one-stop shop" for health and health related information in the African Region. Strengthened buy-in for National Health Observatories and other platforms embedded within the iAHO is expected to improve the availability and use of data and evidence in countries and the Region, while also helping to monitor and evaluate the implementation of programmes, national strategies and plans, and health systems development/strengthening efforts.

After several requests coming from countries, the iAHO team proposed a concept note for workshops to strengthen the capacity of NHOs to generate knowledge products, under the 'Knowledge and evidence' pillar of health information. Two sessions took place, the first with six French speaking countries[1] in Côte d'Ivoire (Grand Bassam) from 29th to 2nd September 2022 and the second session with English speaking countries[2] in Uganda (Kampala) from 5th to 9th September 2022.

1 Burkina Faso, Burundi, Cabo Verde, Cameroon, Côte d'Ivoire and Niger
2 Ghana, Kenya, Mozambique, Nigeria and Uganda

Figure 2: iAHO as enabler of DAK (Data, Analytics and Knowledge)

DATA	ANALYTICS	KNOWLEDGE
Scope - Facility based data - Vital statistics data - Surveillance data - Data from health surveys - Research data	**Scope** - Analytical methods - Comparative analyses - Trend & distribution analyses - Prediction of future trends	**Scope** - Health policy briefs - Blogs and events - UHC best practices - Evidence for policy fora
Products - Data on community events - Data on facility events - Functional data systems: DHIS 2, CRVS - Statistics reports consolidating data	**Products** - Performance reports - Analytical reports for specific areas of the sector - Tools for facility or sector analyses - Repository of analytical results	**Products** - Health policy briefs - Best practices documentations - Evidence syntheses - Scientific articles - Policy and evidence fora - Africa knowledge platforms

Objectives and expected results

General objective

The main objective of these workshop was to train 11 selected countries based on NHO development status in the generation of a range of knowledge products (Analytical fact sheet, Knowledge fact sheet, Blog, Policy brief, Infographic and how to use various communication channels) that will support their decision-making processes.

Specific objectives

1. Introduce and strengthen the capacity of NHO focal points in the production of infographics, policy briefs, analytical and knowledge fact sheets and blog posts;
2. Strengthen the capacity of focal points to synthesize evidence and generate knowledge along the policy-to-action cycle;
3. Provide the focal points with the capacity to train their colleagues who did not participate in the training in the production of knowledge products
4. Enable different countries to share their experiences in knowledge translation for evidence-informed decision-making.

Methodology

The workshops focussed on delivering all proposed content in interactive and immersive ways, including: (i) Presentations and discussions on key knowledge products, (ii) Practical exercises and experience-sharing and (iii) Work plan discussions for the coming months. The products of focus center around AFRO's institutional classification of knowledge product types. Prior to the workshop, participating countries identified topics (based on national priorities) that were developed using two

types of knowledge products, most countries selected to develop policy briefs, analytical fact sheets and infographics. The drafts proposed by the countries were subject to a pre-workshop review session which allowed for improved versions to be presented during the workshops. During the two workshops, the facilitators introduced each product with methodological reminders on the form and content of each type of knowledge product, followed by a peer review, at the end the countries were able to qualitatively improve their products and present final versions ready for dissemination.

Achievements

1. Draft curricula for knowledge generation capacity building is available for cascade training at country level (Table 1).
2. All the countries participating in the workshop had their capacity strengthened to produce knowledge products. At the end of the workshop, **44 knowledge products** were finalized from the five types (Analytical fact sheet, Knowledge fact sheet, Blog, Policy brief, Infographic) presented during the workshop. The different knowledge products are touching on different health topics and issues from countries, below is the table summarizing the different knowledge products by country and type (Table 2).
3. All countries planned the number and types the knowledge products to be developed from Quarter 4 2022 to Quarter 4 2023, these will be achieved with WHO/AFRO support (Table 3).

N°	Module
1	**Setting the scene** - NHO as a pillar of health information system in country - Role & impact of knowledge generation in the health information ecosystem - Range of knowledge products: 6 KT Product Types
2	**Analytical Fact sheet** (ZOOM IN) - Overview and practical demonstration of step-by-step approaches - Presentation of the drafts prepared by the country and peer review
3	**Knowledge Fact sheet** (ZOOM IN) - Overview and practical demonstration of step-by-step approaches - Presentation of the drafts prepared by the country and peer review
4	**Infographic** (ZOOM IN) - Overview and practical demonstration of step-by-step approaches - Presentation of the drafts prepared by the country and peer review
5	**Blog post** (ZOOM IN) - Overview and practical demonstration of step-by-step approaches - Presentation of the drafts prepared by the country and peer review
6	**Policy brief** (ZOOM IN) - Overview and practical demonstration of step-by-step approaches - Presentation of the drafts prepared by the country and peer review
7	**Communication and Dissemination** (ZOOM IN)
8	**The Evidence-to-Policy-to-Practice Pathway Experience-sharing** (ZOOM IN)
9	**Country perspective and target Setting – Planning Knowledge development**
10	**Final presentations of all the knowledge products**

Table 2: Knowledge products developed during French speaking countries session in Cote d'Ivoire (from 29th to 2nd September 2022) and Uganda (from 5 to 9 September 2022)

	Policy Brief	Knowledge Fact Sheet	Analytical Fact Sheet	Infographic	Blog
Burkina Faso	Effects of Covid-19 on hospital mortality in Burkina Faso	Resilience of essential health services		- Major morbidities and mortality in Burkina Faso - Territorial health inequalities in Burkina Faso - Threats and risks to health and health emergencies in Burkina Faso - Dynamics of universal health coverage in Burkina Faso	
Burundi			The functionality of health districts determines the achievement of health system results	Quality of medicines in Burundi	
Cabo Verde			Diabetes in Cape Verde: current situation	Tobacco use in Cape Verde	Advancing Traditional Medicine in Africa
Cameroon	Data collection on causes of death in Cameroon: status and recommendations		Monkeypox: risk of importing the new variant into Cameroon		Building the capacity of NHOs in the production of knowledge products
Côte d'Ivoire	Situation of maternal deaths in Côte d'Ivoire: how to reverse the trend?		Data quality for good decision-making		Status of Universal Health Coverage in Côte d'Ivoire
Ghana		What is e-Tracker	Under 5 mortalities	- Breast cancer awareness - Leading causes of deaths - Doctor to population	Identifying and addressing challenges in deploying electronic registers in Ghana
Kenya	Effectiveness of physical measures for control of mosquito and mosquito borne diseases for Kenya		Taking stock of a decade of UHC implementation	Vaccination against HPV	
Mozambique	Neonatal Mortality from Avoidable Causes: Is it a Public Health Problem in Mozambique? [Still in development]			- Standards for the functioning of public administration - Neonatal mortality: how to prevent?	
Niger	Infant mortality in Niger: a high proportion of new-born deaths			Main risk factors for NCDs	
Nigeria	Strengthening disease surveillance and response system in Anambra State, Nigeria		Nigeria health facility service delivery statistics: where are we?	- SDG 3 in Brief - Malaria in Pregnancy - What is UHC?	Data Governance and Data Quality for Enterprise Health Business; Does the use of Incentives Impact Maternal Mortality? Lessons from a Nigerian State
Uganda			Maternal child health statistics	Education is a key to good health	Where does the dependency of malaria-endemic African countries on external financiers leave the continent? Stronger or more vulnerable?

At the end of the workshop, we agreed with countries on the future plan, and each country develop a one-year plan (by quarter) of knowledge products development by type, and AFRO will provide the necessary technical and if possible financial support for the more than 50 targeted products (Table 2).

Table 3: Knowledge products planned from Q4 2020 to Q4 2023 by French speaking countries 1 English speaking countries who attended sessions in Cote d'Ivoire (from 29th to 2nd September 2022) and Uganda (from 5 to 9 September 2022)

	Q4 2022	Q1 2023	Q2 2023	Q3 2023	Q4 2023
Burkina Faso	- Infographic (2) - Analytical fact sheet (2)	- Analytical fact sheet (1) - Infographics (2)	- Analytical fact sheet (1) - Policy brief (1)	- Analytical fact sheet (1) - Blog post (1)	- Blog post (1) - Knowledge fact sheet (1)
Burundi	- Analytical fact sheet (1) - Infographic (1)	- Infographic (1) - Blog post (1)	- Knowledge fact sheet (1) - Blog post (1)	- Infographic (1) - Policy brief (1)	- Knowledge fact sheet (1) - Infographic (1)
Cabo Verde	- Knowledge fact sheet (1) - Analytical fact sheet (1)	- Blog post (1) - Infographic (1)	- Knowledge fact sheet (1) - Policy brief (1) - Infographic (1)	- Blog post (1)	- Policy brief (1)
Cameroon	- Policy brief (1) - Fact sheet (1) - Blog post (2)	- Policy brief (1) - Infographic (1) - Fact sheet (1) - Blog post (2)	- Policy brief (1) - Infographic (1) - Fact sheet (1) - Blog post (2)	- Policy brief (1) - Infographic (1) - Blog post (2)	- Fact sheet (1) - Policy brief (1) - Infographic (1) - Blog post (2)
Côte d'Ivoire	- Analytical fact sheet (1) - Knowledge fact sheet (1)	- Blog post (2) - Knowledge fact sheet (1)	- Infographic (1) - Analytical fact sheet (1)	- Analytical fact sheet (1) - Blog post (1)	- Blog post (1) - Knowledge fact sheet (1)
Ghana	- Infographic (1) - Analytical fact sheet (1)	- Policy brief (1) - Fact sheet (2) - Infographic (1)	- Policy brief (1) - Fact sheet (2) - Infographic (1)	- Analytical fact sheet (1) - Knowledge fact sheet (1) - Infographic (1)	- Policy brief (1) - Fact sheet (2) - Infographic (1)
Kenya	- Analytical fact sheet (1) - Infographic (1)	- Fact sheet (2) - Infographic (1) - Policy brief (1)	- Fact sheet (2) - Blog post (2) - Policy brief (1)	- Fact sheet (2) - Infographic (1) - Policy brief (1)	- Fact sheet (2) - Blog post (1) - Policy brief (1)
Mozambique	- Infographic (2)	- Policy brief (1) - Knowledge fact sheet (1)	- Analytical fact sheet (1) - Policy brief (1)	- Knowledge fact sheet (1)	Identifying and addressing challenges in deploying electronic registers in Ghana
Niger	- Infographic (1)	- Analytical fact sheet (1)	- Knowledge fact sheet (1)	- Policy brief (1)	- Blog post (1)
Nigeria					
Uganda					

Recommendations / Way forward

1. Continue to provide technical support in the production of knowledge products that have been planned from Q4 2022 to Q4 2023.
2. Share successful practices by countries so that other countries can benefit.
3. Organize a quarterly virtual meeting of the National Health Observatories in two groups (French speaking countries and English-speaking countries).
4. Establish a mechanism for knowledge sharing between countries.
5. Develop partnerships with other national/regional platforms working on knowledge generation.
6. Support cascade training in countries on knowledge production
7. Organize a knowledge capacity building workshops for the remaining countries of the Region (37).

Annexes

Annex 1 – List of participants

	Organisation	Name	Title
Burkina Faso	MOH	BADOLO Hermann	Directeur de l'ONSP
	MOH	BAMOGO/OUEDRAOGO Samiratou	Public health expert
	WHO	TINGUERI Rose	Point focal AHO
Burundi	MOH	NTAHOMVUKIYE Gerard	Directeur de la Recherche à l'INSP
	MOH	NIZIGIYMANA Dionis	Informaticien gestionnaire des données à l'INSP
	WHO	CIZA Alphonse	NPO Universal Health Coverage
Cabo Verde	MOH	Domingos Varela	Cadre à l'ONS
	MOH	Jonas Gomes	Cadre à l'ONS
	WHO	Edith Pereira	Health Promotion Officer
Cameroon	MOH	Bello Djamila Mohamadou	Coordonnateur ONSP
	MOH	Do'o Bessin René	Chef de la Section ONSP
	WHO	Gatcho Modeste	Expert HIS
Côte d'Ivoire	MOH	Ahoty Franck	Chef Service Information sanitaire
	MOH	Halima Bamba	Informaticienne
	MOH	Kone Hamidou	Statisticien
	WHO	ZOMBRE Daogo Sosthene	Health Systems Coordinator
Ghana	MOH	Thomas Ankomah	Principal statistician, Ghana Health Service
	MOH	Mawunyo Segbefia	Ag Head Documentation & Management Unit, Ministry of Healt
	WHO	Mr Dominic Kwabena Atweam	NPO/ Information SHI
Kenya	MOH	Dr Helen Kiarie	Head of Division, M&E MOH
	MOH	Peter Wanjohi	Division of Research, MOH
Mozambique	INS - NHO	Sheila Nhachungue	Head of Platform
	MoH - HRHO	Helena Machai	INS
	WHO	Cidalia Baloi Ogunlana	M&E Officer
Niger	MOH	Ibrahim MOUSSA	Cadre à la Direction des statistiques sanitaires
	MOH	Aïchatou ISSAKA	Cadre à la Direction des statistiques sanitaires
	WHO	ZAMPALIGRE Fatimata	Health Systems Coordinator
Nigeria	WHO	Nkiru Ukor	M&E Officer
	FMOH	Charles Nzelu	Director M&E FMOH
	FMOH	Amara Uche	Head of Unit FMOH
Uganda	MOH	Edgar Buddu	HMIS Officer
	MOH	Andrew Kwiringira	HMIS Officer
WHO/AFRO	WHO	BATALIACK Serge Marcial	Coordinator integrated African Health Observatory
	WHO	SEYDI Aminata Binetou Wahebine	Knowledge Management Officer
	WHO	SY Sokona	Strategic Health Information Officer
	WHO	NGOMO KANOHAS Jeanine	Administrative Assistant

Annex 2 – Country knowledge products

BURKINA FASO

- Policy Brief: Effects of Covid-19 on hospital mortality in Burkina Faso

Effets de la Covid-19 sur la mortalité hospitalière au Burkina Faso

NOTE D'ORIENTATION POLITIQUE

Auteurs : *Hermann Badolo, Richard Bakyono, Herman Bazié, Mimboué Yara, Samiratou Ouedraogo, Rose K Tingueri, Moussa Traoré, Hervé Hien.*

Résumé	Faits saillants
Dans le contexte de la COVID-19, une potentielle augmentation du nombre de décès toutes causes confondues, du fait de la réduction de la disponibilité et/ou de l'utilisation des services de santé est prévisible. A travers une étude quantitative rétrospective à visée descriptive et analytique, l'INSP a évalué l'impact de la COVID-19 sur la mortalité toutes causes confondues avant et pendant la COVID-19. Les résultats montrent qu'il y a eu plus de décès enregistrés par mois pendant le COVID-19 dans les hôpitaux du Burkina Faso. On note une augmentation beaucoup plus importante du nombre de décès en milieu rural comparativement au milieu urbain pendant le COVID-19. Ces résultats plaident en faveur de l'amélioration du système d'information nationale sur les décès et la systématisation de la surveillance de la mortalité à l'échelle nationale pour des prises de décision plus favorables à la réduction de la mortalité au Burkina Faso.	• Plus de décès enregistrés par mois pendant le COVID-19, 1 057 décès en moyenne par mois pendant la COVID-19 contre 657 avant la survenue de la pandémie de COVID-19 • Une augmentation beaucoup plus importante du nombre de décès en milieu rural comparativement au milieu urbain pendant la période de la COVID-19 comparativement à la période avant la COVID-19 • La malnutrition aiguë sévère, les infections du nouveau-né et les pneumopathies tuent plus pendant la COVID-19 comparativement à la période avant la COVID-19.

Introduction

Dans le contexte de la COVID-19, une potentielle augmentation du nombre de décès toutes causes confondues, du fait de la réduction de la disponibilité et/ou de l'utilisation des services de santé est prévisible. Ainsi le bureau régional de l'OMS pour l'Afrique a appuyé la surveillance rapide de la mortalité, dans un certain nombre de pays dont le Burkina Faso, pour assurer la disponibilité des tendances de la mortalité par rapport à l'épidémie de COVID-19. L'objectif de cette étude était d'évaluer le niveau et la répartition de la mortalité due aux maladies et aux traumatismes avant et pendant la COVID-19.

Approche méthodologique

Cette étude a été conduite au Burkina Faso en 2021 par une équipe de l'Institut national de santé publique. Il s'agissait d'une étude quantitative rétrospective à visée descriptive et analytique. Une collecte de données au niveau des sources primaires (dossiers des patients et registres d'hospitalisation) a été organisé dans un certain nombre d'hôpitaux. La collecte

1

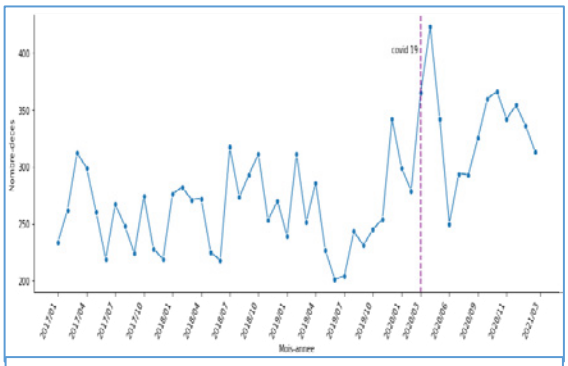
des données auprès des différentes structures s'est déroulée d'avril à septembre 2021 et a porté sur la mortalité pendant la période allant de janvier 2017 à mars 2021.

La collecte de données a concerné au total 30 formations sanitaires. Le choix des formations sanitaires pour cette collecte de données a été fait de façon raisonnée selon les critères suivants : (1) être une formation sanitaire d'une région faiblement représentée dans la base de données du DHIS2 ; (2) être une formation sanitaire de niveau intermédiaire ou tertiaires : CMA, CHR et CHU ; et (3) être située de préférence sur l'un des principaux axes routiers du pays afin de pouvoir prendre suffisamment en compte les décès liés aux accidents de la circulation.

Les analyses statistiques basées sur les objectifs de l'étude étaient essentiellement des tableaux de contingence, des graphiques bidimensionnels de comparaison des moyennes mensuelles, trimestrielles et annuelles de nombre de décès. Le recodage des variables d'intérêts et l'analyse des données a été faits avec le logiciel STATA® 17 et Python 7.

Résultats et conclusion

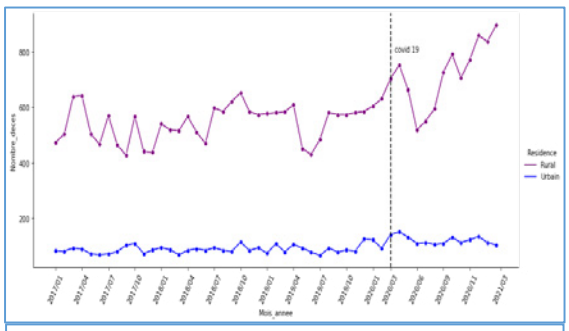
Les résultats montrent qu'il y a eu en Moyenne 1 057 de décès enregistrés par mois pendant le COVID-19 contre 657 et de décès en moyenne avant le COVID-19. On note une augmentation à peu près comparable du nombre de décès chez les hommes et chez les femmes pendant la période de la COVID-19.



Graphique 1 : Évolution mensuelle du nombre de décès entre le 1er janvier 2017 et le 31 mars 2021

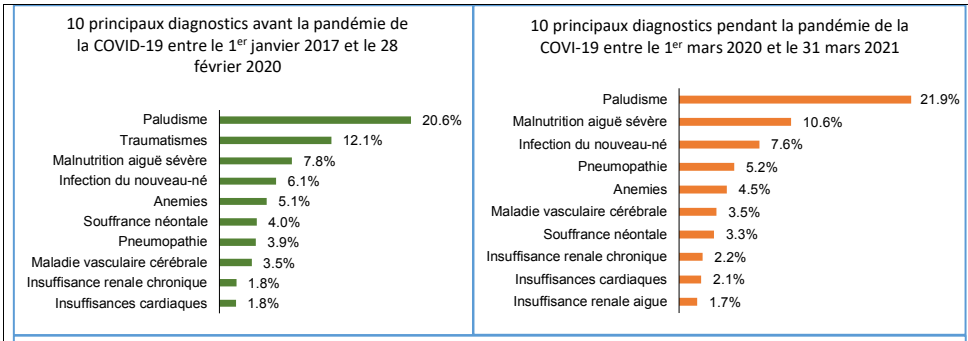
Globalement, la mortalité est plus élevée chez les hommes que chez les femmes. On note une augmentation à peu près comparable du nombre de décès dans les 2 groupes pendant la période de la COVID-19. On note une augmentation beaucoup plus importante du nombre de décès en milieu rural comparativement au milieu urbain pendant le COVID-19.

Dans les formations sanitaires enquêtées, avant la COVID-19, du 1er janvier 2017 au 28 février 2020, le paludisme était la première cause de décès (20,6%), suivi des traumatismes (12,1%) et de la malnutrition aiguë sévère (7,8%). De même, comme le présente le graphique suivant, pendant la COVID-19, du 1er mars 2021 au 31 mars 2021, le paludisme (21,9%) était la première cause de décès, suivi de la malnutrition aiguë sévère (10,6%) et de l'infection du nouveau-né (7,6%).



Graphique 3 : Évolution mensuelle du nombre de décès en fonction du lieu de résidence entre le 1er janvier 2017 et le 31 mars 2021 au Burkina Faso

La malnutrition aiguë sévère, les infections du nouveau-né et les pneumopathies tuent plus pendant la COVID-19 comparativement à la période avant la COVID-19.



Graphique 4 : Répartition des décès selon les 10 principales pathologies diagnostiquées avant et pendant la COVID-19

Le Burkina Faso présentait une surmortalité toutes causes confondues avec l'avènement du Covid-19. Alors que la pandémie se poursuit et même s'aggrave dans le pays, les leçons tirées de la première année de la pandémie peuvent s'avérer utiles pour minimiser la surmortalité toutes causes confondues. Ces résultats plaident en faveur de l'amélioration du système d'information nationale sur les décès et la systématisation de la surveillance de la mortalité à l'échelle nationale pour des prises plus favorables à la réduction de la mortalité au Burkina Faso.

Recommandations pour l'action

- Au gouvernement : Commanditer une étude sur les causes sous-jacentes de la mortalité accrue dans le contexte de la COVID-19 aux fins d'agir efficacement sur ces causes ;
- Au ministère de la Santé et de l'Hygiène publique : Assurer l'exhaustivité des données saisies dans Endos-BF notamment les données en lien avec les décès et améliorer la coordination des structures métiers du ministère qui collectent et gèrent des données sur les décès ;
- Au ministère de la Santé et de l'Hygiène publique : Introduire la collecte des causes de décès avec la Classification Internationale des Maladies (CIM) ;
- Aux partenaires au développement : Appuyer le gouvernement financièrement et techniquement pour une systématisation réussie de la surveillance rapide de la mortalité au plan national.

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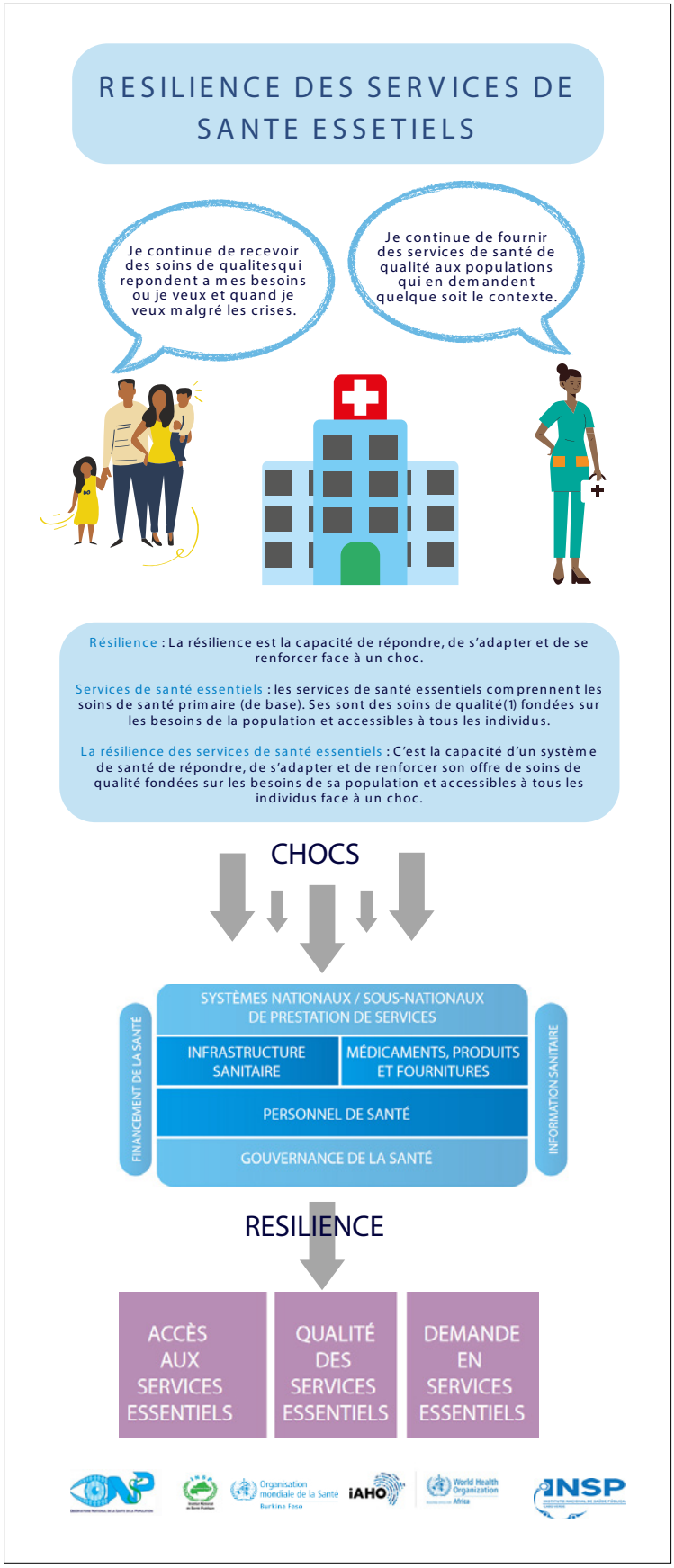
ONSP/INSP

