

**DRAFT**



# Primary Health Care Programme in the WHO African Region **from Alma-Ata to Ouagadougou and beyond**



**The Africa health transformation programme:**

***A Vision for Universal Health Coverage***

***Contribution of WHO/AFRO to WHO Global report***



**October 2018**



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## Foreword

## Acknowledgements

## **Abbreviations and Acronyms**

AFRO	WHO Regional Office for Africa
AIDS	acquired immunodeficiency syndrome
ANC	antenatal care
ART	antiretroviral therapy
AU	African Union
AUC	African Union Commission
CBHC	Community Based Health Care
CBOs	Community Based Organizations
CHW	Community health worker
DHMT	District Health Management Team
EU	European Union
EVIPNet	Evidence-Informed Policy Network
FAO	Food and Agriculture Organization of the United Nations
FENSA	Framework for Engagement with Non-State Actors
FP	Family Planning
Gavi	The Vaccine Alliance
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GPW 13	Thirteenth General Programme of Work
HHA	Harmonization for Health in Africa
HIV	human immunodeficiency virus
HRH	Human Resources for Health
IDSR	Integrated Disease Surveillance and Response
IMCI	Integrated Management of Childhood Illness
ICRC	International Committee of the Red Cross
JICA	Japan International Cooperation Agency
MDGs	Millennium Development Goals
NEPAD	New Partnership for Africa's Development
NGO	Non-Governmental Organization
NHSP	National Health Strategic Plan
OAU	Organization of African Unity
PHC	Primary Health Care
RC	Regional Committee
RDC	Rural Development Committee
SADC	South African Development Community
TB	Tuberculosis
TBA	Traditional birth attendant
UHC	universal health coverage
UN	United Nations

UNAIDS	Joint United Nations Programme on HIV/AIDS
UNESCO	United Nation Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VDC	Village Development Committee
VHC	Village Health Committee
VHW	Village Health Worker
WB	World Bank
WHA	World Health Assembly
WHO	World Health Organization

## Executive summary

The vision of future PHC development in the African Region was established on reflections on the Alma-Ata recommendations and African countries' efforts to respond to it through revitalizing their strategies which were based on lessons learned from past developments. It is not surprising that almost all countries in the WHO African Region regarded health as a foundation for national development, a conception that was reinforced by the PHC strategy adopted through the Alma-Ata Declaration. The African Region's commitment as expressed in numerous strategic documents and resolutions of its Regional Committee remains a valuable asset and opportunity for countries. These include resolution AFR/56/R6 that called upon countries to incorporate in their national and district health plans priority interventions for revitalization of health services based on PHC; the commitment of the African Region to achieving Health For All in the 21<sup>st</sup> century through its strategic directions; the International Conference on Primary Health Care and Health Systems, held in Ouagadougou (2008); the Abuja Declaration to increase to 15% the proportion of the national budget allocated to health (2001); and the Addis Ababa Declaration on Community Health in the African Region (2006).

### ■ *Progress and best practices*

Progress has been made in terms of universal adoption of the decentralization concept by countries, relocating decision-making power to district and community levels with enhanced community participation through community-based committees and availability of various types of community-owned resource persons, such as community health workers, traditional birth attendants (TBAs) or traditional practitioners, community drug distributors and others. Most countries in the African Region have made significant efforts to work with health-related sectors in order to amplify socio-economic gains. Primary health care has assumed a central position in the multisectoral approach and is driving it through the health management committees established at operational level.

The work of WHO/AFRO, UNICEF and other partners in 2008 led to an international conference on primary health care and health systems in Ouagadougou, which ended with a powerful declaration. This became a spring board through the adoption of the Ouagadougou Declaration on Primary Health Care and Health Systems in Africa. For the successful implementation of PHC, the Declaration called for the strengthening of leadership and governance for health, strengthening of health services delivery, increasing and improving human resources for health, increasing health financing, strengthening health information systems, availing and utilizing appropriate health technologies, enhancing community ownership and participation, strengthening partnership for health development, and investing in and using health research.

Over time, countries have initiated and exhibited good health practices that will inform the future of primary health care. Through the Kangaroo mother care (KMC) method, which refers to carrying preterm infants skin-to-skin, usually by the mother, Malawi was able to reduce mortality among preterm babies (<2000 g) in hospitals by 51% when KMC is started in the first week of life compared to incubator care. Strides were made in reducing maternal and neonatal deaths in Eritrea by the introduction of maternity waiting homes targeting nomadic women and those living in remote areas. On the other hand, South Africa has put more people on life-saving ART than anywhere else in the world, estimated at 2.4 million people receiving ART with up to 86% of people living with HIV being aware of their status.

The Health Extension Programme (HEP) in Ethiopia has improved equity in access to services because it reaches all of the 15 000 rural Kebeles, while its linkage with a health centre brings all essential health

services including basic curative care as close as possible to the community. Rwanda, through its National Health Insurance system, with high enrolment of over 80%, has protected the income of members against financial risks associated with illness and increased access to services. In the face of shortage of psychiatric nurses, 110 nursing cadres from the regional hospitals in Mauritius were trained on the adapted mhGAP, which has helped in the management of psychiatric patients both at the regional hospitals and the community health centres where nursing staff work on a rotational basis.

There is evidence of increasing use of information and evidence in countries. For example, in Lilongwe, Malawi, “Science cafés” have been established to assist clients to search and analyse health information using the database and software and make informed decisions; evidence-based policy briefs and dialogue in Nigeria on cost-benefit analysis influenced the Government’s Free Maternal and Child Health-Care Programme, resulting in decreased maternal and child mortality; and in South Africa the “*Ideal Clinic Initiative*” or the Ideal Clinic Realization and Maintenance (ICRM) programme was launched in 2013, and using evidence on performance against standards, has improved the quality of care.

Following the International Conference on Primary Health Care and Health Systems in 2008 in Ouagadougou, Burkina Faso, countries implemented the Ouagadougou Declaration using different forward-looking strategies which included:

- (i) building the capacity of training institutions; recruiting new staff; identifying new approaches for staff motivation and retention;
- (ii) incorporating community health workers into human resources for health;
- (iii) exploring ways of establishing health insurance schemes;
- (iv) providing free health services for specific vulnerable groups;
- (v) updating national health policies, strategic plans, public health acts and laws;
- (vi) using innovative approaches for health technologies such as eHealth and telemedicine;
- (vii) establishing national health observatories while the African Health Observatory continues to act as the repository for country-level data on health status and trends, health systems, priority programmes and services, health determinants and progress towards UHC. These data have been used in policy dialogue and decision-making.

Another historic milestone was the regional conference on “Health district systems 25 years after the Harare declaration” that was organized in Dakar, Senegal from 21 to 23 October 2013 by the “Health Service Delivery” Community of Practice which brought together hundreds of experts as part of the Harmonization for Health in Africa (HHA) initiative. The conference called for a culture of upward and downward accountability by governments, strengthening and reshaping of institutional arrangements, stronger intersectoral action, a greater role for communities and households, and the need for individual and community education, empowerment, voice and freedom.

The progress made by countries could not have been possible without the support of donors and partners. Countries benefited from the implementation of the health-related initiatives of UNICEF’s Strategy for Health 2016-2030 and Regional compacts for child survival, growth and development (realizing the rights of children). Further support was received from UNDP, UNHCR, UNAIDS, UNFPA, UNESCO, FAO, the World Bank, the International Committee of the Red Cross, Gavi and bilateral partners (USAID, ODA, JICA, DANIDA, GIZ, DFID, etc.). HHA in 2012 organized a high-level joint meeting of Ministers of Health and Finance in Tunisia on ensuring sustainable financing and value for money for universal health coverage. A joint declaration (Tunis Declaration) was endorsed by all the African States. The Global Fund to fight AIDS, Tuberculosis and Malaria has so far disbursed at least US\$ 20.7 billion to

the African Region, while Gavi, on the other hand, has disbursed at least US\$ 12.7 billion to the countries in the Region and supported the introduction of new vaccines including Hepatitis B vaccine, rotavirus vaccine, meningitis A vaccine, pentavalent vaccine, pneumococcal vaccine and human papillomavirus vaccine. This has contributed to a significant reduction of morbidity and mortality. However, there are challenges of sustainability as countries graduate from Gavi support when they improve their gross national product beyond the given threshold. At country level, WHO and other UN agencies are actively engaged in the development of the United Nations Development Assistance Framework (UNDAF), a UN joint support programme for country development plans.

- *Main challenges and obstacles*

Despite the progress made, a number of bottlenecks remain, including limited equity in access, poor health infrastructure, shortage and poor distribution of skilled health personnel, poor access to health services for people in hard-to-reach areas; poor referral systems, weak multisectoral action, inadequate focus on preventive and promotive services, limited resources for health and inefficient allocation of available resources. There is great variation in average per capita total health expenditure, ranging from US\$ 99.49 per capita in low-income countries to US\$ 898.40 per capita in high-income countries.

In the African Region, essential health interventions often lack quality and safety. While the rate of skilled care during childbirth increased from 58% in 1990 to 73% in 2013, mostly due to increases in facility-based births, giving birth in a health facility does not equate with a safe birth. WHO estimates that 303 000 mothers and 2.7 million newborn infants die annually around the time of childbirth, and many more are affected by preventable illnesses.

Less than 50% of people with common illnesses obtain the required treatment. Only about 30% of mothers exclusively breastfeed their babies in their first six months. In addition, resource allocation favours curative services at high cost while neglecting primary prevention and health promotion which could prevent up to 70% of the disease burden. There is no institutionalization of the concept that PHC is the hub for coordinating all health services for well-defined communities within the district. Although decentralization has been implemented, certain aspects such as financial and HR management have not been completely handed over to the lower levels. In addition, the technical, political and administrative capacity at the lower level does not match the level of authority transferred. As a result, the benefits of decentralization at district level are minimal, in the absence of adequate participatory planning and organization; effective communication with communities; effective management and coordination of programmes and services at all levels; and adequate intersectoral collaboration particularly with the agricultural, education, water supply and waste disposal sectors.

There is inadequate scaling up of the production of health workers; they are inequitably distributed between urban and rural settings, while incentives for recruiting, deploying and retaining personnel to offset the impact of the HRH crisis remain insufficient. This creates an “exodus” of highly qualified and talented health personnel to Euro-American settings. In most countries in the African Region, there is a paucity of competent teams at district level. Health services, including referral systems in most countries of the Region, are not organized in a manner that ensures the continuum of care and efficient utilization of resources.

Districts are unable to effectively track progress towards the attainment of annual or longer-term goals as there is often inadequate data gathering and analysis for timely and effective decision-making due to the absence of real-time tracking systems. Another phenomenon is the fact that the management of health information systems in some countries is donor-driven. Thus, the data collected at the operational level are transmitted only to the donor at national level without necessarily copying the

Ministry of Health, especially when these data are collected by CHWs paid directly by the CSOs without going through the health centre team.

In the African Region, new and ongoing conflicts have generated further problems for the health sector in host countries due to population displacements. By the end of 2015, there were 4.2 million refugees and 6.4 million internally displaced persons in the Region and currently, sub-Saharan Africa hosts more than 26% of the world's refugee population. The largest numbers were concentrated in Nigeria, South Sudan and the Democratic Republic of the Congo.

The Region bears a disproportionately high burden of neglected tropical diseases (NTDs). All 47 countries in the Region are endemic for at least one NTD and 36 of them (78%) are co-endemic for at least five of these diseases. Although neglected, hundreds of millions of people are at risk of these diseases, which are found only, or mainly in the African continent.

The Region is faced with a double burden of disease as a result of the rising incidence of non-communicable diseases at a time when communicable diseases are still rife. They come with increased health system needs and with higher costs as most of these diseases are chronic and some life-long. The other big challenge is the huge youth bulge, which nonetheless, has potentially significant dividends if well managed. Likewise, as life expectancy continues to improve, the proportion of elderly persons will increase and health systems in the countries of the Region need to prepare to deal with issues of the elderly.

As countries strive to progress towards UHC, they need to surmount a number of challenges that include limited financial resources for making the required services available; inequitable and inefficient allocation of funds to the appropriate service delivery level for effective interventions to address priority health problems; lack of coherent health financing policies; weak and fragmented health systems resulting in inequitable and insufficient provision of health care; poor coordination between an increasing number of global health initiatives; and weak partnership between the private and public sectors.

### ▪ *Way forward*

After the successful implementation of the recommendations of the Alma-Ata and Ouagadougou PHC conferences by Member States, the WHO Regional Office for Africa expressed its commitment to put in place the necessary structures and processes to move towards universal health coverage (AFR/RC64/R3-2014) and achieve good health outcomes through the implementation of the health-related activities expressed in nine Sustainable Development Goals (SDGs).<sup>1</sup> WHO/AFRO committed to provide leadership in the transformation of the health and well-being of the African people, with a clear set of priorities and a renewed commitment to accountability for results, and to the values of equity, transparency, integrity and professionalism.

Health with its social determinants calls for enhanced partnerships and strong intersectoral collaboration. This goes beyond the usual partnerships, bringing on new partnerships, including with the regional economic communities, the private sector, civil society and the academia. Initiatives like the first ever Africa Health Forum that was held in Kigali, Rwanda in 2017, increased partnership with the

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<sup>1</sup> 1. No poverty; 2. No hunger; 3. Health and well-being; 4. Quality education; 5. Clean water and sanitation; 6. Good jobs and economic growth; 7. Reduced inequalities; 8. Life on land; 9. Partnerships for the goals.

African Union Commission (AUC), the International Telecommunication Union (ITU), the FAO and the World Organization for Animal Health (OIE) under the “one health” initiative.

Information and evidence will be critical drivers of health policies and interventions. Strengthening national and regional health observatories and maintaining their network will enrich availability and use of evidence. Improved technology has enabled application of eHealth and mHealth, but more work needs to be done as only 24 countries in the African Region have developed eHealth strategies. The use of e-Health solutions can enhance service delivery; develop the health workforce and improve performance by eliminating distance and time barriers; and improve the availability, quality and use of information and evidence. Other technologies that need to be scaled up include electronic medical records, electronic referrals and prescriptions, and distance learning using electronic resources.

The Africa Health Transformation Programme, 2015–2020: a vision for universal health coverage is a framework that espouses the vision of a health and development approach that will address the unacceptable inequalities in health in a Region that lags behind the others in all health indices and quality of life.

In conclusion, the journey of African nations from Alma-Ata (1978) to Ouagadougou (2008) until present times in their quest to provide their populations with affordable, community-based primary health care has been far from smooth and beset by many challenges. Countries in the Region are diverse, due to cultural, economic, governance and political differences, which make a ‘one-size-fits-all’ approach in addressing health in the agenda impossible. In this journey, however, countries were not alone; they were accompanied by committed partners, among them WHO/AFRO, UNICEF and other country-based UN agencies, bilateral and multilateral partners, the private sector and other sectors in the communities in view of the multisectoral nature of PHC.



## INTRODUCTION

The WHO Regional Office for Africa (AFRO) is located in Brazzaville, the capital city of the Republic of Congo. The operations of the Regional Office are decentralized through three Intercountry Support Teams (ISTs) based in Harare, Libreville and Ouagadougou and WHO country offices in 47 Member States. Each IST is headed by a Coordinator and is composed of multidisciplinary staff.

The mission of the ISTs is to:

- (a) enhance AFRO's technical support to countries for scaling up proven public health interventions; and
- (b) strengthen partnerships with UN agencies, regional economic communities and other stakeholders.

The **IST for Central Africa** covers 10 countries: Angola, Burundi, Cameroon, Central African Republic, Chad, Congo, Democratic Republic of the Congo, Equatorial Guinea, Gabon, and Sao Tome and Principe. The **IST for East and Southern Africa** covers 20 countries: Botswana, Comoros, Eritrea, Eswatini, Ethiopia, Kenya, Lesotho, Madagascar, Malawi, Mauritius, Mozambique, Namibia, Rwanda, South Africa, Seychelles, South Sudan, United Republic of Tanzania, Uganda, Zambia and Zimbabwe. The **IST for West Africa** covers 17 countries: Algeria, Benin, Burkina Faso, Cabo Verde, Côte d'Ivoire, The Gambia, Ghana, Guinea, Guinea-Bissau, Liberia, Mali, Mauritania, Niger, Nigeria, Senegal, Sierra Leone and Togo.

The African Region faces unique challenges that include a rapidly changing demographic profile with a growing elderly population, rural-urban migration, changing environmental conditions, climate change and others. These factors contribute to food insecurity, social unrest and disease outbreaks due in part to inadequate water supply, poor sanitation and lack of other essential supplies necessary for a healthy life. There is a disproportionate distribution of these social amenities between the rich and the poor, men and women, rural and urban dwellers, leading to a widening of the inequalities and inequities gap within countries due to limited preparedness to respond to rapid changes. Disparities between urban (70%) and rural (50%) communities that have access to safely-managed sources of drinking water are also visible in most countries. The richest quintile in most countries has over 50% access to improved sanitation facilities while the poorest population has less than 30% access. Inequitable distribution of water has huge implications on sanitation and hygiene, often resulting in a high burden of diseases like cholera, typhoid, malaria and yellow fever which can spread to epidemic proportions. The Region is particularly vulnerable to outbreaks, with an average of over 40 events registered at any time, among them, the devastating 2014-2015 and 2018 Ebola virus disease (EVD) outbreaks respectively in West and East Africa. Another major issue is the continued presence of HIV/AIDS infection as well as tuberculosis in the Region, while neglected tropical diseases (NTDs) including leprosy, trachoma, filariasis and schistosomiasis also constitute a challenge and impose a heavy burden on health services. Recent data also indicate a steady increase of noncommunicable diseases (NCDs). The survey, conducted in 35 countries in the African Region (2015) on NCD deaths, shows an increasing trend over the years. In 2015, of the 9.2 million total deaths, 3.1 million were due to NCDs including CVDs, cancer and diabetes. The high burden of NCDs is due to an ageing population, urbanization and consumption of harmful products such as tobacco and alcohol, unhealthy diets and a sedentary lifestyle. Other conditions

include mental health, substance abuse, oral diseases, violence and injuries. Five of the 10 countries with the highest road traffic deaths worldwide are from the Region. The African Region has the highest birth rate among adolescent girls who are uneducated, poor and live in rural communities. They are more likely to have unplanned pregnancies and an unmet need for family planning. Problems related to maternal and child nutrition are also among regional priorities.

