

# World Health Organization in Action

## Stories from the African Region



World Health  
Organization

REGIONAL OFFICE FOR **Africa**

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### Acknowledgement

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The following stories show a few of the many ways that the World Health Organization (WHO) is supporting countries in the African Region to help people to be healthier.

## 1. The road to universal health coverage in **Gabon**



Gabon's National Health Insurance scheme is a step towards achieving universal health coverage. WHO

**Mobile phones are becoming one of the world's most important health tools, used in many countries to track exercise, ensure medicines are genuine, and even to read blood glucose levels. In Gabon, they're being used to raise revenue for the national health system.**

A 10% levy on the revenues of mobile phone companies and on mobile phone usage, introduced by Gabon's government in 2008, has helped to more than double the funds for a health insurance programme that now covers 99% of the equatorial nation's poor, giving them access to critical health services such as care during pregnancy.

The levy is one of a set of measures that increased enrolment in health insurance plans in Gabon to 45% of the population in 2012 from less than 20% in 2007. Gabon is one of more than 100 countries that have approached WHO for advice on how to move towards universal health coverage to ensure that their populations can access quality health services without suffering financial hardship.

"From the start the government put the focus on the poor, and then they implemented reforms quickly," said Dr Hélène Barroy, a WHO senior health financing specialist who co-authored a review of Gabon's health finance reforms last year, "In just 5 years they are now covering basically all of their poor."



## The first national health insurance programme

Gabon started on the road to universal health coverage in 2007, when it passed a law creating the country's first national health insurance programme. The following year, it introduced the mobile phone levy, as well as a tax on foreign financial transfers, both of which were earmarked for the health system.

Since then, the government has expanded the insurance programme to include the poor, students, civil servants and employees of private companies.

Since the inception of the programme, catastrophic health expenditures, where households incur health costs that exceed 40% of household spending, have dropped from 35% to 21%, said Dr Hama Boureima-Sambo, the WHO's representative in Gabon. Almost 900 000 people, of whom more than two-thirds are considered poor, now have health insurance cover in Gabon.

The reforms have eased the financial burden on households. Out-of-pocket spending declined to 21% of total health spending in 2014, from 51% in 2008. The government has built new hospitals with modern medical equipment in an effort to increase its standard of health-care to that of other middle-income countries.

## Financial burden of healthcare costs

Those reforms have led to tangible health benefits. The number of children with malnutrition has halved, and 90% of births now take place in a clinic or hospital. The rate of new HIV infections has been halved since 2001, and the proportion of HIV-infected people who can access treatment is five-fold higher than in 2002.

Still, many of the country's health indicators remain comparable to those of poorer nations. Gabon has a life expectancy of 63 years, compared with an average of 74 years in other upper-middle-income countries. Deaths in childhood and childbirth are similar to those of low-middle-income countries, and malaria remains the biggest cause of sickness and the main cause of death for children under five years.

Gabon has increasing rates of high blood pressure, obesity, heart disease, diabetes, cancers and other non-communicable diseases. These are becoming a major public health problem. The country has more than enough hospital beds, and an adequate number of health workers, but its primary care system is weak, especially in regional areas.

## Expanding coverage

"The biggest challenge when you have an ambitious system like this one is sustainability," said Dr Boureimo-Sambo, "You can have brilliant ideas, but down the road you will find that the system is overwhelmed, you can't pay anymore, or even if you can pay, the system runs out of money."

WHO is advising Gabon's government on ways to build sustainability and contain costs by increasing the use of quality generic drugs and by developing district health plans to expand the provision of primary health care services in rural areas.

Further reforms will be needed to contain health costs, including changes to the way goods and services are purchased and measures to encourage patients to use local clinics instead of hospitals, said Dr Barroy.

"The government has not yet put in place mechanisms to manage the increasing demand and expansion of costs," she said. "In other countries we've seen that this is the biggest challenge. My hope is that Gabon takes this seriously in order to maintain universal health coverage."

## 2. Maternity waiting homes protect newborns and mothers in Namibia



In Opuwo, Namibia, tents house pregnant women waiting to give birth. WHO

**Two years ago, under-shade trees in a field adjacent to the Okongo Hospital located in the Ohangwena Region of northern Namibia, 20 to 30 tents housed pregnant women waiting to give birth.**

Many were here because poor roads, lack of transportation and distances of up to 100 kilometres made it difficult for rural pregnant women to be sure they could reach Okongo Hospital in time to give birth.