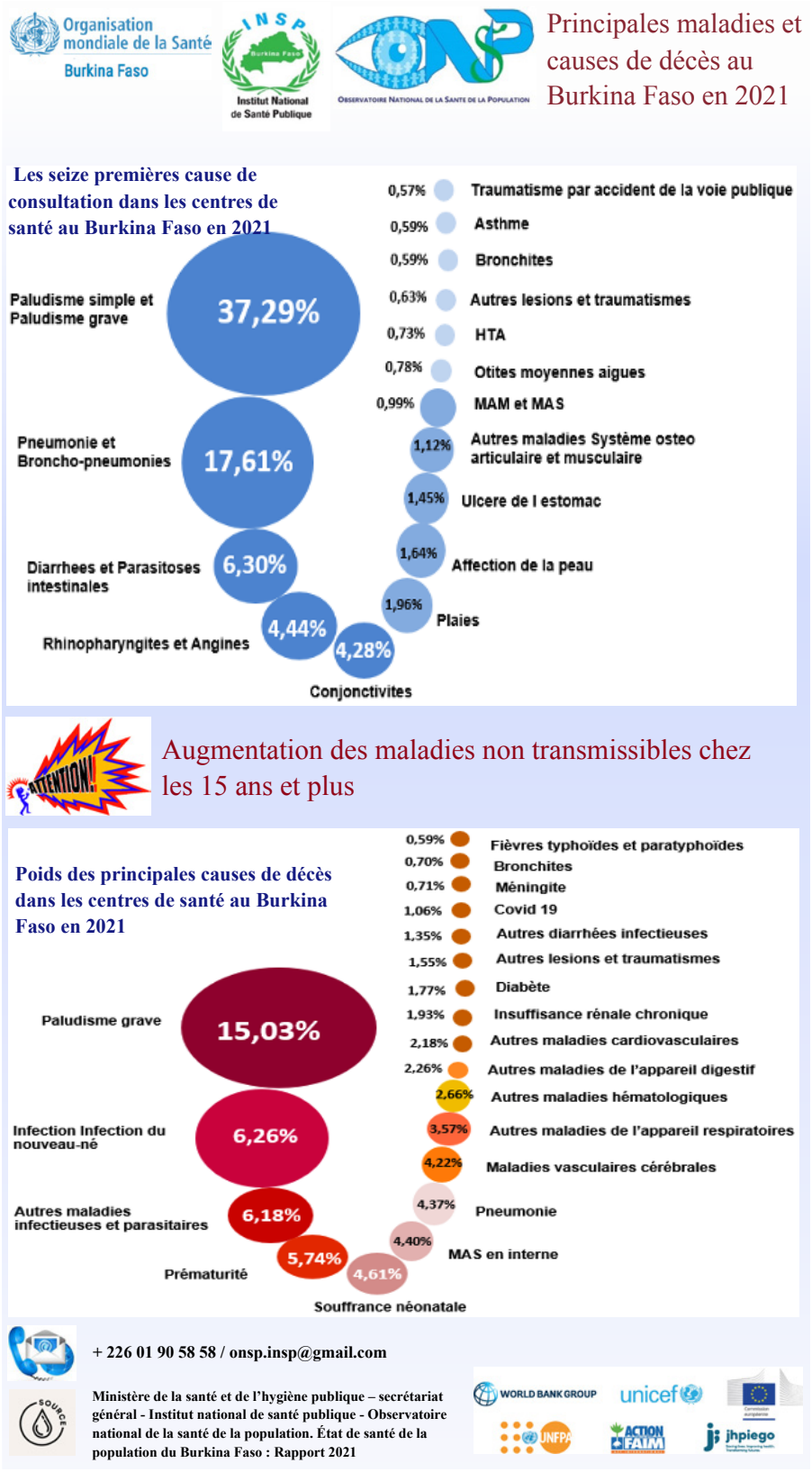
BURKINA FASO

- Knowledge Fact Sheet: Resilience of essential health services



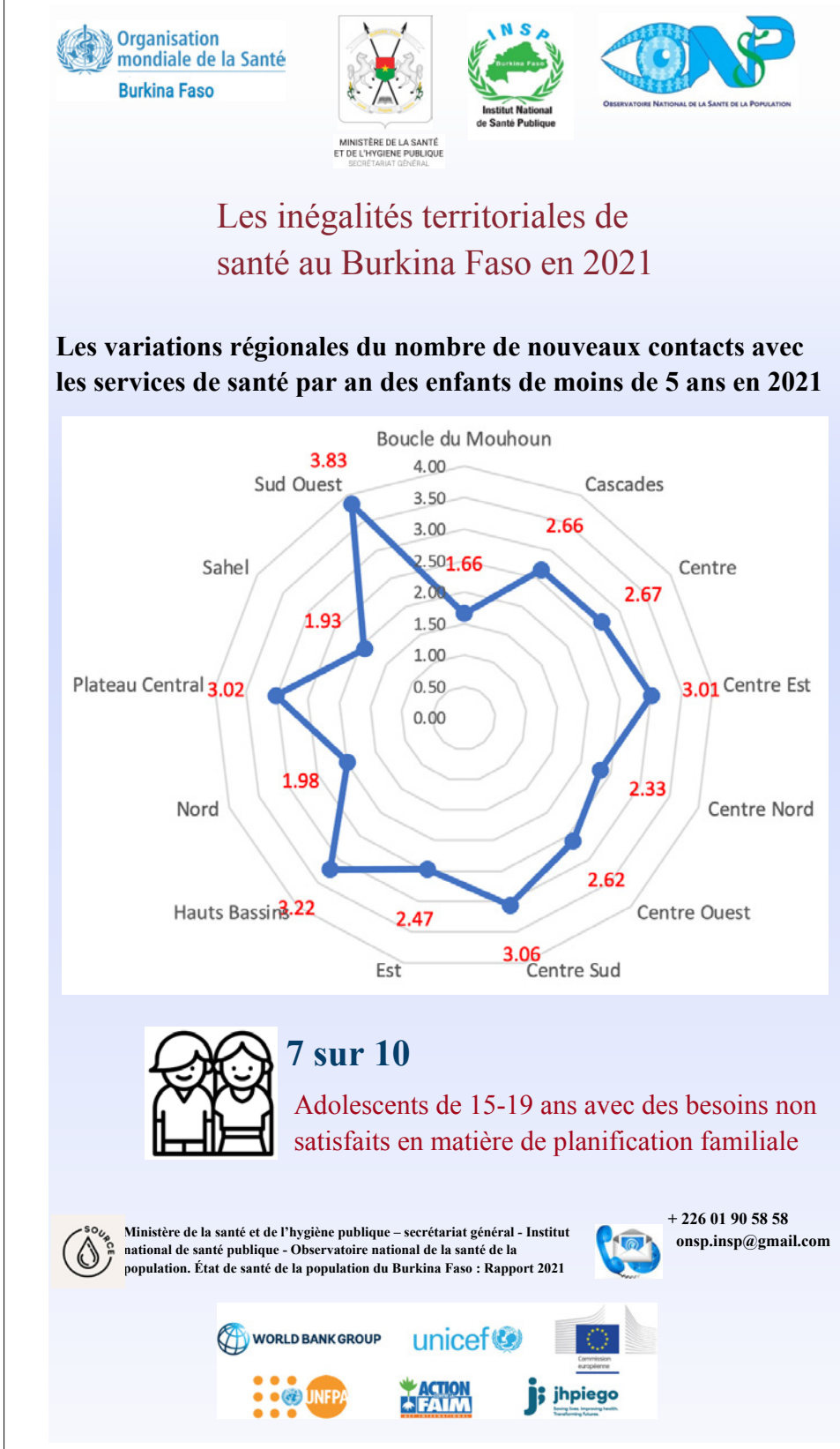
BURKINA FASO

- Infographic: Major morbidities and mortality in Burkina Faso



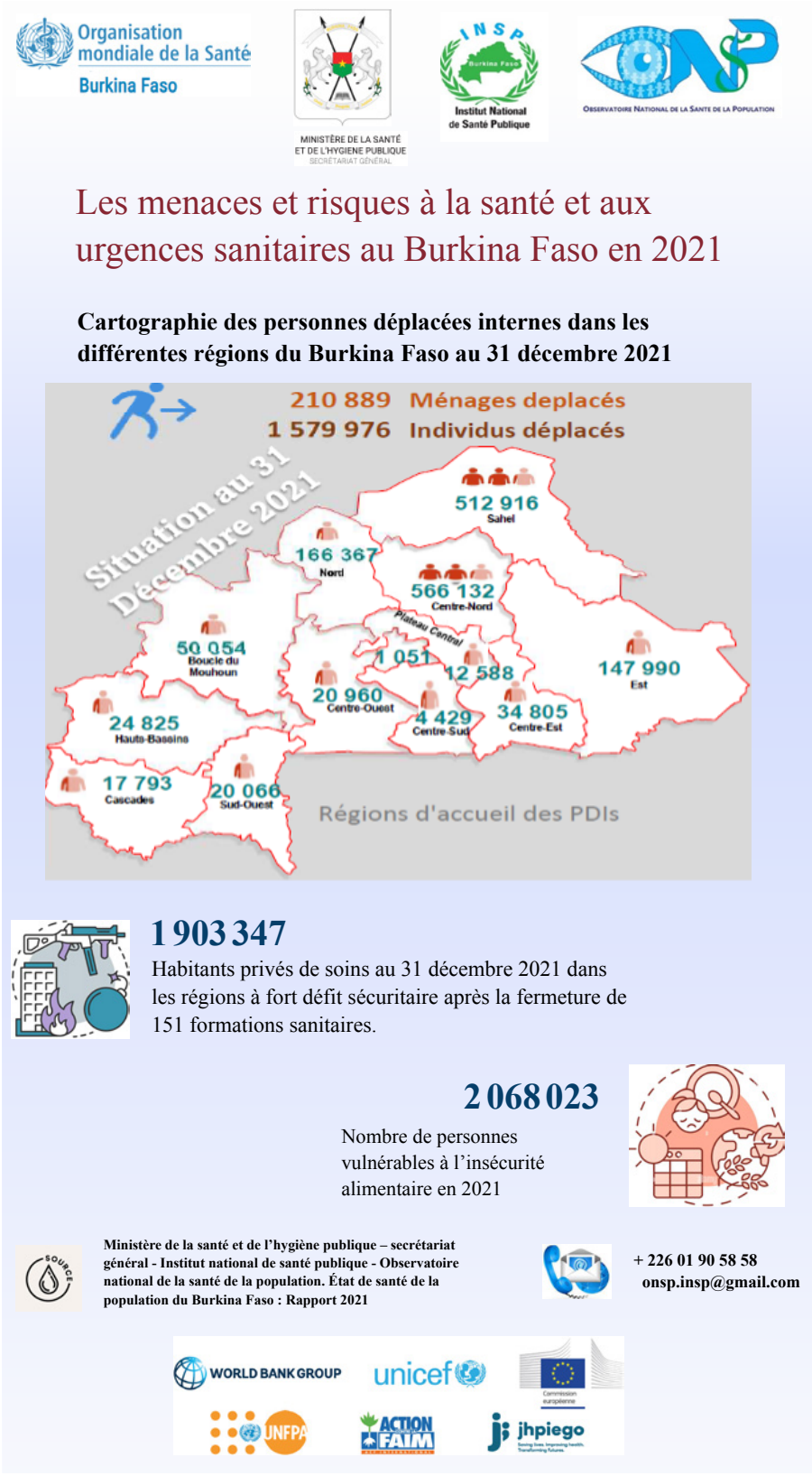
BURKINA FASO

- Infographic: Territorial health inequalities in Burkina Faso



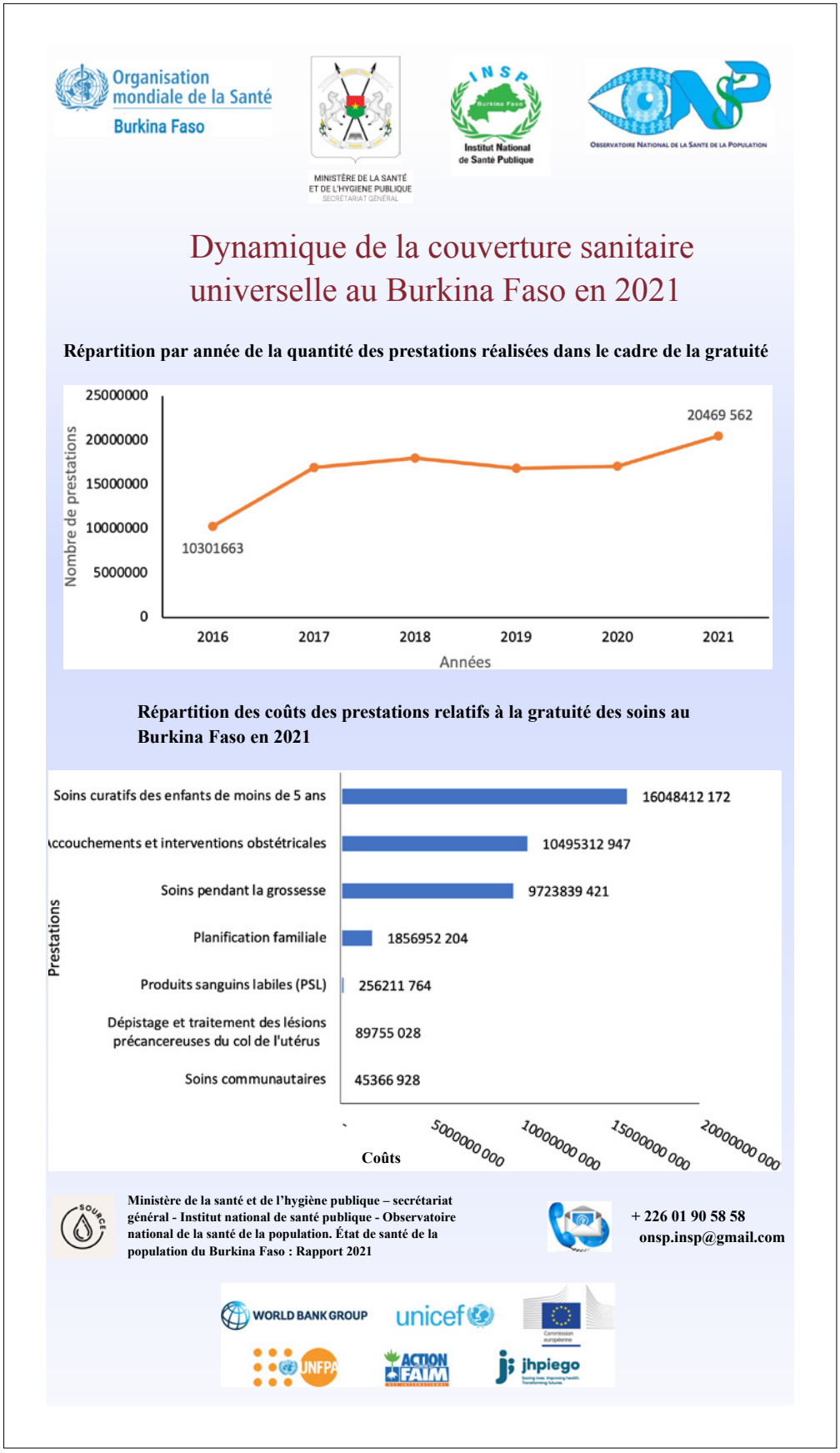
BURKINA FASO

- Infographic: Threats and risks to health and health emergencies in Burkina Faso



BURKINA FASO

- Infographic: Dynamics of universal health coverage in Burkina Faso



BURUNDI

- Analytical Fact Sheet: The functionality of health districts determines the achievement of health system results

Organisation mondiale de la Santé

Fiche d'Information Analytique

Aout 2022

LA FONCTIONNALITÉ DES DISTRICTS SANITAIRES CONDITIONNE L'ATTEINTE DES RESULTATS DU SYSTEME DE SANTE

Justification

Au Burundi, le Ministère de la Santé Publique et de la Lutte contre le SIDA (MSPLS) avec l'appui des Partenaires au Développement a entrepris une relance depuis 2010 pour le renforcement du système de santé avec plusieurs réformes porteuses dans l'organisation des services de santé en districts sanitaires. Cette réforme est en droite ligne avec la mise en œuvre des Objectifs de Développement Durable (ODD) et l'atteinte de la Couverture Sanitaire Universelle (CSU) à l'horizon 2030.

Depuis 2010, aucune évaluation de la fonctionnalité des Districts sanitaires n'a été réalisée. C'est dans ce cadre que le MSPLS appuyé par l'Organisation Mondiale de la Santé (OMS) a mené une évaluation de l'opérationnalisation des Districts Sanitaires avec les outils standards de l'OMS pour avoir une situation réelle de la fonctionnalité des districts sanitaires.

Messages clés :

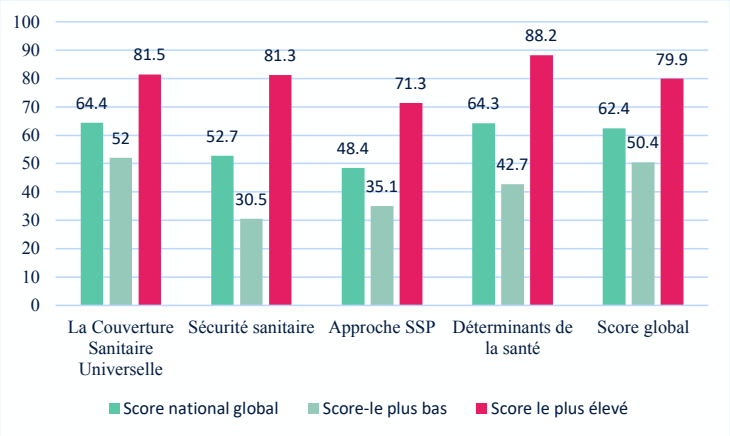
Il s'agit d'une auto-évaluation par les responsables des districts sanitaires portant sur deux modules à savoir :

- Auto-évaluation des résultats du système de santé des DS avec une performance moyenne de 62,4%.
  La couverture sanitaire universelle (64,4%) et la prise en compte des déterminants de la santé (64,3%) sont avancés et nécessitent d'être renforcées alors que la sécurité sanitaire (52,7%) et l'approche des soins de santé primaires (48,4%) restent perfectibles et nécessitent l'introduction de nouvelles interventions.
- Auto-évaluation de la fonctionnalité du système de santé des districts sanitaires avec une performance moyenne de 68,9%. La capacité du système de santé a eu un score de 65,4% ; la capacité de gestion 71,3% et la capacité de surveillance 73,5%. Les interventions pour ces trois dimensions sont à renforcer

www.insp.bi

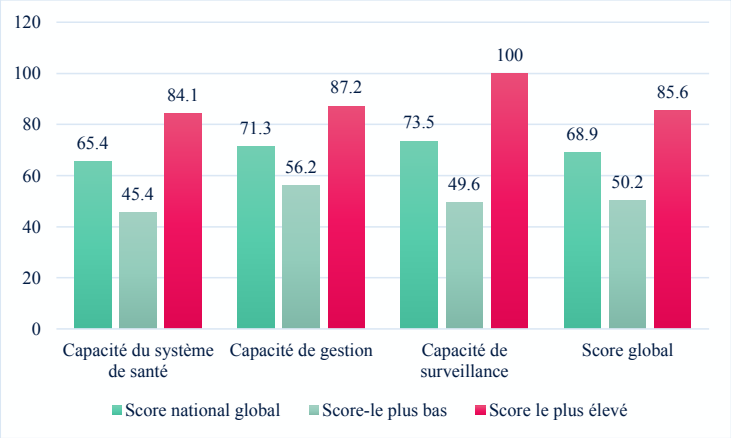
Résultats de l'évaluation des districts sanitaires

III.1. Niveau de performance des résultats du système de santé des districts sanitaires



Pour les résultats du système de santé de district, la performance moyenne obtenue est de 62,4% dans l'ensemble des quatre dimensions.
La performance pour la couverture sanitaire universelle est de 64,4%, la prise en compte des déterminants de la santé est de 64,3%, la sécurité sanitaire est de 52,7% et l'approche des soins de santé primaires est de 48,4%.

III.2. Niveau de performance pour la fonctionnalité du système de santé des districts



Pour la fonctionnalité de du système de santé des DS, la performance moyenne est de 68,9% dans l'ensemble. Des trois composantes. Elle est de 65,4% pour la capacité du système, 71,3% pour la capacité de gestion et de 73,5% pour la capacité de surveillance..

Présentation des résultats par districts.

1. Performance moyenne des différentes dimensions du module résultats du système sanitaire selon districts

Tableau 1: Performance obtenue par dimension et par district sanitaire

District Sanitaire	Couverture Sanitaire Universelle	Sécurité sanitaire	Déterminants de la santé	Approche SSP	Résultats du système de santé	Interprétation et observations
NYANZA LAC	53,0	50,5	42,7	44,2	50,4	Introduire de nouvelles interventions
MURORE	52,0	41,3	54,4	41,5	51,2	
RUMONGE	55,2	30,5	58,9	42,3	51,4	
FOTA	58,2	47,6	53,3	43,6	55,2	Intensifier les interventions
BUKINANYANA	61,0	37,6	57,7	37,3	55,3	
RWIBAGA	55,3	35,4	57,6	40,9	55,6	
GIHOFI	58,3	46,4	61,2	38,0	57,1	
BUBANZA	60,2	39,9	67,2	57,0	58,4	
VUMBI	62,7	42,1	59,1	45,4	58,8	
RUTOVU	60,0	52,9	60,8	43,3	58,8	
RUTANA	67,5	41,6	54,9	37,6	60,2	
RUYIGI	61,7	59,0	62,4	35,1	61,5	
NGOZI	61,1	60,1	64,8	39,5	61,8	
ZONE NORD	60,6	58,5	74,6	67,6	63,0	
GASHOHO	67,5	46,0	66,8	42,1	63,6	
GAHOMBO	66,4	55,1	64,6	52,5	64,3	
MUYINGA	64,2	69,8	62,9	43,7	64,7	
MUZEMA	63,9	64,6	69,5	48,0	65,2	
KIBUYE	74,2	55,2	60,4	61,0	67,3	
NYABIKERE	69,1	69,6	66,5	45,1	68,6	
ISALE	73,8	67,4	74,8	49,8	73,0	
GITEGA	78,3	50,5	80,3	66,7	73,7	
RYANSORO	81,5	61,3	88,2	71,3	79,7	Maintenir les efforts et de partager les leçons apprises
MURAMVYA	79,6	81,3	79,5	68,7	79,9	
Moyenne nationale	64,4	52,7	64,3	48,4	**62,4**	

Il apparaît que la plupart des DS ont mis en place des interventions qui ont besoin d'être intensifiées (score entre 55 et 74%). Néanmoins, les DS de Nyanza-Lac (50,4%), Murore (51,2%) et Rumonge (51,4%) restent en arrière par rapport à l'ensemble des dimensions illustrant les résultats en matière de santé alors que les DS de Ryansoro (79,7%) et Muramvya (79,9%) pourraient partager aux autres districts sanitaires les efforts fournis et les leçons apprises.

2.Performance moyenne de la fonctionnalité du système de santé par districts sanitaires

Tableau 2 : Score obtenu en % par dimension et par district sanitaire

Districts sanitaires	Capacité des systèmes de santé	Capacité de gestion	Capacité de surveillance	Fonctionnalité globale des DS	Interprétation fonctionnalité globale des DS
RUMONGE	45,4	56,6	49,6	50,2	Introduire de nouvelles interventions
RWIBAGA	46,8	58,6	53,2	52,6	
MURORE	50,1	56,2	56,7	53,7	
ISALE	58,4	58	54,5	57,6	Intensifier les interventions
FOTA	50,2	58,1	81,5	57,8	
BUKINANYANA	56,1	60,2	57,6	57,9	
NGOZI	55,5	61,2	60,2	58,6	
VUMBI	54,6	66,2	60,3	59,3	
GAHOMBO	57,8	71,6	66,1	64,3	
GIHOFI	59,8	71,5	79,4	67,4	
MURAMVYA	80,6	71,5	50,7	69,7	
NYANZA LAC	57,8	75,8	87	69,9	
NYABIKERE	73,5	72,1	70,1	72,3	
MUYINGA	70,5	76,5	85,6	75,1	Maintenir les efforts et partager les leçons apprises
RYANSORO	83,4	77,7	76,6	75,7	
RUYIGI	73,5	72,9	87	76	
RUTOVU	66,7	82,4	95,4	76,5	
GITEGA	84,1	70,6	76,9	77,3	
BUBANZA	73,5	80,7	80,3	77,6	
KIBUYE	80	82,8	70	78,7	
GASHOHO	73	87,2	79,1	79,4	
MUSEMA	79	83,3	88,3	80	
RUTANA	70	84,4	100	80,1	
ZONE NORD	80,4	84,4	98,4	85,6	
Moyenne nationale	**65,4**	**71,3**	**73,5**	**68,9**	

Le score global pour la fonctionnalité des DS est de 68,9% avec un score le plus bas de 50,2% et le plus élevé de 85,6%. Parmi les 24 DS évalués,3DS soit 12 ,5% ont un score inférieur ou égal à 54%,9DS soit 37,5% ont un score entre 55-74% et 12DS soit 50% ont un score supérieur 74%.

Implications politique

- Promouvoir l'approche des SSP en renforçant la capacité de production et d'utilisation des connaissances au niveau des DS, la disponibilité des ressources humaines pour les hôpitaux et les centres de santé, la technologie, le financement, le renforcement des capacités des bénéficiaires et l'alignement des parties prenantes sur les priorités du DS ;
- Améliorer la capacité des FOSA et la couverture en services essentiels intégrant les services pour les personnes âgées pour une meilleure accessibilité des bénéficiaires ; Assurer la décentralisation des services de prévention et des réponses aux urgences sanitaires au niveau des DS et y affecter les ressources humaines qualifiées ainsi qu'un financement adéquat ;
- Améliorer les capacités des DS à la prévention des urgences sanitaires par l'application des dispositions du RSI notamment en ce qui concerne le système de cartographie et modélisation prédictive des menaces ;
- Améliorer les capacités des DS à la détection des menaces sanitaires en renforçant les 89 capacités de diagnostic des laboratoires et la collaboration intersectorielle dans une visée de santé unique (One Health) ;
- Améliorer la prise en charge des cas de maladies en étendant l'utilisation des solutions numériques à toutes les FOSA et à l'ensemble du processus de prestation de soins, en augmentant la couverture en personnel de santé et en assurant la fidélisation des prestataires des FOSA reculées ou d'accès difficile
- Agir sur les déterminants socio-économiques de la santé en initiant de nouvelles interventions favorables à la réduction de la pauvreté et à l'accès aux services sociaux de base ;
- Faciliter la disponibilité et l'accès financier aux services de soins en général et aux services spécialisés, de réadaptations et soins palliatifs en particulier par la mise à l'échelle des systèmes de prépaiements (assurances, mutualités) ;

Conclusion

Pour le premier module relatif aux résultats du système de santé des DS, la performance des districts sanitaires en ce qui concerne la sécurité sanitaire et l'approche des soins de santé primaires reste faible et l'introduction de nouvelles interventions s'avère nécessaire. Les districts sanitaires de Nyanza-Lac, Murore et Rumonge sont en arrière par rapport à l'ensemble des dimensions concernant les résultats du système de santé alors que les districts sanitaires de Ryansoro et Muramvya sont plus performants et pourraient partager aux autres les efforts fournis et les leçons apprises.

Par rapport au deuxième module concernant la fonctionnalité du système de santé des DS, la capacité du système de santé a eu le faible score par rapport aux autres dimensions notamment en matiere de résilience aux chocs. Les districts sanitaires de Rwibaga, Murore et Rumonge sont en arrière par rapport à l'ensemble des dimensions concernant la fonctionnalité du systeme de santé alors que les districts sanitaires de Musema, Rutana et Zone Nord (Bujumbura Mairie) sont plus performants et pourraient partager aux autres districts sanitaires les efforts fournis et les lecons apprises.

Lien vers d'autres fiches d'information analytiques :
https://

BURUNDI

- Infographic: Quality of medicines in Burundi

East African Community

Institut National de Santé Publique

République du Burundi

LE CONTROLE DE LA QUALITE DU MEDICAMENT, UNE REALITE AU BURUNDI

RESSOURCES HUMAINES

56 personnels du Laboratoire National de Référence (LNR) dont 7 dédiés au contrôle de qualité du médicament

INFRASTRUCTURES

Le LNR au sein de l'INSP fonctionnel depuis 2011

EQUIPEMENTS

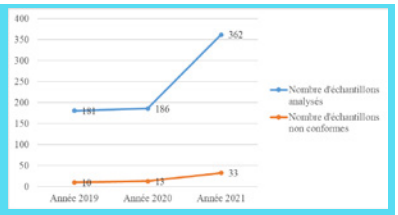
- Chaine HPLC
- Appareil pour le test de dissolution
- Appareil pour test de désintégration

Appareil pour test de désintégration

Appareil pour test de physico chimique de l'eau

ECHANTILLONS DE LOTS NON CONFORMES (3ANNEES)

2019 : 10 échantillons de lots non conformes sur 181 contrôlés (5.5%).
2020 : 13 échantillons de lots non conformes sur 186 contrôlés (7%).
2021 : 33 échantillons de lots non conformes sur 362 contrôlés (9.1 %).



LES FORMES PHARMACEUTIQUES ANALYSEES:

Les gélules, les injectables, les comprimés, les suspensions orale, les sirops ainsi que les solutions désinfectantes.

Source: Laboratoire de contrôle de qualité du médicament
www. insp.bi / BP.6807 Bujumbura

CABO VERDE

- Analytical Fact Sheet: Diabetes in Cape Verde: current situation

INSP
INSTITUTO NACIONAL DE SAÚDE PÚBLICA
CABO VERDE

OBSERVATÓRIO NACIONAL
DE SAÚDE

Ficha Informativa Analitica
Nº 1
Setembro 2022

DIABETES EM CABO VERDE: SITUAÇÃO ACTUAL

3.7%

3.3%

4.2%

Fonte: II IDNT 2020

Justificação

A Diabetes Mellitus é uma doença metabólica crónica e progressiva, que se caracteriza em estado de hiperglicémia persistente, resultante de deficiência, parcial ou total, na secreção da insulina e associado a insulinorresistência periférica. As três primeiras causas de mortalidade geral em Cabo Verde, são causadas pelas doenças do aparelho circulatório com uma taxa de 161,2 por cem mil habitantes, seguido das afeções respiratórias com 70,8 por cem mil habitantes e em terceiro lugar, os tumores ou neoplasias, com 61,6 por cem mil habitantes. A meta 3.4 do ODS, prevê " Até 2030, reduzir em um terço a mortalidade prematura por doenças não transmissíveis via prevenção e tratamento, e promover a saúde mental e o bem-estar".

Constatações

- A nível mundial 537 milhões de adultos (20-79 anos) vivem com diabetes - 1 em cada 10. Este número deverá aumentar para 643 milhões em 2030 e 783 milhões em 2045.
- No Continente Africano, 1 em cada 22 adultos (24 milhões) adultos vivem com diabetes.
- Prevê-se que o número total de pessoas com diabetes aumente em 129% para 55 milhões até 2045.
- Em Cabo Verde segundo os dados do II IDNT de 2020, realizada na população adulta, 18-65 anos:
  - a prevalência é de 3.7% sendo 3.3% nos homens e 4.2% nas mulheres.
  - 2.3% da população que apresentava um plasma venoso ≥110 mg/dl, em risco de ter diabetes.
  - Cerca de 45% da população tem a percepção de que consome muito pouco ou pouco açucar por dia
  - estima-se que 2,8% da população adulta está atualmente sob medicação para diabetes

Implicações Politicas

1. Actualizar o Plano Multissetorial de Controlo e Prevenção das DNTs 2015-2020, tendo em consideração a meta 3.4 dos ODS
2. Existe um Manual de controlo e seguimento da Diabetes mellitus elaborado em 2015 e que vem sendo implementado até a data pelo país, mas carece de revisão.

Diabetes em milhões hab.

ANOS	MUNDIAL	AFRICA
2045	783	55
2030	643	33
2021	537	24

Fonte: International Diabetes Federation (IDF) ATLAS 10 th Edition - 2021.

Diabetes (%) em Cabo Verde

SEXO/ANO	2020	2007
HOMENS	3.3%	8.2%
MULHERES	4.2%	9.0%
TOTAL	3.7%	8.6%

Fonte: IDNT - 2007 e 2020 - M. Saúde - Cabo verde.

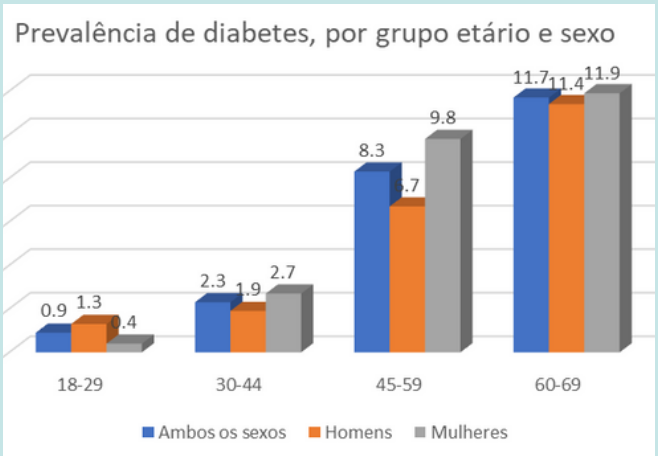
Prevalência de Diabetes por 100.000 hab em Cabo Verde

ANOS	2016	2017	2018	2019
PREVALENCIA	1866.0	2021.9	2303.1	1549.5
Nº CASOS	9913	10871	12531	8530

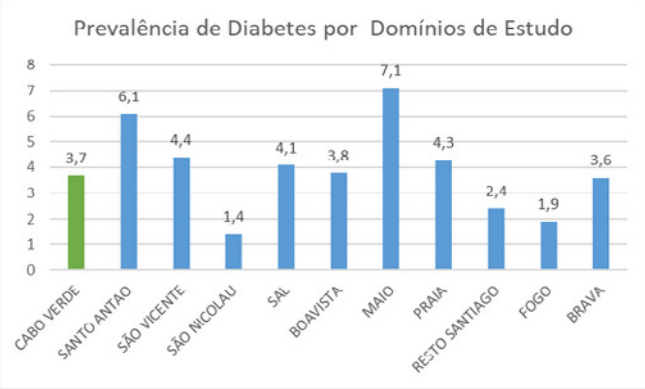
Fonte: Relatório Estatístico - M. Saúde - Cabo verde.

A prevalência de diabetes por 100.000 mil habitantes em Cabo Verde teve um aumento de 2016 a 2018 e uma diminuição em 2019, segundo os dados do relatório estatístico do Ministério da Saúde

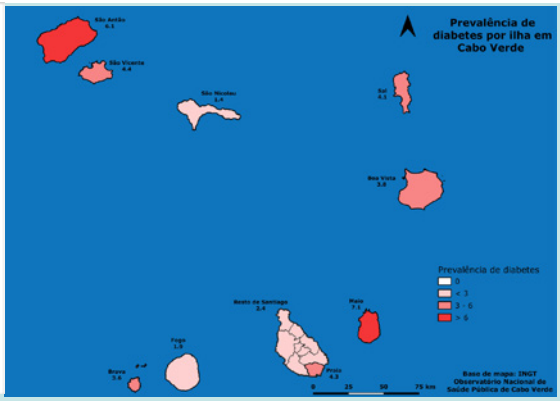
A faixa etária dos 60 aos 69 anos é a que apresenta uma maior prevalência de diabetes.
De notar que apartir dos 45 anos a prevalência de diabetes e superior a média nacional.