The humanitarian crisis in a number of countries in the Region (Nigeria, Cameroon, and South Sudan) imposes an additional burden on health services due to the influx of refugees and migrants into neighbouring countries.

The development of human resources for health is critical to achieving the Sustainable Development Goals in health. Health workforce remains a major challenge in the African Region: 36 Member States are still below the recommended minimum threshold of 2.3 doctors, nurses, and midwives per 1000 population. In the African Region, there is inadequate focus on designing, financing and monitoring the service delivery systems needed for the effective provision of services.

Half of the countries in the Region (24) have a total health expenditure of less than US\$ 140 per capita.

In many cases, countries' capacity to analyse newly collected data is low, with less focus on strengthening capacities of the health workforce to collect, understand and use the data routinely. The translation of research into policy remains a critical challenge in the Region. In some countries, formal research dissemination meetings are held with policy-makers to share findings.

Member States in the WHO African Region are increasingly aware of the importance of the determinants of health and the need for strategic alignment with policies across sectors to enhance actions to address health inequities. They also see the potential opportunities presented by the new drive towards UHC in their move to achieve better health for the people of Africa.

On the occasion of the 40th Anniversary of the Declaration of Alma-Ata, the Government of Kazakhstan with WHO and UNICEF will host the 2nd International Conference on PHC. In the Declaration of Alma-Ata, a generation of leaders expressed their commitment to achieve health for all through PHC. That commitment remains as relevant and essential today as when it was first articulated in 1978. Ensuring people-centred care that offers universal access, social equity and financial protection through a PHC-led approach is critical to the attainment of universal health coverage (UHC) and the health-related Sustainable Development Goals (SDGs).

While there have been great strides toward PHC/UHC in the last four decades, the vision set forth in the Declaration of Alma-Ata has not always been translated into effective transformation of health systems. The upcoming Conference therefore, provides Member States and other stakeholders with the opportunity to renew support for PHC, considering the significant changes in the social, epidemiological, and demographic landscapes as well as evidence of what works. A renewal of PHC is important for all countries and is essential for improving health, social stability, national economies and health security.

The Conference also aims to strengthen PHC as the foundation for UHC and the SDGs, building on lessons learned over the past four decades. On the occasion of this momentous anniversary, Member States in the African Region, individuals, civil society and international partners must

commit to transforming this new vision into a practical reality—a reality that everyone can share, believe in, take action upon, and benefit from.

For WHO in general, this vision is aligned with the 13th General Programme of Work, 2019-2023, and makes progress on the mandates given to the Secretariat in WHA resolutions 62.12 on “Primary health care, including health system strengthening” and 69.24 on “Strengthening integrated people-centred health services”. In addition, it builds on numerous resolutions of the WHO African Region on UHC and health system strengthening to overcome the challenges presented in Annex 1.

This report aims to demonstrate progress on primary health care in the 47 countries of the WHO African Region since the Alma-Ata Declaration on Primary Health Care in 1978. It was commissioned by WHO for the 2nd International Conference on Primary Health Care (PHC), which will take place in Astana, Kazakhstan on 25-26 October 2018.

The documentation will summarize efforts, challenges and progress made by countries in the Region since 1978 as well as actions taken by the WHO Regional Office for Africa (WHO/AFRO), UNICEF and other stakeholders following the adoption of the Ouagadougou Declaration on Primary Health Care and Health Systems in 2008. It also aims to take stock of lessons learned, as well as cast a shared vision for the future with its two major chapters titled: Looking Back (1978-2017) and Looking Forward (2018-and beyond). The report will also advocate for new alliances/partnerships to make PHC/UHC-oriented health systems expansion and scale-up a reality.

The PHC/UHC report from the WHO African Region will be part of the cornerstones of the living history of the work of WHO in the Africa Region and globally.

## LOOKING BACK (1978-2017)

### 1. Implications of The Alma-Ata conference (1978) on PHC in the WHO African Region

#### 1.1 Actions by the WHO Regional Office to advance the PHC approach

The vision of future PHC development in the African Region was shaped by reflections on the Alma-Ata recommendations and African countries' efforts to respond to it through revitalizing their strategies which were based on lessons learned from past developments. It is not surprising that almost all countries in the WHO African Region regarded health as a foundation for national development, a conception that was reinforced by the PHC strategy adopted through the Alma-Ata Declaration. The African Region's commitment as expressed in numerous strategic documents and resolutions of its Regional Committee remains a valuable asset and opportunity that countries benefited from.

The WHO Regional Committee for Africa at its Fifty-sixth Session (2006) adopted a historic resolution requesting countries to incorporate in their national and district health plans priority interventions for revitalizing health services based on PHC. The resolution requested the Regional Director "to facilitate intercountry exchange of experiences and dissemination of good practices" in primary health care.

The "Strategic orientations for WHO action in the African Region, 2005–2009" emphasized the commitment of WHO to achieving Health for All (HFA) in the 21st century. The document pledges support by the Regional Office for revitalizing the PHC approach in Member States amid the changing development context in the Region. In line with these directives, the Regional Office organized an "Internal Workshop on Primary Health Care and Health Systems" which took place on 11–13 September 2007 in Brazzaville. The workshop served as a preparatory phase for the "International Conference on Primary Health Care and Health Systems" which was later held in Ouagadougou (2008).

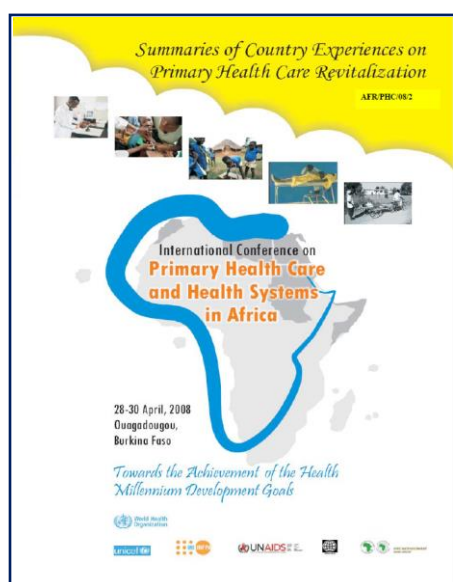
WHO/AFRO has given consistent and substantial support for the implementation of the HFA strategy in the Region in collaboration with other partners: UNICEF, the World Bank, UNFPA, the International Committee of the Red Cross and Red Crescent Societies, FAO, UNESCO and bilateral partners. AFRO's support included advocacy for PHC as well as technical and operational support to countries through creating strong subregional technical support teams for delivering country-specific technical assistance for the realization of the PHC principles in the Region.

There was strong evidence that the Alma-Ata Declaration (1978) generated additional support from the regional and international community for African development in general and health development in particular. Historic declarations by the UN and African regional organizations, such as the OAU "Declaration on Health as Foundation for Development" (1987); the Abuja Declaration, which included a powerful proposal to increase the proportion of the national health budget (2001); the "Addis Ababa Declaration on Community Health in the African Region" (2006); development initiatives by the EU-Africa Summit (2007); global health initiatives such as GFATM, Gavi, PEPFAR, NEPAD, etc., were inspired by the Alma-Ata Declaration. Major

country-based stakeholders including governments, NGOs, the private sector, and community-based organizations (CBOs) were keen to contribute in addressing health challenges. This large network of actors was a great opportunity for expanding health services to the majority of the population. The possibility of building on such a long tradition and strengthening the links with community structures was a great opportunity for implementing PHC activities at grassroots level.

In the AFRO document, “Compendium of public health strategies adopted by WHO Regional Committees (1998-2011)”, Strategic Direction 2 states that “health for all, through primary health care, proclaimed twenty years ago at the Alma-Ata Conference, will remain a major objective for the years and century to come”.

## 1.2 Country initiatives to implement the Alma-Ata Declaration on PHC



There was a visible positive trend towards achieving equity in health by countries in the Region. Despite the fact that countries were not able to achieve HFA, the approach and its principles were still very relevant as evidenced by the universal adoption of the decentralization concept by countries, relocating decision-making power to district and community levels. The creation of community-based committees and availability of various types of community health workers have guaranteed rigorous community participation in health matters in the communities and districts, involving people in decision-making, planning and implementation of health activities in the spirit of self-reliance and ownership. In many countries the health authorities were galvanized by the desire to implement the Millennium Development Goals (MDGs). They considered PHC as the best suited strategy and driving force for the attainment of the health-related goals. Many structures

including PHC committees (managerial processes) were formed at all levels of national health systems, namely the provinces/regions, districts and villages. This was a very good framework for facilitating decision-making, implementation and monitoring of PHC activities and social accountability. Communities in most countries utilized community-owned resource persons, such as community health workers, traditional birth attendants (TBAs) or traditional practitioners, community drug distributors, etc. Most countries in the African Region have made significant efforts to work with health-related sectors in order to amplify the socio-economic gains. Primary health care had assumed a central position in the multisectoral approach, realizing it through the health management committees established at operational level.

However, the road to these achievements has not always been smooth as evidenced by the AFRO baseline study conducted in all 47 countries of the Region as the basis for developing a regional UHC monitoring framework. Data were collected from publicly available sources and included 51 indicators, 17 of which were used for the monitoring framework. The resultant framework was adapted by countries to gauge their progress in achieving UHC and the SDGs.

Some of the critical results include the following:

1. The issue of equity in access to UHC has been limited due to lack of political will or leadership;
2. Poor health infrastructure;
3. Shortages of skilled health personnel;
4. Poor access to health services for people living in inaccessible or hard-to-reach areas;
5. There was also poor understanding of the role of service delivery, which includes conventional medicine, traditional medicine and prayer rooms (evidenced from the multicountry study mentioned above), especially in relation to referral systems for users (the need to start with the PHC health centre) and the issues related to payments when medical evacuation is required.
6. Lack of resources: often hospitals have the lion's share of the national health budget, leaving health centres underfinanced to perform their basic health care role within the PHC structures.

The proportion of health budgets to the national budget in many countries in the Region varied and was very low, thus affecting implementation of large-scale community programmes. Only a few countries respected the Abuja Commitment by allocating 15% of their national budget to health and by increasing the proportion of funds allocated to community health interventions. Furthermore, although on average Total Health Expenditure (THE) per capita has grown at a rate of 6.83% per annum from US\$ 141.65 in 2000 to Int\$ 296.52 in 2015, it is still lower than that experienced in all but the South-East Asia Region. Moreover, there are also marked inequalities in average THE in the Region, ranging from US\$ 99.49 per capita in low-income countries to US\$ 898.40 per capita in high-income countries.

#### 1.2.1 Challenges:

Multisectoral action at central level was cumbersome due to the existence of multiple and different internal and donor-driven coordination and management structures, and this tended to be duplicated at lower levels. Community-based health committee members were not well informed of their duties and decision-making powers. There was poor participation of women, youth, local NGOs and associations involved in health activities.

There was also low commitment of community health workers (CHWs) as the majority of them performed their duties without adequate resource support from either the communities they served or from the health care system. Another constraint was of a programmatic nature: while the PHC policy has been heavily in favour of a preventive PHC approach, services continued to be highly focused on curative care. Some programmes were still operating vertically not only at national but at district level. Motivation towards community health was also lacking among members of health teams due to poor working conditions (lack of transport, poor outreach sites, shortage of drugs, etc.) and low remuneration. There was insufficient communication within the referral system, affecting its coordinated functioning. Many users bypassed the referral structure partly because of shortage of personnel and limited scope of services offered at the primary level. The role of the private sector (particularly private-for-profit) in health service delivery was not well articulated in policy documents.

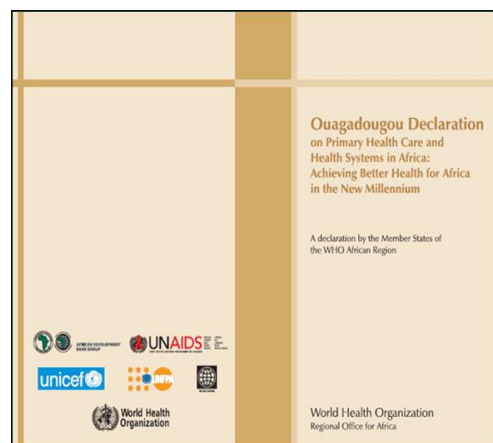
### 1.2.2 Response

To give further enhancement to PHC and UHC initiatives, WHO/AFRO, working with UNICEF and other partners, in 2008 organized an international conference in Ouagadougou, which ended with a powerful declaration. Thereafter, the Ouagadougou Declaration on Primary Health Care and Health Systems in Africa became the most important agenda item discussed and followed up in African Regional Committees and other meetings, the Regional Director's annual and biennial reports, published documents and during country visits by AFRO staff.

## 2. Ouagadougou Conference on PHC as a forum for revitalizing PHC in African Region

### 2.1 Ouagadougou Declaration on PHC as an important leverage to boost PHC implementation

Thirty years after the Alma-Ata International conference on PHC organized under the leadership of the then WHO Director-General, Dr Mahler, the first International Conference on PHC and Health systems in the African Region was held in Ouagadougou (capital city of Burkina Faso) from 28 to 30 April 2008. As a result of that high-level meeting, the health ministers and heads of delegations adopted the Ouagadougou Declaration on Primary Health Care and Health Systems in Africa that was presented by the Secretariat with monitoring indicators aimed at renewing commitment to PHC, thus making this approach the main strategy for health development and accelerating attainment of the health Millennium Development Goals (Annex 1). The Declaration recalled that for the successful implementation of PHC, the following major priority areas should be considered:



#### *(a) Leadership and governance for health.*

The African Union and the regional economic communities should assist Member States, sustain political leadership, and strengthen advocacy, resource mobilization and funding for the health sector.

This area has also been emphasized in the Regional Framework for reaching UHC, thus emphasizing that Governments are responsible for coordinating and ensuring that all interventions are in line with countries' priorities and on budget. They should enable involvement of all relevant stakeholders at all stages from policy, planning and investment to implementation, monitoring and evaluation. Resolution AFR/RC59/4 provides further steps, namely to: (a) develop and adopt a comprehensive national health policy (NHP) that is integrated into the country's overall development strategy through a broad-based, country driven, inclusive and participatory decision-making process; (b) develop and implement a comprehensive and costed national health strategic plan (NHSP) that is consistent with the NHP, taking into account multiple sources of funding within a realistic resource package; (c) develop and implement subsequent operational plans at the local (district) level of health systems, as planned for in the NHSP;

***(b) Health service delivery.***

Countries should update their national health policies and plans according to the PHC approach with a view to strengthening health systems to achieve the MDGs.

The Regional Director's report for 2010-2011 indicated that during the period, 21 countries strengthened the capacity of their district health systems to plan, manage, supervise, monitor and evaluate their work; while 15 countries revised their national health policies and 18 countries revised their national health strategic plans using the WHO guidelines on National Health Strategic Plans (NHSPs).

***(c) Human resources for health. .***

Countries should implement strategies to address their human resources for health needs, better planning, strengthening of the capacity of health training institutions, staff management, motivation and retention in order to enhance the coverage and quality of health care.

development of their national HRH policies and plans, to allow them to perform their governance function in a transparent and accountable manner. Namibia and Zimbabwe developed HRH retention strategies. Comprehensive HRH country profiles were developed in 15 countries; while nine countries established national health workforce observatories needed for evidence-based decision-making and progress monitoring. Sierra Leone and The Gambia established new databases for HRH. Fifty-four policy-makers and managers from 21 countries were trained with a view to strengthening HRH policy, leadership and governance.

***(d) Health financing. .***

The Conference welcomed the commitment by the African Heads of State and Government to create an enabling environment, including incremental funding of health services reaching at least 15% of the overall national budget as earlier recommended by the Abuja Declaration.

Based on this recommendation, as evidenced by resolution AFR/RC67/10 (2017), several countries started to implement the change; however, since 2002 only 18 of them have achieved the target of allocating 15% of their annual budget to health. The same resolution quotes from other sources to indicate that if universal coverage of essential health services is to be achieved, health financing must move towards a predominant reliance on public funding for health services as the priority for governments. Public funds are compulsory and pre-paid (i.e. taxes) whereas voluntary payments are considered private. This will reduce reliance on prepayment to eliminate barriers to access health services, as many countries in the Region are yet to institutionalize robust prepayment systems that eliminate impoverishment of families due to out-of-pocket expenditure at the point of service.

***(e) Health information. .***

Countries were urged to strengthen health information and surveillance systems and promote operational research on health systems for evidence-based decisions and planning.

This proposal was later reinforced by the Regional Framework for reaching UHC, which encouraged Member States to establish data coordination mechanisms to interlink information systems for routine facility data, vital statistics, disease surveillance, surveys and research to foster integration and reduce fragmentation, as well as prioritize capacity for analysis and use of data particularly at the subnational level. During 2010-2011, a new HRH Regional Observatory portal was developed and launched in the three official languages of AFRO. Regional progress on the health and health-related

MDGs was assessed. Two Atlases of Health Statistics, one for 2011 and another for 2016 were produced and a third for 2018 is being finalized with detailed statistical profiles of the countries in the Region. A State of Health Report for the African Region has been produced and was launched at the Sixty-eighth session of the Regional Committee.

***(f) Health technology.***

Countries agreed to set up sustainable mechanisms for increasing availability, affordability and accessibility of essential medicines, commodities, supplies, appropriate technologies and infrastructure through provision of adequate resources and technology transfer.

By resolution AFR/RC59/4, countries were urged to increase access to quality and safe health technologies; develop national policies and plans on health technologies; develop norms and standards for the selection, use and management of appropriate health technologies; and institute a transparent and reliable system for their procurement. This area was further catalysed with the introduction of modern technologies – such as eHealth and mHealth to improve communication among various levels of the national health system within and outside of countries. The Sixtieth session of the Regional Committee for Africa adopted the document “eHealth solutions in the African Region: Current context and perspectives”, laying the basis for intensified action to leverage information and communication technology in health services. To date, a total of 26 countries have developed national eHealth strategies including eight countries in 2016-2017; while seven countries have undertaken national eHealth inventory management using the WHO digital health atlas to support digital health scale-up and coordination. Meanwhile in 2017, the Regional Office and the International Telecommunication Union (ITU) agreed on a joint programme, resulting in a cooperation agreement aimed at building capacities, creating common platforms and strengthening the capacity of local stakeholders towards optimal and efficient use of available resources for eHealth, and promoting the creation of an enabling environment with innovative sustainable models designed for limited-resource contexts.

