

UNION OF THE COMOROS
Unity - Solidarity - Development



NATIONAL HEALTH POLICY (NHP)

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PREFACE

The Union of the Comoros, as a member of the World Health Organization, has adhered to the Declaration of Alma-Ata on Primary Healthcare and the Bamako Initiative, resolutions that lay emphasis on decentralization and community participation as essential pathways to ensuring health for all, with the health district as the kingpin of development in health.

The adoption of the new constitution on 23 December 2001 grants immense autonomy to the Islands and guarantees sharing of power between the Union and its Islands in order to enable the latter to concretize their justifiable aspirations to freely administer and manage their own affairs and promote their socio-economic development within the union.

The present National Health Policy is inspired by the World Initiatives, adapting itself to the new political context and socio-economic reality of the Comoros. It is a tool par excellence with the help of which the Comorian authorities intend to direct their efforts to attaining the Millennium Development Goals concerning the health sector by ensuring good quality healthcare services to all Comorians. It also helps combat poverty and aids socio-economic development in Comoros.

The new configuration of the national health system has to account for the political and institutional changes while guaranteeing greater effectiveness and efficiency of actions taken in health development. Therefore, the operational level of the health system will essentially be led by the health districts, the Autonomous Islands will coordinate district intervention and bring them the technical support necessary for implementation of activities, and the central level will be responsible for coordinating actions among the Autonomous Islands and defining policies, standards, and procedures. The functional relationship among different levels and the missions of entities that provide health management services will also account for this configuration.

With regard to managing the central structures that enjoy autonomy in their management, like the National Autonomous Pharmacy of the Comoros (PNAC), and the Hospital Centers of El-Maarouf, Hombo, and Fomboni, the definition of responsibilities of these different entities will be given in the applicable laws governing them which will decide the division of expertise between the Island authorities and the Union.

The Government of the Union of the Comoros is committed to not spare any efforts in putting together an appropriate framework for effective implementation of this policy. For this purpose, constant consultation with the Island authorities, communities, civil society, and the private sector will be reinforced. The same will apply to partners in development, whether bilateral or multilateral, in order to ensure availability of the technical and financial support necessary for the implementation of the health programs.

This policy constitutes a legitimate reference for any action in health development in the Union of the Comoros and must therefore inspire all actors of development in the health sector.

Moroni, 07 August 2006
Vice-President of the Union of the Comoros, responsible for health

1. SITUATIONAL ANALYSIS

1.1 GENERAL CONTEXT

1.1.1 Physical, demographic, and socio-cultural characteristics

The Union of the Comoros, situated at the Northern entrance of the Mozambique Channel between East Africa and Madagascar, covers an area of 2,236 km². It comprises the four islands of Mwali (Mohéli), Ndzouani (Anjouan), Ngazidja (Grande Comore), and Maoré (Mayotte) with areas of 290 km², 424 km², 1,148 km², and 374 km² respectively. It has tropical climate with one hot and humid season or southern summer from November to April marked by the north-west monsoon winds blowing across the Indian Ocean that bring heavy rainfall sometimes with violent cyclones, and a dry and cool season or southern winter from May to October.

According to the provisional results of the 2003 general census, the Union of the Comoros has a population of 575,660 inhabitants (in the 3 Autonomous Islands), an average population density of 309.3/km² unequally distributed among the Islands of Anjouan (574.8/km²), Grande Comore (258.2/km²), and Mohéli (83.9/km²)¹. Life expectancy has increased from 55 years in 1991 to 63 years in 2002². The population growth rate between 1991 and 2003 is estimated at 2.1%³.

The crude birth rate⁴ has come down from 46 per thousand in 1991 to 35.6 per thousand in 2003. The average number⁵ of children per woman has decreased from 6.8 in 1991 to 5.3 in 2003. As for the Infant and Maternal Mortality rates⁶, they have decreased from 381 and 86.2 per 100,000 live births in 1991 to 381 and 79.3 per 100,000 live births in 2003.

The African and Arab-Muslim cultures constitute the factors of cohesion in the Comorian society. Each island has its uniqueness. Grande Comore and Mohéli predominantly have the matriarchal system, and Anjouan, the patriarchal system. Despite their diverse origins, the Comorians are extremely united among themselves. Everybody can count on their parents, friends, and fellow citizens for help, if and when required. Family forms the fundamental basis for organizing the society and its functioning. Its influence is perceptible to the highest levels of decision-making. All Comorians are Muslim. Islam coexists along with the traditional and customary beliefs and social practices. Religious precepts are a fundamental aspect of the Comorian Law. The amalgamation and mixing up of religious precepts and traditional values often lead to blockages in the necessary evolution of mentalities and behaviors. This situation is the main cause for difficulties faced by the Comorian society in integrating progress in fields as important as the Status of Women and Reproductive Health.

With respect to food habits, generally meals contain starches, tubers, and coconut oil, along with a sauce including fish, meat, vegetables, etc.... Most families consume at least two meals per day; this situation varies from one island to another. Banned food items mainly concern vulnerable groups: pregnant women or nursing mothers, and small children.

Disease is perceived as a natural phenomenon or a spell. In terms of accessing healthcare, the socio-anthropological survey on the therapeutic itineraries of patients in Anjouan⁷ indicates that self-medication is the first step towards healthcare, which is facilitated by unrestricted sale of medicines

¹ RGPH, 2003

² WHO: World Health Report, 2003 (p 156)

³ RGPH, 2003

⁴ RGPH, 2003

⁵ RGPH, 2003

⁶ RGPH, 2003

⁷ Karine Violet: Mot pour maux, Etude anthropologique d'itinéraires thérapeutique et recours aux soins à Anjouan in 2001, ALTER. (Book in French by Karine Violet, published by ALTER)

coming illicitly from across the border and distributed by unqualified vendors (89.5% of medicine vendors are not qualified)¹.

When self-medication fails, the second resort is to access a health facility.

1.1.2 Political and administrative context

The Union of the Comoros, independent since July 1975, comprising the four islands of the archipelago, and accepted as such in the International Community, exercises its sovereignty over three of the four islands, the Island of Mayotte still under the French administration.