Fonte: II IDNT - 2020



Fonte: II IDNT - 2020



Fonte: II IDNT - 2020

Prevalência de Diabetes por domínios de estudo

A nível nacional, a ilha do Maio posiciona-se com maior prevalência seguido de Santo Antão, São vicente, Praia e Sal.
As ilhas de São Nicolau e Fogo tem uma prevalência menor que a média nacional.

Conclusão / Considerações:

Tratamento implica medidas farmacológicas e não farmacológicas. A prevenção da Diabete Melitos através da promoção da saúde e adoção de bons hábitos alimentares, prática de exercícios físicos. O rastreio da Diabete Melito deve ser realizado em adultos sem fatores de risco a partir de 45 anos e em pessoas com fatores de risco.

Referências bibliográficas

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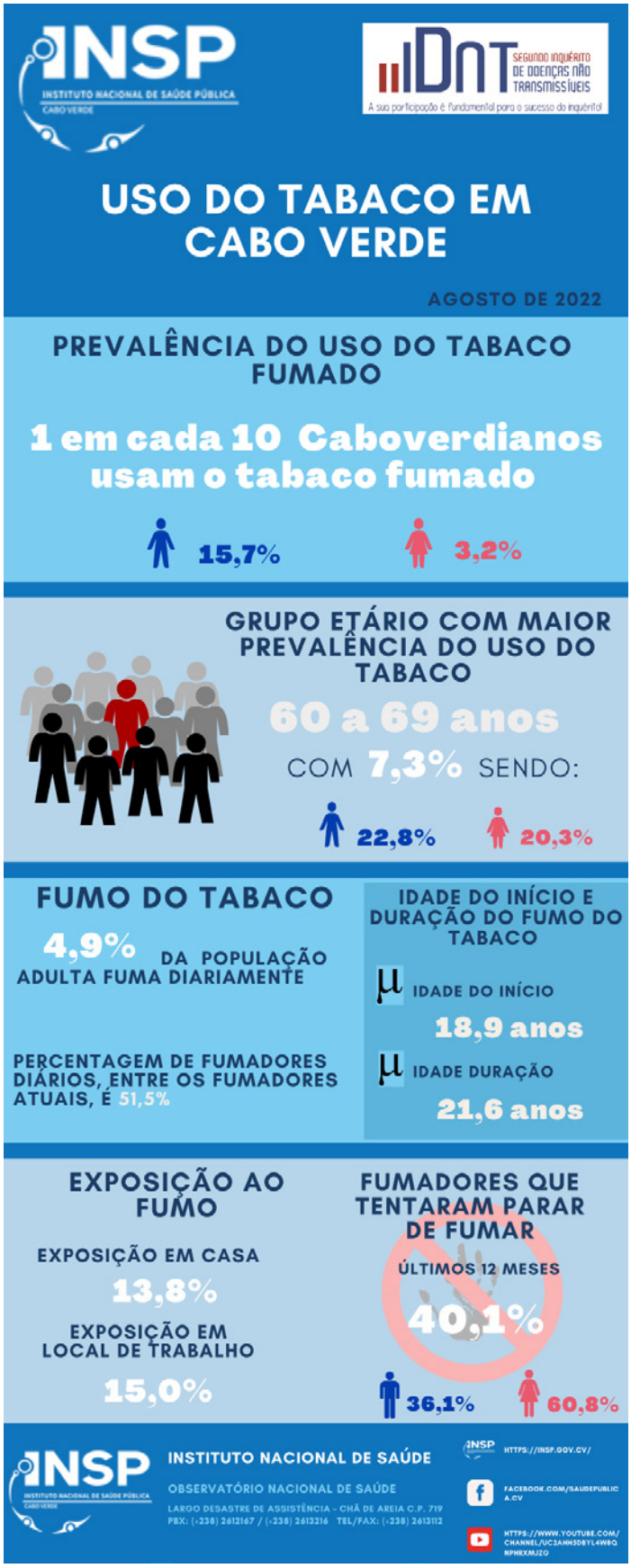
Ficha Informativa produzido pela Equipa do ONS: Domingos Varela, Jonas Gomes, Ngibo Fernandes.
Colaboração: OMS Cabo Verde, Edith Pereira

CABO VERDE

- Infographic: Tobacco use in Cape Verde



CABO VERDE

- Blog: Advancing Traditional Medicine in Africa

Article de blog

Progrès de la médecine traditionnelle en Afrique

Les progrès réalisés dans la médecine traditionnelle en Afrique

La médecine traditionnelle est la somme totale des connaissances, compétences et pratiques qui reposent, rationnellement ou non, sur les théories, croyances et expériences propres à une culture et qui sont utilisées pour maintenir les êtres humains en santé ainsi que pour prévenir, diagnostiquer, traiter et guérir des maladies physiques et mentales.

Depuis des siècles, la médecine traditionnelle constitue une source de soins de santé fiables, acceptables et accessibles à un coût abordable pour les populations africaines.

A ce jour, 80 % de la population du continent dépend de la médecine traditionnelle pour répondre à ses besoins sanitaires essentiels.

Cadre stratégiques et politiques des pays

En Afrique, plus de 40 pays de la Région africaine ont élaboré des politiques nationales sur la médecine traditionnelle en 2022, contre huit pays seulement en 2000. L'intégration de la médecine traditionnelle dans leur politique constitue une réalité dans 30 pays, soit une amélioration de 100 % par rapport à la situation en 2000.

De plus des cadres réglementaires ont été établi dans 39 pays régissant l'activité des tradipraticiens, contre un seul pays en 2000, ce qui témoigne de la bonne gouvernance et du leadership dont ils font preuve.

Recherche en médecine traditionnelle

Au total 34 instituts de recherche consacrés à la médecine traditionnelle sont répartis dans 26 pays africain. Ce secteur reste prometteur et recèle un potentiel économique important, à condition qu'il bénéficie d'une promotion appropriée à l'échelle internationale. Douze de ces pays ont déclaré avoir consacré des financements publics à cette initiative de recherche-développement au cours des 10 dernières années.

Utilisation de médecine traditionnelle dans COVID-19

L'Organisation mondiale de la Santé a soutenu des missions conjointes avec des partenaires en Afrique du Sud, au Ghana, à Madagascar, au Nigéria, en Ouganda et en

République démocratique du Congo, afin de surveiller les **essais cliniques** effectués sur les thérapies issues de la médecine traditionnelle et proposées pour le traitement de la COVID-19, **dont huit sont en cours**. La volonté politique affichée par les pays pour soutenir ces innovations est un motif d'espoir, tout comme le niveau des infrastructures et des compétences disponibles.

A l'occasion de cette Journée africaine de la médecine traditionnelle 2022 sous le thème, « *Deux décennies de la Journée africaine de la médecine traditionnelle: progrès accomplis vers la réalisation de la couverture sanitaire universelle en Afrique* »,, la Dre Matshidiso Moeti, Directrice régionale de l'OMS pour l'Afrique ''… exhorte les gouvernements à renforcer la collaboration entre les institutions scientifiques, technologiques et d'innovation, les tradipraticiens et le secteur privé, afin d'accélérer la recherche-développement et la fabrication locale de traitements issus de la médecine traditionnelle pour la santé et le bien-être des populations africaines''.

Malgré les efforts faits par les Etats membres, l'intégration de la médecine traditionnelle dans le système de santé reste un défi majeur dans la plupart des pays (notamment dans le domaine du financement. Une autre limite rencontrée est l'insuffisance des ressources humaines, financières et techniques pour les institutions de recherche. Enfin, il est important de souligner que la médecine traditionnelle doit être considérée en tant qu'un des moyens très importants pour appuyer les pays à atteindre la couverture sanitaire universelle.

Pour en savoir plus :

- Rapport de situation sur la mise en œuvre de la stratégie régionale pour le renforcement du rôle de la médecine traditionnelle dans les systèmes de santé 2013-2023.
- Renforcement du rôle de la médecine traditionnelle dans les systèmes de santé : Une stratégie pour la Région africaine (2013-2023) (Document AFR/RC63/6).
- Plan d'action pour la Décennie de la médecine traditionnelle de l'Union africaine (2001-2010) : mise en œuvre de la décision du Sommet des chefs d'État et de gouvernement de Lusaka (AHG/DEC.164 (XXXVII)
- Rapport mondial de l'OMS sur la médecine traditionnelle et complémentaire, 2019.
- Traditional and Complementary Medicine in Global Health Care. In: Handbook of Global Health.
- Lancement du Comité consultatif exécutif régional sur la médecine traditionnelle – Allocution de la Directrice régionale de l'OMS pour l'Afrique, 22 juillet 2020.
- Lignes directrices sur l'homologation des médicaments traditionnels, OMS, 2004 mises à jour en 2010.
- L'OMS soutient une médecine traditionnelle reposant sur des éléments scientifiques probants.
- Towards universal health coverage: advancing the development and use of traditional medicines in Africa. *BMJ Global Health*. 2019; 4(Suppl 9): e001517.

CAMEROON

- Policy Brief: Data collection on causes of death in Cameroon: status and recommendations

NOTE D'ORIENTATION POLITIQUE

Collecte des données sur les Causes de décès au Cameroun : état des lieux et recommandations

Auteurs : Dr Bello Djamila, Dr Do'o René, Dr Gatcho Modeste(OMS)

Résumé	Messages clés
L'amélioration des performances des systèmes d'enregistrement des faits et statistiques d'état civil (CRVS) est un pilier fondamental de la réussite de l'Agenda 2063 de l'Union Africaine. Les données sur les causes de décès permettent de définir les priorités, mesurer les progrès accomplis par rapport à de nombreuses cibles des ODD et planifier la réponse aux divers besoins en matière de santé. La pandémie de Covid-19, avec son nombre de décès survenus en communauté, a renforcé le besoin d'informations sur les causes de décès. Les données sur les décès sont principalement collectées au niveau des formations sanitaires et des centres d'état civil au Cameroun. En 2020 le paludisme est la principale cause de décès rapportée dans les formations sanitaires soit 35 503 décès. Ensuite, les causes les plus fréquemment retrouvées sont respectivement les accouchements (11,6%), les affections aigues des voies respiratoires supérieures (3,4%), la malnutrition (3%) et les lésions traumatiques (2,7%).	➢ L'absence de données récentes issues du recensement de la population (le dernier recensement date de 2005), le pays utilise des projections. ➢ L'enregistrement des décès au niveau de l'état civil est très parcellaire avec absence de collecte de données centralisée pour les faits d'état civil. Presque la moitié (48,5%) des Centres d'Etat Civil recensés n'ont pas enregistrés d'acte de décès en 2018. ➢ Environ trois décès sur cinq (61,8%) enregistré dans les formations sanitaires n'ont pas été enregistrés à l'état civil en 2018. ➢ L'enregistrement des causes décès dans l'outil de collecte de données de routine dans le système de santé (DHIS2) n'utilise pas la codification de la Classification Internationale des Maladies (CIM). Par ailleurs, les causes de décès enregistrés ne sont pas désagrégées par âge et par sexe. ➢ En 2020, le paludisme est rapporté comme étant la principale cause de décès dans les formations hospitalières. Les autres causes de décès sont : les accouchements, les affections aigues des voies respiratoires supérieures, la malnutrition et les lésions traumatiques. ➢ Chez les enfants de moins de 5 ans, le paludisme reste la première cause de décès dans les formations sanitaires. Ce dernier est suivi dans l'ordre par la malnutrition, les affections aigues des voies respiratoires supérieures, l'anémie nutritionnelle et les affections aigues des voies respiratoires inferieures pour cette tranche d'âge en 2020. ➢ Chez les personnes âgées de 15 ans et plus, en 2020, le paludisme est la principale cause de décès. Il est suivi dans l'ordre par les accouchements, les lésions traumatiques, les maladies dues au virus de l'immunodéficience humaine (VIH) et les maladies cardiovasculaires. ➢ La certification médicale des causes de décès n'est pas encore systématisée dans le pays, toutefois, des certificats de genre de mort sont délivrés en lieu et place. De même la codification des causes de décès grâce à la CIM est quasiment inexistante.

NOTE D'ORIENTATION POLITIQUE

Introduction

Les données sur les causes de décès permettent de définir les priorités, mesurer les progrès accomplis par rapport à de nombreuses cibles des ODD et planifier la réponse aux divers besoins en matière de santé. La survenue de la Covid-19 en 2020 a entrainé la baisse de la fréquentation des services de santé avec une augmentation du nombre de décès. La présente note se propose de répondre aux questions suivantes :

- Quelle est la situation de l'enregistrement des décès et causes de décès au Cameroun ?
- Quelles sont les principales sources de données utilisées aujourd'hui et leurs limites ?
- Quelles sont les conséquences de l'absence des données de mortalité de qualité dans le suivi-évaluation des interventions de santé publique ?

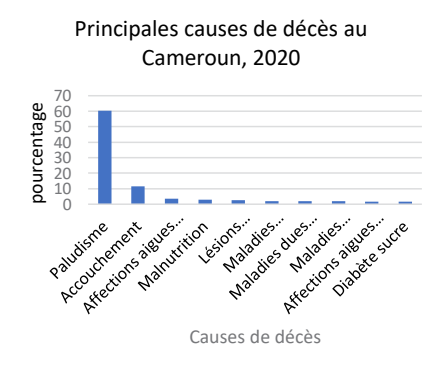
Méthodologie

Une revue documentaire des données des décès sur une période de cinq ans (2016- 2020) a été effectuée. Les données provenaient du système d'information sanitaire, du bureau national d'état civil, de l'institut national de la statistique et autres administrations (Protection civile, gendarmerie). Cette revue a pris en compte également les données issues de l'enquête sur la mortalité en période Covid-19.

Résultats

Enregistrement des décès et causes de décès au Cameroun

L'enregistrement des décès au niveau de l'état civil est très parcellaire avec absence de collecte de données centralisée pour les faits d'état civil. Presque la moitié (48,5%) des Centres d'Etat Civil recensés n'ont pas enregistrés d'acte de décès en 2018. Environ trois décès sur cinq (61,8%) enregistré dans les formations sanitaires n'ont pas été enregistrés à l'état civil en 2018.



En 2020 le paludisme est la principale cause de décès rapportée dans les FOSA et enregistrée dans DHIS2 avec 35 503 décès. Ensuite, les causes les plus fréquemment retrouvées sont respectivement les accouchements (11,6%), les affections aigues des voies respiratoires supérieures (3,4%), la malnutrition (3%) et les lésions traumatiques (2,7%) comme l'illustre le graphique.

NOTE D'ORIENTATION POLITIQUE

La numérisation des registres électroniques avec un accent particulier sur le suivi individuel des patients tuberculeux, VIH/SIDA, etc. permettra dans les prochaines années une nette amélioration de la qualité des données du SNIS et en particulier les causes des décès.

Sources de données utilisées et leurs limites

Au Cameroun, les données de mortalité sont collectées par plusieurs administrations, notamment l'INS, le BUNEC et le MINSANTE en utilisant différentes méthodes telles que les enquêtes, le système CRVS et le DHIS2. Cette collecte n'est pas encore intégrée car chaque secteur fonctionne séparément. Cependant, des efforts sont déployés pour informatiser tout le système de collecte avec une approche d'interopérabilité, afin de permettre le partage des données sur la mortalité.

Au total, l'offre de soins et services de santé au Cameroun est assurée par environ 6 202 formations sanitaires publiques et privées. Le poids des formations sanitaires par statut montre que 2 876 (46%) d'entre elles sont du secteur public, 2 535 (41%) du secteur privé laïc à but lucratif et 791 (13%) sont du secteur privé confessionnel.

Conséquences de l'absence des données de mortalité de qualité dans le suivi-évaluation des interventions de santé publique

Des statistiques vitales et sanitaires précises et fiables, générées par un système d'enregistrement des faits d'état civil et de statistiques vitales (CRVS) et un système d'information sanitaire de routine qui fonctionnent bien, sont fondamentales pour une politique, une planification et une programmation sanitaires adaptées aux réalités sociales. Le rôle central joué par les gouvernements pour garantir que chaque personne compte en générant et en analysant toutes les données sur les naissances et les décès et en partageant les informations est essentiel pour renforcer les piliers du système de santé, la planification nationale et la responsabilité

Conclusion

Au Cameroun, l'enregistrement des décès au niveau de l'état civil est parcellaire en raison de l'absence d'un système de collecte de données centralisée. En plus, la collecte des données dans le système d'information sanitaire n'utilise pas la codification de la Classification Internationale des Maladie (CIM) pour une meilleure standardisation. Ainsi, un engagement politique est nécessaire pour améliorer la qualité des données sur les causes de décès.

NOTE D'ORIENTATION POLITIQUE

Implications politiques

Les actions prioritaires identifiées pour l'amélioration de l'enregistrement des décès et leurs causes sont :

1. Le renforcement de la coordination des acteurs du CRVS, à travers la mise en place des plateformes fonctionnelles ;
2. L'amélioration des processus de gestion des données CRVS, par la définition des indicateurs, l'élaboration des outils et procédures de collecte des données dans les différents secteurs concernés et le suivi de la complétude, de la promptitude, l'exhaustivité et la qualité des données ;
3. Le partage des données à travers l'informatisation et l'interopérabilité des systèmes d'information entre les différents secteurs ;
4. La vulgarisation de la certification des causes de décès, notamment à travers l'introduction de la formation y relative dans les curricula de formation initiale des personnels de santé, le renforcement des capacités des acteurs de terrain, la réalisation des autopsies verbales et le monitoring de la revue des décès à tous les niveaux ;
5. L'élaboration des textes d'application de la loi obligeant la déclaration systématique des décès.

Références

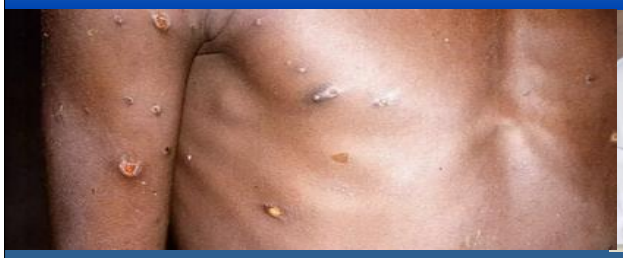
- MINSANTE, Rapport statistique sur la mortalité au Cameroun 2016-2020, (2022)
- Rapport de l'enquête de surveillance rapide de la mortalité en contexte COVID-19 au Cameroun, Janvier 2018 au 31 Mai 2021, (2021)

CAMEROON

- Analytical Fact Sheet: Monkeypox: risk of importing the new variant into Cameroon

Fiche d'Information Analytique

Août 2022



Monkeypox: risque d'importation du nouveau variant au Cameroun

Justification

Maladie à déclaration obligatoire, le Cameroun notifie des cas de Monkeypox depuis les années 1970. Déclarée depuis le 23 Juillet 2022, le Monkeypox clade IIb a été déclarée par l'OMS comme une Urgence de Santé Publique de Portée Internationale (USPPI). Ce variant n'a pas encore été identifié au Cameroun depuis sa propagation au début de l'année 2022. Le flux de voyage entre le Cameroun et les pays en épidémie étant important, une évaluation de risque d'importation identifie les actions à mettre en place pour atténuer tout risque

Faits marquants

- Monde : 49 974 cas avec 15 décès
- Afrique : 406 cas avec 7 décès dans 11 pays
- Cameroun (endémique au Monkeypox)
  - 03 régions touchées (Centre, Sud-Ouest, Nord-Ouest) dont 4 districts de santé touchés
  - 34 cas suspects notifiés dont 7 confirmés (létalité : 5,88%)
- Le risque est modéré pour l'importation de la nouvelle souche au Cameroun
- Le Cameroun doit prendre des mesures pour la gestion d'une éventuelle importation de cette nouvelle souche

Implications politiques

Le Cameroun doit mettre en place des mesures de préparation et de réponse, notamment :

- Renforcement de la surveillance épidémiologique
- Elaboration et diffusion des directives de surveillance de la variole du singe
- Sensibilisation communautaire
- Mobilisation des ressources

http://onsp.minsante.com

Situation épidémiologique au Cameroun, août 2022

Le Cameroun est endémique au Monkeypox. Cependant, la souche qui a été déclarée USPPI n'a pas encore été identifiée au Cameroun. L'évolution de cette nouvelle souche représente un risque pour le Cameroun à travers les différents échanges commerciaux et d'affaires que le Cameroun entretient avec ces pays en épidémie. A ce jour, 06 DS ont été touchés avec 34 cas suspects.

Figure 1.: Districts de santé en épidémie de Monkey Pox au Cameroun, août 2022

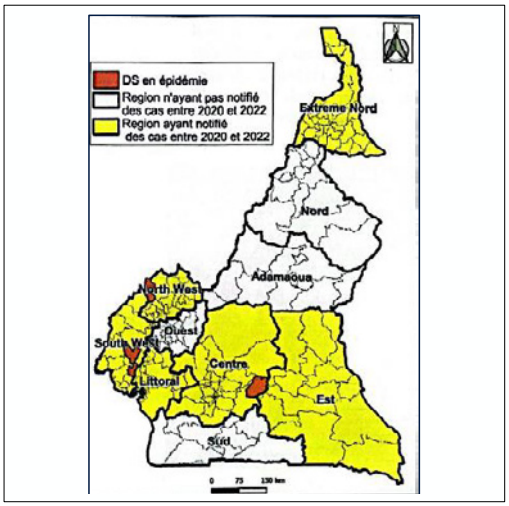


Tableau 1. Situation des cas Monkey Pox au Cameroun, décembre 2021 à août 2022

Régions	Districts	cumul de cas suspects	Nombre de cas prélevés	Nombre de cas confirmés	Nombre de décès	Taux de létalité (%)	Période de notification du dernier cas
Centre	Ayos	6	6	4	0	0,0	SE 26
	Djoungolo	2	2	0	0	0,0	SE 08
	Odza	1	1	0	0	0,0	SE 23
Nord-Ouest	Benakuma	12	2	1	1	8,33	SE 7
		1	0	0	0	0,0	SE 12
Sud-Ouest	Kumba	11	2	2	1	9,09	SE 3
	Konye	1	0	0	0	0,0	SE 1
Total		34	13	7	2	5,88	

Activités menées :

- Mise en place d'une stratégie spéciale pour accéder aux zones d'insécurité (Nord-Ouest et Sud-Ouest)
- Renforcement de la surveillance aux points d'entrée
- Investigations menées autour des cas suspects pour identification des sources de contamination et mise en œuvre des mesures de riposte

Evaluation de risque d'importation au Cameroun

Probability					
	4	Moderate risk	Important risk	Critical risk	Critical risk
	3	Limited risk	Moderate risk	Important risk	Critical risk
	2	Limited risk	Moderate risk	Moderate risk	Important risk
	1	Limited risk	Limited risk	Limited risk	Moderate risk
		1	2	3	4
		Gravity			

Le Cameroun a des échanges fréquents avec plusieurs pays touchés par l'épidémie, avec une probabilité élevée qu'un cas soit importé dans le pays. De même, 03 pays frontaliers au Cameroun notifiaient déjà des cas de Monkey Pox. Les conséquences de l'importation de cette souche seraient ainsi lourdes pour le pays. Le risque d'importation est modéré.

Recommandations :

- Elaborer un plan de préparation et de réponse
- Continuer la sensibilisation de la population
- Renforcer la surveillance aux points d'entrée (aéroportuaire, maritime et terrestre)

References

1. Sitrep 1 du Monkey Pox au Cameroun (1er décembre 2021 au 05 août 2022), août 2022
2. https://www.who.int/news-room/fact-sheets/detail/monkeypox consulté le 29/08/2022
3. Outbreaks and Emergencies Bulletin, Week 34: 15 - 21 August 2022
4. https://www.cdc.gov/poxvirus/monkeypox/response/2022/world-map.html consulté le 31/08/2022
5. https://www.who.int/fr/news/item/12-08-2022-monkeypox--experts-give-virus-variants-new-names consulté le 01/09/2022

Contactez-nous : http://onsp.minsante.com

Fiche d'information réalisée par : *Dr Bello Djamila epse Mohamadou, Dr Do'o Bessin René, Dr Gatcho Modeste*

CAMEROON

- Blog: Building the capacity of NHOs in the production of knowledge products

ARTICLE BLOG

RENFORCEMENT DES OBSERVATOIRES NATIONAUX DE SANTE DANS LA PRODUCTION DES PRODUITS DE CONNAISSANCES

Les observatoires nationaux de la santé publique

Ce sont des plateformes de gestion des connaissances dont les principales fonctions sont : (i) **Rassembler** : il consiste au rassemblement de données standardisées de santé provenant de plusieurs sources ; (ii) **Analyser et synthétiser** : les données collectées vont être analysées et interprétées. Ceci va conduire à la création des produits de connaissances qui seront diffusés ; (iii) **Mettre en réseau** : les ONS favorisent les échanges sur les informations sanitaires ; (iv) **Et partager** : ils assurent la diffusion d'informations via la plateforme web.

L'Observatoire africain intégré de la santé (iAHO) est une plateforme stratégique d'intelligence sanitaire qui héberge les portails numériques des Observatoires Nationaux de la Santé (ONS) des 47 Etats membres de la Région africaine de l'OMS, en même temps que celui de l'Observatoire régional africain. Ce dernier appuie les ONS dans la gestion de l'information sanitaire notamment dans l'élaboration et la diffusion des produits de connaissances. C'est dans cette optique qu'un atelier de renforcement de capacités s'est tenu en Côte d'Ivoire du 29 août au 02 septembre 2022 avec l'appui du Bureau régional de l'OMS pour l'Afrique.

Renforcement des capacités des ONS à Grand Bassam

Cet atelier avait pour objectif de renforcer les capacités du personnel des ONS et des bureaux pays de l'OMS à la génération d'une gamme de produits de connaissance qui soutiendront les processus de prise de décision dans les pays. La présente formation a regroupé les participants de six pays d'expression française à savoir : Burkina Faso, Burundi, Cameroun, Cabo Verde, Cote d'Ivoire et Niger. Chaque pays était représenté par deux participants provenant des ONS et le point focal système d'information et/ou système de santé du bureau pays de l'OMS.

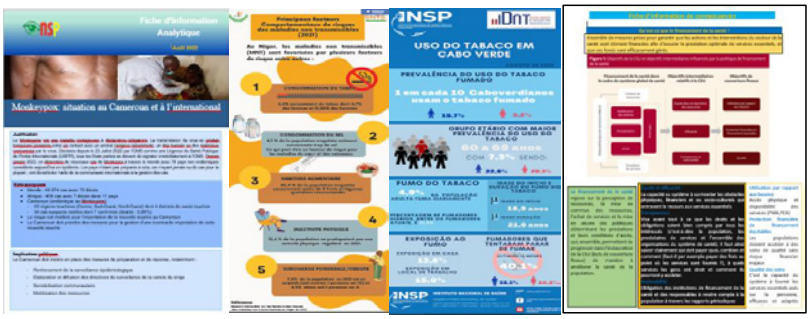
Partage d'expérience inter pays comme méthodologie pratique

Une gamme de produits de connaissances a fait l'objet de présentation méthodologique qui s'en suivait de revue par les pairs des drafts préparés avant l'atelier. C'est ainsi qu' à chaque session, des équipes de deux pays étaient formées

pour les travaux de groupe durant lesquels les échanges ont permis d'améliorer les drafts de produits de connaissances disponibles et/ou de développer des produits (cas des artiles de blogs et des fiches analytiques de connaissances). En effet, en prélude à cette formation, chaque équipe élaborait deux drafts de produits de connaissance. La phase des travaux de groupe était précédée d'une présentation en plénière du produit de connaissance qui faisait l'objet du travail de groupe.

Tableau 1 : Produits de connaissance élaborés par les pays au cours de l'atelier

Pays	Fiche d'information analytique	Fiche d'information de connaissance	Blog	Note d'orientation	Infographie
Burkina Faso		La resilience en santé		Etat des lieux de la mortalité hospitalière dans le contexte de la Covid-19	Etat de santé de la population du Burkina Faso en 2020
Burundi	Etude sur la fonctionnalité des districts de santé	Financement de la Santé			Contrôle de la qualité du médicament
Cameroun	Situation de la variole du Singe	Le Rôle des ONS	Renforcement des Capacités des ONS pour la production des produits de connaissances	Causes de décès : Etat des lieux et recommandations	
Côte d'Ivoire	Qualité des données gage d'une bonne prise de décisions		Couverture Maladie Universelle : Où en sommes-nous ?	Situation des décès maternels	
Cabo Verde	Situation du Diabète		Medecine Traditionnelle en Afrique		Contrôle de la consommation de tabac
Niger	Mortalité néonatale				Les facteurs de risques déterminant les maladies non transmissibles au Niger



Recommandations

1. Les produits de connaissance élaborés par les ONS doivent être diffusés à travers les différents canaux de communication.
2. Une réunion trimestrielle entre les ONS des différents pays doit se tenir de manière virtuelle pour assurer la continuité dans l'élaboration des produits de connaissance.
3. Une implication des différentes parties prenantes est nécessaire dès la conception de certains produits de connaissance tels la note d'orientation politique
4. Chaque ONS doit partager la formation reçue au cours de l'atelier avec les parties prenantes nationales

CÔTE D'IVOIRE

- Policy Brief: Situation of maternal deaths in Côte d'Ivoire: how to reverse the trend?

NOTE D'ORIENTATION POLITIQUE

Situation des décès maternels en Côte d'Ivoire : Comment ré-inverser la tendance ?

Analyse de la disponibilité des capacités litières et des produits sanguins

Messages clés

- Le nombre de cas de décès maternel notifié connaît une hausse en Côte d'Ivoire passant de 764 cas en 2020 à 857 cas en 2021 jusqu'à dépasser la valeur de 2019 (813 cas de décès maternel).
- Les décès maternels surviennent dans plus de 84% des cas dans les établissements sanitaires et que 58% ont eu lieu dans le post-partum immédiat en 2021.
- En Côte Ivoire, la satisfaction des besoins nationaux en sang est d'environ 70% en 2018.
- Sur un besoin de 5208 lits de suite couche en 2017 seulement 3027 ont été disponibles.

