Public Health in Africa

A Report of the CSIS Global Health Policy Center

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PUBLIC HEALTH IN AFRICA

Jennifer G. Cooke[1]

Introduction

Nowhere are global public health challenges more acute than in sub-Saharan Africa. With just 13 percent of the world's population, this region carries 24 percent of the global burden of disease. The continent's immense disease burden and frail health systems are embedded in a broader context of poverty, underdevelopment, conflict, and weak or ill-managed government institutions. These complex, interrelated challenges will ultimately demand sustained, patient, and integrated responses.

Sub-Saharan Africa is—and for the foreseeable future will remain—an enduring preoccupation and target of global public health policies and interventions. In the past decade, the global HIV/AIDS pandemic has spurred a historic and unprecedented mobilization of attention and resources flowing to Africa. HIV/AIDS has generated new global institutions—UNAIDS and the Global Fund to Fight AIDS, TB, and Malaria, for example—mobilized new constituencies, including religious organizations, private foundations, and corporations; and elevated the profile of Africa and of public health among foreign policy experts, development specialists, universities and student groups, and nongovernmental organizations.

The U.S. response to HIV in Africa, the pandemic's epicenter, began gaining momentum in the late 1990s and accelerated quickly in the early tenure of the George W. Bush administration. Announced in January 2003, the President's Emergency Plan for AIDS Relief (PEPFAR) focused primarily on Africa (12 of the program's initial 14 target countries are African). The program benefited from the direct, personal engagement and leadership of President Bush and ultimately broke through considerable skepticism about what was and was not possible in fighting global HIV, in levels of U.S. funding commitments, in garnering domestic support and bipartisan congressional consensus, in catalyzing a dramatic increase in international commitments, and in proving wrong the conventional wisdom that broad-scale provision of antiretroviral therapy was impossible in poor and underdeveloped settings.

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The program was conceived as an "emergency" program, directed solely at HIV/AIDS, with clear, firm, country-specific targets in prevention, care, and access to treatment. With access to treatment the most tangible and measurable benchmark of success, a predominant focus of PEPFAR has been rapid delivery of life-prolonging antiretroviral therapy (ART) to those in need. A recently released study by Eran Bendavid and Jayanta Bhattacharya, published in the *Annals of Internal Medicine*, estimates that approximately 1.2 million deaths were averted because of PEPFAR's activities, with death rates in the 12 African PEPFAR focus countries around 10.5 percent lower than rates in neighboring African states.[2] The same study points out that, despite this accomplishment, the program has not had measurable impact on focus-country prevalence rates, which ultimately will require greater success in prevention of new infections. PEPFAR's achievements have strengthened momentum for greater engagement on other African health challenges, including the President's Malaria Initiative (also focused on Africa), and for congressional reauthorization of PEPFAR, which more than doubles proposed funding to $48 billion over five years and broadens the scope to include tuberculosis, malaria, and greater investments in health systems.

In a period in which U.S. engagement in Africa rose dramatically in a number of key areas—security, energy, conflict resolution, counterterrorism—the PEPFAR program is likely to be one of President Bush's most enduring and positive legacies in Africa. Nonetheless, the program has not been without controversy and has left room for reasonable debate around its internal priorities (in prevention approaches and in balancing prevention with care and treatment, for example); the trade-offs in other public health priorities generated by a largely single-disease, treatment-based approach; and the opportunity costs and potential "crowding out" of attention and resources directed at Africa's many other development and human security challenges.

The administration of Barack Obama confronts a difficult set of choices on priorities and trade-offs, made starker still by the U.S. economic crisis and global recession, the ballooning fiscal deficit, and commitments to two major conflicts in the Middle East. The next five-year phase of PEPFAR is authorized at $48 billion, but congressional appropriators may push back on quick or full disbursement of funds. For ethical and humanitarian reasons, U.S. support to those receiving HIV treatment cannot be shut down, and the mounting costs of those commitments may significantly constrain options for rebalancing U.S. global health priorities or entering major new areas of development engagement. At the same time, the public health challenges in Africa will remain severe and may in fact increase. Africa will be hard hit by the global crisis, with declines in export earnings, two-way trade, remittances from abroad, and foreign assistance flows. In previous global economic downturns, government investments in social services in Africa declined dramatically, and the risk of recurring food security crises in the coming years is serious.