The country is a member of the United Nations since 12 November 1975. It is also a member of the African Union (AU), Non-Aligned Movement, Organization of Islamic Cooperation, and the League of Arab States. At the regional level, the country has adhered to COMESA (Common Market for Eastern and Southern Africa) and the Indian Ocean Southern Islands' Commission (COI).

Since 1975, the country has witnessed political instability due to several Emergencies, and recently in 1997 due to separatist crisis in the Island of Anjouan.

Since 1989, the country lives in a democratic regime with due respect to individual civil freedom and freedom of the press.

Signing of the Fomboni Framework Agreement² (17 February 2001) put an end to the separatist crisis and led to the creation of the new set of Comorian Islands, called the Union of the Comoros. The new constitution adopted on 23 December 2001, grants immense autonomy to the Islands. It guarantees sharing of power between the Union and its Islands in order to enable the latter to concretize their justifiable aspirations to freely administer and manage their own affairs and promote their socio-economic development within the union.

Each island is placed under the authority of its government comprising an elected President and Ministers who ensure regular functioning of the authorities. At this level, a Ministry of Health has the responsibility of planning and operational implementation of activities related to health and development programs in the field.

At the center, the Union Ministry responsible for health ensures coordination in the sector as a whole.

¹ Pharmaceutical Sector Review Report; 2003

² Fomboni Agreement

1.1.3. Economic and social conditions

The per capita GDP in Comoros is US\$ 386 for 2001¹. According to 1995 estimates, 54.7% of the population lives below the absolute poverty line – 70.1% in Anjouan, 40.8% in Grande Comore, and 63.7% in Mohéli².

The Comorians are classified among the poorest countries of the world. This poverty would have increased from 3.5 to 4% between 1995 and 1998 at the national level³. Pregnant women and children, the most vulnerable sections of the population, do not have easy access to health services. According to a report on poverty in Comoros, the proportion of the poor among the population seen seeking consultation in 1995 is lesser than the proportion of the poor that did not seek consultation: 36.6% against 58.3%⁴.

The Interim Poverty Reduction Strategy Paper (IPRSP)⁵, prepared in 2003, seeks to contribute to a significant and sustainable reduction in poverty in the archipelago.

In the absence of any economic growth, the rate of poverty runs the risk of attaining 93% of the population in the year 2015.⁶

Socially, the traditional structures of the country (aged people, hereditary leaders, notables, and religious authorities) are well organized and ensure that appropriate values are maintained in the society, and therefore enjoy deep respect from the population.

However, exclusion of women from some social rights is cause for vulnerability and inequality. While they actively contribute to the developmental process, they have the tendency to get excluded from its resultant benefits. We believe that a better involvement of women in the process of economic and social development and a reduction in gender disparity, not only brings down the dependence of women and raises their status, but is also likely to generate benefits such as decrease in fertility, slower population growth, better survival and child-development, and increase in the proportion of family income allocated to food and health⁷.

With respect to dwellings, construction is unregulated across the national territory, as much in the cities as in the rural areas; laws related to a code of urbanization and town planning exist but are generally not respected, and the manner in which housing is fragmented aggravates the problem of waste disposal.

The net schooling rate⁸ is 69.3% in 2002 for the age bracket 5-14 years. It is 65.1% for girls of the same age group. Growth in these rates has more or less remained stable during the period 1994-2002.

Literacy rate has come down from 53.8% in 2000 to 56% in 2001⁹.

¹ UNDP: *Global Report on Human Development, 2003* (p. 280)

² UNDP: *National Report on Human Development, Comoros 2001* (p. 37)

³ UNDP *Report on Human Development, 2003*

⁴ RFIC, PNUD, BIT : *La pauvreté aux Comores : Concepts, mesure et analyse, 2000* (p.145-146) (Book in French by RFIC, UNDP, and ILO)

⁵ IPRSP, 2003

⁶ UNDP *Report on Human Development, 2003*

⁷ *La Pauvreté aux Comores : Concepts, mesure et analyse, 2000. – Moroni : PNUD/BIT, 2000.* (Book in French by UNDP/ILO)

⁸ Source: EFA 2000 (except 2002 data: UNICEF)

⁹ UNDP *Report on Human Development, 2003*

1.2 HEALTH PROFILE

1.2.1 Health system organization

In Comoros, the health system is organized into three levels. The central level comprises the Offices of the Minister, General Secretary, National Directorate of Health, Directorates and Departments responsible for coordination of the health programs and projects, and the National Autonomous Pharmacy of the Comoros (PNAC). At the intermediate level, that is the islands, the Health System constitutes the Health Administration of the islands (Ministry of Health assisted by the Director of Health and Health Service Officials) and Regional Hospital Centers (RHC). At the peripheral level, we can list 17 health districts, out of which 7 are in Grande Comore, 7 in Anjouan, and 3 in Mohéli. These 17 health districts are covered by 2 Medical and Surgical Centers (CMC) in Anjouan and Ngazidja, and 3 Urban Medical Centers (CMU) on each island¹.

To the above, one must add a network of Army health dispensaries, Catholic Mission's CARITAS dispensary, an expanding private service, 49 peripheral health centers, and several community health structures.

Owing to the existence of all these structures, geographical accessibility to a health center within a 5 km radius is estimated to be 45% in Grande Comore, 74% in Anjouan, and 69% in Mohéli, an average of 63% for the country as a whole. The rates of frequenting a health facility are 14.7%, 20.21%, and 8.92% respectively; the national average is 10.25%.

The average bed occupancy rate is between 20 % and 60% with significant variations depending on the season and the Health Center.²

Quality of health services

20 health structures were recently rehabilitated and reequipped by Health Project III with financial help from the World Bank³. We have, however, recorded frequent stock outs in the availability of essential medicines which however comes under the purview of the national procurement policy. Qualified staff is insufficient and the means of supervision and retraining are lacking.