Résumé analytique

Cette note d'orientation porte sur la problématique des décès maternels et vise à donner une orientation dans la prise de décision pour la réduction des cas de décès maternels. Les décès maternels constituent un véritable problème de santé en Côte d'Ivoire. Selon l'EDS-MICS 2011-2012, le taux de décès maternel était de 614 pour 100 000 naissances vivantes. Plusieurs politiques dont celle de la gratuité des soins aux femmes enceintes, la réalisation des revues des décès et l'intégration de la surveillance des décès dans système de surveillance des maladies à potentielle épidémique. Malgré ces mesures, le nombre de cas de décès maternel notifié connaît une hausse, passant de 764 cas en 2020 à 857 cas en 2021 jusqu'à dépasser la valeur de 2019 (813 cas de décès maternel). Ces décès surviennent dans plus de 84% des cas dans les établissements sanitaires et que 58% ont eu lieu dans le post-partum immédiat en 2021. Les hémorragies du postpartum constituent la première cause de décès maternel (56%) En 2017, pour un besoin de 5208 lits dans les salles de suite de couche ce sont 3027 qui étaient disponibles, ainsi c'est seulement 35% des accouchements dans les établissements sanitaires qui ont reçu une consultation dans les 72 heures. Les besoins nationaux en sang sont satisfaits à environ à 70% en 2018.

1

Introduction

Une des cibles de l'objectif de développement durable 3 est de faire passer le taux mondial de mortalité maternelle au-dessous de 70 pour 100 000 naissances vivantes d'ici 2030, aucun pays ne devant présenter un taux de mortalité maternelle supérieur à deux fois la moyenne mondiale [1].

La grande majorité des morts maternelles se produisent dans les régions les plus pauvres du monde, notamment en Afrique subsaharienne [2].
La côte d'ivoire constitue l'un des pays de l'Afrique de l'Ouest qui enregistre un grand nombre de décès maternels. Selon l'enquête EDS-MICS 2011-2012, le taux de mortalité maternelle est estimé à 614 décès pour 100 000 naissances vivantes.

Pour renverser cette tendance, plusieurs stratégies dont le renforcement du cadre institutionnel et règlementaire avec entre autres (i) la prise de l'arrêté N° 450/MSLS/CAB du 05 Aout 2015 portant obligation de notification des cas de décès maternels, institutionnalisation des revues et création du comité national de surveillance de décès maternels et de riposte, (ii) le renforcement des capacités des CHU, des régions et districts sanitaires à la technique de revue des décès maternels [4].

Aussi, l'instauration en 2012, de la politique de la gratuité ciblé qui donne droit à la femme enceinte de bénéficier gratuitement (i) des Consultations Prénatales, (ii) des examens complémentaires, (iii) de l'accouchement normal et les complications liées à l'accouchement (épisiotomie, réparation de déchirures du périnée, hémorragie etc.) et (iv) de la césarienne [5].

Malgré toutes ces mesures, selon le rapport 2021 de la Surveillance des Décès Maternels, Périnatals et Riposte, le nombre de décès maternel notifié par les établissements de santé qui était de 764 cas en 2020 a connu une augmentation en 2021 avec 857 cas.
Ce nombre est en hausse par rapport à celui de 2019 qui était de 813 cas d'où l'intérêt de porter une attention particulière à la problématique des décès maternels.

L'accroissement des capacités litières en suite de couche et la disponibilité continue en produits sanguins ne pourraient-elle pas contribuer à une réduction significative du nombre de décès maternel en Côte Ivoire ?

Cette note d'orientation s'adresse à Monsieur le Ministre de la Santé, de l'Hygiène Publique et de la Couverture maladie Universelle.

Méthodologie de travail

Notre méthodologie est basée sur une revue documentaire. Cette revue nous a permis d'utiliser à la fois des documents nationaux dont les rapports annuels élaborés à partir

des données de routine et des rapports d'enquête conduites par le programme national de santé de la mère et de l'enfant car traduisant mieux la réalité de la situation. Cependant nous avons eu recours à des documents internationaux pour présenter la situation de la Côte Ivoire sur l'échiquier international.

Résultats

a) Situation des décès maternels

Les rapports 2017-2020 et 2021 de la Surveillance des Décès Maternels, Périnatals et Riposte révèlent que dans plus de 84% des cas, les décès maternels ont lieu dans les établissements sanitaires ce depuis 2017 et que 58% ont lieu dans le post-partum immédiat en 2021.
Les hémorragies du postpartum constituent la première cause de décès maternel (56%) en 2021

Figure 1: Répartition des décès maternels selon le lieu du décès de 2017 à 2020

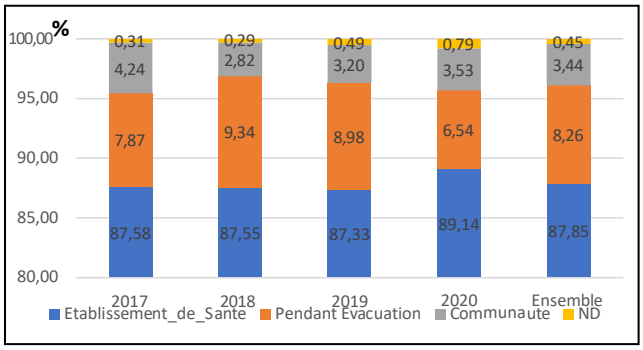


Figure 2 : Répartition des décès maternels selon le déroulement de la grossesse en 2021

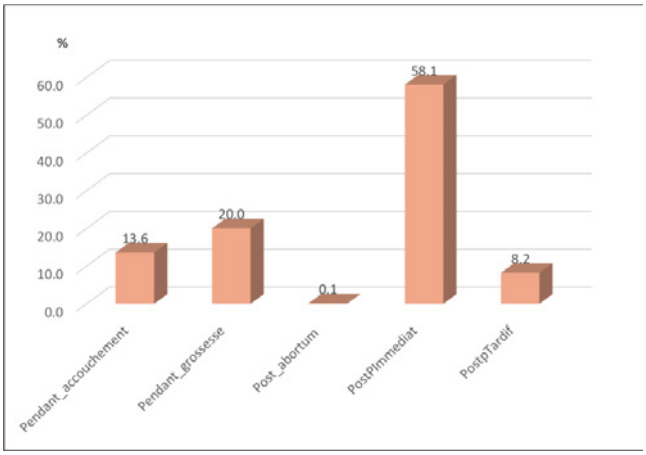


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Figure 3: Répartition des décès maternels selon le lieu du décès en 2021

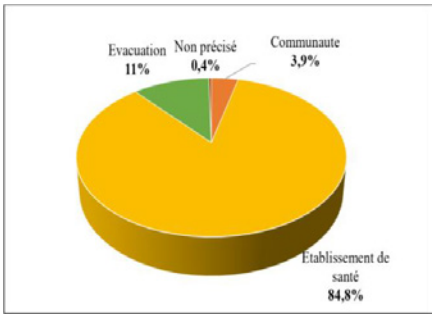
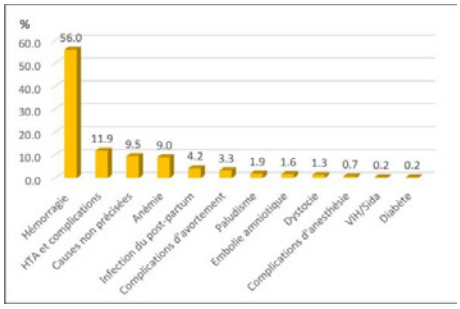


Figure 4: Répartition des décès selon les cause en 2021



b) La capacité litière des salles de suite de couche

En côte d'ivoire, il est recommandé qu'une accouchée par voie normale soit suivie en suite de couche pendant 72 heures. Selon le RASS 2017, la côte d'ivoire a enregistré un total de 633 493 accouchements dans les établissements de santé en une année soit en moyenne 1736 (633 493/365) accouchements par jour. Cela suggère de disposer en moyenne de 5208 (1736*3) lits de suite de couche au plan national pour le respect du maintien des femmes en post-partum immédiat de 72 heures. Alors que le rapport SONU 2017 indiquait une disponibilité de 3027 lits dans les établissements et exclusivement réservés au service d'obstétrique. Aussi ce même rapport révèle que sur 331 809 accouchements spontanés ou réalisés dans l'établissement seul 115 944 ont bénéficié d'une consultation post-natale dans les 72 heures soit 35%.

c) La disponibilité des produits sanguins

Le rapport sur le diagnostic de la chaîne d'approvisionnement conduit en 2018 par l'USAID révèle une satisfaction des besoins nationaux en sang qui est d'environ 70% et cela du fait de la forte dépendance du budget de l'état par le CNTS (le budget total de la chaine d'approvisionnement du CNTS estimé à 4 milliards FCFA est couvert à 90% par l'état) et aussi le manque d'appui par les partenaires [9].

Recommandations

En nous focalisant sur le lieu de survenue du décès (les structures de santé), de la période de survenue de ces décès (post-partum immédiat) et la principale cause de ces décès (les hémorragies du post-partum) nous formulons les recommandations suivantes :

- Assurer un leadership fort pour le respect de la carte sanitaire et le respect des normes de construction des centres de santé ;

- Veiller à la planification de renforcement des capacités des ressources humaines en charge de la santé maternelle et néonatale avec une répartition équitable ;
- Promouvoir le respect des règles régissant la pratique médicale en collaboration avec les différents ordres et
- Renforcer les moyens et la fonctionnalité du Centre National de Transfusion Sanguine pour la production de produits sanguins de qualité.

Conclusion

Les décès maternels constituent un véritable problème de santé en Côte d'Ivoire. Dans leur grande majorité, ces décès surviennent dans les établissements de santé pendant le post-partum immédiat et les hémorragies en sont la première cause. Il ressort des données exposées que la capacité litière des salles de suite de couche et la disponibilité en produits sanguins sont insuffisants pour satisfaire à la demande. Ainsi, des actions efficaces sur ces deux dimensions pourraient avoir un impact important sur la réduction des décès maternels en Côte d'Ivoire.

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2. Réduire la mortalité maternelle dans les pays en développement : quelles sont les interventions efficaces ? Alexandre Dumont ; Revue de Médecine Périnatale 2017/1 (Vol. 9), pages 7 à 14.
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4. Rapport national de la Surveillance des Décès Maternels, Périnatals et Riposte (SDMPR) 2017-2020, Programme national Santé de la Mère et de l'Enfant (PNSME) page 21 à 22.
5. Point de presse sur la mesure de gratuite ciblée des soins du 16 février 2012, Thérèse N'dri Yoman, ministre de la santé côte d'ivoire de juin 2011 à Novembre 2012, consulter le jeudi 21 juillet 2022 sur https://www.gouv.ci/ ministere-une.php?recordID=126
6. Rapport de la Surveillance des Décès Maternels, Périnatals et Riposte (SDMPR) 2021, Programme national Santé de la Mère et de l'Enfant (PNSME) pages 8 ; 16.
7. Rapport Annuel sur la Situation Sanitaire 2017 (RASS 2017), Direction de l'informatique et de l'Information Sanitaire, page 218.
8. Rapport sur les soins obstétricaux Néonataux d'urgence 2017 (SONU 2017), Programme national Santé de la Mère et de l'Enfant (PNSME) page 32.
9. Amélioration de la distribution jusqu'au dernier kilomètre en Côte d'Ivoire : Diagnostic de la chaîne d'approvisionnement, Kate Woods et Simplice Kamdem consulté le 22- 07- 2022 sur https://pdf.usaid.gov/pdf_docs/PA00TR3Jpdf.

CÔTE D'IVOIRE

- Analytical Fact Sheet: Data quality for good decision-making

Direction de l'Informatique et de l'Information Sanitaire

Fiche d'Information Analytique

Septembre 2022

DONNEES DE QUALITE GAGE D'UNE BONNE PRISE DE DECISION

Justification

Le but de tout système d'information sanitaire de routine est de produire des données de qualité pour la planification. L'évaluation du système d'information sanitaire de routine au niveau des établissements sanitaires à travers l'outil PRISM en 2018 a montré une complétude faible des documents source (varie de 38 à 58%) et un niveau global de l'exactitude des données d'environ 20%. Pour garantir la qualité de ces données la Direction en charge du système d'information procède à l'analyse mensuelle de la qualité des données de routine avec les acteurs en charge du suivi et évaluation des programmes de santé et ceux du niveau déconcentré (directeurs régionaux, départementaux de la santé et les suivi et évaluation des régions et districts). Dans le cadre de cet exercice, l'analyse des données portent sur 3 dimensions de la qualité tenant compte des données disponibles.

Complétude : Nombre de formulaire reçu rapport au nombre de formulaire attendu

Promptitude : Nombre de formulaire saisi à temps rapport au nombre de formulaire attendu

Cohérence : Respect du lien de grandeur entre deux indicateurs

Faits marquants

Les faits marquant se présentent comme suit:

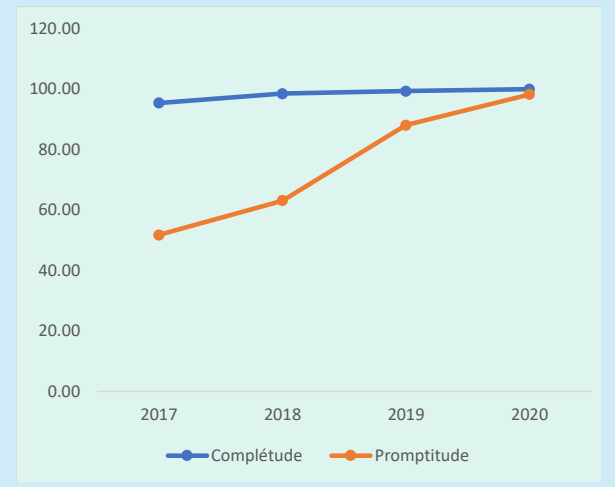
- Amélioration de la promptitude des formulaires
- Amélioration constante de la complétude des formulaires
- Insuffisance de la cohérence des données (paludisme, VIH)

Implications politiques

- Disposer d'infrastructures adéquates pour la sécurisation des équipements de stockage et de gestion des données sanitaires
- Disposer de ressources pour finaliser le processus de dématérialisation des outils de collecte et pérenniser les acquis
- Développer la culture de l'utilisation des données pour prise de décision (Etendre l'utilisation du logiciel DHIS2 à tous les ESPC, les EPN, les établissements sanitaires privés, les établissements communautaires et les établissements sanitaires des autres ministères ;

Complétude et promptitude des formulaires

Figure 1. **Evolution des courbes de complétude et promptitude de 2017 à 2020**

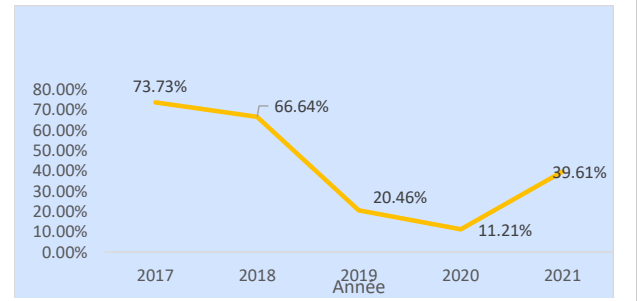


Dimension complétude des formulaires :
Sur la période 2017 à 2020**,** l'exhaustivité de l'ensemble des données produites et collectées au niveau des établissements sanitaires se situe en moyenne à **98,31 %.**

Dimension promptitude des formulaires :
Sur la même période**,** les rapports mensuels d'activités saisis et transmis à temps selon le délai indiqué par le SNIS dans la plateforme DHIS2 ont connu une évolution passant de **51,8% à 98,23**%.

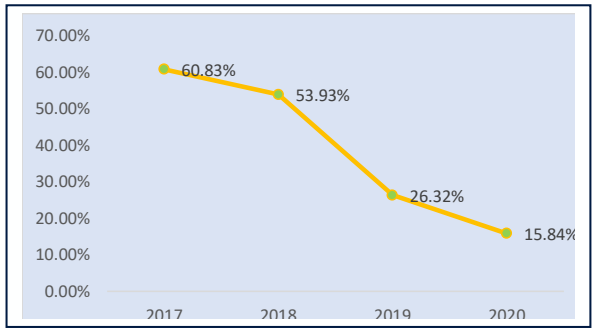
Cohérence des données des formulaires

Graphique 2 : Proportion d'établissements sanitaires ayant des données du Paludisme incohérentes dans DHIS 2



Sur les cinq dernières années, la proportion d'établissements sanitaires ayant des données du paludisme incohérentes dans le DHIS 2 a connu une tendance baissière entre 2017 (73,73%) à 2020 (11,21%) pour une hausse en 2021 (39,61%).

Graphique 3 : Proportion d'établissements sanitaires ayant des données VIH incohérentes dans DHIS 2



De 2017 à 2020, la proportion d'établissements sanitaires ayant des données du VIH incohérentes dans le DHIS 2 est passée de 60,83% à 15,84%.

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1. Rapport annuel sur la situation sanitaire 2017
2. Rapport annuel sur la situation sanitaire 2018
3. Rapport annuel sur la situation sanitaire 2019
4. Rapport annuel sur la situation sanitaire 2020
5. Rapport annuel sur la situation sanitaire 2021
6. Rapport d'activité consolidation des données DHIS2 2021
7. PRISM : cadre conceptuel développé par le projet MEASURE Evaluation pour améliorer la Performance du Système d'Information Sanitaire de Routine (PRISM)

Fiche d'information réalisée par: Ahoty Franck, Kone, Bamba Halima

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CÔTE D'IVOIRE

- Blog: Status of Universal Health Coverage in Côte d'Ivoire

ARTICLE DE BLOG

Couverture maladie universelle : où en sommes-nous en Côte d'Ivoire ?

La Couverture Maladie Universelle (CMU) se définit comme un système obligatoire de couverture du risque maladie dénommé au profit de toutes les personnes résidant sur un territoire. Instituée par la Loi n°2014-131 du 24 mars 2014, l'objectif principal de la CMU est d'offrir des soins de santé de qualité dans des conditions financières soutenables, à toute personne résidante en Côte d'Ivoire. A ce titre 2 régimes coexistent à savoir : (i) Un Régime général de Base (RGB) et (ii) Un Régime d'assistance Médical (RAM)

De plus, le Décret n°2014-395 du 25 juin 2014 porte création de l'Institution de Prévoyance Sociale dénommée Caisse Nationale d'Assurance Maladie (IPS-CNAM) chargée de la gestion de ces deux régimes.

Etat des lieux de la Couverture Maladie Universelle

Au 31 Décembre 2021, 3 244 503 personnes avaient été enrôlées sur une population estimée de 27 087 733 habitants, soit un taux d'enrôlement de 12% de la population totale selon le Ministère de l'Emploi et de la Protection sociale. Sur ce total, 3 054 249 personnes (94%) avaient été immatriculées et disposaient d'un numéro de sécurité sociale. Le nombre de cartes produites s'élevait à 2 998 920 soit 98% des personnes immatriculées et 92% des personnes enrôlées. 2 091 857 cartes d'accès aux soins avaient été distribuées, soit 70% des cadres produites et, 66% des personnes enrôlées disposaient de leur cartes CMU.

Défis rencontrés pour la mise en place de la Couverture Sanitaire Universelle

Après 7 années d'institutionnalisation, les résultats atteints par la CMU semblent peu satisfaisants. Le déploiement de la CMU semble se heurter à des contraintes structurelles et à des

difficultés opérationnelles. Il s'agit notamment des difficultés liées à l'enrôlement et à l'immatriculation des populations, au recouvrement des cotisations, à la prise en charge des populations dans les établissements de santé ou encore à la mise en place d'un système informatique et d'information robustes.

Perspectives

Afin d'adresser ces défis, plusieurs actions doivent être menées. Il s'agit en autres de (i) l'extension de l'installation des box d'enrôlement dans les établissements de santé à forte fréquentation, (ii) l'initiation du paiement des cotisations de la CMU pour 200 000 acteurs du secteur informel en mettant l'accent sur les femmes, (iii) l'acquisition du matériel d'enrôlement nécessaire pour la production in situ des cartes d'assurés, (iv) réalisation d'audience foraine pour les populations bénéficiaires du RAM ne disposant pas de pièces d'identité, (v) le renforcement de la stratégie de communication autour de la CMU, (vi) la formation des professionnels de santé pour permettre à tous les établissements de fournir les soins de santé de la CMU, (vii) l'édition et la diffusion des référentiels santé de la CMU et (viii) la définition d'une stratégie commune PBF/CMU comme outil de financement des soins de santé.

La couverture maladie universelle est effective en CI. Cependant, sa mise en œuvre rencontre des difficultés assez importantes mais elle reste une voie certaine pour aller vers la couverture sanitaire universelle. Des actions majeures doivent être entreprises tant au niveau politique qu'au niveau opérationnel pour adresser ces difficultés afin d'assurer le bien-être des populations. A cet effet, un accent particulier doit être mis sur l'enrôlement et l'immatriculation des populations indigentes car cible privilégiée de la CMU. Par ailleurs, des réflexions doivent être menées pour un arrimage approprié entre la mesure de la gratuité ciblée et la CMU afin de permettre un accès effectif et équitable à la population cible.

Pour en savoir plus

1. 1512400987CODE-DE-PREVOYANCE-SOCIALE2014-131.pdf (www.gouv.ci)
2. https://comprendre.media/cote-divoire-le-regime-dassistance-medicale-de-la-couverture-maladie-universelle-beneficiera-a-25-millions-de-personnes/
3. CMU – SNEDAI GROUPE
4. Journal officiel de la Côte d'Ivoire | DECRET n° 2014-395 du 25 juin 2014 (juriafrica.com)

GHANA

- Knowledge Fact Sheet: What is e-Tracker

KNOWLEDGE FACT SHEET VOL.1

WHAT IS THE E-TRACKER ?

eTracker (eRegistries) is a system designed and developed to collect, manage and analyze transactional case based records at the community level for maternal and child health and TB management and treatment services.

Ghana Health Service the Lead Implementation Agency

First Deployed 2014

The system can capture information about anonymous events and cases as well

Currently being used in 3,000 facilities in 8 regions of Ghana

eRegistries when deployed with the right approach and methodology will eliminate manual reports, paper registers, multiple unique identifiers, tallying, manual summary reports and manual aggregation at all levels.

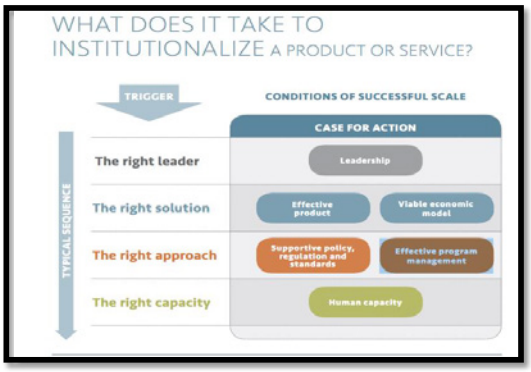
It stores information about individuals and track these persons over time using a flexible set of identifiers.

TRAINING

5,000 Community Health Officers trained on the use of the Maternal and Child Health E-Tracker

1,500 TB Programme Officers trained on the TB E-Tracker

1,200 HIV Programme Officers Trained on the HIV E-Tracker



REASONS TO MOVE TO eREGISTERS (eTRACKER) CLIENT BASED RECORDS
DATA QUALITY Accuracy, Completeness and Timeliness of the data has always been questioned. Primary data collection tools at the Health Facilities are not available to the district , regions and national level Great difficulty in using paper based system for Tracking and default tracing of clients etc
ANALYSIS District level keeps data in electronic aggregates form in the DHIMS2, making detailed analysis on Child and Maternal Health Service limited.- Aggregation have been pre-determined.
DATA Even though data are immediately uploaded and made available online in the DHIMS as real- time data, update are only available monthly when data entry are done

For Further Info
https://aho.afro.who.int/gh
www.moh.gov.gh / www.ghs.gov.gh
www.chimgh.org

GHANA

- Analytical Fact Sheet: Under 5 mortalities

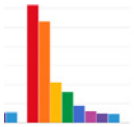
ANALYTICAL FACT SHEET

Under 5 Mortality In Ghana 2021

One of the United Nations Sustainable Development Goals (SDGs) is to reduce infant and under-five mortalities by three-fourth between 1990 and 2015. Although maternal mortality has declined over the past few years, the progress is rather slow in many African countries including Ghana. On the other hand, the increase in population life expectancy since 1990s has been either stagnant or slow, adding an average of only 0.11 years every year (UN 2013a).

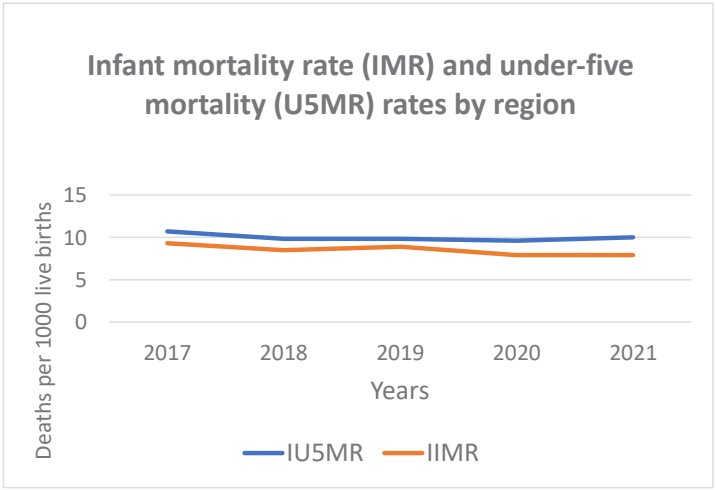
In fact, life expectancy at birth remained low within the mid-50 range for over the last three decades. During this period, both infant and child mortality showed consistent decline. For example, the infant mortality rate was close to 100 deaths per 1000 live births in the late 1970s and towards the end of the 1990s, the infant mortality declined to 70 per 1000 live births and further to 50 per 1000 live births in 2008 (GSS, GHS and ICF Macro 2009; UN 2013).

The number one cause of death amongst children under 5 years in Ghana in the year 2021 was Intrauterine hypoxia and birth asphyxia.

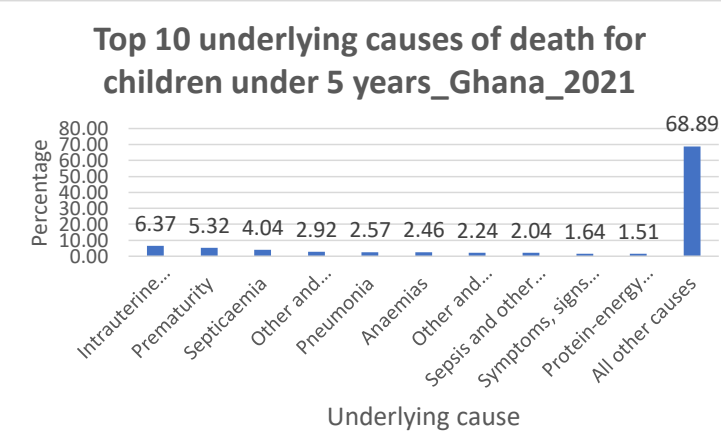


Total number of deaths amongst children under 5 years recorded within the year is 10,696

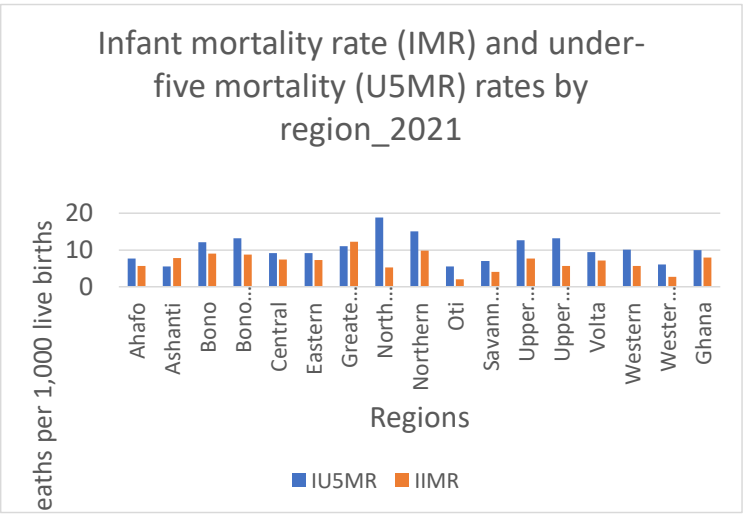
Northern region recorded the highest number of children under 5 years deaths in Ghana.



This chart presents the estimates of infant and under-five mortality rates nationally. However, infant and under-five mortality rates, since 2017 to 2021, has been consistently decreasing and being below the national target of 10 deaths per 1000 live births.



The analysis of underlying cause of death for children under 5 years in Ghana, in the year 2021, shows that intrauterine hypoxia and birth asphyxia followed by prematurity and septicaemia which represented 6.37%, 5.32% and 4.04% of total under-five deaths respectively, were the top causes of deaths. The first top 10 causes of deaths contributed nearly 31.11% whereas the remaining 68.89% represented other causes.



Overall, infant and under five mortality rates were consistently the highest in Northern and North East regions whereas Western North and Oti regions recorded the lowest in terms of infant and under five mortality rates. Moreover, the difference between IMR and U5MR was also the highest in the North East and Upper West regions when compared to other regions. This suggests high mortality rates between ages 1 and 4 in these regions. The Northern, Bono East, Bono and Greater Accra regions have both IMRs and U5MRs above the national average.