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[2] Eran Bendavid and Jayanta Bhattacharya, "The President's Emergency Plan for AIDS Relief in Africa: An Evaluation of Outcomes," *Annals of Internal Medicine* 150, no. 9 (May 19, 2009) (forthcoming), http://www.annals.org/cgi/content/full/0000605-200905190-00117v1.

To date, the Obama administration has not given a strong indication of its priorities in either global public health or in African development challenges more broadly, although both President Obama and Secretary of State Hillary Clinton have each signaled a rising interest in maternal and child health. Presidential vision and leadership will be required to make the case to a potentially hesitant Congress that the last decades of health gains in Africa should not be put at risk, that human security in Africa warrants continued and expanded investment, and that health and development investments can be made in strategic, better integrated, and catalytic ways, in partnership with African governments, corporations, and other donors, that will ultimately redound to the benefit of both the United States and Africa.

Africa's Health Burden: More than Infectious Disease

New U.S. and international attention to HIV/AIDS and other infectious disease in Africa has unquestionably brought concrete health benefits to many millions of individuals. But some evidence also indicates that the massive inflow of resources to fight the continent's "big three" infectious diseases (HIV/AIDS, tuberculosis, and malaria) has also led to some distortions within health systems and in policy priorities and drawn resources and attention away from some of the continent's most important and looming health challenges. Maternal health, bacterial and parasitic diseases, and noncommunicable diseases have received scant international attention, and mental health challenges, almost none. Vehicular deaths, currently ranked tenth among Africa's public health threats and projected to rise to the top three in a decade, are virtually absent from national public health debates and from the global health agenda.

Infectious Disease

HIV/AIDS

The massive global mobilization on HIV/AIDS has achieved important results in Africa, and, according to UNAIDS, most national epidemics in sub-Saharan Africa have begun to stabilize, although many are still at unacceptably high levels. The continent remains the region of the world most heavily affected by the global HIV/AIDS pandemic. Sixty-seven percent of people living with HIV worldwide reside in Africa, and 75 percent of annual global deaths from AIDS occur in Africa. Africa accounted for 70 percent of new HIV infections in 2007, with 1.9 million newly infected. Ninety percent of children living with HIV are African, and 90 percent of new infections among children occur in Africa. Women account for 60 percent of new infections in Africa.

The epidemic varies significantly by region across the continent. West Africa, for instance, where prevalence rates have remained low compared to other regions, has seen declines or continued low rates. East African epidemics appear to be reaching a plateau, although there are some troubling indications of increased risk taking among youth populations. While southern African epidemics appear to be stabilizing, the region remains acutely affected, home to the highest national HIV-prevalence rates in the world.

Antiretroviral treatment is being provided to many of those in need in Africa, in numbers far greater than was thought possible at the beginning of the decade. Nevertheless, for most Africans living with HIV, such treatment remains out of reach. According to the World Health Organization (WHO), only 30 percent of Africans in need of treatment are receiving it, and even low-cost treatments for opportunistic infections remain unavailable to many Africans living with HIV. A number of 2008 studies suggest that ART is optimally initiated before a patient's CD4 count[3] has fallen below 350, and if international guidelines eventually incorporate that standard, an additional 1 million individuals per year in Africa will be added to the ranks of those in need of treatment. Because ART should be sustained throughout an individual's lifetime, the costs of treatment and the burden on weak African health systems are cumulative and ultimately unsustainable absent dramatic strengthening of the health systems. Also of concern are the additional costs and complexity of treatment as more HIV patients develop resistance to antiretroviral drugs and move from first-line to second- and third-line treatment, increases that will need to be factored into the U.S. and international response.