In the absence of appropriate regulations, the disorganized development of the private sector is detrimental to the quality and accessibility of health services, and contributes to their increased and non-standardized costs⁴.

Health Information System

An integrated and coordinated system of collection, analysis, and use of health data⁵ does not exist. Such absence of reliable data is detrimental to the planning, monitoring, and evaluation process of health programs, and implementation of interventions in the health sector. To solve this problem, a Health Information System Master plan (HISM) and an Integrated Disease Surveillance Plan were adopted by the Autonomous Islands and the Union. Their effective implementation will certainly help reverse the trend.

¹ WHO Activity Report 2002-2003,

² Idem

³ Aide-Mémoire of the Health Project III Supervision Mission: January 2004

⁴ Plan Cadre pour l'assistance des Agences du SNU au Développement des Comores, 2003-2007. – Moroni: WHO, 2002. (Master plan for assisting the UNS Agencies in Development in Comoros, published by WHO)

⁵ Health Information System Master plan, 2004

1.2.2 Epidemiological profile

General trends show that the health condition of the Comorian population has improved in recent years. This situation is illustrated by the following indicators:

- life expectancy¹ has increased from 55 years in 1991 to 63 years in 2002;
- the General Mortality rate has increased from 15.7 per 1000 in 1980 to 15.1 per 1000 in 1991;
- the Infant Mortality rate has decreased from 86.2 to 79.3 per 1000 between 1991 and 2003 (RGPH 1991 and 2003);
- the Infant and Child Mortality rate has improved from 103.7 per 1000 in 1996 to 74 per 1000 in 2000 (MICS 2000).

The Maternal Mortality rate² still remains high despite its marked fall from 517 to 381 per 100,000 live births between 1991 and 2003. This high rate could be explained by the poor quality of services, lack of follow-ups in pregnancies, late references to health facilities, childbirth at home, poverty, ignorance, and illiteracy.

Generally, the epidemiological structure of the Comorians has changed little over the recent years and remains dominated by malaria, diarrheal diseases, intestinal parasitosis, lymphatic filariasis, acute respiratory infections (ARI). These diseases are the cause for high morbidity and mortality rates particularly in children of less than 5 years of age and in pregnant women.

Malaria constitutes the main reason for consulting a doctor or a pediatrician and represents 29% of the cases seeking consultation in 1999 as against 30.35% in 1992³. We notice a decline in the occurrence of the disease owing to the efforts made by the Ministry of Health to promote long-lasting insecticide-treated mosquito nets and to take responsibility of such cases, but a lot remains to be done in the field of sanitation to reduce the larvae breeding ground.

Diarrheal diseases constitute one of the frequently recurring causes for consulting a pediatrician. According to the MICS survey, the incidence rate was 18.3% in children during the two weeks preceding the survey.

Acute respiratory infections mostly affect children less than 5 years of age and was the second most frequent reason for consulting a doctor (12%) in 1999 against 14.7% in 2001.

Intestinal parasitosis is also frequent since they make up for 15% of consultations in the general population and mostly affect children less than 10 years of age, who find themselves further weakened by parasitosis when they are malnourished or are affected by multiple diseases.

Sexually transmitted infections: The HIV prevalence rate is estimated at less than 0.12% for December 2002 and the biggest challenge is to maintain the current HIV prevalence rate by strengthening the preventive measures and collaboration among authorities, NGOs, and international partners.

HIV infection affects the 2 sexes with a woman-man ratio equal to 1:1. By 2002, the cumulated number of cases reached 69 out of which 29 deaths. The spread of AIDS gets confirmed year on year. According to projections for the spread of HIV in Comoros, in the absence of trend reversal, the average annual growth rate of the number of people infected by HIV could reach 31.2% in 2018⁴.

¹ RGPH 1991

² RGPH, 2003

³ National Health Development Plan, 2010 perspective, year 1993.

⁴ Advocacy paper for the fight against HIV/AIDS: Projected epidemiological impact of HIV/AIDS in Comoros: 2000-2018, August 2003

As for the other sexually transmitted diseases, there is not much data, but a recent survey in the two reference laboratories (El Maarouf and Hombo) revealed an HIV prevalence of 7.6% of syphilis¹.

Oral diseases constitute one of the frequently recurring causes for consulting a dentist or a pediatrician. The 1999 national survey on oral health in children less than 12 years of age in Comoros showed that 48.1% children have tartar and 60.3% have one or more decayed teeth².

Tuberculosis still remains quite widespread and poses a potential risk with the advent of the AIDS epidemic. The annual risk of infestation is 60/100,000 inhabitants with a detection rate of 24.5/100,000 inhabitants. The mortality rate is of the order of 0.5/100,000; the lethality rate is 2.15/100,000 inhabitants (source: annual report on tuberculosis for the year 2000). As for the recovery rate, it is 90.6%.

Leprosy remains endemic in Comoros since the annual detection rate is still 3.26/10,000, that is, 171 cases in the year 2001. The proportion of children between 0 and 14 years of age represents 52.41% of the cases detected. Among the 171 cases detected, 90.64% are from Anjouan (source: annual report on leprosy for the year 2001).

Lymphatic filariasis is ravaging Comoros to the point of being endemic, with a morbidity rate of 10 to 15%. An elimination program is in process on the 3 islands.

Cholera appeared in 1998 and sporadically ravaged the country. The attack rate during the 1998 epidemic was 3%, with a lethality rate of 1%. The persistence of the disease reflects the precariousness of hygiene and sanitation conditions in the population.

Protein-energy malnutrition is one of the national health concerns. Protein deficiency is observed in pregnant women and nursing mothers as well as in children less than five years of age. This condition is more frequent in its chronic form (33% of children less than two years of age) rather than its acute form (4.6%)³.

The average prevalence rate for goiter is 14.1%⁴: Island of Mohéli (16.9%) and Island of Anjouan (15.5%) are the most affected as compared to Grande-Comore (9.9%). Institutionalization of iodized salt imports in 1997 is one of the beneficial measures taken to reverse the trend.