A Namibian mother from the Himba tribe and her baby. WHO

## Life was not easy

“Conditions in the camps were really tough,” says Hambeleleni Jonas, a mother who lived in the Okongo Camp prior to giving birth. “Women had no security against passers-by and pigs roamed freely throughout the camp. When it rained we couldn’t cook.”

Nevertheless, Jonas valued the opportunity to give birth to her baby in a hospital, a sentiment shared by many women in Namibia. Nearly 6 out of 7 Namibian women deliver in health facilities and 3 out of 4 receive antenatal care.

It has always been harder for rural women to access health facilities when they need them and avoid potentially dangerous delays in seeking care. Lack of care may result in maternal and infant death, or a stillbirth in the third trimester of pregnancy. High teenage pregnancy rates, failure to seek antenatal care, HIV infections and inadequate care during labour and delivery also contribute to the problem.

In 2015, the maternal mortality rate in Namibia was 265 deaths per 100 000 live births and the infant mortality rate was 33 deaths per 1000 live births.

## Extending care, promoting ‘quality facility childbirths’

In 2013, in order to save more lives, WHO, in partnership with the Namibian Ministry of Health and Social Services and the European Union, launched the Programme for Accelerating the Reduction of Maternal and Child Mortality (PARMaCM).

Under the programme, maternity waiting homes are being built next to health facilities in four regions across Namibia to replace the makeshift camps and provide rural women a

safe place to stay. The homes are set up as dormitories with communal kitchens, dining halls, bathrooms and meeting areas and can house up to 80 women. Each woman either pays a small daily fee or volunteers to work to cover her cost.

“The maternity waiting homes bring women closer to the health facilities, which ensures timely access to quality facility childbirths and helps avoid complications during pregnancy, childbirth and the days after the birth,” says Dr Monirul Islam, WHO Representative to Namibia. “They also offer a great opportunity to counsel women on various health topics, including exclusive breastfeeding, family planning, and immunizations.”

The maternity waiting homes are part of a comprehensive approach to bringing better quality care to pregnant women in Namibia. The government is also improving access to primary health services, strengthening maternal and perinatal death surveillance, and supplying more ambulances to transport patients to medical facilities. Additionally, community advocates are encouraging women to give birth in health facilities, and health workers are being trained on emergency obstetric care.

## Saving more mothers and babies

As a result, lives are being saved. Averting stillbirths has been one of the programme’s big successes.

According to the Demographic and Health Survey (DHS), the proportion of stillbirths in Namibia was 8 per 1 000 total births in 2014—one of the lowest rates in Sub-Saharan Africa and below the global target of 12 or fewer stillbirths per 1000 total births by 2030 set in the Every Newborn Action Plan endorsed by the World Health Assembly in 2014.

Of the stillbirths, the number occurring less than 12 hours before or during childbirth, has decreased by 18% in less than five years, mainly due to improvements in quality of facility childbirth, emergency obstetric care and mothers choosing to deliver their babies in maternity facilities, according the Namibian DHS.

“A strong commitment to value childbirth and the life of every baby is encouraging communities to bring women to maternity facilities in time,” says Dr Islam. “Because of this, Namibia is starting to see a gradual decline in maternal and infant mortality.”

## Ending preventable deaths

Despite significant reductions in the number of maternal and child deaths worldwide, there has been little change in the number of stillbirths. According to new estimates by WHO, the London School of Hygiene & Tropical Medicine and UNICEF, more than 2.6 million stillbirths occur globally every year, half of which take place during labour and delivery. Most of these are preventable when high quality and timely care is provided.

Under the Every Newborn Action Plan, Strategies for Ending Preventable Maternal Mortality and the Global Strategy for Women’s, Children’s and Adolescents’ Health, WHO and partners are working to strengthen health systems in every country, so that every mother receives high quality care that enables her to give birth to a healthy baby after many months of pregnancy.

“It’s quite unacceptable that so many mothers and babies die for lack of essential and good quality care,” says Anthony Costello, WHO Director of the Department for Maternal, Newborn, Child and Adolescent Health. “WHO plans to coordinate a global initiative to cut maternal and newborn deaths and stillbirths in health facilities over the next 5 years.”



### 3. Bringing child health services closer to rural communities in Malawi



A community health worker diagnoses and treats a 3 year old boy for malaria at Matapila Village Clinic in Ntcheu District, Malawi. WHO / A. Gumulira

#### Malawi is making progress in its fight against child mortality by moving critical health services closer to families who live in remote, rural areas.

The World Health Organization has been working with Malawi's Ministry of Health to train community health workers to treat common childhood diseases under the Rapid Access Expansion (RAcE) programme funded by the Government of Canada and launched in 2013.