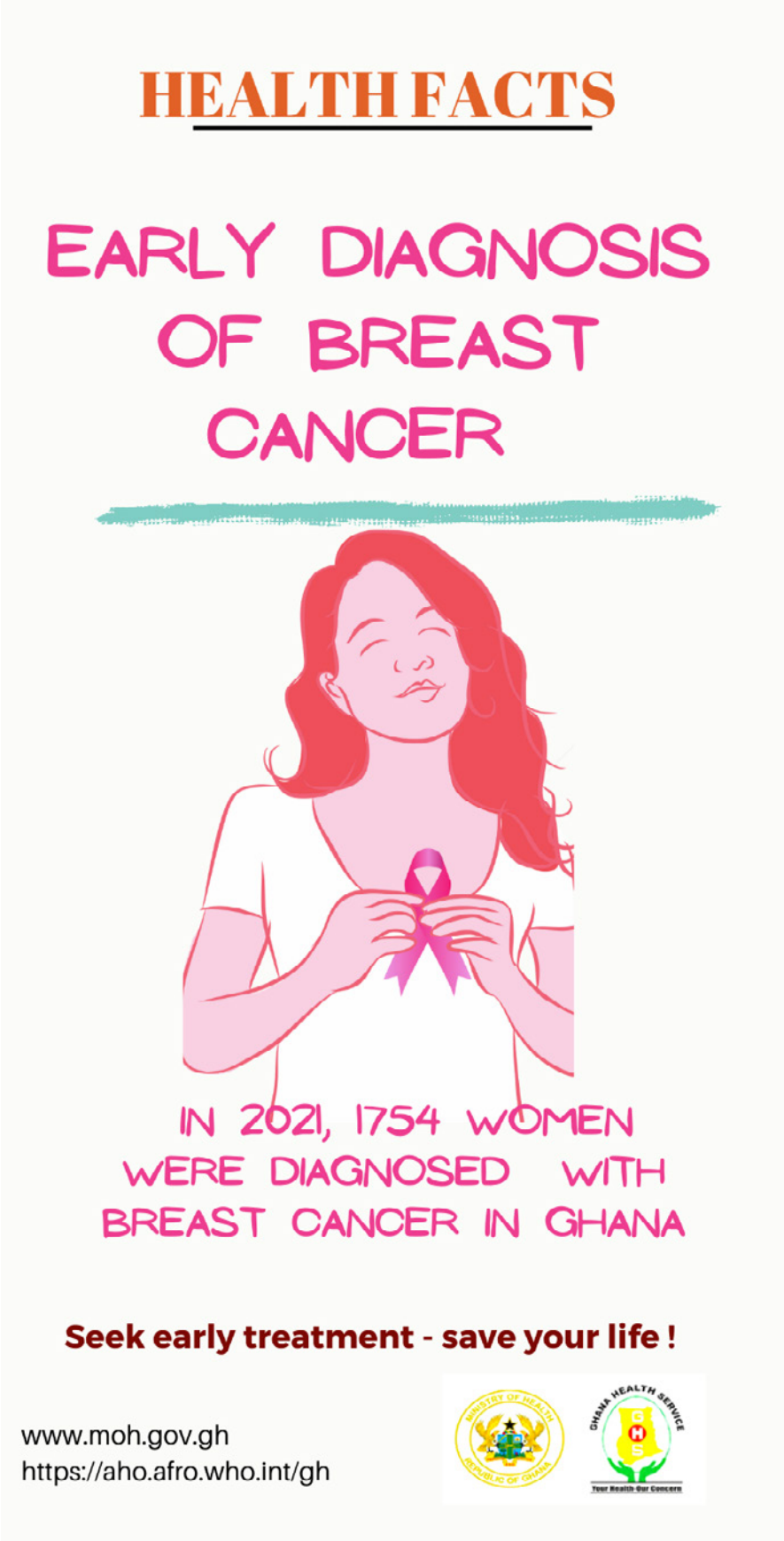
The findings reflect the efforts needed to accelerate Ghana's progress towards the Sustainable Development Goals. There is an urgent need to strengthen and reorient existing safe motherhood and new-born healthcare systems and related community-based intervention programmes in Ghana. Programme efforts, for example health insurance and community health interventions, should be directed more towards these areas: Northern, Bono East, Bono and Greater Accra regions

Source : DHIMS2

For More Information
https://aho.afro.who.int/gh
www.moh.gov.gh /
www.ghs.gov.gh

GHANA

- Infographic: Breast cancer awareness



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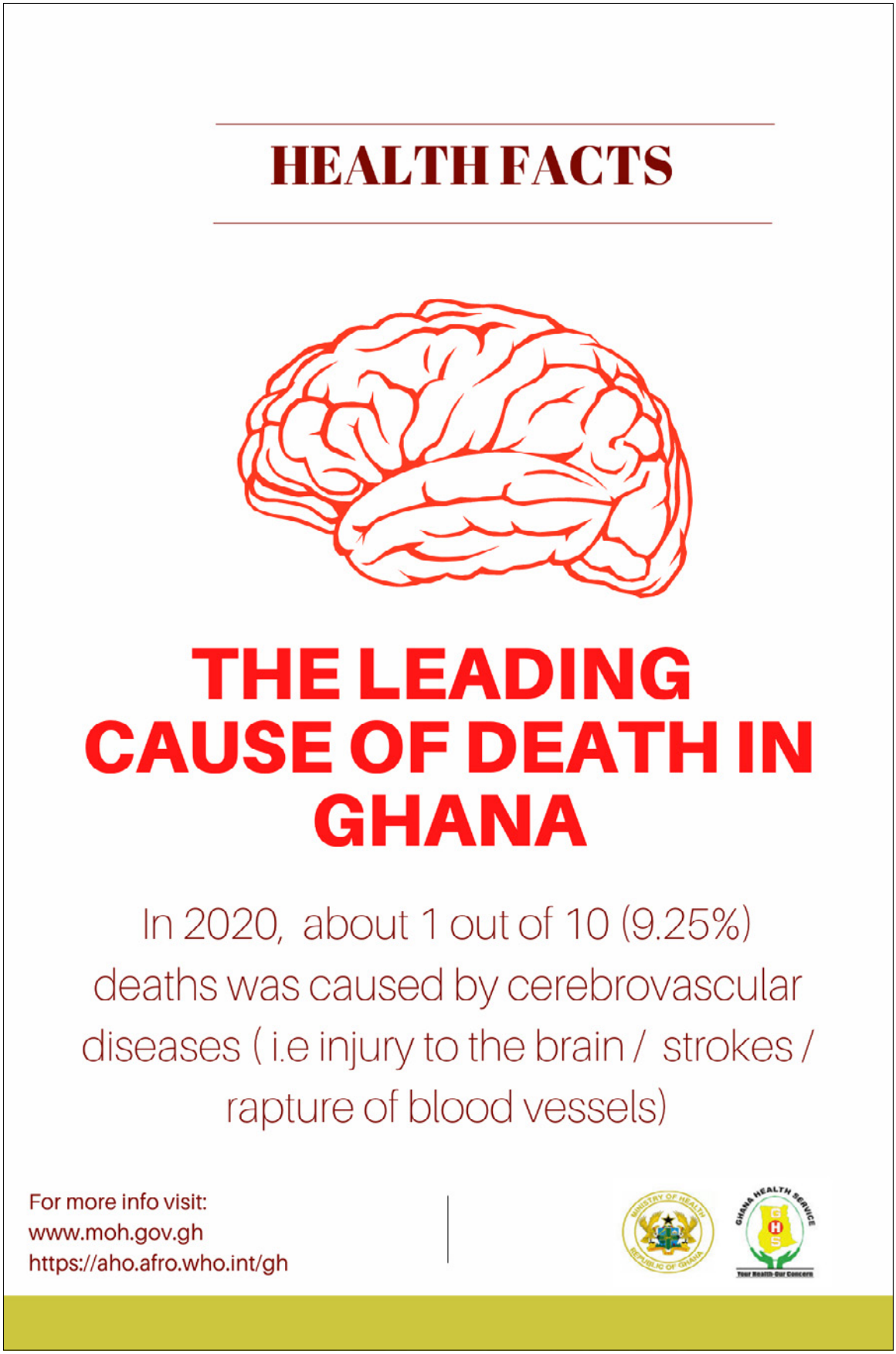
- Infographic: Leading causes of deaths



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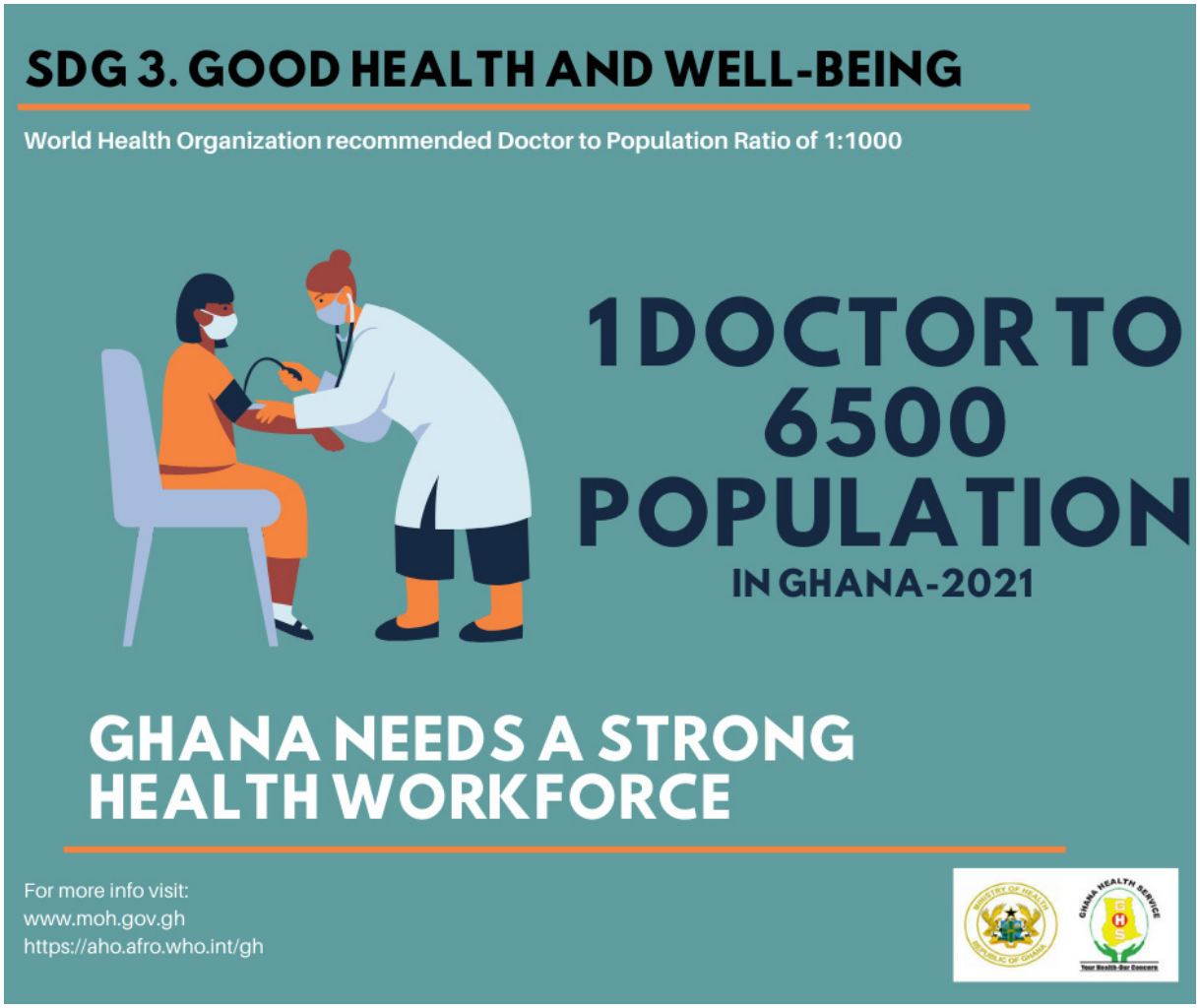
- Infographic: Doctor to population



GHANA

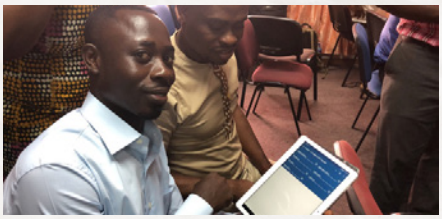
- Blog: Identifying and addressing challenges in deploying electronic registers in Ghana

BLOG POST

VOL . 1

IDENTIFYING AND ADDRESSING CHALLENGES IN DEPLOYING ELECTRONIC REGISTERS IN GHANA

BY: GHANA-NHO TEAM



e-Registers

Routine data are data collected continuously or at least repeatedly with some time intervals. They are collected in various ways, e.g., registration by the health services or by interviews with patients or population groups. The data could then be stored and administered in register format. This information stored in an electronic format is termed as an electronic register.

Health registers contain data on persons with diseases or health-related events. The coverage can vary from a total registration to a population sample and from national to regional or local coverage. Data can be routinely collected for various reasons, from economic and administrative purposes to more strict epidemiological purposes.

Ghana has developed the e-Tracker, an intervention to reduce errors from data collection and collation to improve data quality.

The eTracker (eRegistries) is used to collect, manage and analyze transactional case-based records at the community level for maternal and child health and TB management and treatment services. The aggregated data is then pushed into DHIMS2. Currently the eTracker has been deployed in four districts to address these challenges

Challenges in deploying e-registers

A review on the use of the eTracker in 6 regions with about 3,000 facilities has been done from 2014 through to 2022. The key objective was to document the challenges faced by Community Health Nurses, General Nurses and Midwives in introducing electronic registries in Ghana where internet connectivity and electricity is not very reliable.

There are 3 key stages in transition from the manual aggregate to the national repository (DHIMS2). These include the manual aggregate reports to the national repository, manual aggregate report to the electronic registers to the national repository and the eRegister through to the national repository.

Internet and electricity connectivity are challenges in some communities.

Inadequate logistics for facilities and health directorates

Lack of the requisite capacity in the use and maintenance of the equipment

It was observed that facilities continue to parallel reportin DHIMS2 whiles still using the eTracker because their facilities have not been automated to send data automatically into DHIMS2.

A consistent approach and methodology in deployment.

Way Forward

With the right approach and methodology in the deployment of eRegisters, there will be a gradual elimination of parallel reporting at all service delivery points.

The health service adapting local policies that will support the use of electronic registries for health service delivery and not necessarily buy-in and adopt other countries' systems because it has worked on a pilot basis.

Coherently addressing the economic viability, sustainability and most importantly, the building of capacity of officers.

Further comprehensive evaluation on the use of eTracker to be done to enhance its benefits and use by facilities.

Facilities must ensure that tools are properly maintained and fixed when necessary.

For more information about e-registers
www.ghs.gov.gh
https://aho.afro.who.int/gh

KENYA

- Policy Brief: Effectiveness of physical measures for control of mosquito and mosquito borne diseases for Kenya

POLICY BRIEF FOR KENYA

EFFECTIVENESS OF PHYSICAL MEASURES FOR CONTROL OF MOSQUITO AND MOSQUITO BORNE DISEASES FOR KENYA

Key messages

1. Mosquito-proofing/screening houses could be a game changer for control of mosquitoes and elimination of mosquito-borne diseases including malaria.

2. Some mosquito traps can be used successfully for mosquito and mosquito borne diseases control and surveillance in the country.

3. Eave tubes, are a household protection product against mosquitoes and mosquito-borne diseases that leverages on the natural indoor- biting behavior of mosquitoes. However, the innovation requires further field evaluations under realistic field conditions, as well as their comparison with existing approaches in terms of cost-effectiveness and community acceptance before scale-up.

4. Studies reviewed on Integrated Vector Management (IVM) indicated that, in general, application of physical IVM methods for mosquito control, not only reduces reliance on insecticides, but also lead to rapid and effective mosquito-borne disease control. However, maintenance of the reduced vector density levels for prolonged periods is necessary if IVM is to be a mainstream mosquito control measure for chronic or endemic mosquito-borne diseases like filariasis. Therefore adequate community and stakeholder participation is necessary for successful implementation.

5. Different materials, for mosquito control barrier methods are used either plain or impregnated with insecticides or repellents. Their respective intervention effects can however be enhanced by incorporating a hydrophobic agents.

Executive summary

INTRODUCTION: Mosquitoes are vectors of many diseases of public health importance in lower and middle income countries of the world. Malaria is the most important of these mosquito-borne infectious diseases that affects humans and other animals. The aim of this review was to synthesize available primary research reports on effectiveness of physical mosquito control measures against adult mosquitoes and mosquito- borne diseases in Kenya. This brief is therefore a summary of physical mosquito control knowledge and recommendations available in the main online health research databases from LMICs countries, which are roughly applicable to the Kenyan context.

METHODS: Thirty Two (32) studies on physical measures for mosquito control were identified from databases for this policy brief. These were classified as Mosquito Proofing/screening Houses (8); Environmental Management **(**4) ; Mosquito traps(9); Eaves tubes (3); Integrated Vector Management (3); Materials for Mosquito Control Barrier Methods (5) studies investigating the effectiveness of various materials for this review. These were all identified from electronic search of health research databases and online libraries including PubMed, Mapping malaria risk in Africa group (MARA) database, Cochrane Library, Trip database, African Index Medicus and Scopus using the search terms Mosquito control > Physical control methods > Effectiveness of physical mosquito control methods for control of mosquito- borne diseases in low and middle income countries.

FINDINGS: Overall mean mosquito density reduction per house per night or mosquito-borne disease incidence reductions per household per year attributable to physical mosquito control interventions was 58.94% [(56.46% (Mosquito-proofing/screening);50.02% (mosquito traps);57.65% (Environmental Management);50.24% (Eaves Tubes interventions);38.51% (Integrated Vector Management);37.25% (Zerofly tent sheet material);77% (hydrophobicity agent Amino silicate);61.3% (non-impregnated mosquito net material);70% (non-impregnated shade cloth material);77% (Deltamethrin-impregnated shade cloth); and 84% (Deltamethrin-impregnated mosquito net material)].

CONCLUSIONS: Physical mosquito control significantly reduces both intensity of mosquito infestations in houses and cases of mosquito-borne diseases within the household. They are therefore recommended to supplement existing interventions for achievement of the national

regional and global goals of eliminating malaria and mosquito-borne diseases by the years 2030, 2050 and 2063 respectively.

Introduction

Mosquitoes are vectors of many diseases of public health importance in lower and middle income countries of the world. Malaria is the most important of these mosquito-borne infectious diseases that affects humans and other animals.

Aim and Target audience

The aim of this policy brief is to synthesize available evidence on effectiveness of physical mosquito control measures against adult mosquitoes and mosquito- borne diseases in Kenya and present it to our national mosquito and mosquito-borne diseases control policy makers and decision makers in government, development partners and other stakeholders for consideration.

Policy question

Can putting more investments in physical mosquito control methods help Kenya achieve its national, regional and global commitments on elimination of malaria and vector-borne diseases by the year 2050 ,2063 and 2030 respectively?

Context

This policy brief is a summary of available evidence from published health research and which could be applicable to our national context.

PHC Dimension of Environmental Health for Mosquito Control

From the reviewed studies is presented evidence on effectiveness of interventions that can be leverage on available human resource for health specialized, which has skill-sets in in environmental health technologies including housing improvements. These include building the capacities of masons and artisans for closing or screening eaves and gable ends of houses using various locally available materials, screening windows, doors and other wall opening s using mosquito screens or other effective and durable e.g. fiber-glass wire-mesh, shade mesh etc.

PHC Dimension of Community Health for Mosquito Control

From the reviewed studies is presented evidence on effectiveness of interventions that can be leverage on community and stakeholders participation for health. These include environmental

hygiene and manipulation as well as Integrated Vector Management (IVM) interventions that target the physical environment to reduce conditions that favor mosquito breeding and resting i.e. Clearing and safe disposal of vegetation, liquid and solid wastes and other potential breeding ground s for mosquitoes around human habitats which can be used to leverage on the expanding pool of communities own resource persons, community based organizations and community health volunteers to participate in improving the health of their communities.

Health System dimension of Policy and Research

From the reviewed studies is presented policy implications and the need for further research on several innovative interventions for mosquito control and the control of mosquito-borne diseases such as novel mosquito control materials and technical Eave Tubes that used in combination with other interventions can increase effectiveness . These include hydrophobicity agents for mosquito control materials including cotton cloths, insecticide-embedded plastic sheets and Eaves Tubes.

Health systems Re- engineering

The evidences presented calls for reorientation of mosquito and mosquito-borne diseases from vertical to horizontal programing to accommodate the implementation of interventions from multisector, sector wide and devolved dimensions of health care services and interventions.

Findings

According to findings of the reviewed studies,

1. There was 56.46% mean reduction of anopheles mosquito densities per house per night or incidents of malaria among household members per year (36.612%; 62.11%; 40%; 82.5%; 59%; 56%; 59%) CI 95%, P< 0.05 attributable to full screening/mosquito-proofing of houses.[1]
2. A mean capture rate of 50% for mosquito traps tested (Community-Based Ifakara Tent Traps= 7%; Community Based Light Traps=50%; Modified ovitrap with *Bacillus thuringiensis* israelensis=98.5%) 95%CI, P<0.001. [2]
3. Reduction of house infestation by mosquitoes attributable to Environemntal Management or manipulation was 57.65% (91.8%; 23.5%). [3]

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[1] [Kaindoa *et al* (2018); Ng'ang'a *et al* (2020); Bradley J, *et al* (2013); Atieli, H., *et al* (2009); Sheila B Ogoma *et al* (2009); *Trends in Parasitology* Vol. 18 No. (2002); Gimnig JE, Slutsker L (2009)].

[2] [Oswaldo Cruz (2008); Sikaala *et al* (2014)].

[3] [Correia JC et al; Development of a Community-based-Environmental Management Program for Malaria Control in Kampala and Jinja, Uganda]

4. Elevation above sea level and precipitation were found to be important, respectively, time-invariant and time-dependent variables associated with decreasing and increasing malaria transmission in the elimination phase of malaria control. [4]

5. On the distribution and abundance of adult Anopheles mosquitoes, significant cross-correlation was found between the vector population and larval habitat availability in the western Kenya highlands. Therefore vector control targeted at malaria transmission hotspots and supplemented by larval control may be an effective approach for epidemic malaria control.[5]

6. Mean intervention effects attributable to Eaves Tube Intervention among Reviewed Studies was 50.24 %(86.67%; 23.38%; 40.67%). [6]

7. Mean reduction in malaria incidents attributable to IVM intervention sites was 38.51 %(46.3%; 56%; 13.23%). [7]

8. The Annual Transmission Index (ATI), which is the product of the number of infective mosquitoes biting a man per year and the average number of infective larvae per infective mosquito showed an increasing trend in the comparison area but declined in the IVM intervention areas. [8]

9. ZeroFly tents reduced the biting success rate of mosquitoes by 37.25%(49.75%-12.5%) when compared to ordinary plastic sheeting ; and a reduction by 51% for ordinary plastic sheeting compared with no plastic sheeting at all.

10. Other results showed adulticidal effect of synthetic pyrethroids permethrin, deltamethrin, lambdacyhalothrin when combined with an insect repellent DEPA on cotton material lasted for 1 to 4 weeks with the lower residual activity being attributed to the repellency of the treated fabrics. But the repellency/feeding deterrence increased by 77 % (1 to 17.5 weeks) - (1 to 4 weeks) = 13.5 weeks when the cotton material was treated with a hydrophobicity agent Amino silicate. [9]

11. The efficacy Mosquito netting material in reducing indoor mosquito densities was 61.3% for Non-impregnated mosquito –net material and 70% for non-chemical impregnated shade cloth material. The efficacy was 77% for Deltamethrin impregnated shade cloth and =84% for Mosquito netting. Plain shade cloth reduced the densities by 69% compared with no screening at all.

Conclusions

From the above findings,

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[4] [Izadi Malar J (2016)]

[5] [Mosquito Abundance and Environment in Kenya Highlands]

[6] [Okumu (2017); Snetselaar *et al*. (2017); Waite *et al. (*2016)]

[7] [Mutero *et al*.; Adaptive Integrated Malaria Vector Management at Malindi, Kenya (Final Report, May 2005-April 2006); Kanda, T. *et al*]

[8] [Ramaiah, K D. *et al*.]

[9] [D.D Amalraj, *et al*]

- Physical mosquito control is significantly effective for the reduction of both intensity of infestations and disease transmission and should be used to supplement existing interventions for achievement of the national regional and global goals of eliminating malaria and mosquito-borne diseases by the years 2030,2050 and 2063 respectively.

- Environmental management and IVM interventions significantly reduces transmission of mosquito borne diseases but is labor-intensive and therefore requires household and community participation to succeed.

Policy implications

Review of Mosquito and mosquito-borne diseases control policies, guidelines, strategies and programs to de-emphasize vertical programing and embrace horizontal and devolved approaches such as PHC dimensions of environmental and community health interventions including physical mosquito and mosquito-borne disease control interventions.

KENYA

- Analytical Fact Sheet: Taking stock of a decade of UHC implementation

Ministry of Health

Analytical Fact Sheet

September, 2022

TAKING STOCK AFTER A DECADE OF UHC IMPLEMENTATION

outcome indicator	Baseline (2013)	Achievement 2022	% Change
UHC service coverage Index	**59%**	**77%**	**18%**
Life Expectancy at Birth	63	67	6%
Maternal mortality ratio per 100 000 live births	364	342	6%
Under-5 mortality rate per 1 000 live births	54.5	43.2	21%
Neonatal mortality rate per 1 000 live births	23.7	21.5	9%
Incidence of HIV/AIDS infections per 1000 uninfected population	5	1.4	72%
HIV Prevalence	5.6	4.5	20%
Tuberculosis incidence per 100 000 population	443	238	46%
Malaria incidence per 1000 population	95	85	10%

Key findings

Over the last decade of implementing UHC;

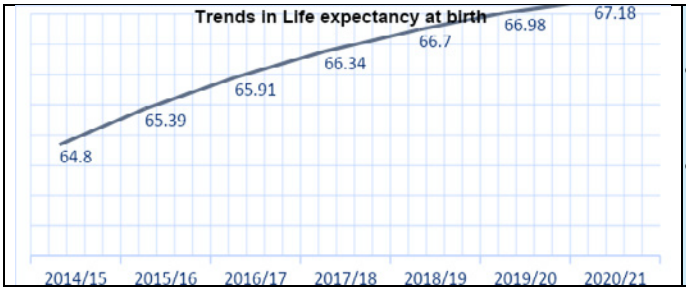
- UHC service coverage index increased by 6% from 59% to 77%.
- Life expectancy increased by 6% over this period
- Maternal mortality declined marginally (by 6%) signifying slow transition of investments to gains in maternal health over the last 10 years
- Gains were made in child health with child mortality decreasing by 21% for under 5 mortality and 9% for neonatal mortality.
- The biggest gain was realized in control of infectious diseases; Incidence of HIV/AIDS reduced by 72% while incidence of TB infections reduced by 46%.
- Overall, all key indicators show some progress which can be associated with implementation of UHC

KENYA'S JOURNEY TO UHC BY 2022:

Rationale

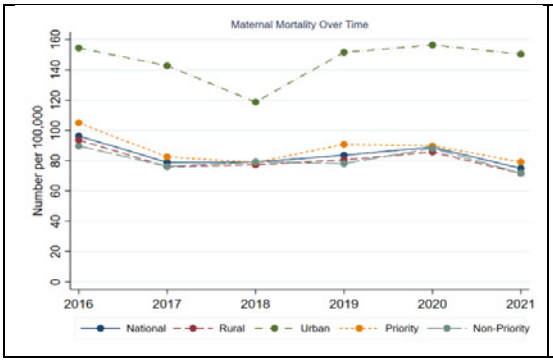
Achievement of Universal Health coverage (UHC) is a key driver towards meeting health related SDG goals. Kenya has prioritized achievement of UHC to ensure all Kenyans have access to quality affordable healthcare without getting impoverished in the process.
The UHC index has been comprehensively computed and reported in the two MTR reports-2016/17 and 2019/20. This was an adoption of the WHO/World Bank framework for measuring UHC service coverage and financial protection index.
Results from the Medium Term Reviews (MTR) augmented by the current reports from the sector from both routine and survey sources were used to inform this fact sheet

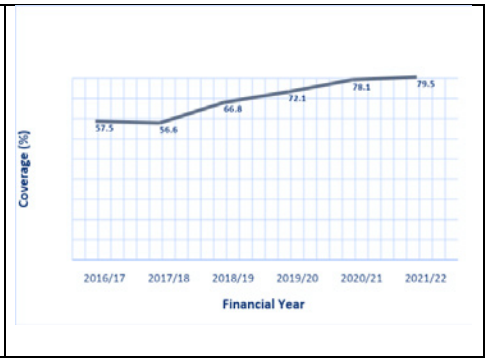
Kenya UHC framework



Life expectancy

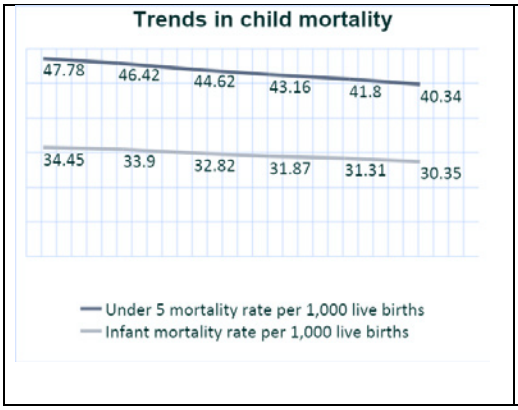
- There has been a gradual increase in life expectancy from 2014/15 to 2020/21
- This signifies a general increase in the health of the population

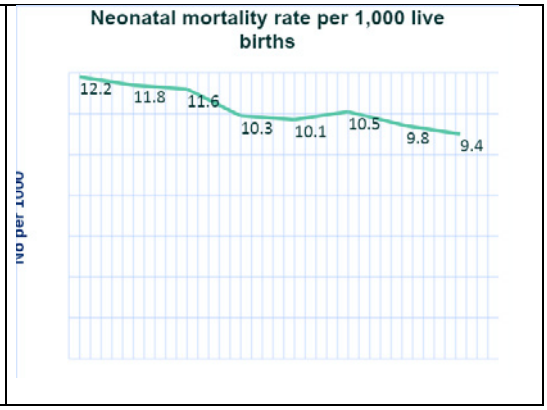




Maternal Heath

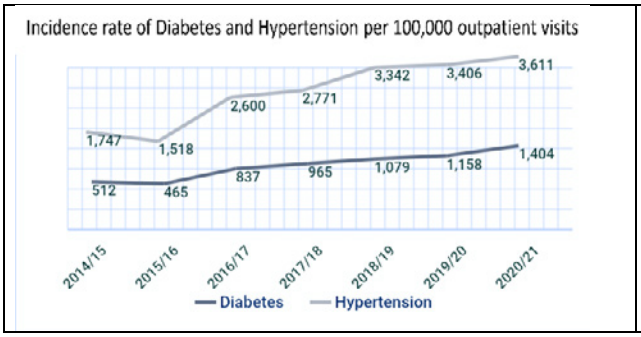
- Maternal mortality has stagnated despite a gradual increase in skilled birth attendance
- Skilled birth attendance (SBA) rate is still below the set target of 87.4%
- The urban SBA rate remain above the target while priority counties, mostly within the arid and semi arid areas had the lowest rates of SBA (Samburu and Narok reported rates <50%)





Child Health

- Child mortality has decreased gradually over the period
- Facility based Neonatal mortality rate decreased from 12.2 to 9.4 per 1000 live births



Non communicable conditions

Number of diabetes and hypertension patients seen in outpatient has risen over the implementation period from 1747 to 3611 and 512 to 1404 per 100,000 visits respectively

This increase could be contributed to both increased service utilization as well as an increase in disease burden

UHC Service coverage index

UHC service coverage Index

- Overall service coverage and service quality index reduced from 83% to 46% and from 73% to 63% respectively, when comparing 2019 to 2020,
- Service access score improved slightly to 79% as compared to 75% in 2019/20,
- Increased service access may have resulted from increased investment in the health sector in such areas as beds, core health workforce, and health facilities secondary to the COVID pandemic may have resulted in improved

Policy implications

- Sustain or scale up investments in UHC to maintatin or increase health gains
- Interventions to reduce maternal moratlity are urgently needed; These need to focus on Counties that are lagging behind, mostly those in rural areas, arid and semi-arid lands
- Strengthen measures to prevent and treat non communicable diseases such as diabetes and heart disease
- Improve quality of health services particularly in public facilities where most people can access them

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2. Kenya RMNCAH framework end term review; INDICATOR ASSESSMENT report; MOH, Kenya, APHRC
3. Kenya Health Sector M & E plan

Authors: Dr Helen Kiarie, Peter Wanjohi

KENYA

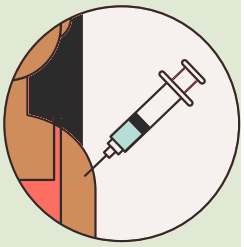
- Infographic: Vaccination against HPV

Ministry of Health
Republic of Kenya

Vaccination against HPV

Control

HPV and cervical cancer can be controlled through vaccination , early screening and timely treatment before disease onset



what is HPV

HPV stands for Human Papilloma virus, a sexually transmitted virus that mostly infects women shortly after onset of sexual activity

vaccination against HPV is a cost effective way of preventing cervical cancer

Why is HPV important?