The most common eye diseases in the general population are refractive errors (5%), cataract (1%) and avitaminosis A.⁵

Out of the 6470 physical and sensory disabled counted in the country, 961 are blind 15%.

Non-communicable diseases especially cancers, diabetes mellitus, cardiovascular diseases, and hypertension: data related to these diseases is almost non-existent. Undertaking investigations to assess their prevalence in the community in order to develop appropriate counter-programs is turning out to be the need of the hour.

Mental disorders: the situation related to these disorders is not clearly known and there are no qualified personnel or structures to take charge of the situation.

Trauma disorders due to road accidents are significantly on the rise and often necessitate medical evacuations.

¹ Report of the survey conducted at the laboratories of the Regional Hospital Centers of El-Maarouf and Hombo.

² National survey on oral health, 1997

³ MICS, 2000

⁴ Assessment of the situation of goiter and avitaminosis, 1995

⁵ National Program for Control of Blindness, 2005-2012.

1.2.3 Human Resources

On implementation of the resolution of the General Assembly in 2001, the Government of Comoros went on to develop a National Human Resource Development Plan 2001-2010.

A significant increase in human resources is observed as shown in Table 1 below¹. The population - health personnel ratios given in the last column are encouraging with regard to the availability of the human resources. However, the latter are unequally distributed across the three islands, and are overall badly managed and not motivated enough.

Since 2003, the National Training and Research Center in Public Health (C.N.F.R.S.P) that has trained a significant number of health workers pertaining to different categories, is set up in the School of Medicine and Public Health (EMSP) within the University of Comoros.

A large number of health personnel are trained abroad and a considerable number of them do not return to the country. Thus, it appears that training in public health continues to suffer from a lack of qualified personnel.

¹ UN Resident Coordinator System: Collective analysis of the developmental situation in the Union of the Comoros, February 2002 for 1992 and 2001 data, and the State Department, Ministry of Social Affairs and Administrative Reforms: General report on the development of surveillance, preparation, and response systems for epidemics in Comoros, July 2003 for 2002 data

Table 3.4: Progress in the number of health workers:

Categories	1992	2001	2002	2004	Number of health workers per 10,000 inhabitants in 2004
Doctors (including specialists)	26	68	109	115	1.99
Pharmacists	0	13	15	15	0.3
State-Qualified Nurses	112	146	202	157	2.7
State Midwives	61	92	77	107	1.8

Problems in Comoros related to human resources were reported in the Human Resource Development Plan. They are as follows:

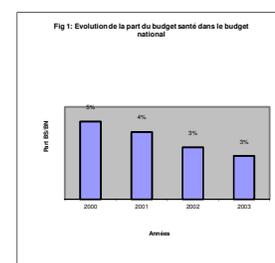
- An excessive imbalance in the distribution of qualified personnel at all levels and particularly at the peripheral level. This brings to light the shortage in personnel in some islands and health care facilities.
- Overall poor staff management, as much with respect to its proper utilization as its training.
- Poor life and work conditions of the personnel being marked by the absence of a genuine career and promotion plan, causing de-motivation and estrangement among the personnel.
- Disrespect on the part of the health workers, of the standards and procedures dictated in the Health Code and Code of Ethics.
- Non-functioning of the National Order for doctors, pharmacists, and medical biologists.

1.2.4 Financial Resources

The national health budget has suffered a regular decline during the last 4 years as shown in Table 3.5. It has thus decreased from 594 million Comorian Francs in 2000 to 408 million in 2003. Its proportion in the national budget has seen the same trend, decreasing from 5% in 2000 to 3% in 2003 (see Figure 1 on the side)¹. 70% to 90% of this budget is spent on payment of salaries.

Table 3.5: Progress in the health Budget in million Comorian Francs²

Year	2000	2001	2002	2003
Salaries	511	503	487	378
Goods and services	38	40	12	25
Transfers	45	55	58	5
total	594	598	557	408



Apart from the national budget, there is significant contribution from the community supported by the Comorian Diaspora towards construction of basic health centers, but the amount of this contribution is not quantified.

¹ Annual Report of the Central Bank - Moroni: WHO, 2000, 2001, 2002

² Annual Reports of the Treasury for the Islands of Mohéli and Ngazidja

The community also contributes to health system financing through cost-recovery at the healthcare facilities. This contribution was assessed in 2001 to be close to 536 million Comorians Francs, approximately 1.2 million Euros¹.

Development in initiatives like promotion of cooperative activities is still in its rudimentary stage. Vulnerable individuals being the main affiliates to cooperatives, special attention needs to be paid to these initiatives in order to help them benefit from the traditional Comorian solidarity and ensure their viability².

With regard to taking responsibility of the impoverished, no official mechanism is in place given that even the criteria for determining the impoverished is not yet defined. It is the need of the hour to determine these criteria as well as the mechanisms for taking charge of all strata of the population with due respect to the principles of equality and the fundamental right to health of all human beings³.

1.2.5 SWOT Analysis (Strengths, Weaknesses, Opportunities, and Threats)

Strengths:

- effective establishment of political institutions in the Union of the Comoros;
- geographical accessibility of primary and secondary health services;
- involvement of the community in health activities;
- adoption of the Health Information System Master plan;
- strengthening of the health workers during capacity-building within the purview of the implementation of PNDRH;
- existence of the National Order for doctors, pharmacists, and medical biologists;
- existence of the PNAC, purchase center for essential medicines.

Weaknesses:

- absence of official documents that define the functional relationship between the central administration and the administration in the Autonomous Islands;
- weak financial contribution of the State to the functioning of the Health system;
- inadequate technical platform at all levels;
- lack of some categories of staff, along with its poor division, excess mobility, and weak motivation;
- weak health information system;
- poor use of health services;
- absence of a system responsible for the impoverished;
- frequent conflicts between the community management bodies and the health workers;
- poor distribution and non-implementation of the regulatory texts in force;
- frequent stock outs in the availability of essential medicines;
- high cost of medicines;
- non-functioning of the National Order for Physicians, pharmacists, and medical biologists;
- non-operational district pharmacies;
- poor level of development of health cooperatives.