The approach, known as the integrated community case management (iCCM) of childhood illnesses, focuses on treating diarrhoea, malaria and pneumonia, which together accounted for 45% of deaths among children younger than 5 years of age in the country in 2012.

"The incidence of preventable deaths among children underscored the need for the program years ago," said Dr Storn Kabuluzi, Director of Preventive Health Services at the Malawi Ministry of Health. "So we adopted an aggressive strategy for child survival in 2008," he said, noting that health workers were trained to treat fevers and other illnesses among children.

#### Better results through an unprecedented partnership

The women waiting in line at the Matapila village clinic in Ntcheu District, in the central region of Malawi, said they have noticed a difference.

"Frida Kabwango, the community health worker here, comes to the village clinic full-time Tuesdays and Fridays and the rest of the time we can go to her home," said Priscilla Laimani, a mother of four. "It's a relief to have these services and medicines available for free, just a few doors away, when our children have fever."

Previous iCCM strategies aimed to serve people outside an 8 km radius of the nearest health facility; the RAcE initiative has reduced that distance to 5 km.

WHO has been facilitating national policies for iCCM scale-up, and serving as the grant's main financial steward. Save the Children Malawi and other nongovernmental organizations have been providing implementation support. When the iCCM programme started, there was 1 supervisor for 137 health workers and now there is 1 for every 3 community health workers. As a result, community health workers are better at providing appropriate diagnosis and treatment.

The programme is now expanding by providing maternal and neonatal care and introducing rapid diagnostic testing for malaria.

**"The progress is encouraging, but we can save even more lives by developing the skills of community health workers and extending the coverage of their services," said Dr Kabuluzi.**

#### By starting small, big things will follow

But there is plenty of room for improvement. "Ideally, we would have 1 community health worker providing a complete range of services in each of the 46 000 villages in Malawi, but the government could not foot such a large wage bill," said Humphreys Nsona, Head of the Integrated Management of Childhood Illnesses unit at the Ministry of Health.

When children have illnesses that require a referral to the district health facility, parents often do not have the means to take them there. Furthermore, community health workers often live far from where they work, which can make it difficult for them to provide services as needed.

Despite the struggles, Health Ministry staff, district hospital management teams, health workers, parents and community representatives said they were hopeful. "This treatment service is very valuable to us because it has been saving the lives of our children," said Samson Gonondo, from Matapila village. "We would like to see it extended to the rest of the community—to individuals above age 5. I remain optimistic. My experiences have shown me that if we have a vision and work together on it, others will be inspired to help us. By starting small, big things will follow."



## 4. Smoking Cessation Programmes help tobacco users kick the habit in **Mauritius**



Community health centre in Mauritius. WHO

**Tobacco products are one of the biggest public health threats and nearly 80% of consumers live in low and middle-income countries. Tobacco use is estimated to be responsible for 10% of adult deaths worldwide and 3% in the African Region.**

Tobacco companies target these countries and encourage people living in poverty to pick up the habit. This is true for Kanta, who comes from a poor family and started working at the age of 13. “With friends at work, I took my first cigarette. We used to share one cigarette

among three friends, and slowly it increased to five sticks, but still sharing puffs,” described Kanta.

Tobacco harms nearly every organ of the body and causes many diseases. The diseases most often seen include heart attacks, strokes, cancer, and chronic lung conditions. As there is a lag of several years between when people start using tobacco and when their health suffers, many people do not see the effects of tobacco until the damage is done.

“I tried to stop a few times, once for a period of one month, then again, for a period of three months, but I could not resist the influence of friends. I gradually increased the number of sticks to 30. After many years of smoking I started feeling breathless and experienced other breathing problems,” Kanta added.

Tobacco users commonly think smoking will help relieve feelings of stress and disregard its devastating effects. Vijay, a 46 year old ECG technician was not aware of the ill-effects of tobacco. “I started smoking at the age of 17 after I lost my father. Life was stressful so I started smoking to get some sort of relief. I started with four to five sticks and when I started working I increased it to 40-50 cigarettes per day,” Vijay described.

Any use of tobacco deprives families of income and causes persistent poverty. “I didn’t pay much attention until my children were born but I started having a “guilt feeling,” because the money I spent on cigarettes was not going to my family, but I could not stop,” said Vijay.

To help people like Kanta and Vijay quit smoking, WHO and the Smoking Cessation Programme of the Ministry of Health & Quality of Life in Mauritius developed innovative tobacco cessation guidelines, established eight smoking cessation clinics and offered an “Infoline” to assist smokers in kicking the habit.