HPV is responsible for 95% of cervical cancer cases among women globally

HPV vaccination

HPV vaccine is recommended given prior to exposure to HPV, and is therefore recommended for girls between 9-14 years

How common is the problem?

Globally, cervical cancer ranks 4th, among cancers affecting women

Screening

Regular screening is recommended to detect pre-cancer and cancer signs among women with no symptoms

HPV and Cervical Cancer in Kenya

Cervical cancer is the 2nd most frequent cancer among women in Kenya, and the 2nd most frequent cancer among women between 15 and 44 years of age.

Treatment

Cervical cancer can be cured if diagnosed early and treated on time

Authors: Peter Wanjohi & Dr Hellen Kiarie; MOH Kenya

MOZAMBIQUE

- Policy Brief: Neonatal Mortality from Avoidable Causes:
Is it a Public Health Problem in Mozambique?

Mortalidade Neonatal por causas evitáveis: É um problema de Saúde Pública em Moçambique?

A Mortalidade Neonatal (MN) é um termo que se refere à morte de um bebé nascido vivo nos primeiros 28 dias de vida. Os cuidados de saúde materna e neonatal de qualidade são serviços de saúde essenciais, que têm de ser mantidos para protecção da vida e saúde da criança e da mulher. Em Moçambique, estima-se que as principais causas evitáveis de MN são a prematuridade, infecções e causas relacionadas com o parto. Estudos consideram que intervenções que se centram na educação das mães sobre a assistência pré-natal, rastreio, monitoria e a gestão das condições maternas durante o período pré-natal são de extrema importância para a prevenção da MN. Adicionalmente, a assistência médica em cada nascimento é importante para assegurar a sobrevivência neonatal precoce e evitar o potencial factor de risco de mortalidade.

A Mortalidade Neonatal ainda constitui um desafio de Saúde Pública em Moçambique com uma Taxa de Mortalidade de 22.6/1000 (COMSA 2020).

A mortalidade neonatal é um termo que se refere à morte de um bebé nascido vivo nos primeiros 28 dias de vida. Pode ser precoce ou perinatal (dos 0 aos 6 dias de vida) ou tardia (dos 7 aos 28 dias de vida). A morte neonatal está intimamente relacionada a vários problemas (ex: falta de acesso aos cuidados médicos básicos, doenças, etc) durante a gravidez, no parto e após o parto e nascimento.

A Mortalidade Neonatal continua a ser um importante desafio de saúde pública em Moçambique representado mais de 1/3 da mortalidade infantil (UNCEF). Sengundo COMSA 2020 ataxa de mortalidade neonatal em Moçambique é de 22.6/1000 nascidos vivos.

Em relação às causas de mortalidade neonatal "potencialmente evitáveis" mais importantes, as mesmas estão intimamente associadas ao estado de saúde da mulher grávida e parturiente e ao manejo das complicações nesses dois momentos (MISAU, 2019).

De acordo com as Estimativas do *Countrywide Mortality Surveillance for Action* (COMSA) 2020, em Moçambique a taxa de Mortalidade Neonatal é de 22.6 em cada 1.000 nados vivos. Com vista a reduzir a Taxa de Mortalidade Neonatal o Ministério da Saúde elaborou um Plano de Acção para Cada Recém-Nascido, 2019-2023, que preconiza esforços conjuntos para reduzir as mortes neonatais com uma meta até 2023, tendo o ano 2011 como referência, a redução da mortalidade neonatal de 30/1000 para 19.3 enqunto que a meta ate 2030 é de 12 (ODS) por 1000 nascidos vivos.

Os dados apresentados como evedência da mortalidade neonatal foram extraidos dos grandes inqueritos nacionais, porém, não se encontram dados relativos a problemática da mortalidade neonatal na plataforma do Sistema Nacional de Saúde – Sistema de Informação em Saude para Monitoria e Avaliação (SISMA/DHIS2), pelo que, a Mortalidade Neonatal constitui um

problema cientifico de Saúde Pública em Moçambique. Dai torna importante apresentar "*policy brief"* sobre a **Mortalidade Neonatal por causas evitáveis**.

Quando se considera morte neonatal por causa evitável?

Considera-se morte neonatal evitável aquela em que poderia ser prevenida, seja com a melhoria da assistência pré-natal, ao parto e ao recém-nascido, não apenas quanto à sua resolubilidade clínica, mas também à organização da assistência em sistemas hierarquizados e regionalizados, assegurando o acesso da gestante e do recém-nascido em tempo oportuno a serviços de qualidade (Lansky et al 2002). É também considerado morte neonatal evitavel aquele que ocorreu em condições que raramente ou nunca deveriam ter evoluido para óbito (Campos, 2014).

Estudos tem demonstrado que a análise dos factores associados aos óbitos evitaveis permite planear intervenções mais adequadas ás necessidades dos grupos populacionais mais vulneraveis, contribuindo para a redução das inequidades.

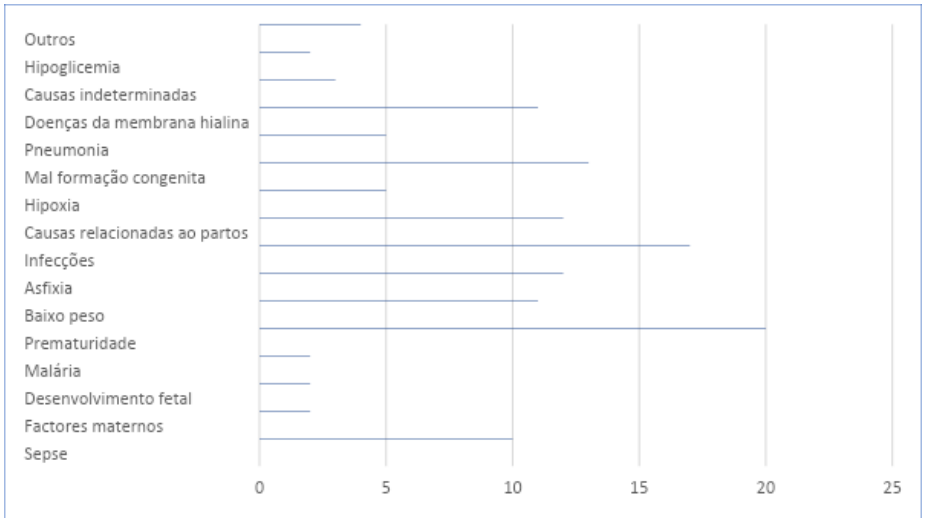
Segundo a Organização Mundial da Saúde, todas as causas que podem ser prevenidas ou tratadas com acesso à intervenções acessíveis no sistema de saúde.

Principais causas evitaveis de Mortalidade Neonatal?

Segundo as Nações Unidas, 80% das mortes de recém-nascidos resultam de três situações evitáveis e tratáveis: complicações decorrentes da prematuridade, mortes ligadas ao intraparto (nomeadamente, asfixia perinatal) e infecções neonatais. Outrussim, segundo a Organização Mundial da Saúde, as crianças que morrem nos primeiros 28 dias após o nascimento sofrem de condições e doenças associadas à falta de cuidados de qualidade no nascimento ou imediatamente após o nascimento e nos primeiros dias de vida.

Foram consultados 33 documentos de literatura nacional e internacional, dentre eles relatorios de dados administrativos, relatorios de pesquisa de mortalidade neonatal, inquéritos populacionais, estimativas de mortalidade que constituiram a fonte para a sistematização e identificação das principais causas de mortalidade neonatal. (Grafico 1)

Gráfico1: Frequência de Causas de Mortalidade Neonatal



Com base na revisão de literatura realizada, constatam-se como principais causas de mortalidade neonatal a prematuridade, infecçoes, malformação congénita e cusas relacionadas ao parto.

À excepção da malformação congénica apresentada como uma das principais causas de mortalidade neonatal, a prematuridade, infecçoes, e cusas relacionadas ao parto são causas evitáveis de mortalidade.

Quais são factores associados Mortalidade Neonatal?

O modelo conceptual (fig.1) representa os factores associados a MN que podem ser: i) *socioeconomicos*, ii) *estruturais* ……..

Factores socioeconicos infuenciam ……

A mortalidade neonatal é reconhecida como um dos mais sensíveis indicadores de qualidade da saúde materno e infantil, pois estima o risco de uma criança morrer nos primeiros dias de vida. Esse risco, frequentemente, reflete a ocorrência de fatores vinculados à gestação e ao parto, associado às condições de acesso aos serviços de saúde e a qualidade da assistência ao prénatal, ao parto e ao Recém Nascido (Oliveira et al 2020).

Moçambique definiu como Metas até 2023, tendo o ano 2011 como referência, a redução da mortalidade neonatal de 30/1000 para 19.3 por 1000 nascidos vivos, onde a mortalidade e a sobrevivência dos recém-nascidos, está associada à sobrevivência, à saúde e à nutrição das mulheres em idade reprodutiva, durante a gravidez e entre as gravidezes (MISAU, 2019).

Que medidas podem contribuir para prevenir a morte neonatal?

Embora a Mortalidade Neonatal seja um poblema de Saúde Pública, é evitável e alterável (OMS & UNICEF, 2020). De acordo com Organização Mundial da Saúde é possível melhorar a sobrevivência e a saúde dos recém-nascidos e acabar com os natimortos evitáveis, alcançando uma elevada cobertura de cuidados pré-natais de qualidade, cuidados qualificados ao nascimento, cuidados pós-natais para a mãe e o bebé, e cuidados de recém-nascidos com baixo peso e doentes.

Vários países demonstraram que é possível reduzir a mortalidade neonatal rápida e dramaticamente sem grandes custos. No entanto, alguns estudos recomendam a aprender com os países de sucesso e concentrar-se nas 3-4 principais causas de morte neonatal: asfixia, infecção, baixo peso/prematuridade à nascença e malformações congénitas (Ola, 2011).

Alguns paises implementaram reformas no Sistema de Saúde para a redução da mortalidade neonatal. Em Portugal o fortalecimento da frota de transportes para a mulher grávida e o rescem-nascido, a intensificação da formação do pessoal com formação pós-graduada em neonatologia teve impacto significativo na reducao da MN de 8.1 (1989) para 2.7 (2003) por 1000 nascidos vivos. No Chile, a mortalidade neonatal tem diminuído drasticamente desde 1990, de 8.3/1000 em 1990 para 5.7/1000 em 2000. Em 2004 foi ainda mais reduzido para 5.0/1000. O Chile fortaleceu a capacidade do pessoal de neonatologia e introduziu novo equipamento nos cuidados intensivos de neonatalogia, introduziu também o uso do surfactante a nível nacional para o tratamento da Sindrome da Dificuldade Respiratoria no RN. Ainda mais importante do que estas intervenções recomenda-se intervenções que levam a redução das inequidades e da pobreza (Ola, 2011).

No subcontinente indiano, tanto no Bangladesh como no Sri Lanka obtiveram resultados notáveis. De 1990 a 2010, a mortalidade neonatal foi reduzida de 65 para 31/1000 no Bangladesh e de 19 a 7/1000 no Sri Lanka. Em Gujarat, na Índia, com mais 55 milhoes de habitantes, grande sucesso foi alcançado através da contratação de obstetras/ginecologistas para prestar cuidados de parto para os pobres nas zonas rurais. Um salário de 46 UDS pelo parto, incluindo o tratamento de complicações foi oferecido (Ola, 2011).

Exemplos demonstram que é possível reduzir a mortalidade neonatal por meios simples. Para além da aspectos médicos, uma infra-estrutura óptima com água limpa, devem ser enfatizados os sistemas de saneamento e transporte. A educação gratuita das raparigas deve, portanto, ser dada prioridade máxima. O livre acesso aos cuidados pré e pós-natais é essencial. Adicionalmente, o cuidado materno canguru reduz as mortes neonatais e a morbilidade em bebés com peso à nascença < 2,000 g (Lawn, 2010).
A disponibilização de pessoal qualificado à assistência ao parto e o aumento da capacidade de fornecer os Cuidados Obstétricos e Neonatais de Emergência Básicos (CONEmB) através do

fortalecimento do equipamento e formação nos CONEmB no Burkina Faso, melhorou a taxa de mortalidade perinatal de 33 a 27.5/1000 nascidos vivos. O acesso ao CONEmB pode ser melhorado aproximando as unidades sanitárias às comunidades, mas onde isto não é possível as casas de mãe espera nas maternidades deve ser previsto para as mulheres que ficam longe das maternidades e não têm transporte (S A Journal of Child Health, 2012).

Em Moçambique está a implementar o Plano de Acção para Cada Recém-Nascido, 2019-2023 que visa garantir a todas as mulheres grávidas e recém-nascidos um alto padrão de qualidade em saúde e o fim de todas as mortes peri e neonatais evitáveis.

Recomendções

Com vista a evitar e reduzir a mortalidade dos neonatal, recomenda-se:

É recomenável colocar-se ênfase no fornecimento de pessoal médico e de enfermagem apropriado, com formação e equipamento adequados

Aprender de outros países as boas praticas para redução da MN.m
Implementar reformas no Sector da Saúde
Promover um estilo de vida materno saudável (evitar o consumo de tabaco e álcool).
Organizar e operacionalizar o sistema de referência e contra-referência.
Acesso fácil e gratuito aos cuidados pré e pós-natal.
Encorajar partos institucionais.
Promover o aleitamento materno.
Investir em infraestrutura/equipamento (monitores, incubadoras, ventiladores), transporte e pessoal qualificado e suficiente.
Assegurar que os profissionais de saude implementem os cuidados pré e pós-natal baseado em evidências e directrizes.
Desenvolver parcerias neonatais nacionais (governo, Sociedade Civil, Associações) e internacionais (Agencias e ONG).
Assegurar a aquisição e distribuição de medicamentos essenciais gratuitos para todas as mulheres grávidas e crianças.
Investir em programas de formação e investigação.

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MOZAMBIQUE

- Infographic: Standards for the functioning of public administration

MOZAMBIQUE

- Infographic: Neonatal mortality: how to prevent?

NIGER

- Policy Brief: Infant mortality in Niger: a high proportion of new-born deaths

Organisation mondiale de la Santé Niger

Août 2022

SNIS

Fiche d'Information Analytique

Mortalité infantile au Niger: une forte part des décès des nouveau-nés

Rational/justification

Au Niger, la mortalité des enfants de moins de 5 ans reste encore élevée dans un contexte marqué par plusieurs crises (humanitaire, sécuritaire, sanitaire, alimentaire et naturel). Elle est exacerbée par la mortalité de nouveaux nés de moins d'un mois.

La Politique Nationale de Santé du Niger prévoit de réduire la mortalité néonatale c-à-d les nouveau-nés de moins d'un mois, de 50 % en 2025 et 75% en 2035 passant de 24‰ en 2012, à 12‰ en 2025 et 5‰ en 2035

D'ici à 2030, éliminer les décès évitables de nouveau-nés et d'enfants de moins de 5 ans, tous les pays devant chercher à ramener la mortalité néonatale à 12 pour 1 000 naissances vivantes au plus et la mortalité des enfants de moins de 5 ans à 25 pour 1 000 naissances vivantes au plus.

Faits marquants/messages clés

- Sur 10 décès d'enfants de moins d'un an, 6 ont moins de 28 jours en 2021
- Les régions ayant une faible densité du personnel ont un faible taux d'accouchement assisté par un personnel qualifié
- Les régions ayant une faible densité du personnel ont un niveau de mortalité néonatale plus élevée.
- Les nouveau-nés issus des mères jeune de moins de 20ans et celles de plus de 40 ans, ont plus de risque mourir.

Implications politiques

Pour améliorer la survie et la santé des nouveau-nés et de mettre fin aux mortinaissances évitables, il faut :

- ✓ Une couverture élevée de soins :
  - prénatals de qualité,
  - qualifiés à l'accouchement,
  - après accouchement pour la mère et le bébé,
  - aux nouveau-nés petits poids et malades.
- ✓ Une répartition équitable du personnel de santé
- ✓ Eviter les grossesses précoces et tardives
- ✓ Réduire les mariages précoces

Qu'est-ce que la mortalité néonatale ?

Selon l'Institut National de la Statistique dans son rapport 2017, sur la situation de référence des Objectifs de Développement Durable (ODD) au Niger, il s'agit de la probabilité qu'un enfant né au cours d'une année ou d'une période spécifique meurt pendant les 28 premiers jours de vie complets. Les décès néonatals peuvent être subdivisés en décès néonatals précoces, survenant au cours des 7 premiers jours de vie et décès néonatals tardifs, après le 7ème jour mais avant le 28ème jour complet de la vie. Il est généralement exprimé pour 1000 naissances vivantes.

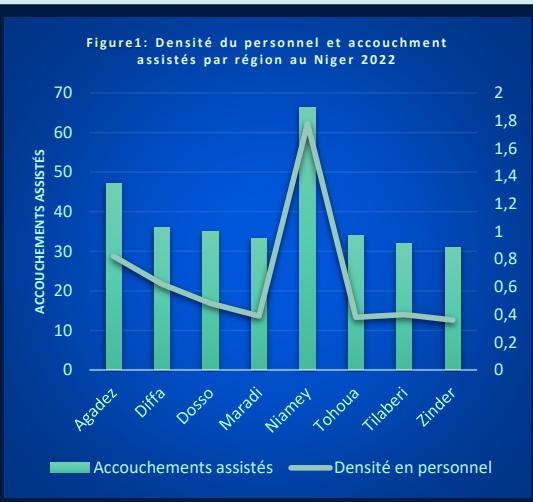
Quelles sont les causes de mortalité néonatale ?

Les principales causes de la mortalité des nouveau-nés

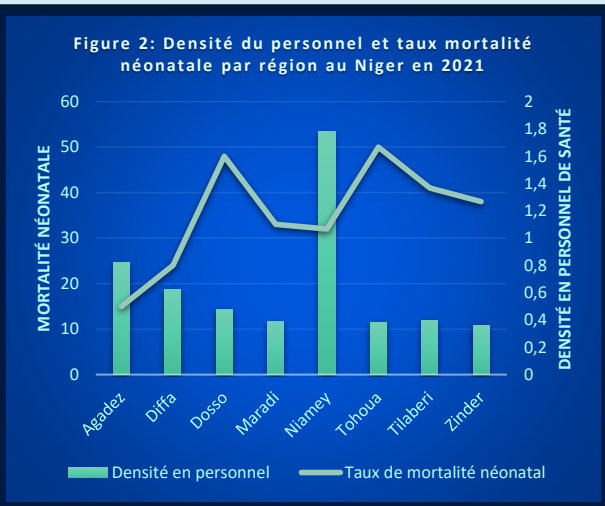
Selon les estimations du Groupe de référence en épidémiologie de la santé de l'enfant (CHERG 2012) de l'OMS et de l'UNICEF les causes de mortalité, et décès néonataux sont dues à la prématurité (30,8%), l'asphyxie (28,42%), les infections néonatales (16,54%) et la pneumonie du Nouveau-Né (5, 51%)

Inégale repartition du personnel de santé

Quel que soit le type de mortalité, la mortalité des enfants est plus élevée en milieu rural qu'en milieu urbain. Cette mortalité serait plus forte dans les régions à faible densité du personnel. La même tendance est observée avec le taux d'accouchement assisté par un personnel qualifié.

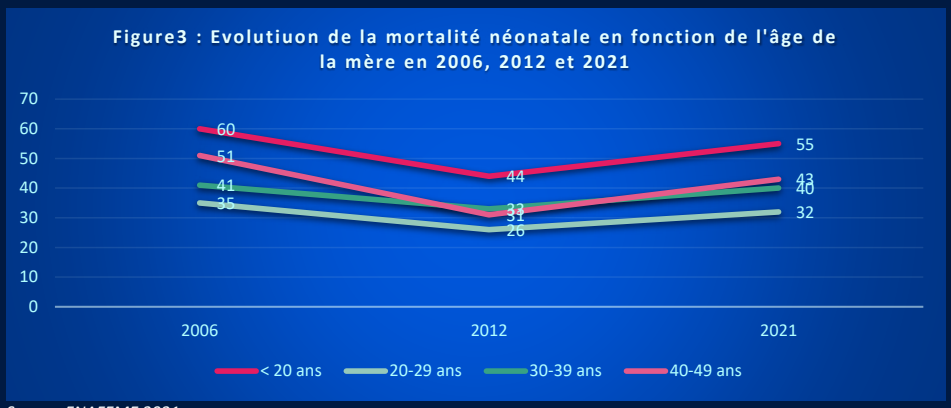


Source: Annuaire 2021



Source: Annuaire et ENAFEME 2021

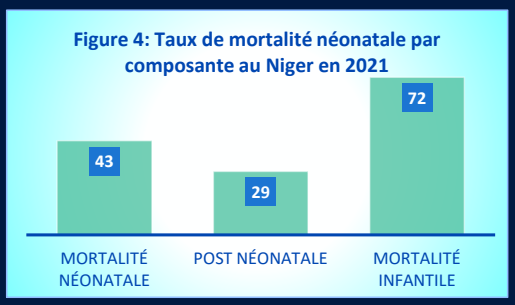
Mortalité des nouveau-nés très élevée chez les mères de moins de 20 ans et celles de plus de 40 ans



Source: ENAFEME 2021

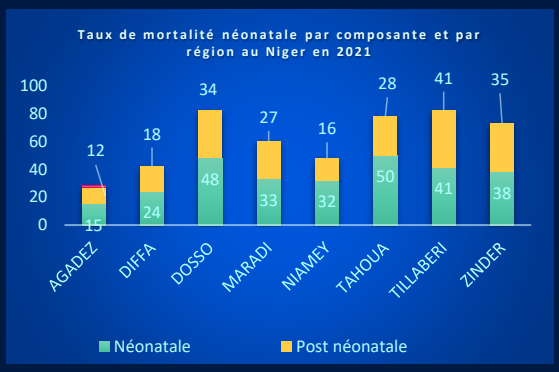
On relève pour la mortalité néonatale, un taux très élevé pour les mères dont l'âge est inférieur à 20 ans : 55‰ contre seulement 32‰ pour celles dont l'âge est situé entre 20-29 ans, 40‰ pour celles âgées de 30-39 ans et 43‰ pour celles âgées de 40-49 ans.

Une part importante de la mortalité néonatale dans la mortalité infantile !



Source: ENAFEME 2021

Cependant, la mortalité juvénile, c'est à-dire la probabilité de décès des enfants entre leur premier (1er) et leur quatrième (4ème) anniversaire, a fortement baissé, passant de 126‰ en 2006 à 81‰ en 2012 et 55‰ en 2021.



Source: ENAFEME 2021

Quant à la mortalité infantile, elle a fortement augmenté par rapport à 2012. Elle est de 72‰ en 2021 contre 51‰ en 2012.

En se focalisant sur les décès des nouveau-nés, on constate qu'ils représentent la composante principale de la mortalité infantile. Elle demeure prédominante au niveau de toutes les régions du pays.

Références

OMS : https://www.who.int/fr/news-room/fact-sheets/detail/newborns-reducing-mortality

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INS : Enquête Nationale sur la Fécondité et la Mortalité des Enfants de Moins de Cinq Ans 2021

DS/MSP/P/AS : annuaire des Statistiques 2021

DS/MSP/P/AS : Rapport enquête SARA 2019

Source: ENAFEME 2021

Unicef : french-version-every-newborn-targets-and-milestones-to-2025.pdf

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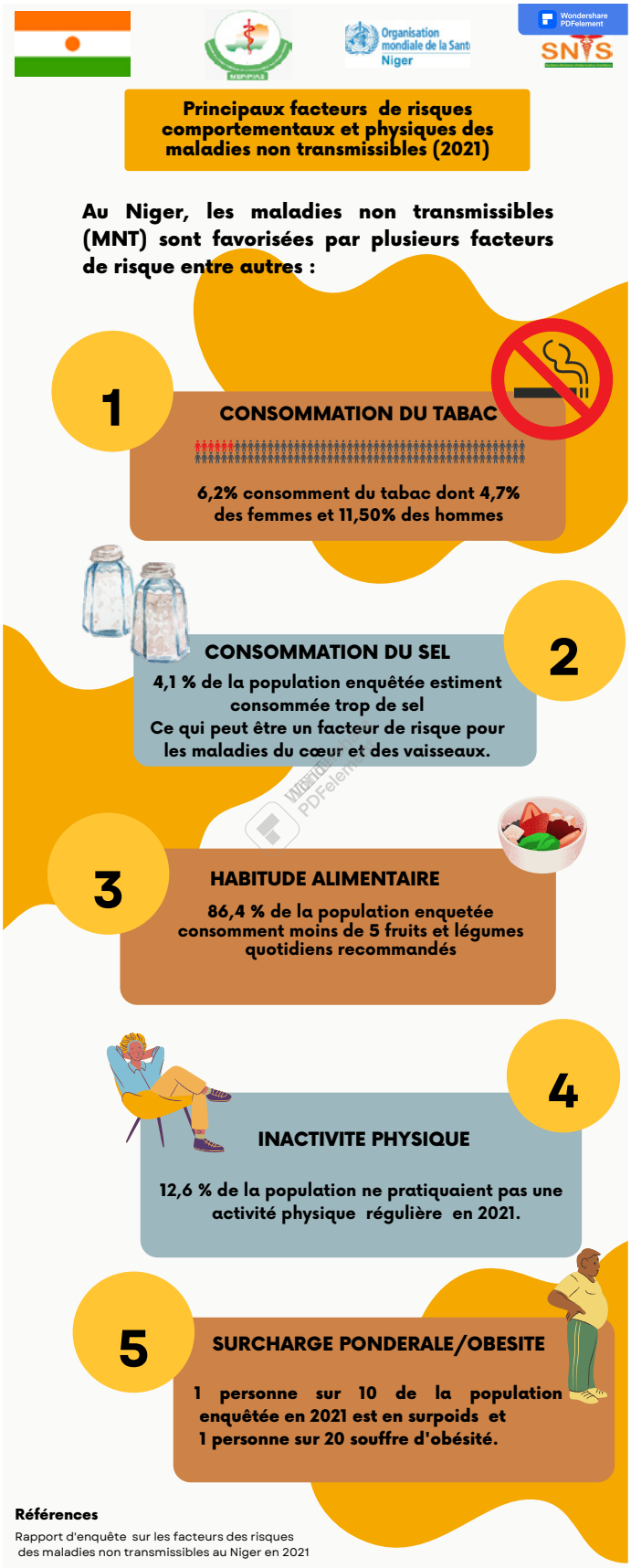
NIGER

- **Infographic:** Main risk factors for NCDs



NIGERIA

- Policy Brief: Strengthening disease surveillance and response system in Anambra State, Nigeria

Strengthening Disease Surveillance and Response System in Anambra State, Nigeria

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KEY MESSAGES:

- **Functional sector and HIS governance are key to a well performing Integrated Disease Surveillance Response (IDSR) system in Nigeria**
- **Prioritizing knowledge transfer to targeted health workers leads to immense benefits in work outputs**
- **The private sector are important partners in health management**
- **Regular data analysis and use improves data quality and programme effectiveness**
- **Improvements in IDSR system requires context-based multi-pronged approach for improving outputs and results**

1. EXECUTIVE SUMMARY

Integrated disease surveillance and response systems have been implemented in Nigeria with good results in disease detection and notification. Although the country prioritized it as the mechanism for strengthening public health surveillance and response systems at all health systems, there has not been a comprehensive capacity building and funding plan for its implementation.

The Anambra State IDSR system was met at a time when frequent outbreaks of diseases were rocking the State back to back because of the dysfunctional nature of the health system. A context -based multi pronged effort was found to be effective in improving programmes and their data systems. This approach was based on recommendations obtained from the gap analysis of the IDSR system in the State.

The specific interventions implemented to improve the status quo include strengthening the HIS governance, training of all health facilities focal persons, active engagement of the private sector practitioners, peer review and data collation and the LGA level and periodic analysis of the outputs. These interventions were implemented in an integrated manner to achieve expected results.

The results achieved were improved representativeness of IDSR data, improved knowledge of the programme and data management by health workers, institutionalization of LGA level reviews and analysis of data.

There is evidence to show the sustainable development of the IDSR system and overall health sector data management improvement in Anambra State due to the implementation of evidence-based plan of action informed by a baseline needs assessment of the health sector and specifically the IDSR system in the State.

2. CONTEXT

2a. Social and Demographic landscape of Anambra State

Anambra State lies in the south-eastern part of Nigeria. It is bounded by Enugu and Abia States in the East, by Delta in the West, and, in the South and Northwest, by Imo and Kogi States respectively. Anambra is home to approximately 4,177,828 people (NPoPC, 2006) with a projected population of 5,724,631 (Statistical Year Book, 2016). It is an indigenous Igbo ethnic population with an estimated annual population growth rate of 2.21% per annum according to the Anambra Bureau of Statistics (2014). It has a landmass area of 4,844 km2 which coordinates between Latitude 6° 20'N and Longitude 7° 00'E. Anambra State is a tropical rainforest vegetation, humid climate with a temperature of about 87F and a rainfall of between 152cm - 203cm.

The State currently has a total of 1,569 health facilities with 71% being privately owned. The state has a paucity of human resources for health data; however, some sources claim that the state has a health care worker (HCW) to population density ratio that is below the national average of 1.95 per 1000 population.

2b. Disease Surveillance and Notification in Nigeria

Disease surveillance is defined as an ongoing systematic collection, collation, analysis, and interpretation of health-care data, essential to the planning, implementation, and evaluation of public health-care practice, closely integrated with the timely dissemination of these data to those who need to know, in order that action may be taken (1).

Health surveillance describes the process of "tracking and forecasting of any health event or health determinant through the continuous collection of high-quality data, integration, analysis and interpretation of data into surveillance products that form policy objectives. This is an essential component of evidence-based decision-making practices.[2] Disease surveillance and notification (DSN) is part of the Health Management Information System (HMIS) which comprises databases, personnel, and materials that are organized to collect data which are utilized for informed decision making (3). Surveillance is useful both for measuring the need for interventions and for directly measuring the effects of interventions. The public health surveillance system ensures that there is an effective dissemination of health data so that stakeholders and decision-makers at all levels can readily understand the implications of the information and use it timely.