¹ Saïd Omar Ben Achirafi et Dr Younoussa Assoumani ; Financement du système de santé (Etats généraux de la Santé), p.3. (Book on Health System Financing by Saïd Omar Ben Achirafi and Dr Younoussa Assoumani)

² Plan Cadre pour l'assistance des Agences du SNU au Développement des Comores, 2003-2007. – Moroni: WHO, 2002. (Master plan for assisting the UNS Agencies on Development of Comoros, published by WHO)

³ Plan Cadre pour l'assistance des Agences du SNU au Développement des Comores, 2003-2007. – Moroni: WHO, 2002. (Master plan for assisting the UNS Agencies on Development of Comoros, published by WHO)

Opportunities:

- effective establishment of all institutions in the State;
- active interest and will to collaborate on the part of the partners in developmental process;
- dynamics of association and community solidarity;
- involvement of the Diaspora in funding the health system.

Threats:

- increased brain drain;
- demotivated staff due to irregular payment of salaries and poor work conditions;
- weak national reconciliation.

1.3 HEALTH REQUIREMENTS AND PRIORITIES

The problems brought out in the situational analysis are diverse and can be classified into three groups:

Problems related to health conditions of the population:

- high level of Maternal mortality and Infant and Child mortality,
- morbidity and mortality related to some communicable diseases like malaria, filariasis, diarrheal diseases, acute respiratory infections, etc.
- slow but definite spread of HIV/AIDS endemic
- morbidity and mortality related to some non-communicable diseases (mental disorders, degenerative disorders, malnutrition, oral diseases, blindness, etc.)

Problems related to access to health services:

- growing impoverishment of the population
- poor awareness of the population about health problems
- poor access of the population to drinking water and clean environment
- high cost of health services
- inadequate reception in the health structures

Problems related to the efficiency of health services:

- lack of coordination and steering of developmental activities of health services
- poor management and motivation of health workers
- inadequate performance of the pharmaceutical sector
- inadequate technical platform
- poor quality of healthcare services

2. VISION FOR THE YEAR 2015

Better health for all Comorians through availability and accessibility of good quality health services by 2015 is the ultimate aim of the current policy. The period in question is judged to be long enough to bring about the desired changes and significant results. It also conforms to the Health for all policy in the African Region for the 21st century. Concretization of this vision constitutes a challenge for the national health authorities in the Union and the Autonomous Islands as well as for the national community and the individuals.

Materialization of this vision presupposes a certain number of conditions: equal distribution and efficient management of resources, stable and favorable socio-political context, appropriate mobilization of resources, accessible health services, increased community participation, and strengthened capacities in all fields.

The health system will then be well-adapted to the new Comorian entirety and should be in a position to anticipate health requirements and adequately fulfill them. The individual and the community will be aware of the risks to which they are exposed and their right to health. They will be aware of the role to be played in the management and funding of health services.

This vision also requires health development strategies that should be formulated on the basis of values and principles of solidarity, equality, ethics, quality, relevance, and transparency.

Therefore, it allows individuals to live longer in a better, healthier environment. The vulnerable section of the population will no more die of avoidable diseases. Mothers and children will have more likelihood of successfully going through the critical period of their lives.

The State is committed to improving the performance of the health system by ensuring effective integration of health services to contribute to the decrease in the incidence of diseases deemed priority diseases. Interventions will be based on prevention, and strengthening of capacities for clinical management, while emphasizing accessibility of healthcare to the poorest people in accordance with the guidelines of the Poverty Reduction Strategy Paper (PRSP). They will also be based on the principles of decentralization, community participation and coordination, in accordance with the constitution of the country.

3. PRINCIPLES AND VALUES OF THE NATIONAL HEALTH POLICY

Health is the responsibility of the State at the highest level. This commitment is reflected by the following measures:

Values:

- Uphold health ethics and human rights
- Ensure equality in access and utilization of healthcare services and take special measures in favor of those who suffer the most from inequality, especially women and children.

Principles:

- The strategy for primary healthcare remains the cornerstone of the health policy;
- Health constitutes a fundamental right for all Comorians without distinction of any kind. The health services will consequently be effective, efficient, and accessible to the entire

- population;
- National solidarity guides all developmental actions of the country. Thus, human, material, and financial resources will be equally shared between the different autonomous entities;
 - Poverty is as much a health problem, comparable to a disease. It is therefore, one of the healthcare priorities of the Government;
 - Health occupies its rightful place in the developmental process as a whole, in the form of both a determinant and a consequence of the latter. The health system benefits from adequate, equitable, and sustainable funding;
 - All actors in the socio-economic developmental process must be involved in the implementation of policies and health programs. The intersectoral coordination, decentralization, and sustainability are essential to guide the choices to be made and actions to be taken.

Based on the freewill of the citizens as is the Comorian Government official, free movement of goods and people, respect of human rights, and democracy are the levers that can be successfully used in Comoros and cannot in any way impede the autonomous development of the Islands. A Comorian remains a Comorian and can be recruited as per requirement by any Island that offers better work conditions.

4. OBJECTIVES AND GENERAL TARGETS

These objectives are inspired by the Poverty Reduction Strategy Paper¹ and take the Millennium Development Goals² into account.

By 2015:

1. Bring down the Maternal mortality rate from 517 per a hundred thousand live births to 250 per hundred thousand
2. Bring down the Infant and Child mortality from 74‰ to 40‰
3. Bring down the Infant mortality rate from 59‰ to 35‰
4. Bring down the Morbidity and Mortality rate related to communicable diseases by 50%
5. Bring down the Morbidity and Mortality rate related to non-communicable diseases by 50%
6. Bring down the chronic malnutrition rate from 25.4% to 10% in children from 0 to 5 years of age
7. Reduce the incidence of classical STIs by 50% and slow down the progress of HIV/AIDS
8. Bring down the annual risk of tuberculosis infection from 60 per 100,000 to 30 per 100,000
9. Bring down the incidence rate of diarrheal diseases from 18.3% to 9%
10. Eliminate maternal and neonatal leprosy, filariasis, and tetanus
11. Eradicate poliomyelitis

5. STRATEGIC GUIDELINES

The four main strategic focal points to help materialize the vision and realize the healthcare development goals are as follows:

- Development in healthcare services including infrastructure and planning capacities, funding, and monitoring (strengthening the technical platform, decentralization, cost-recovery, training

¹ Union of the Comoros: Growth and Poverty Reduction Strategy Paper, provisional document, June 2003

² Union of the Comoros, UNDP: National Report on the Millennium Development Goals (MDG), November 2003

and retraining of staff, activity planning/program/monitoring-evaluation, health information system, and research, etc.)