Most troubling, particularly in southern Africa, is the wide gap between effective prevention efforts and new HIV infections. New infections currently outstrip access to treatment, and for every individual who accesses treatment for the first time, it is estimated that three to four persons are newly infected. As Bendavid and Bhattacharya point out, "Projections of financial resources needed to sustain the treatment scale-up suggest that even with PEPFAR's greater commitment, the gap between the available funds and those needed will continue to increase unless the incidence of HIV in Africa is substantially reduced."[4] WHO estimates that in countries where data are available, just 9.5 percent of women and 7.9 percent of men have ever been tested for HIV and received the test results. Less than 35 percent of pregnant women with HIV have received ART for prevention of mother-to-child transmission. Recent setbacks in vaccine and microbicide trials, as well as cultural and health system obstacles to expanding male circumcision (shown to reduce the risk of HIV transmission significantly), underline the need for more effective outreach and scale-up of tested HIV prevention interventions: testing, behavioral change messaging, condom availability, and programs that reach and empower women to negotiate terms of sexual contact.

Tuberculosis

Southeast Asia has the highest number of new tuberculosis (TB) infections annually, but sub-Saharan Africa has a TB incidence rate double that of Southeast Asia and the highest number of TB-related deaths in the world as well as the highest per capita TB mortality. South Africa and Nigeria have, respectively, the fourth and fifth largest number of new TB cases annually, and

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[3] CD4 cells, also known as T-cells, are specialized cells within the body's immune system that the HIV virus attacks and uses to replicate itself. As HIV progresses, the body is unable to replace these cells, and the individual's CD4 count, or CD4 cells per cubic millimeter of blood, falls. If the CD4 count falls below 200, the individual is classified as having AIDS.

[4] Bendavid and Bhattacharya, "The President's Emergency Plan for AIDS Relief in Africa."

South Africa, by a wide margin, has the highest prevalence, incidence, and death rate per capita worldwide. Zimbabwe and Mozambique rank second and third. According to WHO, HIV is the single most important factor behind Africa's TB resurgence. And there are some indications that as HIV prevalence is stabilizing or declining, so too is TB incidence.[5] Africa has the largest number of people known to be coinfected with HIV and TB.

Of particular concern is the rise in cases of multidrug-resistant (MDR) TB and extensively drug-resistant (XDR) TB in Africa, which, according to at least one study, may currently be underreported.[6] Most cases of drug-resistant TB worldwide are believed to result from nonadherence to TB therapy, but investigation into a highly fatal outbreak of MDR and XDR TB in rural South Africa indicated that many of the cases were due to reinfection with a resistant strain of TB. This research suggests that the primary focus of MDR TB prevention—directly observed treatment—may not be adequate, particularly where many patients are already coinfected with HIV and TB. According to the researchers,

> The combination of a large population of HIV-infected susceptible hosts with poor TB treatment success rates, a lack of airborne infection control, limited drug-resistance testing, and an overburdened MDR-TB treatment program provides ideal conditions for an MDR-TB and XDR-TB epidemic of unparalleled magnitude.[7]

Tackling TB and HIV will require a more integrated approach to treatment, greater airborne infection control, and better capacities for testing and surveillance of drug resistance. Reports that migrants diagnosed with MDR TB in southern Africa have been forcibly returned to their home countries, without treatment or referral to care, highlight the need for cross-border, subregional approaches on TB and other infectious disease.[8]

Malaria

Malaria, the leading cause of death among African children under five years old, represents 10 percent of Africa's overall disease burden. Some 300–500 million people are infected with malaria each year—the majority in Africa—and 90 percent of deaths from malaria, a preventable and treatable disease, occur in Africa. The plasmodium falciparum parasite is most prevalent in Africa and is the most severe and life-threatening cause of malaria infection.

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[5] World Health Organization (WHO), *Global Tuberculosis Control, 2008: Surveillance, Planning, Financing* (Geneva: WHO, 2008), http://www.who.int/tb/publications/global_report/2008/en/index.html.

[6] Yanis Ben Amor, et al., "Underreported Threat of Multidrug-Resistant Tuberculosis in Africa," *CDC: Emerging Infectious Diseases* 14, no. 9 (September 2008).

[7] J.R. Andrews, et al., "Exogenous reinfection as a cause of multidrug-resistant and extensively drug-resistant tuberculosis in rural South Africa," *Journal of Infectious Diseases* (October 10, 2008).

[8] Theo Smart, "Migrants with MDR-TB in southern Africa being dumped off at borders," AIDSMAP.com, October 2008.