Kanta and Vijay both started the Smoking Cessation Programme and received psychological and medical support to quit smoking. “I followed the treatment for 10 weeks and was very regular with my appointments. I did not feel any “crave”. I must say that I am very happy now. I can perform my jogging effortlessly. Financially, I am better-off,” described Kanta.

“I decreased the number of cigarettes to five sticks and stopped completely in five weeks. I continued the treatment for eight weeks in total. While following treatment, the “cravings” were there but, I had made up my mind “No more cigarette ever again”. I used to spend some Rs 7000 – Rs 8000 (Approximately US\$ 235 – 250) monthly to buy cigarettes and I have a huge sense of self-satisfaction as I am now using this money to pay tuition fees for my children,” Vijay added.

While commendable progress has been made in Mauritius, countries throughout the African Region can strengthen tobacco regulation policy and implement highly-effective cessation programmes that provide assistance to users who do not understand the specific health risks of tobacco and want to quit.



## 5. Cholera prevention measures reduce transmission among displaced people in **South Sudan**



A man taking an oral cholera vaccine. WHO

**When violence erupted in South Sudan at the end of 2013, tens of thousands of people fleeing the conflict sought refuge in United Nations bases positioned around the country in the hope that peacekeepers stationed there would protect them. The bases were quickly overwhelmed, with families crammed together with little or no access to safe water or sanitation.**

Then the rainy season approached, increasing the risk of water-borne diseases, in particular cholera, which is endemic to the country – with the potential for explosive outbreaks in the congested camps.

Yet when a cholera outbreak was declared in South Sudan five months later, the displaced people living in the makeshift camps at UN sites were largely unaffected, with little or no transmission of cholera.

A timely decision to initiate prevention and control measures, including pre-emptively vaccinating displaced people in UN sites with oral cholera vaccine (OCV), almost certainly averted increased illness and death amongst the vulnerable camp inhabitants who had been at high-risk of the disease.

## Cholera still places heavy burden on vulnerable peoples

Cholera has been responsible for 7 pandemics in the last two centuries and an estimated 1.4 billion people are at still risk of the disease in endemic countries. More than 100 000 people die of cholera each year, half of them children, although only a fraction of cases and deaths are reported.

Cholera is a preventable and treatable disease, but slow progress in providing access to safe water and sanitation for all populations, lack of access to healthcare for those who are sick, and the emergence of new and more virulent strains of cholera mean the disease still inflicts a heavy burden of disease on society. Humanitarian crises, whether due to conflict or natural disasters, often create conditions in which cholera thrives.

## Averting outbreaks through coordinated action

The actions taken to prevent a full-scale outbreak of cholera in South Sudan's UN-controlled camps were a direct result of a renewed international commitment to combating the disease as well as the availability of a safe and effective vaccine. Since 2013 the WHO, together with three key partners (IFRC, MSF, UNICEF), has managed a global stockpile of OCV, which can be used for outbreak response and humanitarian crises.

“Living conditions in the camps in South Sudan were horrible. By early 2014 acute watery diarrhoea and other water borne diseases were on the rise. We knew that unless we rapidly put in place preventive measures we would have hundreds, if not thousands of cases of cholera,” said Dr Abdinasir Abubakar, medical officer for the WHO in South Sudan. “The Ministry of Health requested vaccines from the global stockpile and within a few weeks 250 000 doses were being shipped in and the vaccination campaigns were carried out by Medair and Médecins Sans Frontières.”

The global stockpile of OCV initially made available 2 million doses of the vaccine, funded by 5 donors: the Bill and Melinda Gates Foundation, the ELMA Vaccines and Immunization Foundation, the EU Humanitarian Aid and Civil Protection department (ECHO), the Margaret A Cargill Foundation and the USAID Office of Foreign Disaster Assistance. In 2015, with funding from the GAVI Alliance, the number of doses available for use in both endemic hotspots and emergency situations is expected to rise to around 3 million.

It was the rapid spread of cholera following the 2010 earthquake in Haiti that reminded the world the disease was still a major killer. An estimated 9000 people have already died of cholera in Haiti since the epidemic began and an estimated 700 000 are infected. But in fact, cholera has always placed a heavy disease burden on countries, particularly in the Regions of Africa and South-East Asia. Recent years have seen epidemics emerge in the Horn of Africa, Sierra Leone, Yemen and Zimbabwe, amongst others.

## Oral cholera vaccine a powerful tool to help combat the disease

In 2011 the WHO World Health Assembly (WHA) recognized cholera as a global public health priority and called for the revitalization of the Global Task Force on Cholera Control (GTFCC), which was originally established in 1991 in response to the re-emergence of the disease in Latin America and Africa. The WHO-led network aims to end cholera deaths through strengthening international collaboration and increasing coordination among partners.