***(g) Community ownership and participation. .***

The conference called for governments' recognition of the role of communities, including the role of civil society in the governance of health services, particularly in relation to community-based public health and other health-related interventions.

Resolution AFR/RC60/7 urged Member States to empower communities (including women, the elderly, children and other disadvantaged groups) to take appropriate actions for the promotion of their own health. As a true partner in health, communities need to be involved in the planning, organization, management, implementation and monitoring of health service delivery within their catchment areas. They should advocate for better health services from government including health information, skilled providers and financial and other resources to ease their participation.

***(h) H Partnership for health development. .***

The United Nations agencies, UNAIDS, UNFPA, UNICEF, WHO, and international financing institutions, including the African Development Bank and other international health partners should provide support for the implementation of this Declaration according to their comparative

In response to this action area, the Regional Director's Report for 2010 indicated that 10 countries in the Region had conducted joint annual health sector reviews on the work and contribution of all stakeholders and partners and assessed the level of their alignment to national policies and strategic

plans. Comoros and the Democratic Republic of the Congo (DRC) developed a Public Health Code. Burundi, Cameroon and Ghana established mechanisms to strengthen partner coordination. To strengthen partnerships for health development, countries were advised to use mechanisms such as the International Health Partnership Plus (IHP+), the Global Health Partnership H6+ and the Harmonization for Health in Africa initiative to promote harmonization and alignment in line with the PHC approach; and adopt intersectoral collaboration, public-private partnerships and civil society participation in policy formulation and service delivery.

***(i) H Partnership for health development. .***

**Countries should allocate at least 2% of their health budget to reinforce national health research systems and create centres of excellence in Africa.**

The Regional framework for implementing the Ouagadougou Declaration urged Member States to prioritize engagement of the research community to maximize the generation and use of research evidence for decision-making and facilitate knowledge translation platforms. To this end, countries were advised by resolution AFR/RC59/4 referring to the Algiers Declaration to Strengthen Research for Health, adopted during the Ministerial Conference on Research for Health in the African Region, held in Algiers (23-26 June 2008), which brought together Ministers from the Region, researchers, NGOs, donors and the private sector. The conference renewed commitments to narrow the knowledge gap in order to improve health development and health equity in the Region. According to the Regional Director's report for 2010, by the end of that year, 20% of the countries in the Region had a functional network of researchers and policy-/decision-makers through EVIPNet. Two new WHO collaborating centres were designated in Burkina Faso and Kenya in 2010, bringing to 27 the total number of collaborating centres in the African Region, located in 11 countries.

## **2.2 Regional strategy to guide the expansion of PHC/UHC**

After the Ouagadougou PHC Conference, the WHO Regional Office for Africa undertook a number of initiatives to address the priorities identified by the conference delegates in collaboration with countries themselves and partners. The renewed focus on primary health care with its principles and values of social justice, equity, solidarity, effective community participation and multisectoral action, offered a sustainable approach to redesigning national health systems in a flexible manner. "Most countries in the Region have now adopted health policies based on PHC values and principles in order to improve equity in access to quality health care" (Regional Director's report: A decade of WHO in the African Region: 2005–2015).

These initiatives were included in the Regional Director's reports, Regional Committee meetings and in the following Regional Committee resolutions: AFR/RC58/R3 (2008) endorsed the "Ouagadougou Declaration on Primary Health Care and Health Systems in Africa: Achieving Better Health for Africa in the New Millennium"; AFR/RC59/4, Framework for the implementation of the Ouagadougou Declaration on Primary Health Care and health systems in Africa: achieving better health for Africa in the new millennium"; AFR/RC60/2, AFR/RC/61/14 and AFR/RC62/R4 (2012), focused on the implementation of the Ouagadougou Declaration on PHC and Health Systems in Africa and the Algiers Declaration on Research for Health in order to improve the performance of health services in terms of quality, effectiveness, efficiency, coverage and equitable access. At Regional Committee meetings, delegates commended the Secretariat for providing countries with a generic framework as a practical guide to operationalize the Declaration. They appreciated its holistic approach and recognized the pivotal role of human resources for health in the proper implementation

of the Framework. It was also underlined that PHC should be considered as an approach rather than a level of care, which would facilitate common understanding of health systems strengthening by countries.

**In his report for 2010, the WHO Regional Director** for Africa mentioned that countries continued to strengthen the capacity of their national health systems in areas of policy, strategies, planning, and implementation using available tools. The web portal of the African Health Observatory (Annex 2) was completed, providing countries with the evidence needed to aid decision-making and to prepare the development agenda of countries in general and districts in particular.

Countries also benefited from the implementation of the health-related initiatives of UNICEF's global strategic plan 2018-2021, as well as the Agency's Strategy for health 2016-2030 and Regional compacts for child survival, growth and development (realizing the rights of children).

A stronger presence of WHO in all 47 countries in the Region has also been made possible by the implementation of the Country Cooperation Strategies (CCS). They take into account each country's national health issues and align them with WHO's regional priorities and the global agenda in order to respond more directly to country needs.

The development of the Communications Strategy for the African Region involved revamping the WHO/AFRO website, setting up social media platforms including Twitter ([twitter.com/WHOAFRO](https://twitter.com/WHOAFRO)) and YouTube ([youtube.com/user/WHO African Region](https://youtube.com/user/WHO_African_Region)), as well as establishing a network of communications officers, stationed from Mozambique to Cabo Verde, to support countries in the event of emergencies. "Social media platforms have played a critical role during disease outbreaks such as Ebola, to share official WHO situation updates, activities and messages with partners, the public and other stakeholders."

## **2.3 Country-specific policies, strategies and approaches**

Several Regional Director's reports and Regional Committee resolutions refer to WHO's work under Strategic Objective 10 which addresses country experiences in the implementation of the Ouagadougou Declaration. The experiences of most countries since the Alma-Ata Declaration and thereafter were related to health system financing, strengthening district health systems, planning, monitoring and evaluation, and establishing new mechanisms for involving communities. Other experiences were reviewed and included in their health packages for implementation of the Ouagadougou Declaration. Some country-specific examples of implementation of the Ouagadougou Declaration are given below, while others are included in chapter 2.5.

### **ANGOLA**

#### **■ Providing health care to refugee populations**

Angola has a long border with countries where the political context poses risks of potential conflicts that might result in additional inflows of refugees. With the support of UN and other humanitarian agencies, these populations were provided access to essential health services in neighbouring provinces. Health services assign neighbouring village health workers (VHWs) and/or health clinic workers to provide the required health care. Angola is working in partnership and with humanitarian organizations operating in the country, namely: the ICRC, Save the Children, MSF and others, which provide the required PHC services. The country in 2010 developed and devolved the municipal health system using community health workers called ADECCOs in 114 municipalities.

## **BOTSWANA**

### **▪ PHC in the national health plan (NHP)**

The country's health budget includes a budget line for PHC. The Permanent Secretary at Ministry of Health is assigned as the PHC focal point. Current geographical coverage of PHC services is quite high, reaching 95% of the total population (89% in rural areas). Community health workers' remuneration is government salary-based to ensure long-term service to the assigned communities. In May 2018, the country participated in the stock-taking of CHWs initiatives in Member States of the AU within the framework of intercountry exchange visits.

## **BURUNDI**

### **▪ Reforms in health financing**

Burundi treats universal health coverage as a priority and looks towards removing financial barriers to access to health services. The country has implemented various reforms and introduced a number of financing systems that include free health care, performance-based financing and insurance schemes for the informal sector (the community-based health insurance (CAM) and health insurance for civil servants. A review in 2012 recommended the introduction of a unified financing system that integrates the different financing systems. This is in line with the country's vision to achieve universal health coverage by increasing the population covered by health insurance and reinforcing the National health financing strategy for universal health coverage.

## **COMOROS**

### **▪ PHC scale-up programme using VHWs**

Comprehensive health care based on the PHC approach is delivered by village health workers and nurses on a voluntary basis. The geographic coverage of the services is 100%. There is no specific budget line for PHC in the country's health budget; however, it enjoys support from civil society, including Consumers' Federation, Blood Donation Association as well as Village Health Association. Primary health care has been integrated in the training curriculum of the School of Nursing. Community health information is provided through radio and television services. There are calls to include PHC/UHC in the political agenda of the Government.

## **DEMOCRATIC REPUBLIC OF CONGO**

### **▪ Achievements in PHC programme management**

The PHC policy document was updated in 2010. PHC has a specific budget line in the National Health Budget. There is a PHC focal point in the Ministry of Health. In 2011 there was a review of the programme, which showed that the PHC coverage with the provision of comprehensive health services is about 75%. It is provided by CHWs, nurses and doctors. Community participation is conducted through Village Health Committees. Exchange visits are arranged between the PHC staff of the various districts. Operational research has been conducted on the level of utilization of PHC services. The main focus of the programme management includes improvement of women's and children's health as well as expansion of preventive and promotive health services through UHC to reduce direct payments for services by the poor.

## **GUINEA BISSAU**

### **▪ Achievements in PHC programme management**

The country has not yet developed a policy document on PHC/UHC, nor does it have a budget line for the same. However, its current coverage of the PHC/UHC programme is assessed at 100%. The main implementing agents at community level are CHWs, who work on a voluntary basis, while beginners undergo training for 15 days, and refresher training is continuous. Incentives are given to them according to targets established by financial partners. In 2017 the country conducted a KAP study led by the National Institute of Health on PHC/UHC related to quality of services at community level.

## **ETHIOPIA**

### **▪ Used a comprehensive national strategy to reduce undernutrition**

Although Ethiopia depends mainly on rain-fed agriculture, making the population vulnerable to recurrent drought and food insecurity; it has managed to reduce stunting and mortality in children below 5 years of age over the past decade. Between 2000 and 2011, under-five mortality fell from an estimated 139 deaths per 1000 live births to 77 per 1000 live births. Rates of stunting among under-five children also decreased during this period, from an estimated 57% to 44%. This programme has been enhanced by Ethiopia's robust social protection strategies which include: (a) a safety net programme covering more than 7 million people in the poorest areas of the country; (b) community-based nutrition interventions that have been integrated into health services through the health extension programme, which increased PHC coverage from 77% of communities in 2004 to 92% in 2010. Evidence from evaluations suggests that services have improved, and people have changed their behaviour. In 2011, seventy-one per cent of children aged 6–59 months were provided with vitamin A supplementation and 52% of children aged 0–5 months were exclusively breastfed. Currently the country is finalizing the vision document on UHC/PHC. The Ethiopian PHC alliance for quality initiative focuses on experience sharing/learning from best performing health centres and hospitals to improve service delivery. Ethiopia has also prepared a PHC clinical treatment guideline and is also revising the essential health service package. The urban PHC reform, which focuses on family health teams is an integrated and people-centred approach. It is expected to be expanded across all urban areas.

### **▪ Proposals on monitoring countries 'course toward PHC/UHC**

Its proposal included the use of technologies and establishing regional online groups and forums on UHC; establishing national, regional or international PHC institutes like the International institute for primary health care in Ethiopia; organizing regional and national conferences on PHC; creating experience-sharing platforms on UHC; and adapting UHC indicators to country context and integrating them into the national routine health information systems and evaluating them regularly.

## **MALAWI**

### **▪ Supply chain management as a component of health system strengthening**

A multi-partner project on essential medicines, coordinated by UNICEF in 2012-2013, reduced stock-outs of essential medicines and supplies from 31% in 2011 to 7% in 2013. The regular supply of essential medicine kits increased patient access to essential medicines and therefore contributed to improved quality of health care. However, standardization of kit content and quantity led to under- or

over-stocking, with potential for expiry of some medicines and calls for redistribution (Malawi Primary Health Care Project Evaluation – Clinton Health Access Initiative, July 2014). A community-directed intervention (CDI) approach in Malawi has improved community participation and increased access of the population to health interventions at community level. The current National Health Sector Plan (2017–2022) places great value on PHC and community participation and this led to the development of the National Community Health Strategy (2017–2022). For the successful implementation of the PHC/UHC initiative, the country is focusing on nationwide implementation of the community health strategy and initiatives, increased efforts towards NCD management, quality of care initiatives, and is supported by a health financing strategy.

## **MOZAMBIC**

### **▪ Proposals on monitoring countries ‘course toward PHC/UHC**

The country proposed a platform, which can be hosted by the WHO Regional Office, to enable countries share information on progress indicators, activities related to decision-making at country, district and local levels; and promote and record best practices by districts in countries. This initiative would be led by a committee that would support government institutions, communities and other stakeholders in promoting UHC. It will include defined indicators of the process: number of visits, number of people involved, changes that occurred during implementation in the communities, health systems, as well as people’s health behaviour.

## **NIGER**

### **▪ Child survival programme**

An analysis of the child survival programme in Niger showed that during the period 1998–2009, mortality rates for under-five children fell from 226 to 128 deaths per 1000 live births and 96 per 1000 live births in 2015. The study concluded that government policies supporting universal access, provision of free health care for pregnant women and under-five children, and decentralized nutrition programmes contributed to these child survival gains. The study also indicated that the coverage of most child survival interventions, namely use of insecticide treated bednets (ITNs), improvements in nutritional status, vitamin supplementation, treatment of diarrhoea with oral rehydration salts and zinc, care-seeking for fever, malaria and/or childhood pneumonia and vaccinations increased during this period. An analysis using the Lives Saved Tool, estimated that in 2009 the lives of 59 000 children aged below 5 years were saved as a result of the introduction of these interventions. During this period, Niger successfully reduced child mortality at an annual rate of 5.1%, a pace which exceeded the level required to meet Target 4 of the Millennium Development Goals (MDGs).

## **RWANDA**

### **▪ Impact of national health system reforms on maternal and child health programmes**

In 1994, post-genocide Rwanda was struggling to provide adequate care for maternal and child-health services. Challenges included a severe health workforce shortage, limited infrastructure, poor access to skilled care and inadequate coverage of emergency obstetric and newborn care. In response, the Government of Rwanda focused on health system strengthening and good governance; quality maternal, neonatal and child services, including the use of Kangaroo Mother Care; strong community involvement; family planning; community-based health insurance; and a performance-based financing system. The combination of supply- and demand-side interventions contributed to an

increase in coverage and access to maternity services. As a result, maternal mortality decreased from 910 per 100 000 live births in 1990 to 340 per 100 000 in 2010 and 290 per 100 000 in 2015. In addition, the under-five mortality rate decreased by 63%, from 151 deaths per 1000 live births in 1990 to 55 per 1000 live births in 2012 and 42 per 1000 live births in 2015.

- **Looks towards UHC through PHC**

The PHC policy document was updated in 2015. PHC has a specific budget line in the National Health Budget. There is a PHC focal point/position in the Ministry of Health. In 2015 there was a review of the PHC programme within the mid-term review (MTR) of the health sector plan, which confirmed that PHC coverage in the country reaches 100%; and services are provided in an integrated and people-centred manner by CHWs (volunteers), nurses, Environmental Health Officers and medical doctors. All CHWs have been trained and their refresher training continues. The community participates in health matters through VHCs and their members carry out monthly community work (UMUGANDA). Other sectors, such as education, agriculture, local government, sports and culture, etc., are also involved in supporting PHC activities. Exchange visits are common within and among districts and sometimes between countries for learning and sharing of PHC experiences. Provision of health services is based on community health insurance, focusing on social protection for the most vulnerable population groups. The main challenges for universal PHC coverage include continuous increasing cost of health services, emergence of the double burden of communicable and noncommunicable diseases, and high population growth rates. The country's current Mid-term programme on health is aiming to achieve a number of milestones by 2024 to improve the health and well-being of the population in their journey towards UHC.

## **ZAMBIA**

- **Caring for refugees**

Zambia has hosted refugees from Angola and Rwanda since the 1960s and 1990s, although they later lost their refugee status in 2012 and 2013 respectively. Following the Government's pledge in 2011, it reintegrated an initial group of former Angolan refugees in 2015; and later expanded the local reintegration criteria to cover all 18 685 Angolans and also some 4000 Rwandans. In April 2014, the Ministry of Home Affairs and UNHCR launched a three-year local integration programme, which ended in December 2016. The programme operated within the dimensions of peacebuilding/coexistence and development: it sought to implement the local integration as a durable solution to protracted displacement, moving from a humanitarian relief approach focused on protection, to a development approach based on enabling sustainability and self-reliance.

- **The path to strengthening the PHC/UHC approach**

The country has not yet developed a policy document on PHC/UHC and does not have a budget line for PHC in the national health budget. The assignment of a focal point at MoH is under consideration. Current coverage of the PHC/UHC programme is estimated at only 4%. The main implementing agents at the community level are CHWs: 307 of them have been trained and deployed. Their remuneration is government salary-based. At village level there are Village Health Committees. The PHC programme is supported by bilateral partners: Clinton Health Access Initiative (CHAI), DFID, and the Governments of the USA and Sweden. CHWs exchange visits were organized between Zambia and Ethiopia. The country has specific goals and targets towards PHC/UHC for the period 2017-2021, the key ones being formalization of community health structures in line with the decentralization policy and inclusion of community health structures and

social accountability in regulatory frameworks such as the Public Health Act and the National Service Act. Other targets include the strengthening of multisectoral collaboration, addressing social determinants of health as well as the Health in All Policies framework. The latter will require the presence of a PHC/UHC-oriented health system in the political agenda of the country.

## **ZIMBABWE**

### **▪ Adolescent and youth-friendly health services**

In 2009, Zimbabwe, with the technical support of WHO, conducted a pilot project to reduce unwanted pregnancies among nursing students at Parirenyatwa Nursing School. The problems identified before launching the project were: (a) high pregnancy rates; (b) high unsafe abortion rates, high rate of unmet family planning needs among students who had discontinued their studies; and (c) lack of friendly health-care services tailored to young people. The pilot project was a student-run programme, so young people were involved in the planning, implementation and monitoring of all activities. As students who attended the health facilities were treated with respect and their privacy and confidentiality protected, more than 75% of students used the services. Key results after three years of implementation were: (a) the incidence of pregnancies reduced from 21 in 2009 to two in 2011; (b) the number of unsafe abortions reduced from five in 2009 to one in 2011; (c) students from other schools and nursing colleges and the university began to use the service; and (d) planning for nationwide provision of such services began in 2011.