Prevention and treatment of malaria are relatively cost effective, although in Africa current efforts are limited by the capacity of health services and choices in public health policies. In number of countries where malaria control has been made a government priority, reductions in malaria mortality and morbidity have been significant. Eritrea, for example, mounted a concerted effort on malaria in 2000 and has seen dramatic results: an 80 percent drop in reported cases and an 85 percent drop in malaria deaths. The introduction of insecticide-treated nets and later long-lasting insecticidal nets, along with indoor residual spraying and artemisinin-based combination therapy, have proved extremely effective in wide-scale malaria control in Eritrea as well as in Zambia, Rwanda, Sao Tomé and Principe, and Tanzania, especially Zanzibar. Political will, public awareness, and community outreach and partnership undergird the cases of success.

Neglected Tropical Diseases

While HIV, TB, and malaria have garnered the lion's share of international attention, the world has missed major opportunities to fight a set of diseases that affect almost exclusively the world's poorest populations. The category of "neglected tropical diseases" includes vector-borne protozoan infections, bacterial infections, and parasitic worms. While these diseases may cause fewer deaths than HIV, TB, and malaria, an estimated 1 billion people worldwide (most in Africa) suffer from one or more of these diseases. Some are fatal; others leave victims blind or with physical deformities, stunt intellectual and physical growth among children, undermine productivity, and affect pregnancy outcomes.

Treatment of many of these diseases is simple and inexpensive. There have been recent efforts to better coordinate the disparate efforts around individual neglected tropical diseases, since in a number of regions many individuals may be infected with several at once. Efforts to deliver low-cost "rapid impact packages" through community-based distributors can also help strengthen public health infrastructures that reach the poorest and most isolated of Africa's rural communities, potentially laying the groundwork for stronger primary care delivery to these communities later on. A number of promising public-private partnerships on neglected tropical diseases have emerged in recent years, making significant inroads, for example, on dracunculiasis (guinea worm) and onchocerciasis (river blindness), and there are important opportunities for greater coordination and scale-up of these efforts.

Family Planning and Maternal Health

Africa has a tremendous unmet need for family planning education, access to contraceptives, programs to empower women and their partners to manage fertility and family size, and effective outreach to pregnant women. Programs to address these issues are vastly underfunded. Maternal death in childbirth is a silent epidemic in Africa, and the past decade, for all the new attention on public health in Africa, has seen little change in maternal death rates. One in seven women in Niger will ultimately die of pregnancy-related causes; in Sierra Leone, one in eight women giving birth will die. Important steps can be taken to integrate reproductive health education and services into vertical disease programs such as HIV services, but rates such as those in Sierra Leone

and Niger emphasize the need for even the most rudimentary steps to strengthen health systems and enable women to overcome cost, transport, and social obstacles to accessing care.

Noncommunicable Diseases

In the coming decade, infectious diseases will remain the predominant health challenge in much of Africa, especially in southern Africa where HIV and TB remain centered. But chronic noncommunicable diseases, including diabetes, hypertension, cancer, and chronic respiratory conditions, are already a major burden in Africa and are increasing rapidly, particularly (though not exclusively) in urban settings, driven by increasingly sedentary lifestyles, changes in diet, and alcohol and tobacco use. Diabetes cases in Africa in 2006, for example, were estimated at 10 million, a figure expected to rise to almost 20 million by 2025, and many cases go undiagnosed.[9]

Noncommunicable diseases have generally been marginalized within African public health strategies, with 80 percent of health budgets allocated to acute communicable diseases. Donor focus on infectious disease has reinforced this tendency, and bringing global attention to chronic disease—too often perceived as a problem of the rich—will be more difficult than for pandemic diseases.

A first step in redressing this imbalance is building awareness and understanding of the threat of chronic disease, with the aim of galvanizing national, comprehensive, and integrated approaches to prevention and treatment. This effort will require strengthening surveillance, reporting, and synthesis of current data on prevalence, morbidity, and mortality to place that information more accurately in the context of other national health challenges and guide resource allocation and public health priorities. Primary prevention will be the most cost-effective intervention and will require much greater investments in research into and surveillance of major risk factors, community-based approaches, and effectiveness of messaging on behavior change.