“Selective use of OCV for so-called endemic ‘hot spots’ and in humanitarian emergencies is a powerful tool to have in our armoury, but to combat this disease we need a global integrated and innovative approach that includes better prevention through improved access to clean water and sanitation as well as better surveillance, preparedness and response to outbreaks,” said Dr William Perea, Coordinator for the Control of Epidemic Diseases in WHO.

“There is a renewed global commitment to the vision of dramatically reducing death and disease from cholera. Through collective action we can focus, catalyse and help coordinate support for countries to help them put in place evidence-based measures to control this disease,” he said.

## 6. One of **Sierra Leone’s** toughest slums beats Ebola



WHO Social mobilisation team in action in Sierra Leone. WHO/K. Kamara

**Moa Wharf is one of Sierra Leone’s worst slums. In this overcrowded, beachfront neighbourhood, Ebola arrived and seemed poised to burn through the area like wildfire. So how did one of the most challenging areas in Sierra Leone get to zero cases and what can the Ebola response learn from its success?**

On a stretch of scenic coastline at the edge of the Atlantic Ocean sits one of Freetown, Sierra Leone’s, toughest neighbourhoods – Moa Wharf. It is a cluster of congested, tightly-packed corrugated iron and brick homes and shops. The passageways are narrow and crowded. Residents and visitors find themselves in close, intimate contact as they navigate swampy land and heaps of refuse.

The first case of Ebola occurred around 9 March 2014. As a result of this initial case, the Government instituted a quarantine, which was lifted on 10 April following the last positive case on 26 March. But with more than 8 000 people living in this area that is less than 1 square kilometre, Ebola response teams were fearful that the virus would re-emerge in this enclave.

### A death in the community

On 15 April those fears became a reality when teams received word of a death in the community – a 34-year old fisherman who presented Ebola symptoms, tested positive in a post-mortem examination. Disease surveillance officers, epidemiologists and WHO social mobilization teams assisted in identifying a 22-year old commercial biker as the possible index case. He also tested positive for Ebola and died on 17 April. Three additional individuals who were infected were also found following further investigations.

Immediately after these cases were identified and confirmed, the Ministry of Health, WHO, UNICEF, Médecins Sans Frontières, other partners, local leaders, members of various task forces and 2 local chiefs mounted an intensive community engagement and social mobilization programme to end the Ebola outbreak.

### Getting to zero starts and ends with the community

Mr Osman Kabia, a WHO social mobilization team lead, encouraged his team to embrace this philosophy: “For all community engagement and social mobilization activities in all outbreaks where solutions in stopping an outbreak are needed, particularly where communities are involved, all strategies, planning and activities should start with the community and end with the community.”

Doing this involved meetings with the community landlords, traditional healers, religious leaders, survivors, chiefs, community taskforce members, harbour masters and other key community members. Total community participation and involvement had been lacking when the earlier cases occurred. As Chief Pa Alimamy Komeh Ka-pen put it, “Moa Wharf community was abandoned and left to fend for itself.”

The teams were determined not to repeat that mistake and developed a strategy for the whole community. The WHO social mobilization team divided the area into 5 zones. Each team included an epidemiologist, a district surveillance officer, and was primarily made up of community members. These teams were responsible for winning the hearts and minds of the residents of Moa Wharf to accept the Ebola messages and gain greater awareness of the disease outbreak within their community.

Taskforce members consisting of young adults selected from Moa Wharf were also part of the teams. They included members of the Three Poli Boys, a local fraternal society with significant influence, who helped to conduct active case investigations. They also helped on the search for sick members of the community, regardless of their disease symptoms.



## Survivors provide support in finding and following cases

Within these teams, Ebola survivors also played a critical role in the contact tracing efforts. They were instrumental in providing key messages to those within quarantined homes and ensured that anyone who was on a contact list was seen every day.

They, along with other community members, assisted with searches along the seashores, where transmission of the virus was most active among young men involved in secret fraternal societies.

Prior to this, survivors were not part of the community engagement, but that changed during the response in Moa Wharf. The survivor strategy proved to be a success for the social mobilization, disease surveillance and epidemiological teams in containing and ending the Ebola outbreak in the area.



Public health awareness campaign in Sierra Leone. WHO/S. Gborie

“For the Ebola response teams, it was encouraging to be able to mobilize the community and transform deep-seated beliefs that had initially thwarted positive intervention and response activities,” said WHO medical officer, Dr Kande-Bure K.B. Kamara.