## **SOUTH SUDAN**

### **▪ Progress towards UHC**

The country has adopted a strategy that promotes UHC and people-centred PHC services. The Basic Package of Health and Nutrition Services has been defined to guide and inform service delivery by Ministry of Health and partners at facility and community levels. The PHC/UHC policy document was updated in May 2018, providing for a budget line for PHC and the assignment of a focal point. Current CHWs are on the Ministry of Health payroll. However, current PHC/UHC coverage is estimated at 44% due to poor geographical access, insecurity due to ongoing conflict; reduced funding for health service delivery and critical shortage of human resources. In the Health Sector Strategic Plan (HSSP) 2017-2022, the target is to increase access (5 km radius) from 44% to 50% and to increase the integrated community case management (ICCM)/Boma Health Initiative (BHI) coverage from 30% to 100% of all BOMAS.

## **2.3 Diversity of PHC/UHC implementation in the Region**

Some countries went further in their actions to implement the Ouagadougou Declaration and applied more forward-looking strategies which included:

- (i) Building the capacity of training institutions; recruiting new staff; identifying new approaches for staff motivation and retention;
- (ii) Incorporating community health workers into human resources for health;
- (iii) Exploring ways of establishing health insurance schemes;
- (iv) Providing free health services for specific vulnerable groups;

- (v) Updating national health policies (13 countries), strategic plans (14 countries), public health acts and laws;
- (vi) Using innovative approaches for health technologies such as eHealth and telemedicine. The latter was further developed in the Region under the guidance of the AFRO Strategic Directions for 2015–2020. WHO supported countries to establish knowledge transmission platforms and facilitated their access to the Evidence-Informed Policy Network (EVIPNet), thus bringing the total number of countries with a national platform to 12 in 2014. This further improved access to evidence for policy development and decision-making. The Regional Ethics Review Committee (ERC) was reconstituted and has reviewed 19 research proposals from seven countries, leading to improved adherence to research ethics principles.
- (vii) The African Health Observatory continued to act as the repository for country-level data on health status and trends, health systems, priority programmes and services, health determinants and progress towards UHC. These data have been used in policy dialogue and decision-making. Countries were supported to develop eHealth strategies to facilitate the use of information technology for health system strengthening, including service delivery. Several countries assessed the state of eHealth with the support of WHO to inform the development of eHealth policies. To improve WHO technical support to Member States, the Regional Director set up a Regional Task Force to serve as a Regional advisory team on reproductive, maternal, newborn and child health policies. At its first meeting held in 2014, the Task Force identified gaps and made key recommendations, which included strengthening health systems, pursuing a multisectoral approach, improving coordination and increasing investments in health. These recommendations were shared with African Ministers of Health. Guidelines for the development of national health policies and national health strategic plans were revisited, published and disseminated. However, these are currently being revised to take into consideration the new global and regional developments including UHC and the SDGs and private sector involvement.
- (viii) Institutionalization of a biennial technical meeting for monitoring of implementation of the Ouagadougou Declaration in the WAHO subregion. The monitoring includes PHC development processes and sharing of experiences between the countries of the subregion (reforms, good practices). AFRO is regularly invited by the Intercountry Support Team (IST) of West Africa. The recommendations from these biennial meetings are submitted to the Ministry of Health, which from time to time invites participants from other Ministries (Finance, Budget, and Labour).
- (ix) A regional conference on health district systems 25 years after the Harare Declaration was organized in Dakar, Senegal from 21 to 23 October 2013 by the Community of Practice “Health Service Delivery”, and brought together hundreds of experts as part of the Harmonization for Health in Africa (HHA) initiative. It was attended by 20 country delegations and 170 experts who shared their experiences in running PHC services at the local level. By highlighting African-grown innovative approaches to local health system coordination and service delivery and by featuring the use of innovative formats and platforms for creative discussion, the event kicked off a new era. Meeting participants observed that with people’s rising expectations, ministries of health needed to embrace a culture of upward and downward accountability. In many countries, this means involving new actors and substantially reshaping institutional arrangements. Participants also agreed that individuals, households and the community at large could and should play a much greater role in procuring their own good health and curbing the rising morbidity and mortality. Individual and

community education, empowerment, voice and freedom issues therefore require much more attention and intersectoral coordination to address them.

## **2.5 Country best practices and their dissemination in the African Region**

A guide for documenting and sharing best practices in health programmes was prepared by the Regional Office and disseminated among countries of the Region. AFRO regional staff also participated in the process of dissemination best practices conducted by their national programme counterparts. Some of the best practices shared include the following:

### **▪ Kangaroo mother care (KMC) in Malawi**

KMC is carrying preterm infants skin-to-skin, usually by the mother. This approach was adopted as a means of reducing infant morbidity and mortality by promoting breastfeeding, thermal maintenance and maternal-infant bonding for infants with breathing and other life-threatening problems. Using KMC is especially beneficial in resource-poor settings, as incubators are usually in short supply. It has been shown to reduce mortality among preterm babies (< 2000 g) in hospitals by 51% if started in the first week of life, compared with incubator care. In Malawi, complications from preterm birth before the introduction of KMC contributed to almost four out of every 10 neonatal deaths, claiming more than 5600 lives each year. For more than a decade, Malawi has worked to establish KMC units in facilities, trained service providers, and revised protocols and policies to include KMC. By 2014, seventy-nine per cent of hospitals (69/87) were reported to be providing inpatient KMC services. This has been a significant contributor to the reduction of neonatal and under-five mortality, making Malawi one of the few countries in the Region that achieved Target 4 of the Millennium Development Goals (MDGs).

### **▪ Health Extension Programme (HEP) - Ethiopia**

The national health policy developed by the Government adopted PHC as its core strategy. A 20-year Health Sector Development Strategic Plan (HSDP) is divided into three-to-five-year rolling plans, based on the national health policy. This focuses on comprehensive and integrated PHC services with a major shift towards community level care, emphasizing the preventive and promotive approach without neglecting essential curative care. The policy includes a Health Extension Programme (HEP) which ensures equitable access to services because it reaches all of the 15 000 rural Kebeles, while its linkage with a health centre brings all essential health services including basic curative care as close as possible to the community. The HEP is believed to be the best mechanism for putting PHC into action. It covers 16 packages delivered by two Health Extension Workers (HEWs). The HEW represents health as a member of the Kebele cabinet which consists of elected community members and representatives of the education, agriculture and health sectors, thus creating a mechanism for forming an intersectoral group and establishing linkages with the community. Ethiopia's Health Transformation Plan (2015–2020) puts a lot of emphasis on equity, quality of care, coverage and utilization of essential health services in line with its second growth and transformation plan (GTPII). To improve access, special attention has been paid to hard-to-reach populations while the second generation health extension programme has been extended to model Woreda and family concepts.

- **Community-Based Health Insurance (CBHI) - Rwanda**

The country has a National Health Insurance system comprising of a social health insurance scheme for the formal public and private sector: Rwanda Social Security Board (RSSB) Medical Scheme, and the Community-Based Health Insurance (CBHI) which caters for the poor and the informal sector. The management of the RSSB medical scheme and the CBHI scheme has been brought under the Rwanda Social Security Board (RSSB) that manages both schemes and the health care providers. Provider participation in the scheme is voluntary, on the basis of a contract. CBHI membership is mandatory at a cost that varies according to the family's ability to pay, with the use of a local system of categorization called Ubudehe that stratifies families into income groups. The premiums for the poor are covered by public funds. The package of services for CBHI includes preventive, curative services, antenatal and delivery care, laboratory tests, essential drugs and ambulance services. With a health centre referral, members also receive a hospital package. CBHI schemes protect the income of their members against financial risks associated with illness and have increased access to services for enrolled members reaching 84.3% of those eligible in 2016/2017.

- **Maternity waiting homes- a strategy to improve access to emergency obstetric care, Eritrea**

To overcome high death rates during childbirth among nomadic women and those living in remote areas, Eritrea introduced maternity waiting homes in 2006. These enabled women living far from centres requiring skilled obstetric services to travel and stay close to such a centre before they were due to give birth. The high maternal mortality rate among women living in remote areas and in nomadic groups was attributed to the “second delay”— delay in getting to the health facility even when the decision to seek care has been made in time. Maternity waiting homes increase access to skilled birth attendance and hence, reduce maternal and newborn deaths.

Eritrea has since reduced its maternal mortality rates every year and the number of women dying from pregnancy or childbirth-related complications reduced from 1509 to 501 per 100 000 live births between 1990 and 2015. The annual average rate of reduction of maternal mortality was estimated at 4.6%, very close to the required MDG rate of 5.5%.

- **Reducing mother to child transmission rates of HIV in Ghana**

In 1996 an act of Parliament created the Ghana Health Service (GHS) as an extra-ministerial agency that lies outside the civil service, allowing the health sector to change, innovate, and reform health care operations in Ghana. Ghana adopted Community-based Health Planning and Services (CHPS) which is a decentralized health service approach to innovate and adapt service strategies to local needs. It has a set of strategies aimed at bringing health services to the communities. District Health Management Teams throughout the country have been mandated to develop approaches that are aligned to community health care and are consistent with local traditions, sustainable and include community participation and stewardship with an enhanced close-to-client (CTC) system. The CHPS strategy entails placing community health officers (CHO) who are nurses to live in the community with the people to whom they provide health care. The CHPS strategy has led to reorienting and relocating PHC from subdistrict health centres to convenient community locations.

The CHPS initiative provides the key strategy for changing PHC and family planning from a focus on clinical care at district and subdistrict levels to a new focus on convenient and high-quality services at community and doorstep locations. This national programme of service delivery change was achieved by forging partnerships between health care providers and the communities they serve. By 2002, the CHPS programme was providing doorstep health care in all regions of Ghana through a programme that is supported by the Government of Ghana and community resources. In all, 95 of the

110 District Health Management Teams (DHMT) have launched the planning phase of the CHPS programme; of these, 20 districts have implemented most of the components of the CHPS programme in at least one pilot zone. The CHPS system for organizational change and thorough reforms has encountered constraints that are resource-related. However, CHPS has developed mechanisms to solve major problems if these resource constraints are resolved.

▪ **Increasing access to antiretroviral treatment (ART) in the Republic of South Africa**

South Africa has more people on life-saving ART than anywhere else in the world; this is a decade after the country's leaders launched a public sector programme to combat the HIV/AIDS epidemic. An estimated, 2.4 million people are receiving ART, constituting roughly 80% of those who require treatment based on WHO 2010 guidelines. Accredited nurses are initiating therapy. The successes of the national ART programme and prevention and research efforts in South Africa are clear: for example; (a) life expectancy among adults has increased by 11 years in rural Kwa-Zulu-Natal, the province worst hit by HIV/AIDS; (b) fewer babies are born with HIV – rates dropped from between 25% and 30% in infants born HIV-positive in 2003 to 2.7% in 2011; (c) the rate of new infections among adults is also declining; (d) more than 20 million South Africans had been tested for HIV by December 2013 and by 2016, up to 86% of people living with HIV were aware of their status as compared to 66.2 % in 2014; (e) by December 2013, one million two hundred thousand men had undergone medical male circumcision to reduce the risk of HIV infection and by 2016, coverage had reached 50-79% of eligible men.

▪ **Integrated community case management (iCCM) of childhood illness in Senegal**

Senegal successfully started implementing iCCM since 2003, with more than 4000 community sites in 72 out of 76 districts covered in 2013. This enabled community health workers to manage malaria, diarrhoea and pneumonia effectively. Malaria, diarrhoea and pneumonia were responsible for 19%, 14% and 13% respectively of deaths in children below five years of age. An evaluation indicated that after the training of community health workers in the use of rapid diagnostic tests, the number of cases diagnosed as malaria declined significantly and therefore antimalarial drug use became more rational and cost-effective. Ninety three per cent of suspected cases benefited from a rapid diagnostic test and 100% of malaria-confirmed cases received adequate treatment.

Lessons learnt from the implementation of iCCM include: (a) establishing a favourable policy environment and effective institutional support; (b) reinforcing links between the health system and the communities; (c) rapid scaling up of the delivery of quality services by community health workers to households; (d) designing and implementing behaviour-change community activities for iCCM through family and community dialogue.

▪ **Elimination of lymphatic filariasis in Togo: a success story**

In 2017, Togo was the first country in the WHO African Region to be acknowledged for having eliminated lymphatic filariasis. The country conducted at least six consecutive rounds of mass treatments in targeted districts. The mass drug administration (MDA), conducted door-to-door with the support of community health workers, led to the killing of the microfilaria and interrupted local transmission of the disease. The success of the mass treatments was due to social mobilization and information; education and communication campaigns carried out before and during the medicine distribution; and involvement of community health workers in the distribution of the medicines. Since then the country has been under post-MDA surveillance, which is carried out nationwide

through a network of district level laboratories and has confirmed the interruption of local transmission of the disease.

- **Elimination of blinding trachoma in Ghana**

Ghana began activities to control the disease in 2000, when 16% of children had trachomatous follicular inflammation. The full SAFE (Surgery, Antibiotics, Face washing and Environmental changes) strategy was implemented from 2004 and by 2007-2008, the highest prevalence detected was 2.8%. By that time, 70% of households had access to potable water and 38% to household latrines. The success of the SAFE programme has been linked to the strong collaboration between the MoH, other ministries and NGOs. Many stakeholders from the health, education and water, sanitation and hygiene sectors were involved in initial planning and budgeting to implement the SAFE strategy, especially in the endemic districts. Active screening has been carried out by ophthalmic nurses using a magnifying glass and flashlight. Passive screening was conducted by trained health workers, who submit a list of suspected cases to the subdistrict health authorities every two weeks. Active case-finding/treatment is performed by an ophthalmic nurse who visits the community, screens schoolchildren and families with suspected cases. Ghana eliminated blinding trachoma since 2013 and this was acknowledged by the WHO Director General in May 2018.

- **Social mobilization/community participation: the COMBI project, Northern provinces of Mozambique**

In the beginning of 2000, Mozambique was highly endemic for leprosy, especially in the three northern provinces: Nampula, Niassa and Cabo Delgado, with a prevalence rate higher than five cases per 10 000 population. The burden of the disease was worsened by poor health services coverage and difficult-to-access areas, with many health facilities and roads destroyed during the civil war. To enable early case finding and treatment, a project entitled COMBI (Communication for Behaviour Impact) was launched in schools. Children were given a small sheet of paper with a body chart to report any skin patch found in their family members with the theme “Check your Skin for ELSI” – ELSI is the acronym for Early Leprosy Sign. In addition, in peripheral health centres, some community members volunteered to refer suspected leprosy cases to the nearest health centre for confirmation. After confirmation, the community volunteer would collect quantities of multiple drug chemotherapy blister packs for treating the leprosy patients at their respective localities. Using the COMBI project and the community volunteers, Mozambique was able to reduce the prevalence of leprosy in these three provinces within five years (2002–2007) and achieve leprosy elimination as a public health problem at national level.

- **Managing mental health/neurological disorders through the Gap Action Programme (mhGAP) in Mauritius**

The WHO mhGAP Intervention Guide was adapted to local settings and disseminated to all medical and health officers and community physicians by the Ministry of Health. In the country there has been only partial decentralization of psychiatric services. Although the country has psychiatrists at the regional hospitals and they attend clinics at some of the area health centres, there are no such clinics at the community health centres. There is a shortage of psychiatric nurses in all of the five regional hospitals and there are no community psychiatric nurses. A total of 110 nursing cadres from the regional hospitals were trained on the adapted mhGAP, which has helped in the management of

psychiatric patients both at the regional hospitals, and the community health centres where nursing staff work on a rotational basis. They are now in a better position to observe and manage the patients and counsel them.

- **Changing the diet in Kenya**

The Government has embarked on an Eat More Fish Campaign, while at the same time encouraging fish farming. Today aquaculture, which takes many different forms ranging from small hand-dug kitchen ponds to fairly large earth ponds of 1000 m<sup>2</sup>, is now popular among poor peasant farmers. Production has increased more than tenfold, from 4700 metric tons in 2007 to 48 790 metric tons in 2013, valued at about US\$ 21 million. There are now more than 150 000 fish farmers. Under a programme known as the Fish Farming Economic Stimulus started in 2009, the Government has invested approximately US\$ 70 million in pond construction and provision of fish fingerlings and feed to farmers. Local universities have also introduced courses on aquaculture for farmers as well as for regular students. Aquaculture in Kenya now produces nearly six times more fish than marine capture fisheries. In addition, it has created employment for over 500 000 and indirect employment for over 1 million Kenyans, according to Kenya's Department of Fisheries. Fish farming has the potential to improve the quality of the Kenyan diet particularly for arid and semi-arid land communities which did not traditionally consume fish and had high rates of malnutrition.

- **Improving access to water, sanitation and hygiene in health-care facilities during emergencies in the northern region of Mali**

Since 2012, Mali has been facing a serious humanitarian crisis causing displacement of over 300 000 people. This large influx of people from conflict zones in the north has affected health-care facilities, overwhelming their capacity to provide safe drinking water and maintain good sanitation. In the conflict zones the water supply has been interrupted frequently, contributing to degradation of sanitation in health facilities. WHO worked with the MoH and a local NGO (Groupe de Recherche pour l'Amelioration des Initiatives) to provide assistance in the districts of Gao and Ansongo. Interventions included provision of sanitation equipment, bleach, water treatment kits; development of posters and leaflets and health education on hygiene practices. A post-intervention evaluation found significant improvements: the percentage of facilities with safe drinking water increased from Zero to 77% and those with safe water storage increased from 26% to 100%. The problem of wastewater around the facilities improved considerably, from 42% with wastewater to 0%. Fewer facilities had stagnant water around their water points. Management of medical waste also improved. The number of facilities with adequate rubbish bins increased from Zero to 92%. This experience is now being applied to water and sanitation interventions in conflict zones of South Sudan.