Among Africa's many neglected and underfunded public health challenges, mental health and vehicular deaths and injuries receive virtually no international or national support and yet have major impacts on mortality rates and productivity. According to WHO predictions, by 2020 road traffic injuries will rank third among causes of disability-adjusted life years in Africa, as the per capita ratio of vehicles increases. Few studies have been conducted on the impact of mental illness on morbidity, disability, and productivity in Africa, and mental illness is highly stigmatized and vastly underreported. HIV interventions may offer an opening into the broader field of mental health as the mental health effect of infection on individuals and heavily affected communities gains greater attention.

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[9] International Diabetes Federation, "The Diabetes Declaration and Strategy for Africa" (December 4, 2006), http://www.idf.org/home/index.cfm?unode=14A26179-13DD-4220-A865-6576D4D417FB.

Africa's Health Systems: Toward Sustainable Health Capacity

Despite the dramatic increases in resources devoted to HIV and other infectious diseases in Africa in the past decade, these resource investments clearly will quickly reach a point of diminishing marginal returns without stronger and more capable public health capacity in recipient countries. Today there is far greater awareness of the need to strengthen health systems, but gaining support for such programs is far more difficult than for rapid, disease-specific interventions that show quick, tangible results in numbers of lives saved. And defining precisely what is meant by strengthening health systems, devising effective measures of results, and minimizing waste are inherently difficult. In this area, senior leaders, from within Africa as well as in the United States and the broader international community, will need to make a strong and compelling case that investments in health systems, although less politically attractive in the short term, will ultimately be essential to meeting Africa's health challenges.

Programs that focus on one disease of interest but fail to provide people with the full range of basic health services can have distorting effects, may be unsustainable over time, and may reinforce health inequities and undermine broader efforts. In northern Nigeria, for example, a number of rural imams obstructed the donor-driven polio eradication campaign, leading to a renewed outbreak of the disease over several years, with cases spreading as far as Sudan and Kenya. Health workers and religious leaders in the northern city of Kano suggested that the singular focus on polio, when few people living in rural areas could access even the most basic of medicines or health care, was a key component in generating suspicion of the eradiation campaign and Western interventions more generally.[10]

There are important opportunities to build out from vertical programs to deliver more comprehensive care and, if properly coordinated, to strengthen networks of procurement and outreach. But a pressing need remains for sustained, patient investments in the basic building blocks of the health system:

- *Public health research, health information, and surveillance:* Strengthening African research, surveillance, and reporting capacity will be critical to more accurately determining the national disease burden and providing the evidence base for policy prioritization and resource allocation.

- *Human and physical health infrastructure:* With 24 percent of the world's disease burden, Africa has only 3 percent of the world's health professionals, with massive shortages of physicians, nurses, technicians, health managers, administrators, and planners. In addition to emigrating to better-paying employment in the developed world, health professionals are

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[10] Interviews by Jennifer G. Cooke with health workers and religious leaders in Kano, Nigeria, November 2006.

being drawn from rural to urban centers, from the public to the private sector, and from lower-income to higher-income countries within Africa.

- *Health financing:* Ensuring affordable access to health services on a continent where one-third of the population lives on less that $1 per day is a daunting challenge. Public hospitals and health centers often charge user fees (and transportation costs are often an additional burden); and private services, which are growing rapidly in urban centers, are prohibitively expensive for a large number of Africans. This burden is likely to grow as the global crisis unfolds and with remittances, government revenues, and foreign assistance levels across the continent likely to fall. A number of countries, including Ghana and Tanzania, for example, have made important progress in expanding national health insurance systems that ensure protection for those most in need.

- *Health policy and leadership:* The key to strengthening African health systems will ultimately reside in national leadership and sound national health governance. At an African Union meeting in Nigeria in 2001, African heads of state issued the Abuja Declaration, in which they pledged to raise public health spending to 15 percent of their respective national budgets. Very few have made noticeable progress toward this goal, although a number of countries, Botswana in particular, stand out in tackling these challenges and mobilizing significant government resources to complement external funding. In addition to resources, governmental leadership will need to have the political vision to give priority to health as opposed to other national challenges; national strategies that meet a country's national health challenges and are based on demand rather than on supply- or donor-driven agendas; greater interchange between ministries of health and other national institutions, particularly legislatures and ministries of finance and planning; and stronger management capacity to coordinate the multiple mechanisms, institutions, and actors engaged in public health. Governments can now draw on a growing number of nongovernmental institutions for assistance in formulating and implementing effective policies.