### Building the trust and confidence

Choosing the best approach and interventions is key in order to continue building trust and confidence with the community. To do this, the social mobilization teams leaned away from another quarantine and instead relied on the strong relationships that had been built to spread the right

messages. “Quarantining a whole community where soldiers and police officers are utilized for security purposes is not the answer to ending the transmission chain,” said Mr Kabia. “It will only elevate the fear of the community and lead to sick members going into hiding.”

The Moa Wharf community is now fully aware of the reality and dangers of Ebola and have been proactive in taking ownership of outreach and sensitization programmes. Their collaboration with the various response teams has been invaluable and they have shown energy, drive and a willingness to end the outbreak. Relationships with the international response community are stronger and community members believe in the process of being the gatekeepers for keeping their neighbourhood safe and vigilant.

The Moa Wharf community stands as a testament of an efficient, timely and respectful Ebola response and serves as a model for getting to zero.

## 7. WHO coordinating vaccination of contacts to contain Ebola flare-up in **Guinea**



WHO Social mobilisation team in action. WHO Guinea/Lancei Touré

**Hundreds of people who may have been in contact with 8 individuals infected with Ebola virus in Guinea’s southern prefectures of Nzérékoré and Macenta have been vaccinated with the experimental Ebola vaccine in a bid to contain the latest flare-up of Ebola.**

WHO’s office in Guinea says more than 1,000 contacts have been identified and placed under medical observation. Nearly 800 have been vaccinated over the past week, including 182 who are considered to be high-risk contacts.

The VSV-EBOV vaccine currently being administered was found to be highly effective in preventing Ebola infection in a large trial conducted by Guinea’s Ministry of Health, WHO and partner agencies last year. It has since been used in Sierra Leone to contain a recent flare-up there, and now, once again, in Guinea.

The “ring vaccination” strategy involves vaccinating anyone who has come into contact with a person infected with Ebola, as well as contacts of theirs.

In this latest flare-up, there have been 8 cases of Ebola and 7 deaths since late February. The most recent case, an 11-year old girl, is being treated at an Ebola care facility in Nzérékoré and as of today, is reported to be in a stable condition. Six of the deceased are from three generations of the same extended family in the village of Koropara Centre.

## Inter-agency response in full motion

Local health authorities reactivated the emergency coordination mechanism that was in place during the height of the Ebola epidemic in Nzérékoré and a large-scale inter-agency response is in progress. WHO has a team of 75 staff members working in the affected areas to support the government-led response, including epidemiologists, surveillance experts, contact tracers, vaccinators, social mobilizers and infection prevention and control experts. WHO has also dispatched two top-level Ebola-experienced clinicians to assist at the Ebola treatment centre in Nzérékoré.

Households under medical monitoring are receiving a range of assistance from partner agencies, including food packages, hygiene kits and cash stipends to purchase additional items.

Infection prevention and disease control measures, including a public awareness campaign and other health promotion and community engagement activities, are taking place in the affected areas.

Tests from blood samples of the confirmed cases indicate that this latest cluster of Ebola stems from a known transmission chain and not a new chain introduced by the animal population.

## Ongoing flare-ups expected

Both Nzérékoré and Macenta have been hard hit by Ebola in the West Africa outbreak. In the sub-prefecture of Koropara, at the centre of this latest flare-up, there were 24 Ebola cases, 15 deaths and 9 survivors between October and December of 2014.

This re-emergence of Ebola in Guinea is the first since the original outbreak in the country was declared over on 29 December 2015. WHO has continuously stressed that flare-ups like this one should be anticipated, largely due to virus persistence in some survivors, and that the three Ebola-affected countries must maintain strong capacity to prevent, detect and respond to further outbreaks.

## 8. Building back better mental health services in Liberia



Community-based training is providing health practitioners across Liberia with the skills to be able to recognize symptoms of mental illness. WHO/A. Brunier

**As many as 1 in 5 Liberians suffer a mild to moderate mental disorder, according to WHO estimates, yet the country has only one registered psychiatrist and, until recently, the vast majority of health workers had a limited understanding of mental illness.**

This is changing however, as WHO and partners are helping to equip health workers across the country with the skills to provide front-line care for people with mental illness.

Roland M Dolo, a registered nurse from Lofa County in the north of Liberia, is one of 380 health workers who have received intensive training from WHO in the management and treatment of mental disorders such as psychosis, depression and epilepsy.