- **Strengthening national adaptive capacity to prevent epidemic highland malaria in Kenya,**

In Kenya, communities living at altitudes greater than 1100 m, especially those in the western highlands, are more vulnerable to malaria epidemics due to lack of immunity, lack of preparedness and climate variability. At present about 33 million Kenyans are at risk of malaria. In response to this, the Ministry of Health worked with WHO on a four-year climate change adaptation project which started in late 2010. It aims to strengthen capacity to prevent malaria epidemics in the western highlands. The project compiled 10 years of baseline retrospective (clinical- and laboratory-confirmed malaria) and climate data (temperature and rainfall) to develop a prior three-month national malaria epidemic prediction model and decision support tool. This user-friendly early warning tool is based on a simple algorithm that correlates meteorological and malaria data. District health officers have been trained in the use of the tool, and automatic weather stations have been equipped with the necessary software. The malaria early warning tools enabled the National Malaria

Control Programme to plan response activities, including prepositioning commodities, capacity-building and community sensitization in epidemic-prone settings such as Kericho, Kisii and Nandi zones. WHO is currently supporting Kenya to further develop the malaria early warning tool for use in other countries with similar epidemiological patterns of malaria.

- **Identification and management of mass poisoning by bromide in Angola**

In 2007 Angolan health authorities detected a massive outbreak of acute neurological disease affecting many people in the Cacuaco Municipality, Luanda Province. Signs suggested a toxic etiology. Site surveys revealed toxic chemicals around the community. Reference laboratories detected high levels of bromide in blood samples taken from affected people and high levels of sodium bromide in table salt samples collected from the homes of people with symptoms. WHO coordinated several partners to eventually identify the largest outbreak of bromide poisoning ever reported, with 458 cases recorded between 19 October and 5 December 2007. The identification of bromide proved challenging for different reasons, in particular because of the atypical presentation of this intoxication, resulting from cumulative exposure to bromide over a period of several days. This mass poisoning highlights the need to implement effective national chemical and food safety programmes and surveillance systems.

- **Adoption of results based financing (RBF) in Burundi,**

Faced with challenges of underfunding user-fee schemes with subsequent impoverishment, underutilization of services of poor quality and poor health indicators, the Government of Burundi introduced fee exemptions for pregnant women and children less than 5 years of age in 2006. Although this led to a marked increase in utilization, the persistent underfunding of health by the Government further compromised the quality of health services, caused disgruntlement among health workers and subsequently reduced utilization rates. Official user fees were replaced by under-the-table payments. RBF pilots were introduced in 2008. RBF is a health financing strategy that links funding to outputs. The health facilities in the pilots received performance bonuses for both the quantity and quality of services delivered; and quantity indicators related to a basic health package, which included services that were exempted from the fee scheme. The pilots produced positive results with an average increase of 50–60% for each indicator compared with the period before the introduction of RBF. RBF has been scaled up to more provinces and a national RBF scheme was launched in April 2010.

- **Health financing in Botswana**

Botswana is one of the few countries in the Region where the Government has made a significant investment in health. The current health financing system, based largely on domestic financing from Government, provides a high level of financial risk protection for its population compared with other countries in the Region. Botswana uses a tax-based system to cover the population for a wide range of services and has one of the Region's lowest levels of out-of-pocket spending on health at only 5% of total health expenditure (Global Health Expenditure Database; 2015). Government expenditure on health, at US\$ 389 per capita is also considerably higher than the average for other countries in the Region (US\$ 147 per capita) (IBID).

- **Promotion of traditional medicine (PROMETRA), Senegal**

At PROMETRA International's Experimental Centre for Traditional Medicine (CEMETRA) in Fatick, Senegal, a 450-member association of traditional health practitioners from Sine, known as MALANGO, collaborates with western-trained medical doctors. An important characteristic of CEMETRA is that the traditional health practitioners are officially recognized by the Government of Senegal but only authorized to treat patients within the health centre. The medical doctor checks the patient's vital signs, such as blood pressure, pulse, respiratory cycle, temperature, weight, etc., and makes a diagnosis after analysis of laboratory tests, but does not take part in treatment. The role of the medical doctor is to make an initial diagnosis and send the patient to a qualified traditional health practitioner. After treatment, the traditional health practitioner sends the patient back to the medical unit to measure the impact of the traditional medicine treatment. Physical examinations and laboratory tests are again carried out and the outcome of treatment is determined by comparison of pre- and post-treatment laboratory results, vital signs and physical examination findings. This collaboration helped to reduce health workers' scepticism and strengthened mutual appreciation and respect between practitioners of the two medicine systems.

- **Optimizing epidemic-prone diseases surveillance networks using ICT in Cameroon**

Between 2010 and 2012, Cameroon distributed mobile telephones to 310 key personnel to enable them communicate epidemiological information at no cost and thus improve the response to cholera, yellow fever, measles and polio epidemics. Staff who received the telephones worked in 181 districts and at all levels of the health system. The mobile network now comprises nearly 2000 members at all levels of the health system, all listed in a dedicated telephone directory. As a result, coverage of the epidemic-prone disease surveillance network, which was 30% before the provision of the mobile telephones, reached 98% during the last week of 2013. Readiness also increased from 6% to 77% on average for the same period. The mobile network has permitted the enforcement of deadlines for providing laboratory results to regions and health districts, enabling a quick response to outbreaks. The pilot project proved very effective and in 2013 the initiative was extended to cover the entire country.

- **“Science cafés” in Malawi**

In Lilongwe “Science cafés” have been established where national health statistics and policy briefs on important public health issues are displayed. Staff of “science cafés” also assist clients to search and analyse health information using the database and software. Ministry of Health staff and policy-makers can now access, appraise, synthesize and apply evidence, eventually enabling them to do this on their own.

- **Impact of evidence-based policy briefs and dialogue on MCH programme in Nigeria**

Through evidence-based policy briefs and dialogue that demonstrated the cost-benefit analysis, EVIPNet in Nigeria influenced the establishment of the Government's Free Maternal and Child Health-Care Programme. The policy options called for focus on community-based participatory interventions which were implemented, resulting in greater community mobilization of pregnant women in rural areas with increased home-based maternal and child health care and decreased maternal and child mortality.

## ▪ **Ideal Clinic Initiative in Republic of South Africa**

The Government of South Africa launched the **Ideal Clinic Initiative** or the Ideal Clinic Realization and Maintenance (ICRM) programme in July 2013 to address the prevailing deficiencies in PHC services and to lay a strong foundation for the implementation of National Health Insurance. An Ideal Clinic is defined as a clinic with good infrastructure, adequate staff, medicine and supplies, good administrative processes, and sufficient bulk supplies. It uses applicable clinical policies, protocols and guidelines, and harnesses partner and stakeholder support. An Ideal Clinic also collaborates with other government departments, the private sector and NGOs to address the social determinants of health. Integrated Clinical Services Management will be a key focus within an Ideal Clinic (<https://www.idealclinic.org.za/>; Ideal Clinic Manual, version 18 [2018]). Every district in South Africa has appointed a Perfect Permanent Team for ICRM (PPTICRM) to function in line with the national quality standards. The teams are responsible for conducting a status determination at all the clinics and assisting them to improve their quality of care. The Ideal Clinic manual has been developed to assist managers at various levels of health-care service provision to correctly interpret and understand the requirement for achieving the elements as depicted in the Ideal Clinic dashboard. The manual is comprised of detailed steps that should be followed to achieve every element. The Ideal Clinic dashboard comprising of six vital elements, 84 essential elements and 118 important elements to determine the Ideal Clinic category of the facility: Silver (70-79%), Gold (80-89%), or Platinum (90-100%). An Ideal Clinic status is achieved when a clinic improves integrated clinical-service management, infrastructure, human resources for health, service-user waiting times, financial and supply-chain management. By the time the NHI is fully implemented over the next five to seven years, the Ideal clinic platform will have established a solid PHC-oriented health system backbone that will be instrumental in accelerating South Africa's move towards UHC.

## **2.6 Support by partners for the implementation of the Ouagadougou Declaration on PHC**

The implementation of the HFA strategy in the Region since the Alma-Ata and later the Ouagadougou PHC Conferences has always been conducted in close collaboration with AFRO's regular partners: UNDP, UNICEF, UNHCR, UNAIDS, UNFPA, UNESCO, FAO, World Bank, International Committee of the Red Cross, Gavi and bilateral partners (USAID, ODA, JICA, DANIDA, GTZ, DFID, etc.).

**The Harmonization for Health in Africa (HHA)** partnership was expanded with new members (USAID, JICA and GFATM). This partnership, led by the WHO Regional Office for Africa, has further improved joint advocacy and technical support to countries. Furthermore, HHA is working to build an alliance between the health and financial sectors through joint ministerial meetings with the Ministry of Finance. The meetings include High-level meetings such as the 2012 meeting between Ministers of Health and Finance in Tunisia on ensuring sustainable financing and value for money for universal health coverage. A joint Declaration (Tunis Declaration) was endorsed by all the African States. At a technical level, joint ministerial meetings have been held to facilitate capacity building and raise awareness on value for money in health with participants from Ministries of Health, Finance and Parliament.

**Global Fund-** the purpose of this partnership is to provide financial support to fight AIDS, tuberculosis and malaria. Established in 2002, the Global Fund partners with countries and implementing agencies that are striving to improve health outcomes. It joins other partners to optimize the interventions related to Millennium Development Goals (MDGs) 4, 5 and 6. So far, an amount of at least US\$ 20.7 billion has been disbursed to the African Region.

**The Gavi Alliance** launched in 2001 and still functional today, brings together developing countries, private and government partners, international organizations and the vaccine industry to increase access to immunization in the world's poorest countries, most of which are in the African Region. Health ministries identify their priorities, integrate Gavi Alliance support into their national health and immunization plans, and contribute through co-financing towards the cost of the vaccines. WHO has played a critical role in supporting countries to develop financing proposals and implement the grants, alongside other Gavi partners. To date Gavi has disbursed at least US\$ 12.7 billion to the countries in the African Region. Gavi support has helped introduce new vaccines such as hepatitis B vaccine, rotavirus vaccine, meningitis A vaccine, pentavalent vaccine, pneumococcal vaccine and human papillomavirus vaccine, among others. They have resulted in significant reductions of morbidity and mortality. However, there are challenges of sustainability as countries graduate out of Gavi support when they improve their gross national product beyond the given threshold.

**UNDAF-** At country level, WHO and other UN Agencies are actively engaged in the development of the United Nations Development Assistance Framework (UNDAF), a UN joint support programme for country development plans. WHO is the health lead agency within UN country teams in providing support for national development plans which include a health sector plan, previously discussed and agreed with the Ministry of Health of Member States.

## **2.7. Main challenges and obstacles to the implementation of the strategy at Regional and country levels**

In the African Region, the coverage of essential health interventions is inequitable and lacking in quality and safety. While the rate of skilled care during childbirth increased from 58% in 1990 to 73% in 2013, mostly due to increases in facility-based births, giving birth in a health facility does not equate to a safe birth. WHO estimates that 303 000 mothers and 2.7 million newborn infants die annually around the time of childbirth, and many more are affected by preventable illness.

Less than 50% of people with common illnesses obtain the required treatment. Only about 30% of mothers exclusively breastfeed their babies in their first six months. In addition, resource allocation favours curative services at high cost while neglecting primary prevention and health promotion which could prevent up to 70% of the disease burden. This is due to ineffective priority-setting, poor integration and lack of harmonization and alignment to a single national strategic health plan and a poor culture of accountability. There is no institutionalization of the concept that PHC is the hub for coordinating all health services for well-defined communities within the district. Decentralization has been undertaken but certain aspects such as financial and human resource management have not been completely handed over to the lower levels – hence it is partial decentralization.

There is inadequate scaling up of the production of health workers, coupled with their inequitable distribution between urban and rural settings as well as insufficient incentives to recruit, retain, develop and appropriately and equitably deploy personnel to offset the impact of the HRH crisis. This creates an “exodus” of highly qualified and talented health personnel to Euro-American settings. The effect of political instability on security, the labour market and the social sector in some parts of Africa (Central Africa) should not be underestimated as contributing factors to the movement of cadres to the southern part of Africa in quest of jobs and well-being. In most countries in the African Region, there is a paucity of competent teams at district level. Health services including referral systems in most countries of the Region are not organized in a manner that ensures a continuum of care, efficient utilization of resources and reduction of hospital visits.

There are inadequate mechanisms to strengthen health information management systems with established standards and to encourage their use by various departments and health care levels, such that districts are unable to effectively track progress towards the attainment of annual or longer-term goals. There is inadequate data gathering and analysis for timely and effective decision-making due to the absence of real-time tracking systems to ensure that an appropriate response/correction can be made before annual reporting of progress. Another phenomenon is the fact that the management of health information systems in some countries is donor-driven. Thus, the data collected at the operational level are transmitted only to the donor at national level, without necessarily copying the MoH, especially when these data are collected by the CHWs paid directly by the CSOs; they do not go through the health centre team to be used by the health facilities that generated them to inform the decision-making process.

In addition, the technical, political and administrative capacity at the lower level does not match the level of authority transferred. As a result, the benefits of decentralization at district level are minimal in the absence of adequate participatory planning and organization; effective communication with communities; effective management and coordination of programmes and services at all levels; and adequate intersectoral collaboration particularly with the agricultural, education, water supply and waste disposal sectors.

Emerging verticalization of health interventions resulting from the rise in the number of global health initiatives with a disease focus and aiming to produce quick results may weaken district health systems and affect their sustainability.

In the African Region, new and ongoing conflicts have generated further problems for the health sector in the host countries due to population displacements. For example, violence in Burundi, the Central African Republic, Nigeria and South Sudan has displaced hundreds of thousands of people internally and across borders, while the deteriorating situation in Yemen has caused significant numbers to seek safety in different countries in the Region. Meanwhile, protracted conflicts in the Democratic Republic of the Congo, Mali and South Sudan have prevented millions from returning home. By the end of 2015, there were 4.2 million refugees and 6.4 million internally displaced persons in the Region and currently sub-Saharan Africa hosts more than 26% of the world's refugee population. Their largest numbers were concentrated in Nigeria, South Sudan and the Democratic Republic of the Congo.

The Region bears a disproportionately high burden of neglected tropical diseases (NTDs), such as guinea-worm disease, Buruli ulcer and human African trypanosomiasis which affect mainly impoverished and disempowered populations. All 47 countries in the Region are endemic for at least one NTD and 36 of them (78%) are co-endemic for at least five of these diseases. Although neglected, hundreds of millions of people are at risk of these diseases, which are found only, or mainly in the African continent.

Major health issues affecting young people in the Region include HIV infection, violence and injuries, substance abuse, suicides, child marriage, early initiation of sex, complications after female genital mutilation, etc.

The Region is faced with a double burden of disease as a result of the rising incidence of noncommunicable diseases at a time when communicable diseases are still rife. They come with increased health system needs and with higher costs as most of these diseases are chronic and some life-long. The other big challenge is the huge youth bulge, which nonetheless, has potentially significant dividends if well managed. Likewise, as life expectancy continues to improve, the

proportion of elderly persons will increase and health systems in the countries in the Region need to prepare to deal with issues of the elderly.

## LOOKING FORWARD (2018 and beyond)

### 3. Vision for UNIVERSAL HEALTH COVERAGE

#### 3.1 Enhancing partnerships, strengthening intersectoral collaboration

As can be observed in the list of SDGs, health, as a sector in modern society, vitally depends on multiple other sectors and should work closely with them in order to ensure its own success in providing “good health” to the poor or rich, newborn or adolescent child, women or men, disabled, old, refugees or people living in inaccessible communities.

In her 2016-2017 biennial report, the WHO Regional Director pledged that the opportunities offered by the 2030 Agenda for Sustainable Development for multisectoral collaboration in addressing the socioeconomic determinants of health would be exploited for mutual benefit and further developed and promoted for action in countries. WHO in the African Region will reinforce collaboration with relevant partners within the United Nations system and beyond. At country and regional levels, WHO’s contribution to joint UN action through the UN Development Group will be further strengthened.

Achieving the health targets of the SDGs calls for new alliances/partnerships to make the expansion of PHC/UHC-oriented health systems a reality. It is therefore vital to work together to reach UHC and the SDG goals. WHO’s working relations with UN agencies: UNDP, UNICEF, UNFPA, UNHCR, etc., and traditional partners, including USAID, CDC, DFID, the Bill and Melinda Gates Foundation, Gavi and others, have been enhanced. New partnerships have been formed too, and collaboration with regional economic communities, civil society and global health initiatives intensified, including through the International Health Partnership for UHC 2030. There have been important trends and activities in this direction as follows:

- (a) Harmonization for Health in Africa (HHA), a regional mechanism to coordinate partners’ support to countries and enhance synergies in the health sector was relaunched after an independent review in 2016. The renewed HHA partnership agreed to pursue the analysis and promote greater understanding of the contribution of the private sector to UHC.
- (b) For the first time, the Regional Office convened a regional forum on health systems strengthening for UHC and the SDGs for senior Ministry of Health officials from all 47 Member States and other technical experts, partners and academics in Namibia (2016), in which four Communities of Practice were established, allowing participants to continue sharing experiences and solving problems jointly on country challenges relating to governance, human resources for health, district health systems and health financing.
- (c) WHO/AFRO convened another Africa Health Forum in Kigali, Rwanda from 27 to 28 June 2017, bringing together leaders from the public and private sectors, research institutions and academia, NGOs and CSOs and youth organizations. The theme was “Putting People First: The Road to UHC in Africa”. The main areas discussed included: (i) health financing; (ii) health security; (iii) health research, innovation and data; (iv) UHC and the private sector in Africa; and (v) old enemies including HIV and the rise of new threats such as NCDs. The Forum adopted the Kigali Call to Action for the different stakeholders to engage and undertake specific roles for

UHC and promote collective action for improved health in general and health security in particular in the African Region. The second such forum will take place in Praia, Cabo Verde, from 26 to 28 March 2019 on the theme: “Achieving UHC Coverage and Health Security in Africa: The Africa we want to see”.