Public health surveillance is operated in two channels; can be implemented actively or passively based on seeking reports or case-based or enhanced based on the collection of specific data or additional data [3, 4]. Active and reliable valid data with prompt response are the cornerstones of good Surveillance systems. In Nigeria and prior to 1988, there was no coordinated system of disease reporting and surveillance system in place until after a major yellow fever outbreak in 1986/87 that claimed many lives. [105] Nigeria is one of the polio endemic countries globally hence implicated in exporting polio to polio free countries. This is complicated by the high burden of Measles; Yellow fever, Neonatal Tetanus (NNT) and Malaria and lack of concern by policy makers in the country. The burden of these diseases is determined using the surveillance systems; hence the system must be sensitive and reliable in order to impact adversely on the certification process especially in this era of eradication of polio and sustained control for malaria and measles [6,7 and 8].

Nigeria as any other nation relies on her surveillance systems for detection of disease burden, its incidence rate, prevalence rate, mortality rate, its general trend and outbreaks. The information from Surveillance guides policy makers in implementing public health policies, interventions, strategic objectives with methodology of public health operations and equitable resources distributions. Nigeria IDSR policy

monitored 23 diseases before but now monitors 40 diseases [82]' within the national IDSR framework including newly evolving diseases. It has five case-based surveillance frameworks (AFP for polio, Measles case based, Yellow Fever case based, Guinea worms and NNT). It is the framework of AFP case-based surveillance supported by WHO established for global polio eradication initiative that formed the basis for Nigeria surveillance since it is the most effective system with good reporting networks that has helped in developing other networks. [9]. This Surveillance and IDSR network in Nigeria is made up of 5,557 focal sites manned by focal persons in health facilities, 825 DSNOs in 774 LGAs with 37 SEs in 36 states of the country including Abuja.

Anambra State has a functional M&E office with a trained M&E officer. Information on surveillance of notifiable diseases in the State are collected by the DSNOs at the LGAs through a network of health facility focal persons who collect and report information to them on all the targeted diseases using surveillance case definitions and designated reporting forms. The process is coordinated by the State Epidemiologist.

2c. Status of Integrated Disease Surveillance and Response System in Nigeria

Integrated Disease Surveillance and Response (IDSR) is an evidence-based strategy for strengthening public health surveillance and response systems at all health systems levels in countries in the African region. The threat of disease outbreaks and emergencies are universal; every country is vulnerable to epidemics and emergencies. Early detection, risk assessment, information sharing and rapid response are essential to avoid illness, death and economic losses on a large scale. Enabling capacity of frontline health workers including both the public and private sector is key to driving effective surveillance and timely response. Adequate sensitization and engagement of the private sector especially in settings where significant proportions of health services are provided by them will contribute to advancing progress. Additionally, establishing and sustaining a systematic process for making data available in a timely manner will contribute to resilience building and universal health coverage.

The Integrated Disease Surveillance and Response (IDSR) strategy was adopted in Nigeria in 2001 as the strategy for public health surveillance in the country. The IDSR technical guideline was adapted and revised in 2010 and printed in 2013. Experience from outbreaks shows that the capacity for early detection of outbreaks and other public health events is weak nationwide. National effort was intensified towards protecting people from health emergencies including disease epidemics. This led to the establishment of the Nigerian Centre for Disease Control (NCDC) in 2011. Its core mandate is to detect, investigate, prevent and control diseases of national and international public health importance.
The mission for NCDC in the last five years (2017-2021) was 'To protect the health of Nigerians through evidence-based prevention, integrated disease surveillance and response activities, using a one health approach, **guided by research and led by a skilled workforce'** (10). Some of the core functions of NCDC include to prevent, detect, and control diseases of public health importance and to coordinate surveillance systems to collect, analyze and interpret data on these diseases.

A rapid assessment of IDSR in three north east states of Borno, Adamawa and Yobe state led by NCDC in October 2017 confirmed the national picture of a weak system. Although the national IDSR system is still weak, progress has been made towards strengthening it. Phased national scale up of IDSR capacity has commenced this year with the view of changing the narrative on IDSR in Nigeria. Despite these efforts, poor capacity of healthcare workers at all levels including in detection, testing, diagnosing, case management, stock management and recording/reporting contribute to the weakness. Inadequate motivation of grass root workers in data collection, unavailability of IDSR documentation tools, dearth of infrastructure for data management; incomplete and untimely data reporting and inadequate numbers of public health laboratories for sample testing and case confirmation are some of the challenges. Furthermore, low involvement of the private sector in planning, implementation, analysis and review are challenges to the system performance.

3. STATUS OF INTEGRATED DISEASE SURVEILLANCE AND RESPONSE IN ANAMBRA STATE

The concept of Integrated Disease Surveillance and Response is not new to Anambra state. There is a surveillance system in existence that is well accepted by stakeholders. The system only needs strengthening. The state has been able to put up structures for IDSR albeit a lot of operational challenges.

A situational analysis of the IDSR in Anambra state revealed the gaps in the system. These ranged from the poor functioning policy and environment for IDSR, weak skills of health workers, inadequate logistics and reporting tools at the LGAs and health facilities, weak laboratory capacities and inadequate preparedness for emergencies.

Although disease surveillance data flow from health facilities to the state, this data is not representative of the entire service delivery points. Only about 56% of health facilities in the state ever reported surveillance data (11). Some of these facilities reported only intermittently. Weekly reports were not being generated but mainly monthly reports, with focus being on 'focal sites'. Implementation of IDSR is dependent on the structures for polio surveillance and reporting largely uses Polio Eradication Initiative (PEI) reporting sites which are not all the health facilities.

The perpetual exclusion of private health facilities when health policies are disseminated and implemented has led to their being left out in surveillance activities as well, even though a large proportion of patients utilize privately owned health facilities.

Prior to the health systems strengthening support in the state, very few of the health workers were trained on IDSR; even so, the focus was only on the epidemic-prone diseases. Clinicians trained were drawn from the focal sites for Acute Flaccid Paralysis (AFP) surveillance. The training focused on the epidemic-prone diseases with little or no focus on the basic concepts of IDSR, the core indicators and roles and responsibilities of the major players involved in detecting, reporting and responding to the disease outbreaks. Supportive supervision to non-AFP focal facilities is ad hoc and does not utilize a tool, the findings are not archived and therefore not effective.

Having prioritized IDSR as one of the key areas of focus in the health systems strengthening project, a systematic roll out of activities to improve the baseline situation commenced in 2018. Priority focus areas were the production of reliable disease surveillance data and stimulation of evidence-based decision making for public health actions.

The immediate deliverables targeted at achieving the objectives are strengthening Health Information System (HIS) governance and coordination and expansion of health data reporting sites to cover all health facilities in the state.

4. METHODOLOGY

There was a scoping mission to the state to understand the state HIS landscape. A rapid survey of the health facilities was conducted across the state. The state has 21 LGAs divided into 3 senatorial zones. 3 LGAs per senatorial zone were selected based on those that have been reported to have frequent outbreak. An equal sample size of 10 health facilities in each LGA was selected. Data was collected on availability of persons, capacity, documentation tools, method of transmission of data and data management activities.

A rapid survey of the Disease Surveillance Notification units at 9 LGAs were also conducted to understand the data management practices at the level and ascertain the data reporting rate. The staff at the state epidemiology department were interviewed using a structured questionnaire to understand the process of data collection as well as the trend of facilities reporting. Additionally, other components of the IDSR were also assessed at the LGA and state level.

5. APPROACH TO STRENGTHENING IDSR SYSTEM IN ANAMBRA STATE

1. ***Governance: Reactivation of State Heath Data Consultative Committee (HDCC) meetings/inauguration of the Health Data Governance Council (HDGC)***

   There was no overarching health sector HIS coordination although various programmes had their internal platforms which in some cases, were not specific to health information. The initial step was to set up a health Partners Forum to help the state understand what support is available to them and to begin the process of integration of Partners' workplan. Following this achievement was the reactivation of the HDCC and inauguration of the HDGC with both having a good representation including the private sector and civil society.

2. ***Human Resource:***

   a. Training of State, LGA and health facility level health workers on IDSR

   A 6-day state level ToT was conducted to build the capacity of State DSNOs, LGA DSNOs and LGA M&E officers on IDSR. In the training, the 7 modules of IDSR training manual were covered to adequately equip participants with adequate capacity to implement IDSR activities and enable them train the health facilities' staff. A total of 72 health workers were trained. At the health facility level, 862 surveillance focal persons attended the training (601 from public and 261 from private).

   b. Sensitization of Anambra State Association of General and Private Medical Practitioners of Nigeria (AGPMPN):

   Repeated advocacy to the AGPMPN executive and eventual orientation of the members in a meeting where 93 members attended were effective first steps towards good relationship with the private sector. The orientation served as a platform to sensitize them on the provisions of the National Health Act and HIS Policy. It also served the purpose of building their capacity on TB surveillance.

3. ***Health Information System:***

   a. Local Government Integrated Data Validation meeting (LIHDVM)

   This LGA level peer review meeting is active in all 21 LGAs of Anambra state. It involves the M&E and programme officers at the LGA level meeting with representatives of all the health facilities in an LGA for validation of the NHMIS and IDSR reports. This is a monthly meeting and always had supervisors coming from the SMOH to observe and (or) support capacity building events.

   b. Quarterly meeting DSNO review meetings and development of quarterly analytic bulletin

   Every quarter, the State and LGA DSNOs meetings to review progress made on the agreed roadmap for improvement and develop actionable implementation and course correction plans. The number of health facilities reporting and indicators are reviewed across the LGAs and sometimes drilling down to the Ward and health facilities at these meetings.

   In addition to the above, statistical bulletins are produced quarterly following the meetings which are disseminated through several health sector meetings.

Results achieved

i. IDSR capacity scale up

The IDSR assessment of LGAs and health facilities in Anambra state showed that majority (89.8%) of the health workers were aware of the concept of IDSR and its usefulness but only 33% of them were able to correctly identify IDSR tools and how they are used. To improve health worker's knowledge in disease surveillance and data management in the state especially from private health facilities, a state-wide IDSR trainings was conducted. Immediate output from this effort was an increased State reporting rate, this was noted for both public and private health facilities. Table 1 below shows the distribution of participants at the state level training of trainers while table 2 show the number of each kind of health facilities whose health care workers participated in LGA level training for health facility staff.

Table 1: Distribution of Participants at State-level IDSR Training of Trainers

Designation	LGA DSNO	LGA Assistant DSNO	LGA M&E Officer	LGA Facilitator	State level officer	Total
Number	21	21	21	1	8	72

Table 2: Contributions of health workers per health facility (HF) type and ownership at LGA-level training

Clinical Care Facility	Primary Health Centre	Secondary HF	Tertiary HF	Private HF	Total
Number	578	21	2	261	862

The training facilitated the increase in disease surveillance reporting in the state from 41.2% to 71.3%; 55.4% from the public facilities and 16% from the private. Figure 1 shows that after the trainings, surveillance reporting in the state increased from 81% to 97% for the public facilities and 11% to 37% for the private sector.

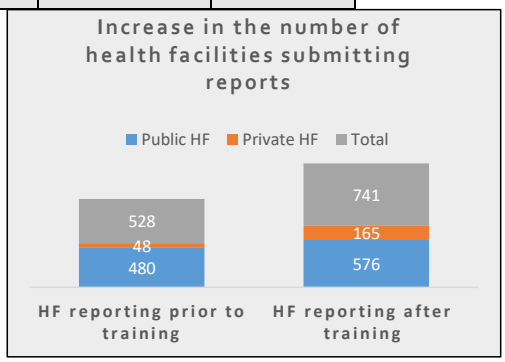
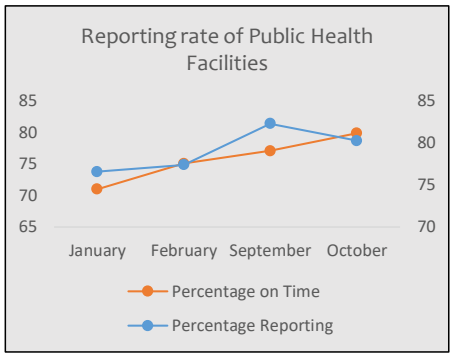


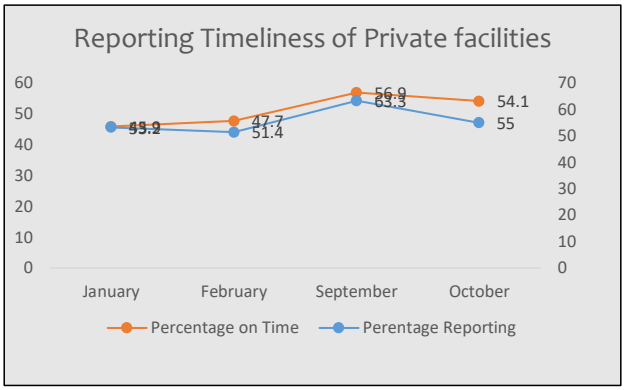
Figure 1: Increased IDSR reporting coverage

ii. LGA meetings lead to improved coverage of IDSR and NHMIS reports

Prior to strengthening support to the state, NHMIS reporting rate and timeliness were around 70% as shown in figure 2. Reporting rate for disease surveillance data was even worse than the NHMIS. Funding and technical support to the state for LGA data validation meetings commenced in June 2018. Currently the reporting rate and timeliness has increased to about 80% for the NHMIS. Data for IDSR is as shown above; LGA meetings contributed to that achievement as it facilitated report generation, validation and collation.

Figure 2: Reporting coverage for public HF





Reporting rate of private health facilities in Anambra state has also improved as seen in figure 3 below.

Figure 3: Reporting coverage for private HF

iii. Engagement of the private sector for improved participation and ownership

Sensitization meeting of the Anambra branch of the Association of General and Private Medical Practitioners of Nigeria (AGPMPN) on HIS policy and the National Health Act and orientation on TB surveillance was the first of its kind in the state. This activity opened discussions on roles and responsibilities of the private sector in health information and decision making.

6. CONCLUSION

Updates from disease surveillance activities in Anambra state show that within two months of completion of the State-wide IDSR training and other interventions, the state had recorded significant improvement in health facility reporting rate and IDSR skills among health facilities, LGA and State level staff. Anambra state health systems has the potential to achieve almost 100% coverage of surveillance reporting including a high proportion from the private sector. This can only be achieved if mechanisms for validation and collection of data such as the Integrated Health Management/data validation meetings are in place. This alone may not achieve the desired result without the involvement of the private sector. Engagement of the private health facilities to obtain their buy-in on health information management and sector decision making is key to improving service delivery, policy making and effective planning. A functional HIS coordination platform that brings stakeholders together is also vital to driving joint decisions, planning, implementation, monitoring and evaluation.

7. POLICY IMPLICATION

I. Prioritization of the development of annual health sector workplan and ensuring timely and complete release of planned budget.

II. Availability and implementation of a funded IDSR Capacity building plan for health workers.

III. Prioritize the development of clear action plan for engaging the private sector in health programme and data management.

IV. Advocacy to states and LGA health managers to prioritize IDSR in their workplan and provision of funding for the implementation.

V. Development and funding of periodic analytical product on IDSR to track sustainable improvements in the surveillance systems.

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NIGERIA

- Analytical Fact Sheet: Nigeria health facility service delivery statistics: where are we?

FEDERAL MINISTRY OF HEALTH

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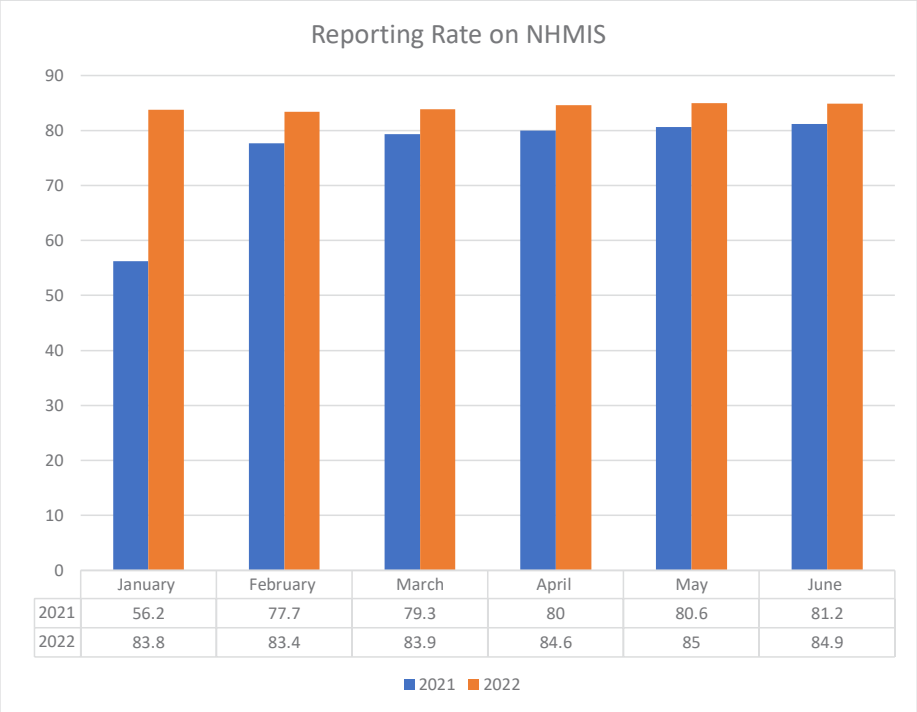
ANALYTICAL FACTSHEET JUNE 2022

Nigeria Health Facility Service Delivery Statistics: Where are we?

Rationale

Nigeria committed to the attainment of Universal Health Coverage which is a target for achieving sustainable Development Goal 3 by the year 2030. The second National Strategic Health Development Plan prioritized a core list of indicators for tracking progress towards this commitment. Periodic tracking of these selected health and service delivery statistics has helped the country in assessing its performance and course corrections in relevant interventions towards the attainment of

Health Facility Reporting Rate



	January	February	March	April	May	June
2021	56.2	77.7	79.3	80	80.6	81.2
2022	83.8	83.4	83.9	84.6	85	84.9

The Figure above shows the facility reporting rate between 2021 and 2022. Decision

For more information, contact Department of Health Planning Research and Statistics, FMOH Abuja

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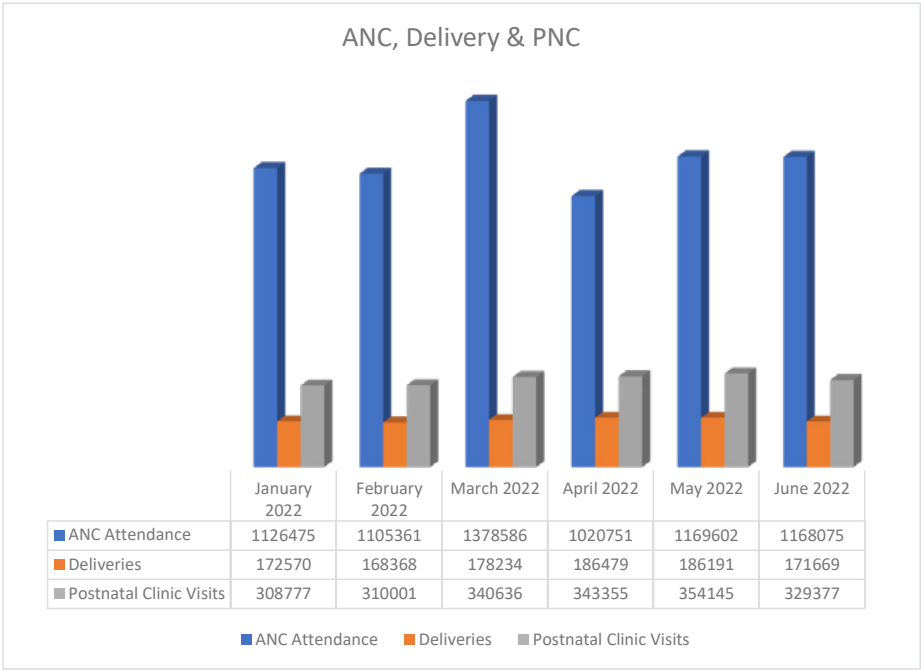
Makers requires quality data that is representative to make informed decision. The 2019 NHMIS tools were introduce in 2020, however, roll out were not feasible during the year because of COVID 19. In 2021, the roll out of 2019 version of the tools commenced fully, thus when comparing Jan – June 2021 and Jan - June 2022, it could be observed that most facilities have commenced using the revised tools resulting in an increase in the reporting rate

MATERNAL HEALTH – ANC CASCADE



	January 2022	February 2022	March 2022	April 2022	May 2022	June 2022
ANC Attendance	1126475	1105361	1378586	1020751	1169602	1168075
Deliveries	172570	168368	178234	186479	186191	171669
Postnatal Clinic Visits	308777	310001	340636	343355	354145	329377

The figure above shows that although more women attended ANC at the health facilities, only about one-tenth of them delivered at the health facility. Post-natal care attendants are higher than the health facility delivery. This implies that more deliveries are done outside the health facilities and the children brought to the facilities after delivery. This has resulted in higher numbers for the PNC visits.

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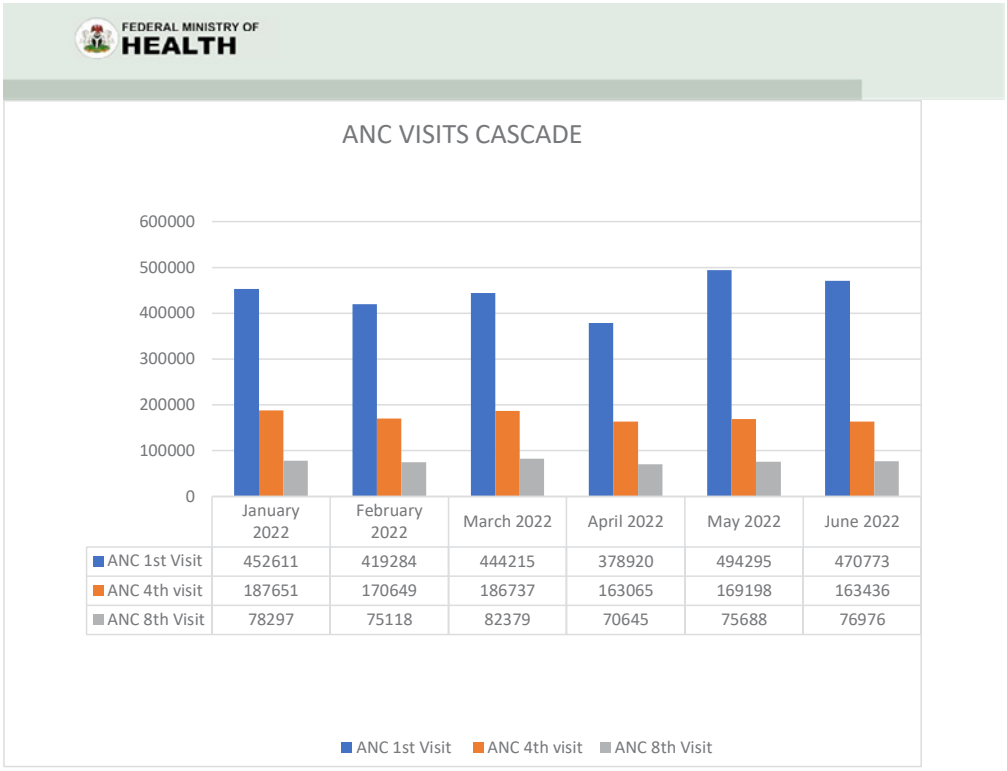

	January 2022	February 2022	March 2022	April 2022	May 2022	June 2022
ANC 1st Visit	452611	419284	444215	378920	494295	470773
ANC 4th visit	187651	170649	186737	163065	169198	163436
ANC 8th Visit	78297	75118	82379	70645	75688	76976

The figure above compares the number of ANC visits attended by pregnant women. The WHO recommends that all pregnant women have at least 8 ANC visits during pregnancy, this is to ensure that cases of maternal mortality are reduced during birth. However, it could be observed that the number of women who 8th visits are far lower than the 1st visits. This could be attributed to distance to health facilities, user fees and general attitude to attending ANC services given that most women commence antenatal late.

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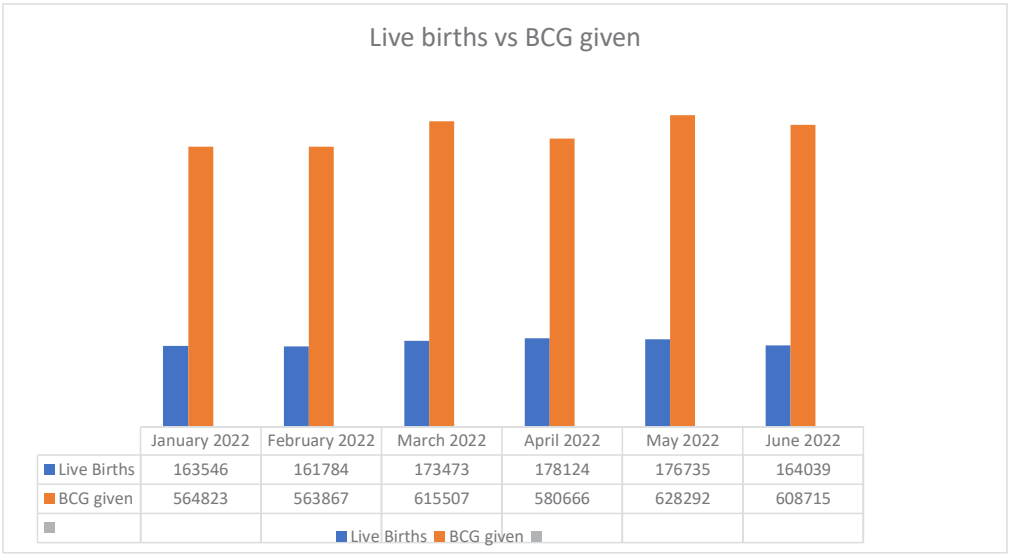
IMMUNIZATION



The figure above compares the total BcG vaccines given at birth to total live births in reporting health facilities. The number of live births includes babies who were delivered in the facilities and those delivered outside the facilities within the community. The report shows that the total BCG vaccine doses given were more than the total live births in the facilityfor the same period. This is partly due to the combination of fixed immunization sessions (in the facility) and outreach/mobile (within the community) immunization services data which covers for under-1 children delivered both in the community and at facilities

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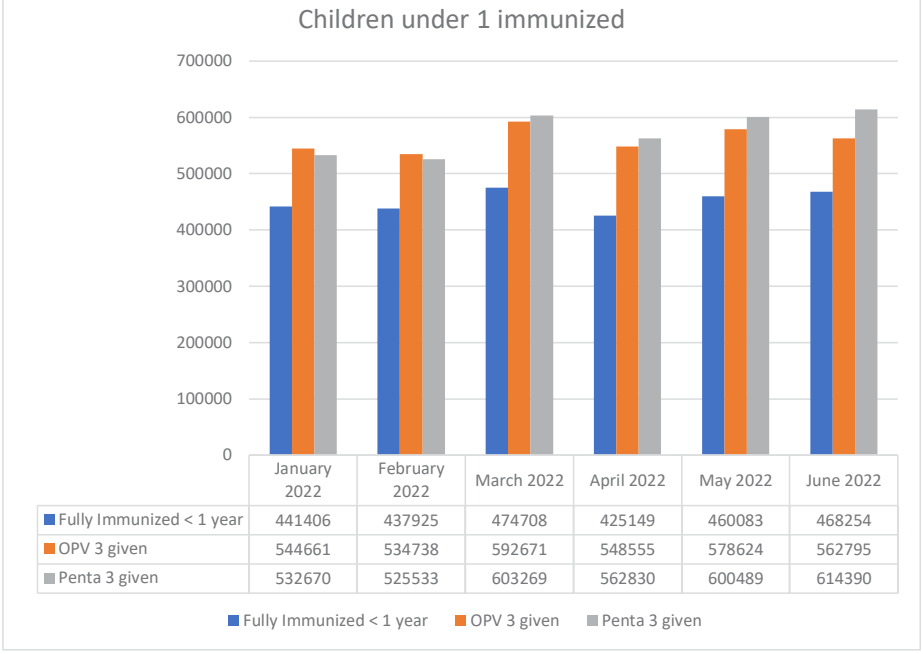

	January 2022	February 2022	March 2022	April 2022	May 2022	June 2022
Fully Immunized < 1 year	441406	437925	474708	425149	460083	468254
OPV 3 given	544661	534738	592671	548555	578624	562795
Penta 3 given	532670	525533	603269	562830	600489	614390

MALARIA

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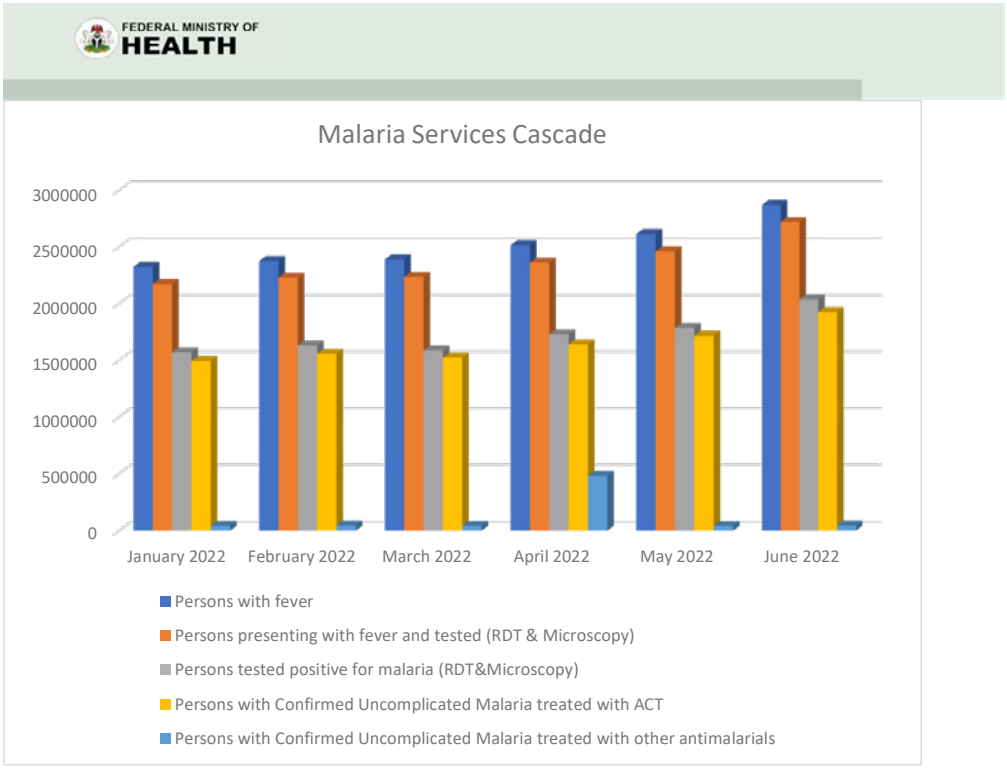
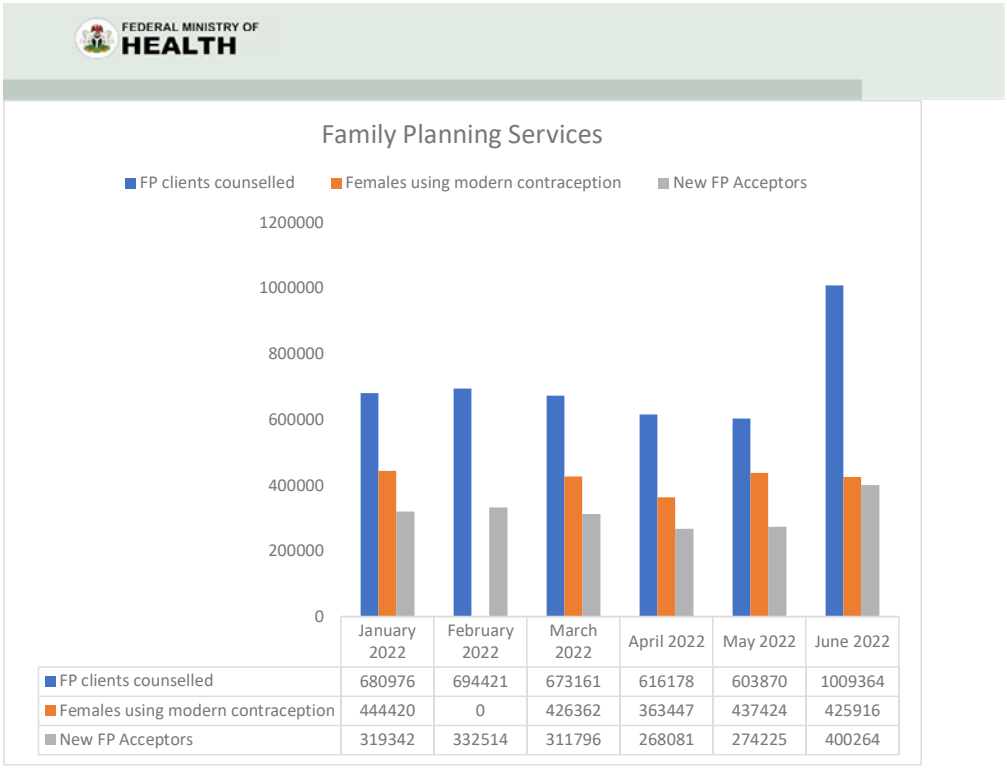


The chart above shows the Malaria service delivery cascade. There is consistency in the performance with over 93% of patients presenting with fever been tested for malaria and over 95% treatment of confirmed malaria cases using ACT. The month of June has the highest number of fever cases, patients tested and treated with ACT.