- Development of strategies and actions specific to different health programs in order to bring down morbidity and mortality related to communicable and non-communicable diseases ;
- Promotion and protection of health (IEC, Health and environment, communication in health, healthy behavior, etc.)
- Development of the pharmaceutical sector

Operationalization of these strategic focal points will be underpinned by the following measures:

Government’s political involvement:

The State will dedicate more internal resources to health developmental activities in order to pave the way towards fulfilling the commitment to Abuja which requires that the proportion of health budget in the national budget reaches 15%.

Motivated participation:

This participative approach rests on the theory that those who are directly affected by the decision must participate in its formulation, in order to lend their support and hence implement the decision. This involves negotiating with the communities such that everyone is interested in uniting for a common cause. Individuals, family, and the community at large must be aware of the interest behind participating in management and funding of health services. The end users must be regarded as real partners.

Health system reform:

Health system reform initiated in 1994 which helped materialize certain goals will continue. It will be based on decentralization and redeployment of staff to the periphery in order to reduce inequalities in the field health, and increase participation of the community, NGOs, and the private sector in the implementation and functioning of the health system. To bring about greater equality, it is essential to implement better management in the health sector: a more efficient administration, rigorous exercising of responsibilities towards the population, and more efficient and better quality services.

Creation and management of a favorable health environment:

This involves promoting health in the households and in the community by adopting the following measures, in the context of multi-sectoral development:

- provide a positive political and legal environment;
- guarantee access to drinking water and sanitation;
- promote clean and safe environment;
- encourage accountability of the communities;
- promote appropriate food regimes and life styles favorable to health;
- promote work conditions favorable to health.

Most determinants of health are not directly related to the field of health. The Authorities continue to channelize contributions to sectors related to health. Poverty remains one of the main factors for bad health and premature deaths. It is essential to significantly strengthen advocacy in the health sector to fight poverty.

Make the population responsible and provide support to the individual, family, and the community:

This mainly involves valuing and strengthening of positive cultural values to build solidarity in the community at large and in the family in particular. The family and the immediate milieu of the diseased will be in a position to provide emotional, psychological, and practical support, particularly to children, youngsters, handicapped, and the aged.

Contractual approach among the interveners in the sector:

Involving all the actors (populations, NGOs, private sector, etc.) whether national or external, will help cover health requirements in their entirety. Coordinating all organized healthcare actions under this umbrella will contribute to better synergy and will aim for better performance in the health system. However, this contractual approach as an implementation tool for the national health policy will not include eventual non-involvement of the State and the privatization of health services. This will eventually hinder utilization of services by the population.

Diversifying methods of funding the health sector:

The meager financial resources of the State have made the health system of the country almost entirely dependent on external aid, and consequently on factors over which the country has no control. It is visibly essential that the State immediately provides fresh direction with the aim of implementing new local health funding mechanisms. These mechanisms could include:

- Strengthening the system of health cooperatives, a pilot project of which is currently in progress in Grande Comore and in Mohéli, funded by UNDP and CIDR, has proved convincing.
- Creating a medical insurance system that would cater to the State-owned companies, large private companies, and civil servants to begin with; for the State-owned, the system needs to be improved since some companies (SNPT, Hydrocarbons, Airport, etc.) partially take care of the their employees health;
- Gradually establishing medical insurance in the community which will rely on credit unions (MECK) in urban centers and on savings banks in villages (SANDUK);

6. NATIONAL HEALTH POLICY IMPLEMENTATION FRAMEWORK

The new configuration of the national health system takes political and institutional changes into account. Thus, the new operations of the health system will essentially be run by the Autonomous Islands. The central level is responsible for coordinating actions and defining policies, standards, and procedures. Missions at the different levels will take this reality into account and the vital role that health districts will play.

At the central level:

This level constitutes the general framework for directing and laying down policies related to development at large and health in particular, ensuring effective involvement of the islands. Therefore, it has the following objectives:

- To conceptualize, lay down, coordinate, and monitor implementation of the Government policy related to health and oversee its conformity to the World Health Policy;
- To lay down standards and norms and ensure their implementation
- Ensure resource mobilization through partners in development and coordinate their interventions;

- Negotiate and conclude multilateral and bilateral cooperation agreements
- Ensure health planning that befits the global process of national socio-economic development;
- Centralize health information;
- Ensure national level supervision of the establishments and structures.
- Ensure compliance with the legislative and regulatory documents that govern the functioning of the health system, and the appropriateness of the activities.
- Support the Autonomous Islands in the implementation of the national health policy.

In each Autonomous Island:

This level will include the place of implementation of the national health policy. It is therefore, at this level that the implementation of the national health policy will be planned. In fact, it is for each island to:

- Implement the policy agreed upon by the Union at its local division,
- Plan, coordinate, and monitor the implementation of different health interventions and regulations in the island,
- Lay down guidelines specific to the island with reference to the National Health Policy and the local concerns required to be taken into account for ensuring the health of the population,
- Centralize and utilize health information in the islands and send them to the central level.
- Ensure supervision of the establishments and structures concerning the Autonomous Island.
- Ensure compliance with the legislative and regulatory documents that govern the functioning of the health system, and the appropriateness of the activities.
- Negotiate and conclude partnership and sister concern agreements within the purview of decentralized cooperation.