- (d) Partnership with the African Union Commission (AUC) has facilitated the adoption of important decisions on health by Heads of State and led to agreement on a framework for collaboration with the Africa Centre for Disease Control and Prevention (Africa CDC). WHO supported the establishment of the Africa CDC and will sign a framework for collaboration with the AUC to synergize efforts in addressing health security.
- (e) In March 2017, the Regional Director, together with the UN Economic Commission for Africa (UNECA), organized an advocacy event on health financing in the Region. The aim was to understand the perspectives of Ministries of Finance and build consensus towards sustainable financing for health.
- (f) WHO signed a cooperation agreement with the International Telecommunication Union (ITU) and has implemented an mHealth programme called “Be Healthy. Be Mobile”, which is helping to alleviate NCDs in the Region. Digital solutions are the future of equitable, quality health care and resilient health systems and over the past years, great strides have been made in boosting telemedicine, eLearning, mHealth and social media in the African Region.
- (g) To support countries in the Region in implementing the Global Action Plan on Antimicrobial Resistance, WHO, FAO, the World Organization for Animal Health (OIE) and the relevant government sectors, trained nearly 300 officials from 44 countries in 2016-2017 to develop national action plans (NAPs) for antimicrobial resistance using the “One Health approach” encompassing human, animal and environmental health.
- (h) Working across sectors, WHO, UNICEF and other partners put in place preventive and control measures relating to the quality of water and sanitation facilities in camps, promoted community mobilization on hygiene, and provided support for case management and surveillance.
- (i) In order to address the health needs of refugees, migrants, asylum seekers and internally displaced persons, in the African Region, WHO, UNICEF, UNHCR and other partners have provided support to strengthen local health systems and enhance surveillance, preparedness for and response to diseases. In Ghana, by the end of 2015, eighty-seven per cent of refugees had access to the national health insurance scheme. In Ethiopia, vaccines against measles and polio for children under 15 years of age were delivered, with over 19 600 refugee children being vaccinated against measles and over 21 000 against polio.
- (j) AFRO continued to work with Member States and partners to improve national capacity for preparedness and response, notably by conducting a regional risk analysis and mapping exercise. So far, 36 countries have completed the Joint External Evaluations (JEEs), accounting for 77% of AFRO Member States.

### 3.2 Exploiting technological advances

Knowledge gaps and the state of research, information and knowledge management in the WHO African Region have paved the way for better approaches aiming to improve access to information and evidence. One such platform is the African Health Observatory. Several countries are also establishing their own national health observatories. As mentioned above, a number of countries have started to develop and use mobile health (mHealth), which is the most cost-effective and secure use of information and communication technologies for health and health-related purposes. However, the eHealth success rate is not as yet clear, due to lack of documentation and formal evaluations. Internet users in the Region are estimated at 16 per 100 inhabitants, and mobile phone users at 63 per 100 inhabitants. In both cases, rates are lower in rural than urban areas. Very few countries have fibre-optic or satellite broadband connections to access health information and knowledge. Only 26 countries in the African Region have developed eHealth Strategies. Existing eHealth solutions in the Region include national health observatories, enterprise resource planning for better management, and telemedicine and mHealth. Other examples are electronic medical records, electronic referrals and prescriptions, and distance learning using electronic resources. A wide range of technologies and devices is used, enabling services such as mobile telephony, text messaging, teleconferencing, electronic mail and video-conferencing. Many initiatives have been launched in countries by both the public and private sectors.

#### **Success stories: Democratic Republic of the Congo (DRC) : Using of Mobile applications**

Mobile applications are being used as part of the response to the Ebola outbreak in the DRC to collect and transmit contact tracing information and alert data. The launch of an electronic portal using geographic information management systems now allows all partners to have access to epidemiological data, information on entry points and health infrastructures, allowing for a better understanding of the dynamics of the Ebola virus epidemic and ensuring an appropriate response.

Through Regional Committee sessions, AFRO has been encouraging Member States to apply electronic applications through telemedicine which can contribute to improving equity in health by connecting underserved populations in rural areas to urban health facilities with highly qualified personnel and medical technologies (AFR/RC60/5). In order to achieve the required impact in the use of eHealth, the Regional Committee underscored the importance of training national staff, and through resolution AFR/RC63/R5 adopted since 2013, requested Member States to work with education institutions to include eHealth in their curricula, identify and establish specialized eHealth courses and qualifications and implement formalized training/education programmes.

The use of eHealth solutions can enhance service delivery; develop the health workforce and improve performance by eliminating distance and time barriers; and improve the availability, quality and use of information and evidence. WHO will work with the ITU and other partners to advance eHealth in countries.

## Success stories: Kenya : Using of Mobile applications

Civil registration/vital statistics systems strengthening: Although the coverage of death registration is still below 60%, the country is working to improve registers and re-engineer mobile-based applications for better tracking and cause-of death data quality verification, as well as real-time death notification. Under the Health Data Collaborative initiative in Kenya, development partners have worked together to synergize efforts on investing in the national health information system. The recent analysis of results indicates a remarkable improvement of routine health facility data through HMIS, and consistency with data generated through surveys.

## 4. STRATEGIC DIRECTIONS OF THE REGIONAL OFFICE FOR AFRICA: The Africa Health Transformation programme 2015–2020: A vision for Universal Health Coverage

The Africa Health Transformation Programme, 2015–2020: a vision for universal health coverage is a framework that describes the strategic directions that will guide WHO's contribution to the sustainable development platform in Africa. The activities, which have already started and deliverables related to these strategic directions are provided in Annex 4. Below are the strategic directions and the strategic actions anticipated.



### Strategic direction 1: Improving health security by tackling epidemic-prone diseases, emergencies and new health threats

#### Strategic actions

- (i) WHO in Africa shall continue to contribute to maintaining **zero** Ebola cases and rebuilding national health Systems in the three severely affected countries of West Africa through: high-level advocacy missions and engagement with the relevant national, continental and regional stakeholders;
- (ii) A regional strategic plan for Ebola virus disease (EVD) response, recovery and restoration of health services will be prepared to guide the work of WHO in the African Region;
- (iii) A broader regional strategic plan on health security and emergencies will be developed by 2016;

- (iv) In all 47 Member States, WHO will help to build countries' capacities to prepare for and respond to epidemics, emergencies and humanitarian crises;
- (v) WHO will enhance regional capacity to respond to emergencies through technical support and collaboration with the AUC to establish an Africa Centre for Disease Control and Prevention;
- (vi) WHO will create a multidisciplinary African Health Corps to serve as a continental rapid response platform and as part of the global public health reserve workforce;
  - The use of the Strategic Health Operations Centre (SHOC) in the WHO Regional Office will be enhanced to facilitate preparedness and response to public health events;
  - WHO will support countries to strengthen antimicrobial resistance (AMR) surveillance in the Region.

## **Strategic direction 2: Driving progress towards equity and universal health coverage**

### **Strategic actions**

WHO will focus on the following strategic actions to ensure equitable access to health and attainment of UHC:

#### **(a) Support countries to translate health-related SDGs into national goals/targets by providing technical assistance for:**

- (i) revising national health policies, strategic and investment plans;
- (ii) conducting a baseline assessment of health systems and UHC to monitor health trends towards 2030;
- (iii) developing an investment case for an integrated health systems approach;
- (iv) strengthening evidence-based targeting and scale-up of interventions to reduce the burden of HIV/AIDS, viral hepatitis, TB, malaria, NTDs and NCDs;
- (v) increasing access to and improving the quality of maternal, child and adolescent health services;
- (vi) managing the social and environmental determinants of health, including environmental hygiene.

#### **(b) Support the development of a regional roadmap for the implementation of UHC by:**

- (i) building on the AUC/WHO commitment on UHC to develop a regional roadmap to accelerate implementation of UHC in the African Region and reducing geographical, social and financial barriers to accessing services;
- (ii) providing technical assistance and capacity to implement the regional UHC roadmap with WHO support structured to the different country contexts.

#### **(c) Invest in the expansion of knowledge generation, utilization and management capacity by:**

- (i) developing a regional health research strategy aimed at strengthening national health research systems;
- (ii) expanding the use of WHO collaborating centres in the Region to undertake research on regional priorities;
- (iii) enhancing the analytical role of the African Health Observatory;

- (iv) supporting the translation of evidence from research into health policies and implementation strategies.
- (v) a baseline study organized by AFRO in 2016 capturing data from every Member State that will be used to develop a monitoring framework to inform on progress made towards UHC and the SDGs.

**(d) Strengthen and coordinate partnerships for the achievement of the SDGs by:**

- (i) reviewing and refocusing the “Harmonization for Health in Africa” (HHA) partnership;
- (ii) creating the framework for strengthening and supporting health sector partnerships at country level;
- (iii) establishing the Africa Health Forum for a broader engagement with all stakeholders.

**Strategic direction 3: Strengthening the capacity of WHO in the African Region**

**Strategic actions**

**(a) Mainstreaming WHO reforms**

WHO in the African Region will establish training and monitoring mechanisms to ensure accountability, ethical standards and excellence among its staff; strengthen systems for enhanced efficiency and accountability on finance, procurement and general management; maximize the use of available e-business platforms and tools; strengthen information-sharing among staff and teams; and strengthen WHO communication. The governance functions of Member States shall be enhanced through the establishment of a stronger oversight role for the Regional Committee’s “Programme Subcommittee” (PSC).

**(b) Enhancing human resource capacity at all levels**

Staff recruitment processes will be strengthened with new mechanisms that are more transparent in ensuring that the best qualified candidates are recruited into the relevant positions. Special efforts will be made to address gender and language imbalances in the workforce while ensuring excellence. A structured and harmonized human resource functional review will be organized across all of the offices of WHO in the African Region. An appropriate organizational structure with optimal staffing will be defined, followed by the development of a strategic human resource plan. The performance management and development system will be strengthened and linked to policies on recognition and rewards or to address underperformance. A revised system for assignment of WHO Representatives and assessment of country office performance will be introduced.

## **Success stories: Burundi meets its managerial key performance indicators (KPIs)**

The Burundi WHO Country Office (WCO) had been facing difficulties in meeting its KPIs in 2016. When the new WHO Representative (WR) assumed office in 2016, he soon mobilized his staff around the Transformation Agenda, with a strong focus on WHO's accountability and internal control frameworks. Soon the WCO developed its road map for implementation of the reform agenda. Change agents appointed by their peers were regularly involved in management committee meetings chaired by the WR, to report progress on key transformation milestones. To further support the WR, experts from AFRO, IST, WHO/HQ undertook a programme monitoring and assessment mission to help in risk and compliance management, accountability in administration. Recommendations from the review led to a management response action plan. Workflows and internal controls were strengthened and the WCO's responsiveness to emergencies and cooperation with key stakeholders was reinforced. Managerial KPIs improved significantly over time. A cholera outbreak was quickly brought under control after the WCO effectively coordinated and implemented the WHO Emergency Response Framework and related standard operating procedures. As a result, the Ministry of Public Health, donors and other stakeholders are now relying on WHO leadership to further guide their actions during emergencies. A malaria outbreak response plan, developed under the aegis of the WCO, has received strong support and is being used to guide malaria outbreaks. The Burundi Country Office has now selected 20 KPIs and is strengthening its operations to focus on effective transformation.

### **(c) Improving efficiency, compliance and accountability in operations**

A review of the business processes of WHO in the African Region will be conducted to identify and improve human resources, procurement, finance and logistics, ameliorate the services expected of the Secretariat, and enhance compliance and accountability. External functional/operational assessments of WHO in the African Region will be conducted in partnership with interested organizations. An independent evaluation of the Transformation Agenda, AFRO's implementation of WHO's global reform, will be conducted. As part of the Transformation Agenda, WHO in the African Region developed a results framework with indicators linked to performance management – a first for the Organization globally - to better serve Member States while improving transparency, reinforcing accountability and demonstrating results. A mandatory end-term evaluation shall be conducted for all donor-supported projects and grants managed by AFRO.

### **(d) Strengthening country focus**

There will be a review and revision of WHO's technical and structural capacity to deliver at country level in order to tailor the composition of WHO country teams to the needs of countries. Each country office shall be expected to engage with other sectors that impact health and with non-State actors. The African Region shall also review and strengthen its subregional hubs (subregional teams) in innovative ways to provide targeted support that closely matches country needs.

### **(e) Strengthening partnerships for health**

The WHO Secretariat in Africa shall engage regularly with the AUC to ensure synergy in the roles and functions of both organizations, and to support implementation of the AUC "Agenda 2063." Other priority partnerships include engagement with subregional economic communities; bilateral, multilateral relations and with UN agencies, especially UNICEF, UNHCR, UNFPA, the African Development Bank, academic, professional and research institutions and associations. The Africa

Health Forum will be established to engage with NGOs, CSOs and other non-State actors to exchange ideas and coordinate efforts towards transforming health in Africa.

**(f) Enhancing Strategic communication**

The WHO Secretariat in Africa will establish a new strategic approach to all communications and foster a more responsive and interactive organization. Actions will include strengthening systems for both internal communications among staff and external communications with stakeholders. A communication strategy will be developed that shall actively utilize social media, with accounts for the Regional Office as well as for the leadership. Internal communication will be enhanced. An online forum for staff suggestions and ideas will be developed. Furthermore, the Senior Management Team shall be required to provide regular updates on the events they are engaged in. Other methods of staff networking will be stimulated to encourage knowledge and experience-sharing and joint problem-solving.

**Success stories: AFRO establishes an online forum for the Region's Small Island Developing States (SIDS) to exchange experiences**

The five SIDS (Cabo Verde, Comoros, Mauritius, Sao Tome and Principe and Seychelles) now have a space where they can address their specific vulnerabilities and the increasing problem of drug, alcohol and tobacco abuse, particularly among the youth, and build sustainable resilience to them. As a result, the SIDS Network Web Community for collaborative work was established to disseminate reliable health evidence and health risks facing SIDS and facilitate technical cooperation among the islands.

#### 4. IMPORTANCE OF THE PRESENCE OF THE PHC/UHC-Oriented health system approach in the Political agenda of the countries in African region

To capture data on UHC, a baseline study was conducted in all 47 countries as the basis for developing a regional UHC monitoring framework. Data were collected from publicly available sources and included 51 indicators, 17 of which were used for the proposed monitoring framework. The “**Framework for Health Systems Development towards Universal Health Coverage in the Context of the Sustainable Development Goals in the African Region**” was presented to the WHO/AFRO Regional Committee as Document AFR/RC67/10, which it adopted. The Framework has been shared with the Directors of Planning in the Ministries of Health through their annual meetings and WHO is providing support to countries for implementing the Framework. WHO/AFRO has established a flagship programme for UHC to support the implementation of the Framework. It is envisaged that by 2022, all countries will have implemented the Framework and made significant progress towards UHC. **Annex 3** presents the initial steps towards implementation of the Framework, which promotes multisectoral action to address the socioeconomic determinants of health. WHO has also developed tools for integrating health in the policies of other development sectors. The Health in All Policies Training Manual has been used to build capacity in some countries, while the Action Toolkit for Social Determinants in the African Region, a learning and problem-solving resource for health and non-health professionals, is available online.

**Annex 5** is an important excerpt from “UNICEF’s Strategy for Health (2016-2030)” document developed by UNICEF’s strategy core team. It confirms UHC from a child rights perspective, given the well-acknowledged joint work of WHO and UNICEF in supporting the PHC movement since Alma-Ata 1978 through Astana 2018.

#### 6. REFLECTIONS ON NEW OR ALREADY TESTED STRATEGIES AND APPROACHES AT VARIOUS LEVELS OF WHO

##### (a) Global level

The complex and emerging health challenges of the 21st century demand a more proactive and innovative approach to health development. To respond to these emerging challenges, WHO at global level is calling for a transformation agenda for its work to be implemented at global, regional and country level. At global level, WHO as the international leader in health matters, should reflect these challenges in its actions in order to properly address them. However, it cannot stand alone in resolving these emerging complexities. There is hope that the new WHO leadership at global level, working in collaboration and in harmony with regional and other levels of WHO, will take the Organization to new levels where health coverage can reach every one, everywhere.

##### (b) Regional level

Within the WHO Secretariat, the Africa Health Transformation Programme was and will continue to be implemented through a fundamental shift in organizational culture and systems to improve engagement with the WHO programme budget and programme of work across the 2018–2019 biennium. The Regional Director will prepare progress reports on the status of implementation of the Health Transformation Programme at the end of the biennium. This will be in addition to the existing statutory, semi-annual monitoring and mid-term review mechanisms of WHO’s work. A final report

on the implementation of the Transformation Programme will be published in July 2019 and submitted to the Sixty-ninth session of the WHO Regional Committee for Africa. The Regional Director will also provide a progress report on the Africa Health Transformation Programme at the biennial AUC-WHO Joint Ministers of Health Forum and will work with countries to develop health performance scorecards for ensuring countries' accountability for relevant resolutions and decisions adopted at meetings of the AU and WHO governing bodies. These scorecards will be presented to the Assembly of African Heads of State and Government every two years as part of a peer review mechanism.

The Africa Health Transformation Programme is the commitment of WHO in the African Region to a renewal that sets a new health agenda to guide progress towards UHC in Africa. The Secretariat in the African Region will work through political platforms offered by the AUC and the Summit of Heads of State and Government to develop, implement, monitor and evaluate a 'business plan' to transform health in Africa.

Africa has specific issues of poverty and inequality that influence the burden of disease, and the Region remains highly dependent on development assistance. This requires a rethinking of WHO's operations in the African Region and how the Organization should support countries to plan and implement health programmes. The Africa Health Transformation Programme presents the vision for this change; a vision of a health and development approach that will address the unacceptable inequalities in health in a Region that lags behind others in all health indices and quality of life. WHO in the African Region is committed to working with its Member States and partners to implement the Africa Health Transformation Programme, and to attain the highest possible level of health for people in Africa by achieving the Sustainable Development Goals and universal health coverage.

### **Success stories: WHO Transformation Agenda**

As part of the Transformation Agenda, WHO in the African Region developed a results framework with indicators linked to performance management – a first for the Organization globally - to better serve Member States while improving transparency, reinforcing accountability and demonstrating results. Managerial and programmatic key performance indicators (KPIs) were developed to measure WHO's contribution to Africa's health. They are aligned with the SDGs and the Programme budget, staff performance appraisals, and at country level with Country Cooperation Strategies. The WHO Country Office experience in Burundi is a tangible account of how the KPIs have helped to improve performance at country level.