Now, when someone comes to his clinic with symptoms of mental distress, he knows how to differentiate between different mental disorders. More importantly, he no longer stigmatizes these people. "I now know that these people can be treated, get well and play meaningful roles in their families, communities, and society at large," he says.

The week-long training that Dolo received also covers post-traumatic stress disorder, grief and psychological first aid. The need for treatment for all of these conditions is heightened during emergencies such as the recent Ebola outbreak.



## Training for primary health workers scaled up during Ebola response

Dr John Mahoney, Head of Mental Health and Psychosocial Services at the WHO office in Liberia, has been coordinating the training, which was funded by USAID. “Paradoxically, the Ebola outbreak provided an opportunity to scale up mental health services in Liberia, thanks to the funds that flowed into the country,” he says.

“In a country that has just one psychiatrist, and where the needs are so great, training that enables generalists to provide first-line support to people in mental distress can be the difference, in many cases, between life and death.” Dr John Mahoney, Head of Mental Health and Psychosocial Services at the WHO office in Liberia

WHO plans to train 1300 health workers in this programme by the end of 2016.

## A focus on ensuring care in the community

In addition, The Carter Center, a United States nongovernmental organization, has established and scaled up mental health training for nurses and physicians’ assistants, in partnership with the Ministry of Health.

After graduating from the 6-month course, graduates return to their former mid-level positions in primary care clinics as mental health clinicians who can help integrate mental health services into the larger health-care system. The Center has already trained more than 160 people and plans to train a further 100 in child and adolescent mental health. Care in the community is a cornerstone of The Carter Center’s mental health work in Liberia.

WHO has also been supporting care in the community through Community Healing Dialogues. The purpose of this initiative, which was introduced in Liberia by partner organizations during the height of the Ebola outbreak, is to provide Ebola survivors with a forum to share their daily struggles during and after the Ebola outbreak and to help one another to rebuild their lives. Through this initiative, WHO trained mental health clinicians and community health directors to run the sessions, subsequently taking on a supporting role. Over 80 groups have been set up across Liberia. Many of the groups are deciding to continue with the sessions when the initial 12-week period is up.

## Nongovernmental organizations can help reduce stigma

To help address the stigma that is still often associated with mental illness, the nongovernmental sector plays an important role. So far, there is just one nationally-registered mental health consumer organization in Liberia, Cultivation for Users’ Hope, set up in July 2015 by Reverend Bill Jallah, who has bipolar disorder. Together with his friend and colleague Sidney, Reverend Jallah runs training courses in rural areas of Liberia for staff in health posts, and for community leaders and law enforcement officers. The purpose of the training is to improve understanding of mental disorders and to break down myths that are still an obstacle to treatment in many parts of the country.

The team is also starting to set up support groups to train people with mental illness in income-generating activities such as soap-making. Says Reverend Jallah: “There is still a commonly-held view that people with mental illness cannot hold down jobs. As a result, we often have to be creative and create our own.”



Reverend Bill Jallah, founder of the non-governmental organization, Cultivation for Users’ Hope, runs a training session at a community health post in Sinoe County in the south of Liberia. WHO/A. Brunier

## Severe shortage of medicines an ongoing challenge

While training programmes are expanding access to care, the lack of a sustained supply of medicines for mental health treatment is an ongoing challenge. According to John Mahoney at WHO: “Medication and the funds for it are severely lacking. There has never been a functioning supply system for psychotropic medicines. On occasion, the country receives donated medicines, but often these are close to their expiry date or have even expired.”

The lack of medicines is keenly felt by Mamuyan Cooper, the Administrator of Liberia’s only psychiatric hospital, E.S. Grant. She says: “The lack of psychotropic medicines in the facility is a huge problem. If all the people staying here received the medication they needed, the average stay would be much shorter than it is now.”

The reasons given for the lack of a sustained supply of medicines for mental disorders across the country are several: The lack of a supply system and funds, unwillingness to import medicines and hesitation among health staff to prescribe. The Ministry of Health is taking leadership in identifying appropriate strategies to address the underlying causes of this shortage of medicines for mental disorders.

## New 5-year strategy for mental health

Buoyed by recent progress, the Government of Liberia, with the support of WHO and partners, is developing a Mental Health Strategy for 2016-2021. The Strategy includes detailed plans for a strong and comprehensive system of mental health care, with robust community-based services, clinicians, nurses, social workers and community volunteers trained in mental health, and a sustained supply of psychotropic medicines. Funding, however, is needed to put these plans into action.

## 9. Investing in trained midwives across Liberia



A mother and her baby 24 hours after delivery. WHO A Midwife assisting a mother to properly position and breastfeed her baby.