Africa's Development Context: Interconnected Challenges

Africa's health issues are part of a broad array of developmental challenges, challenges important in their own right but also critically intertwined with health and well-being. Failure to address any one of these challenges will put health investments at risk. In a world of unlimited resources, each would warrant a major mobilization of funding and attention. Given current financial constraints, however, the United States, other donor countries, and African partner states will need to manage and coordinate efforts carefully to ensure that no one of these areas is neglected, that an appropriate balance is struck among them, and that opportunities to integrate health and developmental responses are seized upon.

Among the foremost of these challenges are:

- *Gender inequities and norms:* Legal, financial, and social obstacles prevent women from accessing education, health care, and financial independence; from controlling terms of sexual relations or fertility; or from protecting themselves against violence.

- *Water and sanitation:* Every year an estimated 2 million children die as a result of not having access to clean water, over 40 percent of them in Africa. Only 62 percent of Africans have access to safe water, and only 60 percent have access to adequate sanitation, the lowest rates in the world.

- *Nutrition and food security:* Poor nutrition contributes to 53 percent of deaths associated with infectious diseases among children under five in developing countries. Today, added to the burden of pervasive micronutrient deficiencies, Africa is also seeing a troubling rise in malnutrition and lifestyle practices that result in cardiovascular disease, cancer, and diabetes.

- *Rural/urban infrastructure:* Providing rural populations with health and other social services presents a multitude of challenges, but rapidly growing urban centers face challenges in water and sanitation infrastructure and additional stresses on urban health systems.

- *Complex emergencies and post-conflict issues:* Conflict and displacement generate a unique set of health challenges, and delivery of health services in complex emergencies requires a unique set of capacities, services, and political sensitivities. Health care in post-conflict situations can be a powerful component of reconstruction and offer populations a tangible peace dividend, but it must be balanced as well against other pressing post-conflict requirements.

The U.S. Response: Learning from PEPFAR

PEPFAR's first phase, as its name conveys, was conceived as an emergency plan, focused in the first instance on getting antiretroviral therapy quickly to those most in need and on showing demonstrable progress in meeting targets in prevention, care, and treatment. The "emergency" approach, with the personal backing of President Bush, lent urgency to the endeavor, built quickly on an area of bipartisan consensus and public support, and promised quick, visible results, measured in lives directly saved, to potentially skeptical members of Congress. By virtually any measure, PEPFAR has made important and impressive gains in providing life-saving treatment to people infected with HIV, in making inroads in tackling the pandemic, and in drawing new actors to the cause.

PEPFAR, however, has also offered important lessons on the limitations of a strictly vertical, emergency approach and to its credit has incorporated a number of these lessons as it has developed. Early on, it was recognized that, without addressing the fundamental vulnerability of women, prevention interventions, as conceived in the first phase, would have little relevance to many African women; that creating parallel systems to deliver HIV interventions could have distorting effects on health policy overall and exclude important links among HIV, TB, and malaria, for example; that limitations on health capacity and trained personnel would ultimately

undercut efforts to broaden coverage and reach; and that delivery of treatment that cannot keep pace with new infections would ultimately be unsustainable.

The PEPFAR reauthorization bill (PEPFAR II), signed by President Bush in July 2008, broadens the program's approach, adding $4 billion for TB control and $5 billion for malaria control. It requires that global HIV- prevention strategies specifically address the vulnerabilities of women and adds more detailed accountability measures for reaching girls and women. It supports food and nutrition assistance and authorizes food purchases as a component of treatment. It places significantly greater emphasis on health workforce issues, with a target to train at least 140,000 new health workers, and it adds "framework agreements" with recipient countries to promote host country commitment to integrate HIV services and strengthen health systems.