### **(c) Subregional level**

One of the important structural changes that took place in 2006 was the establishment of the three Inter-country Support Teams (ISTs). These were part of an organizational reform strategy, which saw the Regional Director delegate financial and programme and human resource management to Cluster Directors and their Programme Area Coordinators, WHO Representatives and IST Coordinators. Empowering different parts of the Organization meant that decisions could be made more quickly, flexibly and adapted to local contexts. The creation of the ISTs also meant that the technical support

offered to countries for the implementation of WHO norms and standards and to strengthen health systems, was reinforced.

Staffed by technical experts and administrative teams reassigned from Brazzaville, as well as newly recruited staff, the ISTs were launched with enthusiastic support and investment from host governments, who loaned and built offices to house them. The team in Harare, Zimbabwe, serves 20 countries in East and Southern Africa; the one in Libreville, Gabon, caters for 10 countries in Central Africa; and the one in Ouagadougou, Burkina Faso, supports 17 countries in West Africa. They collaborate effectively with the UN Development Group, UN Regional Directors' Teams in those subregions, and regional economic communities. Accordingly, they have been commended by Member States and the UN Joint Inspection Unit.

#### **(d) Country level**

WHO in the African Region is committed to working with its Member States and partners in health to achieve universal health coverage and the Sustainable Development Goals. The document "Framework for health systems development towards universal health coverage in the context of the Sustainable Development Goals in the African Region" which was adopted by the WHO/AFRO Regional Committee, will guide countries in their progress towards achieving UHC and the SDGs. WHO country offices throughout the Region will be closely involved in this country-led journey, providing advisory manpower, targeted budget allocations for UHC initiatives backed up by the involvement of the respective ISTs, as well as the strategic support of the Regional Office and WHO Headquarters. A stronger WHO presence in all 47 countries in the Region has been made possible by the implementation of the Country Cooperation Strategy (CCS) initiative. This takes into account each country's national health issues and aligns them with WHO regional priorities and the global UHC agenda. The new GPW 13, which has a country focus through country support plans (CSP), will further orient countries' activities towards achievement of UHC and the SDG objectives. There is also an ongoing functional review of the WHO country offices to transform them into fit-for-purpose structures that are better able to respond to the needs of the countries, while also working in synergy with other partners and stakeholders in the countries.

It is interesting to note that improving the health system is critical for the countries' UHC agenda in the context of the SDGs. It is obvious that as long as the district health system is not developed optimally, UHC as well as the expectation of achieving the SDGs will not be guaranteed. The latest Ebola outbreak in the three West African countries (Guinea, Liberia and Sierra Leone) and even recurrent ones in the Democratic Republic of the Congo have consistently demonstrated the level of health system weaknesses at the subnational level. Thus, national reforms of the health district approach remain a priority.

### **Success story: Building resilient subnational health systems – Strengthening the Leadership and Management Capacity of District Health Management Teams (Guinea, Liberia and Sierra Leone)**

Governance and management were found to be inadequate, particularly the skills of managers occupying district leadership positions. They tended to be stronger in clinical rather than management tasks. Hence, there was weakness in planning, budgeting, monitoring and evaluation, as well as building partnerships. District health management teams (DHMTs) lacked adequate human resources to fulfil some of their important functions. Weak engagement with communities, civil society and the private sector was also identified. Normally, the DHMTs needed authority that was commensurate with their responsibilities, for autonomy in decision-making and for building partnerships to function better. Weak coordination within the DHMT and between this team and partners was highlighted. The phenomenon of donor dependency leading to donor-driven programmes which did not match DHMT plans was mentioned. In addition, the DHMTs experienced funding gaps and late disbursements, which affected the implementation of health activities due to inadequate financial management and low economic capacity due to the absence of a budget for public health emergencies.

To address the challenges and bring about sustained improvement, a joint workshop was organized at which participants drafted frameworks aimed at improving their health systems. After the workshop, all three countries refined their roadmaps with involvement of key stakeholders to harmonize critical interventions, financing and engagement in implementation. The key elements in the roadmaps were aimed at strengthening the leadership and management capacities of DHMTs. In each of these three countries, improvements were noted: availability of national guidelines, disbursement of funds to the operational level, etc., to ensure that the DHMTs could easily carry out their missions.

## 7. CONCLUSION

This report presents the resolute and dedicated journey of African nations from Alma-Ata (1978) through Ouagadougou (2008) and until present in their quest to provide their populations with affordable and accessible, community-based primary health care. The journey has not been smooth however, and many challenges abound, as described in Annex 1, needing to be addressed. Countries in the Region are diverse, due to cultural, economic, governance and political differences, which make a ‘one-size-fits-all’ approach in addressing health in the agenda impossible. On this journey, however, countries are not alone; as they continue to enjoy the support of committed partners, among them WHO/AFRO, UNICEF and other country-based UN agencies, bilateral and multilateral partners, the private sector and other sectors in the communities in view of the multisectoral nature of PHC.

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## **ANNEX 1: OUAGADOUGOU DECLARATION ON PRIMARY HEALTH CARE AND HEALTH SYSTEMS IN AFRICA: ACHIEVING BETTER HEALTH FOR AFRICA IN THE NEW MILLENNIUM**

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The International Conference on Primary Health Care and Health Systems in Africa, meeting in Ouagadougou, Burkina Faso, from 28 to 30 April 2008, reaffirms the principles of the Declaration of Alma-Ata of September 1978, particularly in regard to health as a fundamental human right and the responsibility that governments have for the health of their people. Having analysed the experience of Primary Health Care implementation in the countries of Africa in the last 30 years, the Conference expresses the need for accelerated action by African governments, partners and communities to improve health; the Conference, also reaffirming the importance of the involvement, participation and empowerment of communities in health development in order to improve their well-being; and recognizing the importance of a concerted partnership, in particular, civil society, private sector and development partners to translate commitments into action; hereby makes the following Declaration:

**I.** The strong interrelationship among health determinants such as economic development, governance, education, gender, food security and nutrition, environment, peace, and security underscores the need to address health determinants in Africa, especially in resource-poor settings where health inequalities and limited access to health care are more critical.

**II.** Progress has been made by countries since Alma-Ata such as eradication of smallpox and control of measles, and there are encouraging achievements in eradication of poliomyelitis and guinea-worm disease and elimination of leprosy and river blindness notwithstanding the several constraints to the achievement of the goal of Health for All, including man-made disasters, economic and financial crises, and the emergence of HIV/AIDS in the early 1980s. However, accelerated progress is needed in a number of African countries in order to achieve internationally-agreed health goals, including the Millennium Development Goals by 2015. The Primary Health Care approach has the potential to accelerate the achievement of the Millennium Development Goals.

**III.** The Conference welcomes the commitment by the African Heads of State and Government to create an enabling environment, including incremental funding of health services reaching at least 15% of the overall national budget and also welcomes the commitments made in the 2005 Paris Declaration on Aid Effectiveness, Ownership, Harmonization, Alignment, Results and Mutual Accountability; however the Conference expresses concern about the 10/90 gap, referring to the fact that only 10% of the worldwide expenditures on health research and development is devoted to the health problems that affect 90% of the world's population. The Conference further expresses concern about the current unfavourable terms of trade that have a negative impact on health and development in Africa.

**IV.** The Conference is encouraged by the important successes in health, the renewed political commitment as evidenced by the adoption of the Africa Health Strategy 2007–2015 of the African Union, and the existing environment that is conducive to health development such as improved peace, security, economic growth in some countries and the increasing involvement of regional economic communities in health. The Conference is further encouraged by the new opportunities in international health financing and the United Nations Secretary-General's initiative on the Millennium Development Goals in Africa.

**V.** The Conference urges Member States to: 1. update their national health policies and plans according to the Primary Health Care approach with a view to strengthening health systems to achieve the Millennium Development Goals, specifically regarding communicable diseases, including HIV/AIDS, tuberculosis and malaria; child health; maternal health; trauma; and the emerging burden of chronic diseases; 2. use priority health interventions as an entry point to strengthen national health systems, based on the Primary Health Care approach, including referral systems; expedite the process of decentralization by focusing on local health system development to improve access, equity and quality of health services in order to better meet the health needs of the populations; 3. promote intersectoral collaboration and public-private partnership including civil society and communities with a view to improving the use of health services and taking appropriate action on the economic, social, demographic,

nutritional, cultural and environmental determinants of health including climate change; 4. implement strategies to address the human resources for health needs and aimed at better planning, strengthening of the capacity of health training institutions, management, motivation and retention in order to enhance the coverage and quality of health care; 5. set up sustainable mechanisms for increasing availability, affordability and accessibility of essential medicines, commodities, supplies, appropriate technologies and infrastructure through provision of adequate resources, technology transfer, South-South cooperation, the use of community-directed approaches and African traditional medicines; 6. strengthen health information and surveillance systems and promote operational research on health systems for evidence-based decisions; 7. develop and implement strategic health financing policies and plans, integrated into the overall national development framework, that protect the poor and vulnerable, in particular women and children, while ensuring equitable and sustainable allocation of resources by level of care and the right balance between promotive, preventive, curative and rehabilitative care; develop and implement national health insurance schemes that prevent catastrophic health expenditures and ensure solidarity and social protection; implement the Abuja Declaration to incrementally allocate at least 15% of the overall national budget to health; allocate at least 2% of the health budget to reinforce national health research systems and create centres of excellence in Africa; 8. promote health awareness among the people, particularly adolescents and youth; build the capacity of communities to change behaviours, adopt healthier lifestyles, take ownership of their health and be more involved in health-related activities; and create an environment to empower communities in the governance of health care services in accordance with the Primary Health Care approach.

**VI.** Communities, including civil society, should seek recognition of their role in governance of health services, particularly in what relates to community-based, public health and other health-related interventions; and explore with governments the possibility of undertaking awareness campaigns among the African diaspora in order to facilitate their effective involvement in development activities.

**VII.** The international community should:

1. provide coordinated and cohesive long-term technical and financial support to countries for the development and implementation of health policies and national health development plans consistent with internationally-agreed health goals including the Millennium Development Goals; and support Member States to translate the recommendations of this Conference into concrete actions;

2. increase investments in national health systems, with particular attention to the production of health workforces by ensuring that donor countries deliver on their commitments to allocate 0.7% of their Gross Domestic Products to Official Development Assistance; reaffirm their commitment to the implementation of the principles of the 2005 Paris Declaration; and support existing related mechanisms such as the International Health Partnership and Harmonization for Health in Africa.

**VIII.** The African Union and the regional economic communities should sustain political leadership; strengthen advocacy, resource mobilization and funding for the health sector; and further explore South-South cooperation within the Region.

**IX.** WHO, in consultation with Member States and other UN agencies, should establish a regional health observatory and other mechanisms for monitoring the implementation of this Declaration, and to share best practices.

**X.** The United Nations agencies, UNAIDS, UNFPA, UNICEF, WHO, and international financing institutions, in particular the World Bank and the African Development Bank, and other international health partners should provide support for the implementation of this Declaration according to their comparative advantages.

Ouagadougou, 30 April 2008

## **ANNEX 2: THE AFRICAN HEALTH OBSERVATORY: BETTER INFORMATION, BETTER ACTION ON HEALTH**

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The African Health Observatory is a web-based platform whose objectives are to improve the availability and use of information and evidence on health status and trends for policy dialogue, and to monitor and evaluate the implementation of national strategies and plans. The observatory data and statistics platform offers the best available health-related data and statistics on the Region. It includes the Atlas of African health statistics, which is updated yearly, and comprehensive statistical health profiles for the Region as a whole and for each of the 47 countries in the Region. Another platform offers comprehensive and analytical country health profiles to inform policy and decision-making on a wide range of areas: health status, health systems, specific programmes and diseases, health determinants and progress on the Millennium Development Goals (MDGs) and other internationally agreed goals. A key observatory publication is the African health monitor – a serial publication that comes out four times a year. The observatory also offers a platform for networking and communities of practice. Members of communities learn and work together and strive to translate and use the best available evidence for policy-making and decision-making. The observatory provides support to countries to establish their own national health observatories with similar functions and structure. Several countries are in the process of establishing national health observatories that will also serve as multistakeholder and collaborative platforms to strengthen national health information systems. Further information can be obtained from the observatory website ([www.aho.afro.who.int](http://www.aho.afro.who.int)).

There is also the African Health Workforce Observatory (AHWO) which contains specific information on health manpower in the Region.

## ANNEX 3:

### FRAMEWORK FOR HEALTH SYSTEMS DEVELOPMENT TOWARDS UNIVERSAL HEALTH COVERAGE IN THE CONTEXT OF THE SUSTAINABLE DEVELOPMENT GOALS IN THE AFRICAN REGION (DOCUMENT AFR/RC67/10)

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**Vision:** A Region with the highest possible levels of health and well-being of its population.

**Goal:** To guide Member States' efforts towards re-aligning their health systems in a manner that facilitates movement towards universal health coverage, and attainment of their aspirations for health in sustainable development.

**Objectives:**

- (i) To provide guidance on a comprehensive menu of health and related services which Member States need to consider to facilitate attainment of population health and well-being.
- (ii) To provide a comprehensive scope of health system investments that Member States can consider in line with the Sustainable Development Goals.
- (iii) To define measures for monitoring the performance of health systems towards better alignment with health needs.

**Targets: by 2030,**

- (a) at least 80% of Member States have health systems that are performing optimally for effective delivery of essential package of health and related services.
- (b) all Member States have at least 80% of their populations utilizing the identified essential package of health and related services.
- (c) all Member States have in place and are implementing the investment plans needed to align their health systems with the SDGs.

**Milestones: by 2021,**

- (a) 50% of all Member States show evidence of improving population coverage of agreed standards and assessments;
- (b) 50% of Member States have evidence of improving health system performance as measured by the framework;
- (c) 80% of Member States will have started implementing the health system investment plans required for optimal performance;

**By 2025,**

- (a) 80% of Member States show evidence of improving population coverage of agreed standards and assessments;
- (b) 80% of Member States show evidence of improving health system performance;
- (c) All Member States will have started implementing the health system investment plans required for optimal performance.

▪ **Guiding principles:**

**Country leadership and ownership:** Governments are responsible for coordinating and ensuring that all interventions are in line with country priorities and enable involvement of all relevant stakeholders at all stages from policy, planning and investment making through implementation to monitoring and evaluation.

**Equity:** Ensuring that no one is left behind and that all age cohorts, vulnerable and marginalized groups receive adequate focus, using a human rights and gender sensitive approach.

**Partnership and collaboration:** Strengthening partnerships with actors from the health and other sectors for developing and sustaining resilient health systems with improved harmonization and alignment of support.

**Integrated approach:** A holistic and integrated approach should be used at all levels to implement the framework.

**Community engagement and participation:** There should be an emphasis on engaging with communities to ensure their voice is heard in policy-making and the organization of service delivery.

**Innovation and use of technology:** In the context of resource constraints, using information and communication technology to improve coverage especially in hard-to-reach areas.

## **PRIORITY INTERVENTIONS AND ACTIONS**

### **A comprehensive menu of options for health and related services:**

**Improve availability of essential services.** Make available a set of priority services needed to sustain health for all at all ages. These should be defined across the life course to ensure planning for the unique health needs for each age. Life cohorts are defined to cover pregnancy/childbirth, childhood, adolescence, adulthood, old age.

**Scale up coverage with essential health interventions.** Ensure that the populations are utilizing the essential health interventions they need. These are prioritized based on country income, health profile and other needs, and targeted to ensure that both person- and community-centred services are available and utilized by those most in need. Priority actions should include health promotion, communicable and non-communicable disease prevention and control, and routine and emergency medical, rehabilitation and palliative services.

**Protect populations from catastrophic health expenditure.** The proportion of populations that are protected from catastrophic expenditures arising from accessing and using health services should be increased through greater public financing such as increments in government budget, and prepayment schemes. Vulnerable populations should be identified based on income, disability, gender, age and social status, and their health expenditures monitored to ensure financial barriers to accessing services are minimized.

**Ensure effective health security.** The health systems and services of Member States should be redesigned for better preparedness and response to epidemics and other disasters. Actions should be defined across the prevention, detection and response areas in line with the International Health Regulations (2005) core capacity needs. In addition, transition and recovery needs should be planned for and addressed following response to an emergency/disaster.

**Promote client satisfaction and health system responsiveness.** Ensure that health services are responsive to the needs of targeted individuals and communities and encourage the role of communities as co-producers of health. This will improve the potential for better community engagement and sustainability. Provide avenues for clients to express their level of satisfaction with health services.

**Expand coverage with essential health interventions in other SDGs.** Identify targets in other SDGs that influence attainment of health and well-being (SDG 3). These targets encompass the social, economic, environmental and/or governance domains. Member States should proactively map required interventions and stakeholder actions, and leverage multisectoral mechanisms and platforms to ensure their implementation.

## **Measures for monitoring the performance of health systems**

**Health system resilience.** Increase the proportion of populations that are protected from emergencies and disasters, avoidable and preventable disability and loss of life. Regular assessments should identify vulnerabilities and propose mitigating actions to be implemented. There should be inbuilt flexibility in the system to allow deployment of resources where needed with adequate communication across actors as and when required.

**Equitable and efficient access.** Monitor and plan for interventions to reduce physical, financial and/or cultural barriers to accessing services. Establish and monitor strategies to deliver essential services to populations in hard-to-reach areas. Policies and practices should aim to reduce social and cultural barriers to health services that are due to age, gender, ethnicity, sexual orientation, disability or other sources of discrimination.

**Quality of care.** The quality of care of services should be regularly monitored and the identified gaps addressed to build trust and confidence of communities. Mechanisms should be put in place to ensure positive client experiences.

**Effective demand for health services.** Ensure that communities and households are able to use services that are essential to their needs. Encourage households and communities to have the required awareness of, and knowledge on, available services, and to practice healthy lifestyles and positive health-seeking behaviours.

### **▪ A comprehensive scope of health system investments**

**Promote holistic approach to health governance.** Health policies, strategic planning, budgeting and operational processes as well as their legal frameworks should be aligned to attaining the SDGs. Capacity for coordinating SDG implementation as well as managerial, technical, and regulatory capacity should be identified and strengthened. Mechanisms for strengthening accountability and engagement with stakeholders, including other sectors, external partners, academia, civil society, communities and private sector actors, should be established.