Although 20 years have passed since the first time Bentoe Tehoungue assisted a woman to give birth in rural Liberia, she remembers the experience like it was yesterday. The pregnant woman was only 13 – an age when childbirth can be a death sentence for both mother and baby.

“I kept thinking this child should have been in school, not giving birth to a baby,” recalls Bentoe, a WHO midwife in Liberia.

Since the girl’s pelvis was narrow and underdeveloped an episiotomy was needed to ensure the baby could be delivered safely. As a result, a healthy 6-pound baby boy arrived with no complications. The mother and baby were lucky, they had help from a trained midwife, a luxury that many women in rural Liberia may not have. Bentoe also provided the mother with post-natal care and education about delaying future pregnancies until she was physically and mentally ready.

### Lack of skilled birth attendants

In Liberia, about 44% of women give birth at home without a skilled birth attendant, putting them at risk of dying if there are any complications.

Nearly 1 in 138 live births result in a mother dying from preventable causes such as haemorrhage, sepsis or other reasons related to limited access to either basic midwifery or emergency obstetric care; such as caesarean sections. The lack of trained midwives in most rural health facilities and the long distances women have to travel to access care are hindering the country’s progress in reducing maternal and newborn mortality.

Today, Liberia has less than 2000 trained midwives for more than 4 million people. Inequitable distribution of available midwives is compounding the situation for rural women. Additionally, there are only two specialists in obstetrics and gynaecology and two in paediatrics. This is partly a result of the 14-year civil war and the Ebola crisis, which left health facilities in disrepair.

“Saving the lives of women and babies remains close to my heart,” says Dr Francis Kateh, Deputy Minister and Chief Medical Officer Republic of Liberia. “We need midwives who can deliver on this national priority of ensuring that pregnancy is wanted, safe and has a happy and healthy outcome. I am delighted that support being given by WHO and partners will contribute towards this goal.”

To improve access to quality midwifery care, the Liberian Ministry of Health (MOH), WHO and other partners are working to strengthen the country’s 6 midwifery schools, 3 of which are located in rural areas.

### Meeting their needs

Beyond training midwives, Liberia is working to retain them. At present, many midwives in the country lack safe accommodation and transport, are overworked, paid less attractive salaries, and have limited opportunities for career advancement.

A new Bachelor of Science midwifery programme is providing further professional development to help midwives advance their careers, and can graduate 50 - 75 registered midwives each cohort, which will help staff more than 700 health facilities in the country.

In order to have a successful degree programme, Liberia is also working to build its teaching faculty. To do so, the country is working with the Danish Midwives Association to “twin” Liberian midwives with Danish midwives so that they can develop skills in advanced level midwifery care, such as methods to prevent and treat haemorrhages. With funding from the Swedish International Development Cooperation Agency (SIDA), the H6 Partnership (WHO, UNICEF, UNFPA, UN Women, UNAIDS and the World Bank) is also providing support to these training institutions.

“Strengthening midwifery is essential to the provision of high-quality maternal and newborn care for all women and newborn babies worldwide, and is critical to the implementation of the Global Strategy for Women’s, Children’s, and Adolescents’ Health,” says Dr Anthony Costello, WHO Director, Department of Maternal, Newborn, Child and Adolescent Health.

In addition, WHO with H6 is working to strengthen all aspects of providing quality care, including increasing the provision of antibiotics and family planning supplies, supporting community groups to prioritize their maternal and child health needs, and increasing access to water and sanitation in health facilities.

Dr Alex Gasasira WHO Country Representative in Liberia said: “Enhancing the capacity of the health workforce in terms of numbers, quality and equitable distribution across the country is essential to saving the lives of women giving birth and forms an integral part of a resilient health system.”

The work in Liberia is part of WHO’s global effort to provide countries with the guidelines, tools and evidence base to strengthen midwifery so that care can be improved and maternal and neonatal mortality rates can be reduced.



The World Health Organization contributes to a better future for people everywhere. Good health lays the foundation for vibrant and productive communities, stronger economies, safer nations and a better world. Our work touches people's lives around the world every day. As the lead health authority within the United Nations system, we help ensure the safety of the medicines and vaccines that treat and protect us, the air we breathe, the food we eat, and the water we drink. We support countries to prepare for and respond to disease outbreaks and emergencies. We aim to provide every child, woman and man with the best chance to lead a long, healthy and fulfilled life. We listen to countries and monitor health trends to work out what needs to be done to protect human health. We use the best scientific evidence available to establish the most effective ways to prevent, treat and cure health problems. The vision of health for all is no longer a dream, but an achievable concrete reality.

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