For more information, contact Department of Health Planning Research and Statistics, FMOH Abuja



	January 2022	February 2022	March 2022	April 2022	May 2022	June 2022
FP clients counselled	680976	694421	673161	616178	603870	1009364
Females using modern contraception	444420	0	426362	363447	437424	425916
New FP Acceptors	319342	332514	311796	268081	274225	400264

The chart above depicts services for family planning which included males and females for the period in review. It also shows the number of clients provided with family planning services for the first time within the months and finally the number of females only who were provided with modern contraception services. The month of June has the highest total number of new clients and new acceptors. There is an obvious data quality issue in February with no data point for females using modern contraception method.

INTEGRATED MANAGEMENT OF CHILDHOOD ILLNESSES (IMCI)

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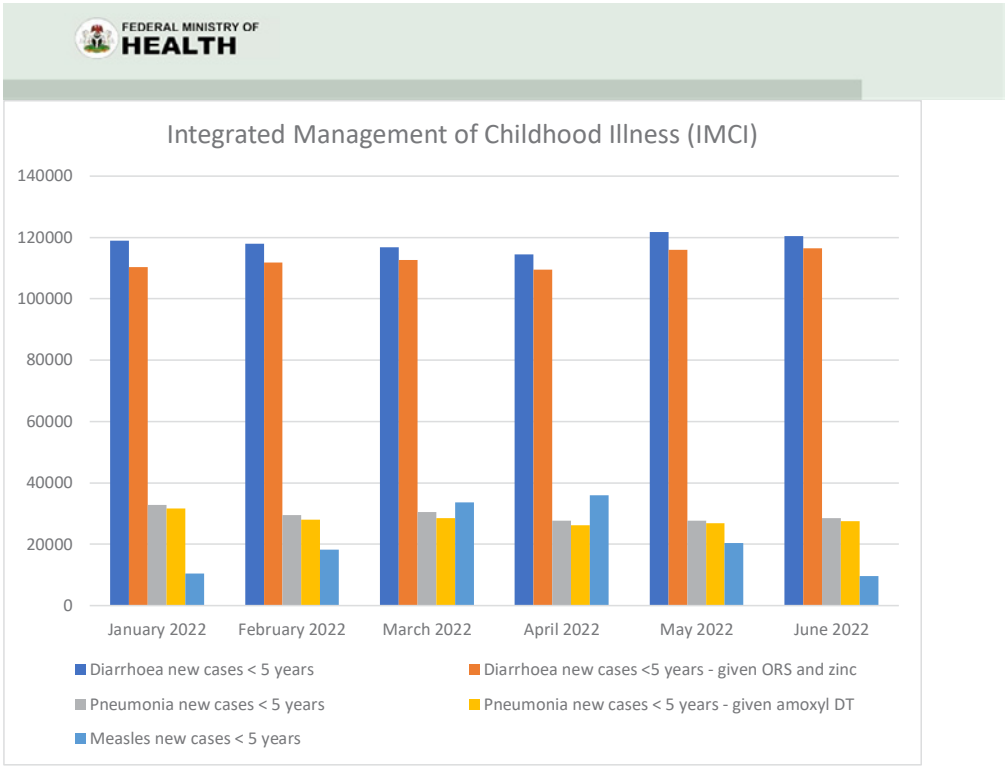

This chart showing the performance on IMCI shows diarrhoea was the highest cause of illness among under 5 children. The data show that over 90% of children with diarrhoea and pneumonia were treated in the months reviewed. Measles represents the lowest cause of illness in that age group

For more information, contact Department of Health Planning Research and Statistics, FMOH Abuja

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UNDER 5 DEATHS

Malaria and Pneumonia diseases remain some of the leading causes of under-5 deaths in Nigeria.

All states are encouraged to train their health workers on proper reporting of diagnosis and management of diarrhea disease.

States are also advised to intensify efforts in the prevention, treatment and overall control of Pneumonia and Malaria

Figure 7: Causes of under 5 deaths - Diarrhea

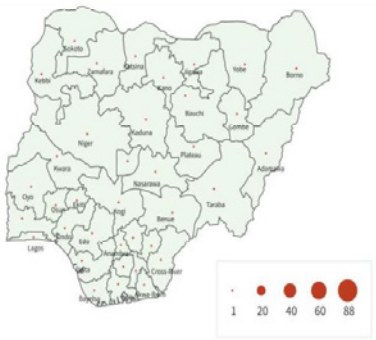

Figure 8: Causes of under 5 deaths - Malaria

Figure 9: Causes of under 5 deaths - Pneumonia

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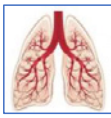
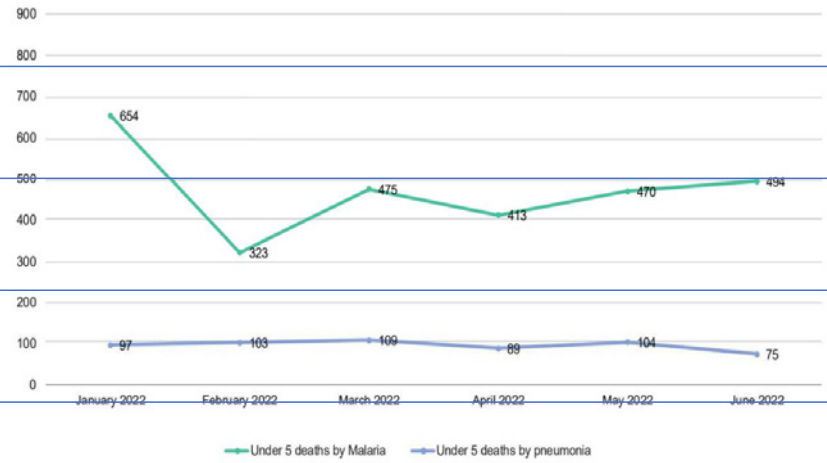


Malaria remains the le ading cause of death among under-5 children in the country. The value reported for the month of June 202 2 is 494 deaths, higher than the previous month (May 2022 with 470 deaths)

Figure 10: Under 5 Deaths by Malaria and Pneumonia



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- Infographic: SDG 3 in Brief

GOOD HEALTH AND WELL BEING

SDG3 IN BRIEF

3 GOOD HEALTH AND WELL-BEING

IN 2015, WORLD LEADERS AGREED TO IMPLEMENT 17 GOALS TO END POVERTY, HUNGER, AIDS AND DISCRIMINATION AGAINST WOMEN AND GIRLS BY 2030. ONE OF THESE GOALS IS SDG3 WHICH IS "TO ENSURE GOOD HEALTH AND WELL-BEING FOR ALL AT ALL AGES". ACHIEVEING SDG3 ENTAILS;

By 2030, reduce the global maternal mortality ratio to less than 70 per 100 000 live births.

By 2030, end preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1000 live births and under-5 mortality to at least as low as 25 per 1000 live births.

By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases, and combat hepatitis, waterborne diseases and other communicable diseases.

By 2030, reduce by one third premature mortality from noncommunicable diseases through prevention and treatment, and promote mental health and well-being.

Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol

GOOD HEALTH AND WELL BEING

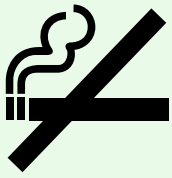
SDG3

By 2020, halve the number of global deaths and injuries from road traffic accidents

By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes

Achieve universal health coverage, including financial risk protection, access to quality essential health-care services, and access to safe, effective, quality and affordable essential medicines and vaccines for all

By 2030, substantially reduce the number of deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination.



Strengthen the implementation of the WHO Framework Convention on Tobacco Control in all countries, as appropriate.

GOOD HEALTH AND WELL BEING

SDG3

Support the research and development of vaccines and medicines for the communicable and noncommunicable diseases that primarily affect developing countries

Substantially increase health financing and the recruitment, development, training and retention of the health workforce in developing countries

Strengthen the capacity of all countries, in particular developing countries, for early warning, risk reduction and management of national and global health risks.

GOOD HEALTH AND WELL BEING

SDG3

- Find an SDG3 charity you want to support. Any donation, big or small, can make a difference!
- Vaccinate yourself and your kids. Protecting your family from disease also aids public health.
- Place yourself on the organ and tissue donors' registry in your country.
- Donate your blood. Safe blood saves lives!
- Join a pressure group to demand action on this issue.
- Share the facts about Global health to family and friends.

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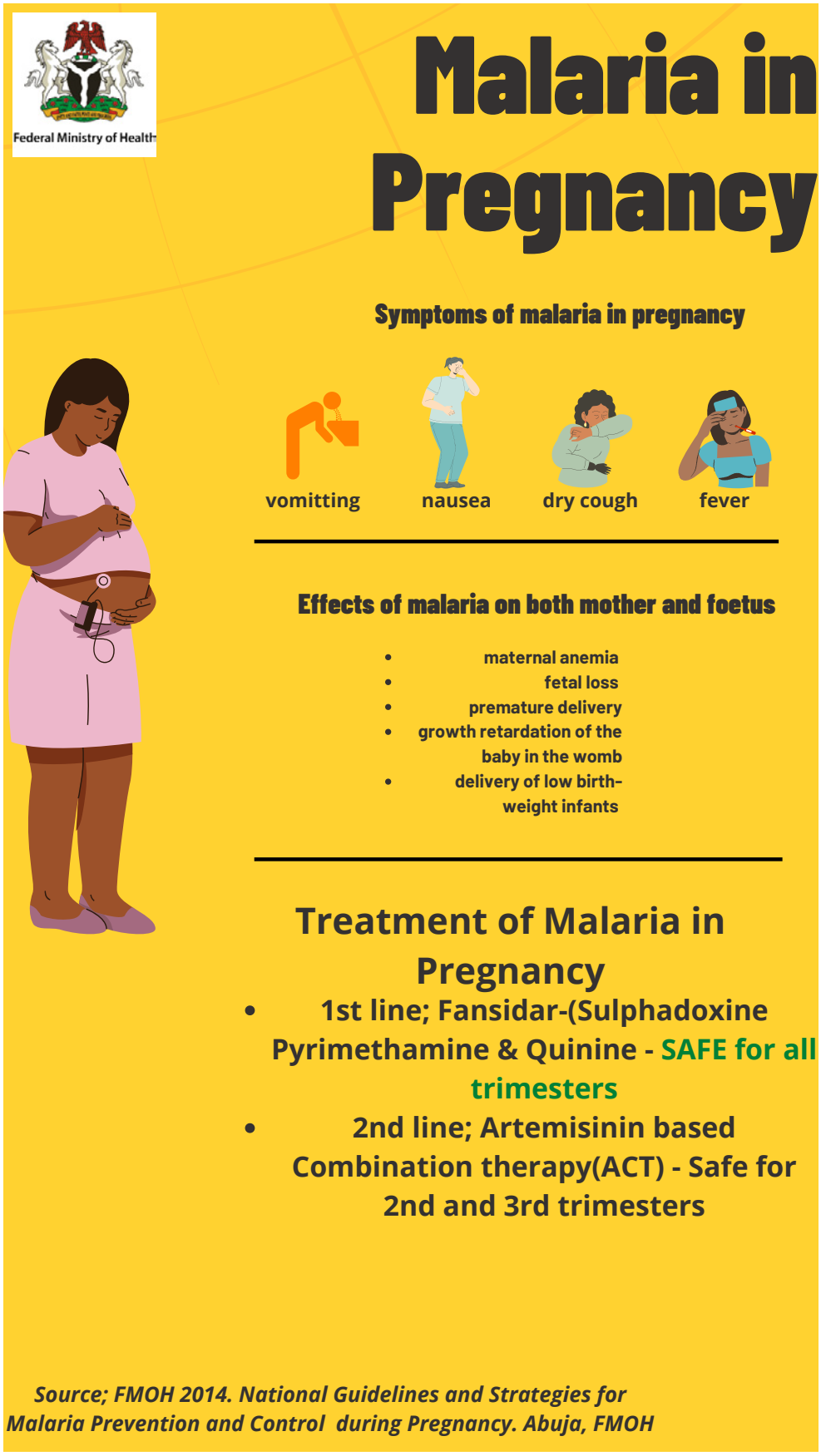
- Infographic: Malaria in Pregnancy



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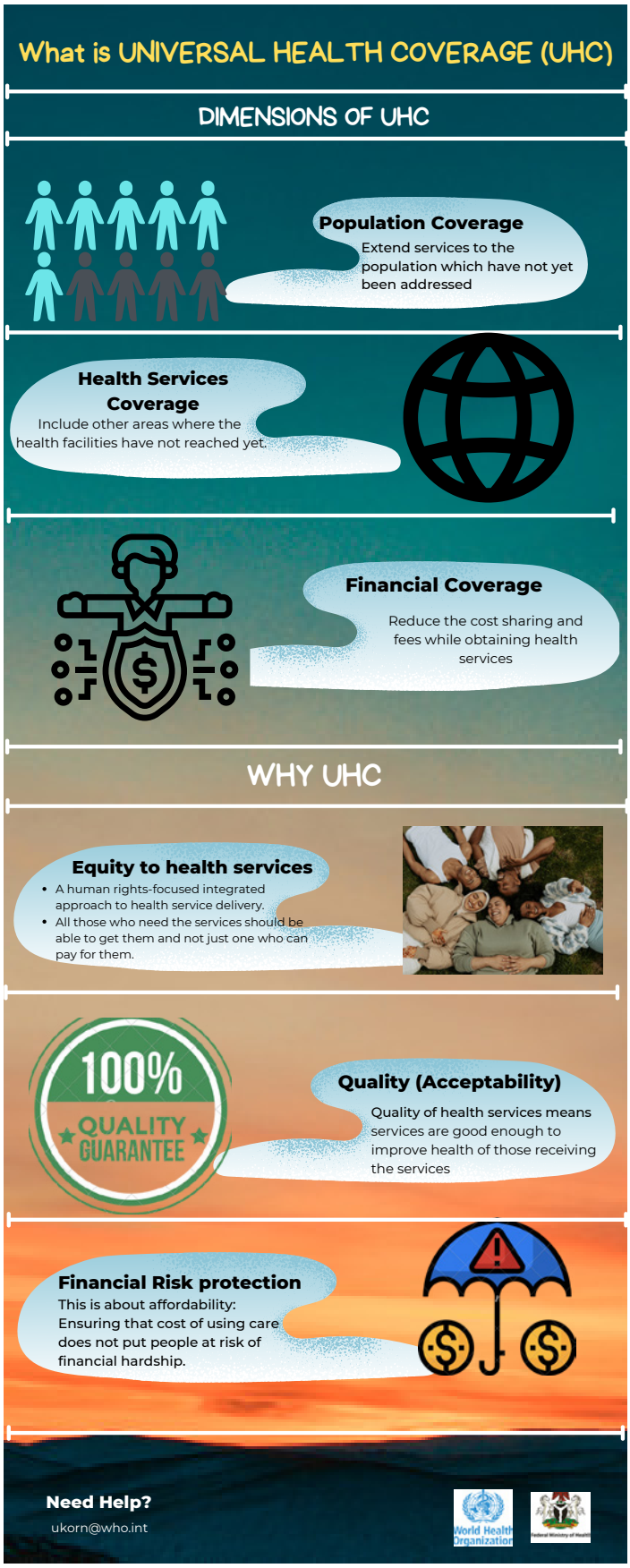
- Infographic: What is UHC?



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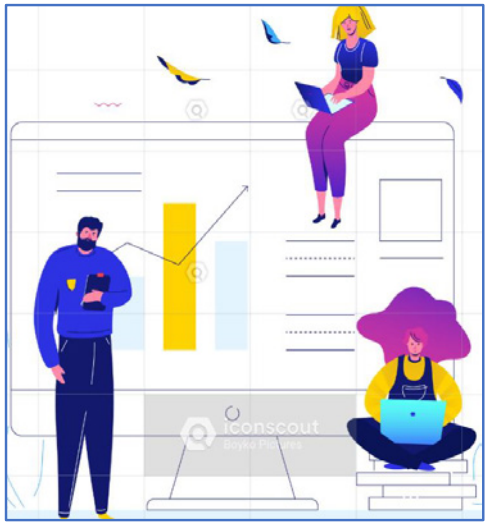
- Blog: Data Governance and Data Quality for Enterprise Health Business;
Does the use of Incentives Impact Maternal Mortality? Lessons from a Nigerian State

Data Governance and Data Quality for Enterprise Health Business

Introduction



The health sector and others have understood the value of data and data quality for years. Data has been termed the new oil because of the recognition by sectors and economies at large about the great potential of data as a strategic asset. Just as other types of assets require maintenance and oversight to sustain its usefulness, data also requires close attention to ensure it is of good quality in order to serve its usefulness – data governance.

Data quality ensures that critical information is accurate, complete, and consistent across multiple domains within the enterprise. Accuracy, completeness, and consistency are impacted due to a number of reasons. This could be due to a change of an element or resulting from errors in data entry processes. Poor data quality may also arise from information that is incomplete. Finally, data may be incomplete if integration processes are poorly designed. Poor data quality can distort the insights derived from advanced analytics. It can lead to a "garbage in, garbage out" scenario in which important business decisions are driven by information that is simply wrong.

Data Quality and Data Governance implication

Data governance and data quality exist in a symbiotic relationship. Each one is essential to the other, and organizations that intend to extract meaningful value from their data assets must be mindful of both. Both require ongoing efforts; neither is a "one and done" proposition. In some respects, data quality almost functions as a component of data governance. After all, it is hard to imagine effective data governance without addressing data quality. The reverse is also true, though. It is difficult to achieve meaningful levels of data quality without an effective governance framework in place. This is especially true at scale. In smaller, more focused scenarios, we can imagine an effort to improve quality in the context of a well-defined domain. However, in order to really do the job effectively, data governance and data quality must be seen as two sides of the same coin. This is especially true where larger volumes of data and multiple software systems are involved.

Conclusion

Ultimately, data quality and data governance work together to ensure that the information available to stakeholders throughout the organization is trustworthy, secure, and available when it's needed. By building a meaningful strategy around these two pillars, business leaders can ensure that their organizations are well positioned to optimize the value of their data assets. The health sector specifically has so much to benefit in terms of strong health systems and improved health outcomes by utilizing and maximizing the inputs and outputs available to it.

Visit for more details: https://www.precisely.com/blog/data-quality/what-role-does-data-quality-play-in-data-governance

UGANDA

- Analytical Fact Sheet: Maternal child health statistics

Maternal & Child Health Statistics of Uganda 2020/21

Rationale

It is a statutory requirement for the Ministry of Health to undertake semi-annual reviews of the performance of the health sector, review progress on the agreed outcomes and outputs and develop strategies and recommendations to improve healthcare service delivery.

Key Findings

Indicator	2020	2021
Maternal and Child Mortality		
Perinatal death/1000 live birth	23	20
Maternal deaths/100,000 health facility deliveries	95	97

Policy implications

- Strengthen essential obstetric care across the country to address the major causes of maternal mortality
- Continuous onsite CME's of health care providers

1.0 Perinatal death

Cumulative 27,509 perinatal death were reported in 2021. Perinatal death reduced from 23/1000 live birth in 2021 to 20/1000 live birth in 2022. Districts with the highest perinatal death per 1000 live births include; Mubende (52), Hoima (49), Masaka (46) and Kampala (41).

Figure 1. 1 Types of perinatal death reported in 2021

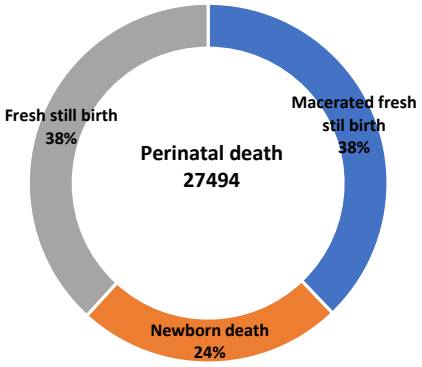
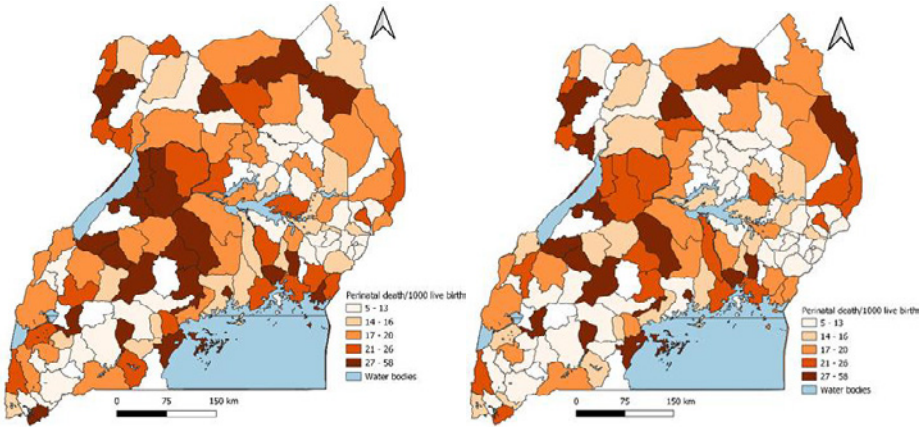


Figure 1. 2 Distribution of perinatal death per 1,000 live birth



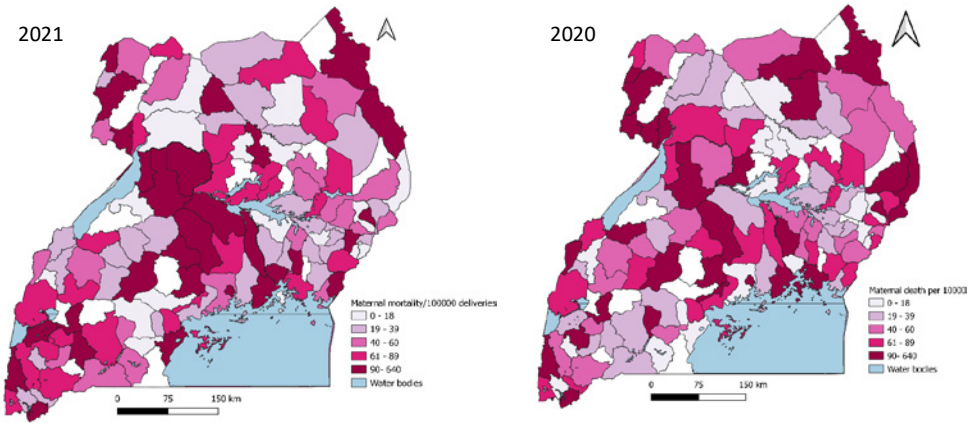
2020 **2021**

1.2 Maternal mortality

Cumulative 1,232 maternal death were reported in 2021. Maternal mortality increased from 95 per 100,000 in 2020 to 97 per 100,000 health facility deliveries.

The highest number of maternal deaths per 100,000 health facility deliveries were reported in the following districts; Kampala (184), Mbarara city (59), Hoima city (52), Masaka city (49), Mbale city (45) and Arua city (35). All these cities have regional referral hospitals where most of the mothers with complications during delivery are referred.

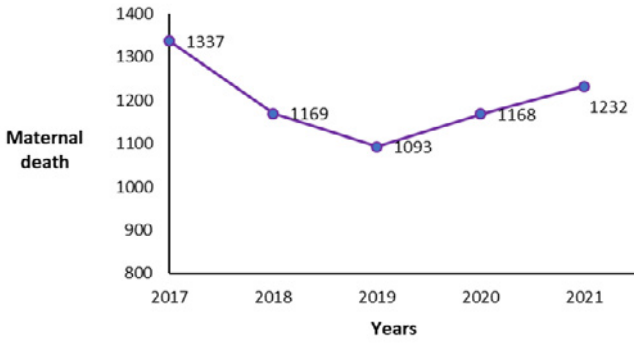
Figure 1. 3 Distribution of maternal death per 100,000 health facility deliveries



1.2.1 Trend of maternal mortality

The trend of maternal death was on a steady decline before. Maternal death increased by 7%, from 1,093 in 2019 to 1,168 in 2020, and an increased by 5% from 1,168 in 2020 to 1,232 in 2021.

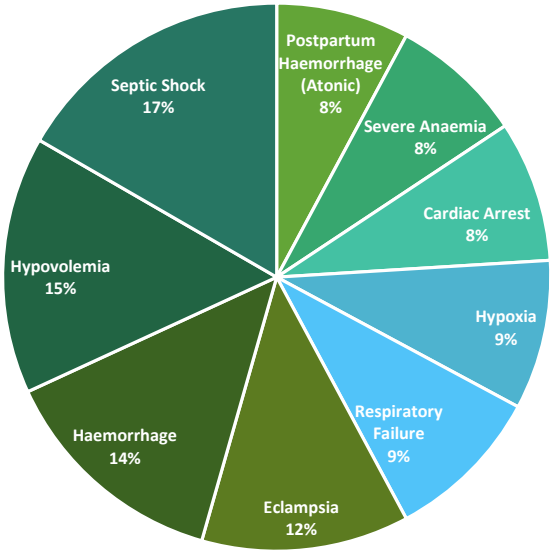
Figure 1. 4 Trend of maternal death in Uganda, 2021



1.2.2 Leading causes of maternal mortality

New estimates show that the leading causes of maternal deaths are septic shock, hypovolemia, and haemorrhage, which together account for almost half of maternal deaths (Fig. X)

Figure 3. 1 Leading causes of Maternal mortality, 2021



References

District Health Information System-2

Authors

UGANDA

- Infographic: Education is a key to good health

EDUCATION, DOES IT MATTER FOR HEALTH?

The social determinants of health include; Education, Employment, Access to healthcare, social environment.
Education is one of the key determinants for health.

HEALTHY FAMILY

My Education enabled me to make an informed decision to seek health care for My self and my family. We Are all Healthy Now.

MORE ACCESS TO INFORMATION

I am more likely to look for more information about my health for my self because am Educated.

LIFE STYLE

I am more likely to choose a healthy life style if I am educated.

ACCESS HEALTH SERVICES

Education has enabled me to get a better income to access quality health services.

RESIST MISINFORMATION

I can choose the right information about my health because of my education.

Authours: Andrew Kwiringira, Edgar Buddu, Annet Christine, Nasan Nasteri, Paula Bankunda, Haroon Seruli; www.moh.gov.ug

UGANDA

- **Blog:** Where does the dependency of malaria-endemic African countries on external financiers leave the continent? Stronger or more vulnerable?

WHERE DOES THE DEPENDENCY OF MALARIA-ENDEMIC AFRICAN COUNTRIES ON EXTERNAL FINANCIERS LEAVE THE CONTINENT? STRONGER OR MORE VULNERABLE?

Malaria Response

Over the past 20 years, the scale-up of malaria control efforts has led to marked reductions in morbidity and mortality globally. Approximately 1.5 billion cases and 7.6 million deaths have been averted over the past two decades; nearly 70% of cases averted were attributed to the use of long-lasting insecticidal nets (LLINs). However, global progress has slowed in recent years, particularly in sub-Saharan Africa, which accounted for 94% of the world's 219 million cases in 2019.

Heavy Dependence

Africa heavily relies on donor funding to scale up malaria control interventions. Even before allowing the continent to explore its own potential, Gavi has already declared its intention to devote $155.7 million to support the introduction, purchase, and delivery of malaria vaccines for Gavi-eligible nations in sub-Saharan Africa in 2022-2025. While some of these externally-driven mechanisms may be beneficial in the short term, the fact is that they have long-term negative impact on Africa.

This dependency demotivates the continent to develop its own institutions and transfers accountability from African leaders to influencers outside the continent. The recent enormous discrepancy in access to COVID-19 vaccinations has exposed the negative impact of dependency. Can you imagine the calamity that can befall the African continent if the external funding for malaria control programs is suddenly withdrawn?

A NEW STRATEGY

It is time to re-think the dependency strategy. A more effective course of action may be to finally assume financial accountability for the continent's fight against malaria. There are critical steps to this strategic shift. First, African nations should first fund those domestic budgets from their own general resources, with the addition of carefully controlled domestic and foreign borrowing that is within their control and on budget.

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