**Build efficient integrated person-centred service delivery systems.** The service delivery systems should be reorganized at all levels to reflect the SDG targets. Integrated service delivery should be emphasized and facilitated at all levels of care. Ensure linkages to communities for better responsiveness to peoples' needs.

**Provide adequate, competent and well distributed health workforce.** Investments need to be made in both pre-service and in-service training programs to ensure the workforce reflects both current and future health needs. Staff cadres should be rationalized according to the needs for essential services and this should be reflected in staffing needs, norms, standards and accreditation. Training programs and curricula should also respond to new and emerging priorities.

**Provide good quality affordable essential medicines, diagnostics and other health products.** This should be done through a well-regulated estimation, procurement and supply system. Policies and regulations should be updated to promote local production and to build capacity for rational use of medicines and other health products, including during emergencies. Surveillance systems for monitoring adverse effects, medicines quality and antimicrobial resistance should be strengthened.

**Provide adequate infrastructure and equipment.** Establish standards and management operational procedures for fixed, movable, transport and ICT infrastructure. Long-term master plans for expansion of fixed infrastructure should be developed. Medium-term plans for investment in equipment, transport and ICT infrastructure should be developed. Maintenance and disposal of infrastructure assets should be pro-actively planned to reflect SDG 3 targets.

**Provide sustainable financing for health.** Establish mechanisms to mobilize more domestic sustainable resources, while ensuring improved coordination platforms for alignment of external resources for health. Member States should strengthen financing policy, public financial management, accountability systems and institutional arrangements, including strategic purchasing of health services.

**Strengthen health information systems and surveillance platforms at all levels.** Establish data coordination mechanisms to interlink information systems for routine facility data, vital statistics,

surveillance, surveys and research to foster integration and reduce fragmentation. Prioritize capacity for analysis and use of data particularly at the subnational level. Scale up innovative approaches to collection and use of data – such as eHealth and mHealth technologies. Member States should prioritize engagement of the research community to maximize the generation and use of research evidence for decision-making and facilitate knowledge translation platforms.

In June 2017, WHO held the first ever Africa Health Forum, themed “Putting People First: The Road to Universal Health Coverage in Africa” in Kigali, Rwanda. The Forum provided a platform for a unique mix of stakeholders – government ministers, international agencies, youth and the private sector – to discuss public health challenges and opportunities in the Region through the lens of UHC. It explored innovative ways to advance the health agenda in Africa, including through a new partnership between WHO AFRO and the International Telecommunication Union to scale-up eHealth interventions in health systems delivery. The Forum adopted the Kigali Call to Action to promote working together for improved health in the Region. Partnership with the African Union Commission (AUC) has facilitated the adoption of important decisions on health by Heads of State and led to agreement on a framework for collaboration with the Africa CDC. The Regional Director paid visits to, and welcomed a number of partners, including the African Development Bank, the Bill and Melinda Gates Foundation, the UK Department for International Development, USAID, and the US Department of Health and Human Security.

## ANNEX 4.

### STRATEGIC DIRECTIONS OF THE REGIONAL OFFICE FOR AFRICA: THE AFRICA HEALTH TRANSFORMATION PROGRAMME 2015–2020: WHO DELIVERABLES AND THEIR CURRENT IMPLEMENTATION STATUS

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#### 1. Strategic direction 1: Improving health security by tackling epidemic-prone diseases, emergencies and new health threats

##### 1.1 WHO deliverables and their current implementation status

- (i) *The three countries severely affected by EVD reach/remain at zero cases and have restored routine health services by 31 December 2016.*

**Implementation status:** 1. All three countries: Sierra Leone, Liberia and Guinea were declared free of EVD in 2016. No cases subsequently emerged over a 90-day period of heightened surveillance. 2. Due to sound preparedness with both AFRO and the national staff working with other partners, the Ebola case reported in the DRC was contained within two months. The swift containment of the flare-ups indicates that capacity has been built in these countries 3. The Regional Office is also collaborating with partners to support the countries to restore and strengthen key public health programmes, especially maternal and child health.

Two additional Ebola virus outbreaks have occurred in the DRC in 2018, one in the Equateur Province that has since ended and the other in Beni in North Kivu Province, declared by the Government of the DRC not long after the end of the one in Equateur Province. WHO has timeously responded to these outbreaks, applying ring vaccination with the Ebola virus vaccine.

- (ii) *Implementation of the regional plan for the EVD recovery phase in the three affected countries initiated by September 2015.*

**Implementation status:** 1. The Regional Office coordinated the deployment of over 2500 experts in 2016 to respond to major public health events including Ebola, yellow fever, cholera and Rift Valley fever outbreaks. 2. Vigilance continues to be maintained in all three countries to prevent, detect and respond to suspected cases.

- (iii) *Regional outbreak and emergency risk mapping conducted by the end of 2015.*

**Implementation status:** 1. Risk mapping exercise has been updated since 2015. 2. AFRO also developed Volume 1 of the WHO e-atlas which could be used to plan and prioritize areas for mitigation activities to minimize the effects of natural disasters. The AFRO/e-atlas provides a powerful tool for national decision-makers at all levels on vulnerability and risks of natural hazards faced by populations.

- (iv) *Regional strategic plan for health security and emergencies developed by the end of 2016.*

**Implementation status:** 1. A new WHO Health Emergencies Programme has been established (2016) and will offer a single platform across all the three levels of the Organization to address disease outbreaks and other health emergencies. 2. The WHO Secretariat in the African Region will have capacity to better support Member States to prevent, detect and respond to health emergencies using the “all-hazards approach”. Health security hubs have been established in Dakar, Senegal and Nairobi, Kenya for quicker response to emergencies. 3. WHO has supported the establishment of the Africa Centre for

Disease Control and Prevention (Africa CDC) and will sign a document on a framework for collaboration with the AUC for synergy in addressing health security.

- (v) ***Not less than 85% of the human and financial resource requirements for the Health Security and Emergencies Cluster are met by the end of December 2016 through budget re-allocation.***

**Implementation status:** 1. In AFRO's 2016-2017 biennial allocated budget, 78% was for Emergency Programmes (WHE Programme on preparedness, surveillance and response; polio eradication programme).

- (vi) ***The multidisciplinary Regional Health Corps is established by December 2016.***

**Implementation status:** 1. Multidisciplinary teams of experts were deployed to give technical support to East and Southern African countries experiencing the effects of El Niño, where they assisted in developing national health sector El Niño response plans, and providing financial resources for the cholera response. 2. To broaden partnership and intersectoral collaboration on climate change, the Regional Office hosted an "Africa Pavilion Event" at the Climate Change Conference in Paris.

- (vii) ***Some 25% of countries shall be supported to reach the minimum IHR core capacities by 2017 with 75% reaching this minimum by the end of 2020.***

**Implementation status:** 1. The adoption of the Declaration on Accelerating Implementation of the International Health Regulations in Africa by African Union Heads of State and Government is an unprecedented opportunity to advance health security in the Region 2. The most vulnerable countries are currently receiving support to strengthen preparedness and to develop national plans and road maps towards achieving and sustaining the IHR core capacities. 3. Thirty six countries have completed the IHR joint external evaluations and 15<sup>2</sup> have already developed their national plans for health security.

## **2 Strategic direction 2: Driving progress towards equity and universal health coverage**

### **2.1 WHO deliverables and their current implementation status**

- (i) ***Baseline assessment on UHC in the African Region conducted and the data published by the end of 2016.***

**Implementation status:** 1. The Regional Office has developed "The Africa Health Transformation Programme, 2015-2020: A Vision for Universal Health Coverage" to provide a framework for the future work of WHO in the Region 2. An unprecedented baseline study was organized by AFRO in 2016, capturing data from every Member State that will be used to develop a monitoring framework to inform on the progress made on UHC and the SDGs 3. An independent evaluation of the first two years (2015-2016) of the WHO AFRO Transformation Agenda was undertaken in April 2017.

- (ii) ***Regional Strategy on integrated health systems approach to UHC developed/approved by Ministers of Health by 2017.***

**Implementation status:** 1. In December 2016 WHO AFRO, organized the first ever Regional Forum on Health Systems Strengthening for the SDGs and UHC in Namibia, where the framework was agreed

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<sup>2</sup> Benin, Chad, Côte d'Ivoire, Eritrea, Ethiopia, Ghana, Kenya, Liberia, Mauritania, Mozambique, Namibia, Senegal, Sierra Leone, Tanzania and Uganda.

upon with senior Ministry of Health officials from all 47 Member States and partners. It was adopted by the Sixty-seventh Regional Committee of Health Ministers and will now guide action towards the SDGs.

***(iii) African National Health Research Systems Barometer developed to track progress on knowledge generation and management in the Region by 2017.***

**Implementation status:** 1. In December 2015, WHO developed the first African National Health Research Systems (NHRS) Barometer in line with the framework of the regional strategy for research, which was adopted in 2015. This tool measures the performance of 17 parameters of governance, finance, human and infrastructural resources, as well as the production and utilization of health research. 2. The Barometer has been shared with all Member States to monitor the performance of their NHRS. In February 2016, WHO used the NHRS Barometer to determine the Regional score from data collected on NHRS from all Members States.

***(iv) All Member States supported to establish routine monitoring systems that include the collection of disaggregated data and health equity analysis by 2020.***

**Implementation status:** 1. Eight countries were supported (2016-2017) to develop their national health observatories (NHO). 2. Country health profiles including UHC indicators are now available for Burkina Faso, Cameroon, Ghana, Rwanda and will be updated with more analytical work and data from routine health information systems. This will help in tracking progress on UHC and the SDGs. 3. WHO assisted six countries to develop or review their national eHealth strategies during the period, and is partnering with the International Telecommunication Union (ITU), through a collaborative agreement, and others to strengthen eHealth support.

***(v) An investment case prepared with a benefits analysis of a coordinated approach to UHC that incorporates the expertise and resources of all WHO technical programmes by the end of 2016.***

**Implementation status:** 1. The Accountability and Internal Control Strengthening (AICS) website has been launched with all relevant policies, standard operating procedures and guidelines. The website also hosts the Key Performance Indicator (KPI) dashboard and includes information on audits, best practices and generic control weaknesses. 2. The number of audits carried out in WHO country offices in the Region in 2016: unsatisfactory outcomes were reduced to 0%, compared to 50-80% in previous years. Of the new audits, 100% were fully or partially satisfactory.

***(vi) A framework for implementing the Global Strategy for Women's, Children's and Adolescents' Health in the African Region endorsed by the RC by 2016: at least 15 Member States implementing the Global Strategy by 2017.***

**Implementation status:** 1. The Sixty-sixth WHO Regional Committee for Africa adopted the implementation framework of the Global Strategy for Women's, Children's and Adolescents' Health (2016-2030) in 2016. 2. In collaboration with partners WHO organized workshops to orient Ministry of Health officials of 41 countries, WHO country offices and UN agencies on the objectives and priority actions of the Global Strategy. 3. Thirteen Member States reviewed their RMNCAH programmes in order to develop integrated strategic plans, and the process is still underway in seven more countries.

***(vii) At least 35 countries supported to use reproductive, maternal, neonatal and child health (RMNCH) scorecards to monitor Programmes' performance by 2020.***

**Implementation status:** 1. The Regional Director will work with countries to develop health performance scorecards for ensuring countries' accountability for relevant resolutions and decisions adopted at meetings of the AU and WHO governing bodies. 2. These scorecards will be presented to the Assembly of African Heads of State and Government every two years as part of a peer review.

- (viii) ***Three frameworks for action (HIV/AIDS; Prevention/Control of Sexually Transmitted Infections; and Prevention, Care and Treatment of Viral Hepatitis) in the African Region, 2016–2021, developed, adopted by Member States and implementation commenced by 2017.***

**Implementation status:** 1. WHO developed four regional frameworks to guide the implementation of global strategies, which were endorsed by the Sixty-sixth Regional Committee for Africa. These are the Regional Frameworks for implementing the Global HIV, TB and Hepatitis and Malaria technical strategies. 2. Following the dissemination of WHO's consolidated guidelines on HIV prevention and treatment in 2016, countries are rapidly shifting their HIV policies to adopt the "Treat All" recommendations, to allow for prompt uptake of antiretroviral therapy (ART) among HIV-positive patients, regardless of their CD4 cell count. 3. Eleven countries have developed national action plans, while five Member States established national treatment programmes for viral hepatitis.

- (ix) ***A regional framework for implementation of the global "End TB Strategy" in the African Region developed and implementation commenced in 2016.***

**Implementation status:** 1. Capacity to detect MDR-TB and XDR-TB has been established in 32 and 22 Member States respectively. Furthermore, MDR-TB treatment programmes have been established in 40 of the 44 countries that have ever reported a case of MDR-TB. 2. WHO worked with 11 countries in the African Region to generate evidence on the effectiveness of a short treatment regimen for multidrug-resistant TB (MDR-TB) between 2014 and 2016. Based on the results from this pilot work, WHO recommended shortening the duration of treatment for uncomplicated MDR-TB from 24 to 9-12 months. 3. In 2016, WHO's TB and HIV programmes organized the first joint national TB and HIV programme managers' meeting in Addis Ababa for 21 countries.

- (x) ***Africa malaria strategy as framework for implementation of the Global Technical Strategy for Malaria (GTS) 2016-2030, developed and adopted by Ministers of Health, and implementation commenced in 2016.***

**Implementation status:** 1. In line with the GTS, WHO supported 104 microscopists from 24 countries to undertake refresher training and complete external competency assessments. Of these, 35 now have expertise in malaria parasite species and quantification. 2. To strengthen the use of data for malaria programme decision-making and action in the Region, WHO is improving data availability through a project funded by DFID. 3. A regional atlas of insecticide resistance in malaria vectors was produced to guide targeted interventions.

- (x) ***All three guinea-worm disease endemic countries (Chad, Ethiopia, Mali and South Sudan) supported to interrupt transmission by the end of 2016.***

**Implementation status:** 1. Guinea-worm disease (GWD) surveillance was sustained. In 2016, for the first year ever, Mali, one of the four endemic countries, reported no human case of GWD. 2. In addition, in July 2016, WHO celebrated success in the control of onchocerciasis in the Region, after more than 40 years of work.

- (xi) ***The African Health Report on Noncommunicable diseases published by December 2017.***

**Implementation status:** 1. WHO supported 33 countries to conduct Stepwise surveys to assess prevalence and trends in related risk factors. The results show that most adults have at least one risk

factor that increases their chances of developing a life-threatening NCD. **2.** WHO organized two meetings in Mauritius in 2016, aimed at strengthening networking, advocacy, partnership and action for the prevention and control of NCDs. The first, organized in partnership with the NCD Alliance, was a regional consultation for civil society organizations (CSOs) involved in NCD prevention and control in the African Region. The main outcome of the meeting was the formation of an AFRO Regional NCD CSO Network which will focus on information sharing and capacity building, strengthening advocacy for prioritizing NCDs in national development agendas. A report on the status of implementation of the four time-bound commitments on noncommunicable diseases in the African Region was presented to the Sixty-eighth Regional Committee in Dakar, Senegal in August 2018.

### **3 Strategic direction 3: Strengthening the capacity of WHO in the African Region**

#### **3.1 WHO Deliverables and their current implementation status**

##### ***(i) External functional/operational assessments of WHO in the African Region conducted by December 2015.***

**Implementation status:** **1.** According to the above assessment, implementation of the 2015-2020 WHO strategic agenda is proceeding apace, with a focus on strengthening WHO's human resources, delivering results, and improving accountability and transparency. **2.** The Regional Office has moved forward on realigning human resources at Cluster, IST and Country Office levels to match regional and national priorities. **4.** Staffing at country level takes into account the needs prioritized by Member States and WHO's competitive advantage. **5.** An independent evaluation of the Transformation Agenda, AFRO's implementation of WHO's global reform, was completed in April 2017. The evaluation noted completion of, and progress in many activities that were planned and also an emerging change in behaviours and mindset.

##### ***(ii) A revised system for assignment of WHO Representatives and assessment of country office performance introduced by 2016.***

**Implementation status:** **1.** During 2015-2016 improved recruitment processes were introduced using standardized assessment approaches, including selection panels; written tests, interviews, background checking and recourse to recruitment agencies when necessary. This was to ensure that the Secretariat recruits candidates of the highest quality. **2.** In 2016 staff realignment had taken place at the Regional Office and in Intercountry Teams, to ensure that human resources matched regional priority health needs. **3.** The process is now being rolled out in country offices through functional reviews that will objectively assess human resource needs while aligning them to country priorities. This also includes identifying WHO Representatives for deployment in ways that ensure optimal fit of their profiles with the needs of the countries. **4.** To increase the success rate of candidates from the Region, two orientation workshops were organized in December 2015 to prepare 50 potential candidates for the placement test for the roster of WHO Representatives. **5.** To assist newly appointed heads of country offices, joint administrative and programme reviews were conducted as from 2015 in countries within six months of their arrival.

***(iii) A regional communications strategy developed by the end of December 2016.***

**Implementation status:** 1. Strategy development is underway (2016-2017) to identify and ensure the presence of the WHO Secretariat in Africa at all significant and strategic health and development events and to build a global network of partners and advocates. 2. An Independent Advisory Group was established in 2016 by the Regional Director as part of this network. 3. Media engagement has been significantly enhanced with regular media briefings and slots utilized on key regional and global television and radio channels to boost information on health in the African Region.

***(iv) A regional human resource capacity-building plan developed by the end of December 2016.***

**Implementation status:** 1. An appropriate organizational structure with optimal staffing will be defined followed by the development of a strategic human resource plan to achieve appropriate staffing levels, skill requirements and training needs. 2. To address the perceived culture of non-compliance, a Compliance and Risk Management Committee was formally established in the Regional Office (2015-2016) to ensure a strategic, transparent and effective approach to risk and compliance management. 3. Given that many of the identified risks require action from Member States, WHO developed a Handbook for ministries of health to inform their administrative and financial personnel on WHO rules and procedures. 4. As part of the Transformation Agenda, WHO in the African Region developed a results framework with indicators linked to performance management – a first for the Organization globally - to better serve Member States while improving transparency, reinforcing accountability and demonstrating results. 5. An induction programme for newly-recruited staff members has been developed and put in action.

## ANNEX 5:

### VISION AND GOALS: OVERVIEW OF UNICEF STRATEGY FOR HEALTH (2016–2030)