The PEPFAR program has also opened the door for attention to other infectious disease challenges in Africa. The United States provided essential diplomatic and financial support to the Global Fund to Fight AIDS, TB, and Malaria, and PEPFAR II provides an additional $2 billion to the fund. In addition, in 2006 the Bush administration established the President's Malaria Initiative, a five-year, $1.2 billion program that seeks to reduce malaria deaths in its 15 focus countries by 50 percent by 2010. In February 2008, the White House announced an initiative focused on neglected tropical diseases, which will raise funding levels to 30 focus countries to $350 million between FY2009 and FY2013.

With PEPFAR support, a number of military-to-military programs have provided direct support for HIV/AIDS prevention and treatment to militaries and military laboratories and hospitals. The advent of the U.S. Africa Command may offer opportunities to draw on U.S. military health and research expertise as a component of military-to-military cooperation or leverage U.S. logistics capacity to support health delivery in post-conflict or emergency settings.

Priorities: Maintaining U.S. Commitment

Sustaining and strengthening U.S. commitment to public health in Africa in the midst of a global and domestic economic crisis will require vision, commitment, and support from the Obama administration's senior leadership. The administration will need to make the case to a potentially skeptical Congress that the United States cannot put at risk the many health gains in Africa that U.S. investment and support have made possible. There is a strong case to make.

Africa today is hard hit by the global recession, putting at risk ever larger segments of already impoverished populations. Health budgets are especially vulnerable to deep cuts. The HIV pandemic has created broad domestic constituencies who are sensitized to Africa's health challenges and who deem it a moral obligation for the United States to lend support. Emerging infectious diseases such as SARS, avian flu, and XDR TB have generated awareness of the potential global risk of initially localized diseases. And commitment to health and to the world's poorest is increasingly seen as tool of soft power that elevates the global stature of the United States and enhances relations with those with whom it partners. U.S. commitment has also spurred international partners to raise their commitments to global health.

Opportunities

- *U.S. leadership:* U.S. leadership needs to make the case to the public and Congress for continuing health commitments in Africa, based on humanitarian, "smart power," and security interests. The argument must be made that such support can be delivered in strategic, sustainable ways that leverage support from other donors, from the private sector, and from African governments and communities and that such synergy will strengthen the capacity of Africa to respond to multiple health challenges in a sustainable way.

- *African leadership:* African leaders must make the case that the United States will encourage and support African leadership and health governance, rewarding and providing incentives for sound health policy and national investments in health capacity and services. But U.S. support should not be a substitute for recipient government commitments and leadership.

- *Global coordination and burden sharing:* To ensure adequate coverage of the challenges to Africa's health systems, the U.S. administration should urge continued commitment by—and seek greater cooperation with—multilateral institutions, the United Nations, the G-8, and new investors in Africa, particularly China and India.

- *Responding to African health priorities:* Support for African health leadership should include working with African governments to create evidence-based national public health strategies that allow governments to prioritize and allocate resources in a strategic rather than a donor-driven manner. While the three major infectious diseases may be the most politically attractive to address, Africa's disease burden indicates that maternal health, chronic disease, and even multisectoral approaches to vehicular deaths require attention and resources as well. Ultimately, the United States may need to balance its current range of health assistance to account for enormous variation in health burdens across regions and countries and to respond to the strategic priorities of host governments.

- *Strengthening and integrating health systems:* The United States will need to make strategic investments in strengthening health systems to allow countries to respond to multiple health challenges, to track and anticipate through research disease trends and impact of interventions, and to build health-financing mechanisms that ensure equitable and affordable access to care. Special attention will be needed to spell out credibly and clearly what investing in systems strengthening is, in concrete, focused terms. The United States should ensure that its efforts do not create parallel, disparate responses that fail to take advantage of areas of synergy and economies of scale and build on existing outreach and community-based networks. Single-disease interventions should be monitored and evaluated not only for individuals reached but also for how they affect, directly or indirectly, the strengthening of health systems.

- *Integrating health and other development challenges:* The administration should identify areas in which health and other development challenges overlap. It should encourage integrated or

"wrap around" programming as it has increasingly done in the area of women's empowerment and HIV.

- *Health in complex emergencies and fragile states:* The United States should pay special attention to strategies for delivering emergency health assistance and building rudimentary health capacity in fragile and post-conflict countries, including the Democratic Republic of Congo, Somalia, Sudan, and Zimbabwe.