At the peripheral or the health district level:

The health district constitutes the operational level of the health system. It includes district health centers and health posts offering health services to the population. It will thus be organized by the health authorities of the island in such a way that they are made responsible for the health of the population on the island, and will consequently have the following principal mission:

- Plan, coordinate, and implement activities in the districts;
- Organize and manage health activities in the district;
- Ensure availability of health services;
- Collect and utilize statistical data on health and send them to the higher level.

Relationship between the central structures and those of the Autonomous Islands

The central government governs the outlining of the major strategic guidelines and coordinates the developmental actions in the country in the field of health, in collaboration with the Autonomous Islands. In accordance with the National Health Policy, the Governments of the Autonomous Islands lay down and implement their health developmental plans. A functional work relationship framework will be agreed upon in a concrete manner and implemented among the different levels.

Central structures

For the purpose of ensuring integration, efficiency, and solidarity, some structures cannot be duplicated in every island. Therefore, structures like the National Autonomous Pharmacy of the Comoros (PNAC) and the School of Medicine and Public Health (EMSP) are governed by the central authority. Consequently, it would be appropriate to redefine their functioning mechanisms to ensure total and responsible commitment of the Autonomous Islands. Other central structures could be identified or created in joint agreement with the island authorities and the Union. Thus,

- (1) The PNAC will continue to play the role of producer, importer, and distributor of pharmaceutical products and other medical consumables for the entire Comorian nation. It will retain its branches in the Autonomous Islands, where they will be endowed with greater autonomy in their management and their role of a distributor. An appropriate representative of the Islands in the management structures of PNAC will be there.
- (2) EMSP will provide the initial and on-going training of quality personnel for all the Autonomous Islands of the Union of the Comoros. The latter will be equally represented on its management authorities; practical trainings and retraining of personnel will be organized on the Islands; the modalities of just and fair access to training will be defined and put in place.

As for the Regional Hospital Centers, they will be strengthened to provide all secondary and tertiary services in a complementary manner. They will be jointly managed by the Island and the Central authorities in compliance with the applicable Law governing the bodies. Accordingly, development of excellence centers on the Autonomous Islands has been foreseen in order to preserve complementarity among them.

Health map:

The health map must be reviewed for each Island while keeping the established norms in mind, in order to strengthen the reference level in the district. Accordingly, the technical platform of some health districts will be strengthened to ensure top level surgical interventions. These districts will be selected in a manner to ensure easy accessibility of and efficiency in surgical and obstetric care services. Each Island will decide on the choice of districts in question while ensuring high support of the people for this choice.

The districts will preserve their autonomous management status with higher commitment on the part of the political and administrative officials, as well as the communities that they serve. The administrative councils will be rearranged and strengthened to cater to this concern. Complementing the receipts from cost-recovery, they will benefit from greater financial support from the State (Central level and Autonomous Islands).

At the most peripheral level, the health map should cater to the concern regarding the geographical accessibility of the population to primary health services and viable funding. The health posts that will be set up will be fully managed by the community that they serve. Accordingly, the population will organize itself into community associations to ensure this kind of management.

Promoting the private sector:

A more appropriate organization of the private sector will be taken up. It will not only involve regulation but also implementation of an incentive policy contributing to an assured and balanced establishment of private structures in the national territory and their involvement in the implementation of the National Health Policy.

7. MODALITIES FOR IMPLEMENTATION, COORDINATION, MONITORING, AND EVALUATION

In order to cater to the different concerns stated, the national health policy of the Union of the Comoros foresees facilities adapted to different target audiences with appropriate level of services as per the health pyramid. The administrative structures in the Union and the Islands are responsible for planning, monitoring, and evaluation of programs. They also have the task of coordinating

interventions and facilitating intrasectoral and intersectoral collaboration. With regard to the operational level, the modalities of implementation of the national policy are arranged in different health development plans and programs of the health districts.

Intrasectoral and intersectoral coordination mechanisms must be laid down and instituted at all levels of the health pyramid in order to avoid overlapping in activities of different partners.

Monitoring and evaluation mechanisms must also be laid down and put in place at all levels of the health system in order to help the health officers make decisions on the basis of the performance observed. Special emphasis will be laid on strengthening capacities of the Islands and health districts.

8. CONCLUSION

The National Health Policy gives the main guidelines for all developmental actions to be taken to improve the health of the Comorian population. Creation and utilization of appropriate tools will facilitate its implementation at all levels.

It enjoys full and unequivocal support of the various actors of development in the health sector, especially the health authorities of the Islands and the Central Government, partners in national and international development, and the beneficiary community.

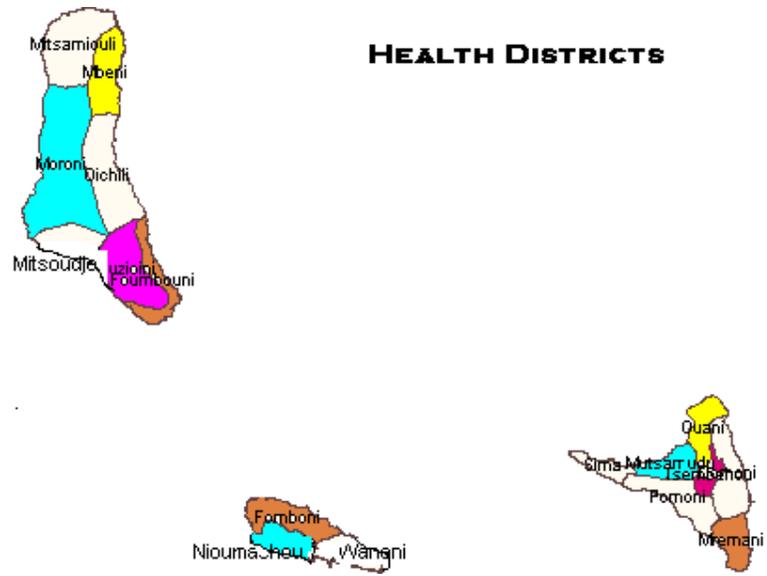
It is based on the principles and values that comply with human rights and the commitment of the country towards the international community and the Comorian population.

Its objectives and the political guidelines to achieve these objectives are realistic enough to be materialized within the given timeframe. The commitment of the national authorities at all levels is a definite assurance of its success.

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ATTACHMENT 1. CURRENT HEALTH MAP



ATTACHMENT 2. INDICATORS FOR MONITORING AND EVALUATION OF IMPLEMENTATION OF NHP

Name	Base level	Year	Source
1. Demographic indicators			
Infant Mortality Rate (No. of children that died between 0 and 1 year for 1,000 live births)	79.3	2003	RGPH, 2003
Mortality Rate for children less than five years of age (for 1,000 live births)	74	2000	MICS, 2000
Maternal Mortality Rate (for 100,000 live births)	381	2000	RGPH, 2003
Number of illegal abortions			
2. Indicators of morbidity and mortality			
Malaria prevalence rate (%)	34.6	2004	National report on MDGs
Number of malaria cases that sought consultation at the healthcare facilities	12,026	2004	Report , 1 st Quarter, 2004 by SIS
Mortality Rate attributable to malaria (%)	24	2000	MICS, 2000
Proportion of population sleeping under mosquito nets	Not available		
Prevalence of HIV infection	0.025	2002	AIDS National survey Provisional results 2003
Percentage of PLWHA having access to ARV	0		
Condom usage rate			
Number of children orphaned by AIDS			
Number of deaths due to AIDS			
AIDS infected Men-Women ratio			
Tuberculosis prevalence rate (for 100,000 inhabitants)	15	2004	National report on MDGs, 2005
Proportion of tuberculosis patients under DOTS	94.5%	2004	National report on MDGs, 2005
Number of ARI cases in healthcare facilities for children <5 years of age	2031	2004	Report , 1 st Quarter, 2004 by SIS
Number of deaths due to ARI cases for children <5 years of age at the healthcare facilities			
Number of cases of complications of pregnancy registered at the healthcare facilities	908	2004	Report , 1 st Quarter, 2004 by SIS
Number of deaths due to complications of pregnancy registered at the healthcare facilities			
Number of cases of cardiovascular diseases registered at the healthcare facilities	806	2004	Report , 1 st Quarter, 2004 by SIS
Number of deaths due to cardiovascular diseases registered at the healthcare facilities			
Number of cases of acute diarrheal diseases in children <5 years of age	707	2004	Report , 1 st Quarter, 2004 by SIS
Number of deaths in children <5 years of age due to acute diarrhea			
Percentage of live births with weight less than 2,500 grams	27.23	2000	MICS, 2000
Percentage of underweight children <5 years of age	25.4	2000	MICS, 2000

Proportion of the population that is not able to attain the minimum level of dietary energy requirement (FAO indicator)	11.5	2000	MICS, 2000
Number of cases of malnutrition registered at the healthcare facilities	163	2004	Report , 1 st Quarter, 2004 by SIS
Number of deaths due to malnutrition registered at the healthcare facilities			
Number of cases of diabetes registered at the healthcare facilities	162	2004	Report , 1 st Quarter, 2004 by SIS
Number of deaths due to diabetes registered at the healthcare facilities			
Number of cases of hepatitis B registered at the healthcare facilities	93	2004	Report , 1 st Quarter, 2004 by SIS
Number of deaths due to hepatitis B registered at the healthcare facilities			
Number of cases of leprosy registered at the healthcare facilities	90	2004	Report , 1 st Quarter, 2004 by SIS
Number of deaths due to leprosy registered at the healthcare facilities			
3. Health services' indicators			
The rate of frequenting a healthcare facility (number of times contact was made per year per inhabitant)	0.10		
Percentage of births assisted by a qualified staff	62	2000	MICS, 2000
Percentage of women of child-bearing age having recourse to FP services	19.4	2000	MICS, 2000
Percentage of women vaccinated against tetanus during pregnancy			
Percentage of children of 12 months of age having received all their vaccines			
Coverage rate of DTP3	76%	2004	EPI Report
Coverage rate of vaccines against poliomyelitis	73%	2004	EPI Report
Coverage rate of MV	73%	2004	EPI Report
Coverage rate of BCG	79%	2004	EPI Report
Coverage rate of vaccines against yellow fever		2004	
Coverage rate of vaccines against hepatitis B	60.54	2004	EPI Report
Rate of availability of essential medicines	54.6	2003	Pharmaceutical Sector Review Report, 2003
4. Health and environment indicators			
Proportion of the urban population having access to drinking water	28.3	2001	CCA/UNDAF, 2002
Proportion of the rural population having access to drinking water	8.6	2001	CCA/UNDAF, 2002
Proportion of the urban population having access to appropriate sewage system	84.6	2000	MICS, 2000
Proportion of the rural population having access to appropriate sewage system			
5. Health resources' indicators			
Number of doctors per 10,000 inhabitants	1.8	2002	Health system profile, 2004
Number of midwives per 10,000 inhabitants	1.3	2002	Health system profile
Number of pharmacists per 10,000 inhabitants	0.3	2002	Health system profile
Number of dentists per 10,000 inhabitants			
Number of nurses per 10,000 inhabitants	3.4	2002	Health system profile
Number of hospital beds per 10,000 inhabitants	837	2001	Statistical Yearbook, 2001

Total expenditure on health in percentage of GDP	2.2	2002	PIP/Central Bank Report
Share of Government health expenditure in the total health expenditure	78.3	2002	PIP/Central Bank Report
Share of Government health expenditure in the total expenditure of the public sector	8	2002	PIP/Central Bank Report
Percentage of public expenditure dedicated to tertiary institutions			
Percentage of public expenditure dedicated to primary and secondary institutions			
Share of direct payments in the total health expenditure	21.7	2002	PIP/Central Bank Report
Percentage of recurring public expenditure on purchase of medicines			
Proportion of the rural population having access to essential medicines			
Share of international contributions in the total health expenditure of the public sector			
Total per capita health expenditure (US\$)	8	2002	PIP/Central Bank Report
Total per capita health expenditure of the public sector (US\$)	6	2002	PIP/Central Bank Report