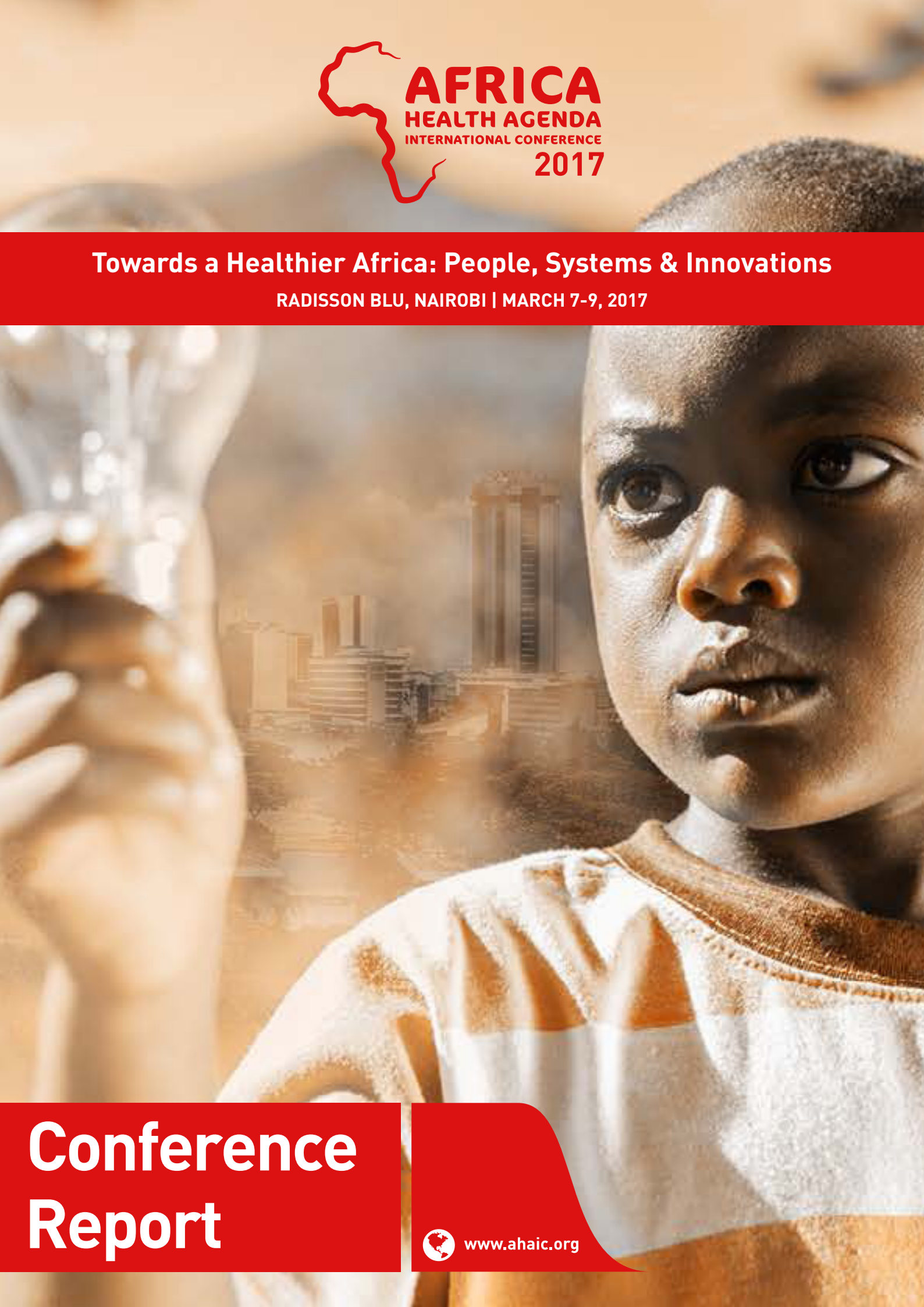
AFRICA HEALTH AGENDA INTERNATIONAL CONFERENCE 2017

Towards a Healthier Africa: People, Systems & Innovations

RADISSON BLU, NAIROBI | MARCH 7-9, 2017



Conference Report

www.ahaic.org

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Acronyms

AHAIC	Africa Health Agenda International Conference
CBHIS	Community-Based Health Insurance Schemes
CHWs	Community Health Workers
EHRS	Electronic Health Records System
EOC	Emergency Operations Centres
FGM	Female Genital Mutilation
FP	Family Planning
GSK	GlaxoSmithKline
IHR	International Health Regulations
SDGs	Sustainable Development Goals
UHC	Universal Health Coverage
PLAC	Participatory Learning Action Cycle
PMTCT	Prevention of Mother-to-Child HIV Transmission
PPP	Public-Private Partnership
SRHR	Sexual & Reproductive Health & Rights
WHO	World Health Organization

Word from the Chair, AHAIC

The Africa Health Agenda International Conference (AHAIC 2017) took place in Nairobi, Kenya, from March 7-9, 2017. 871 delegates from 11 countries converged in Nairobi to move forward Africa's health agenda through the exchange of scientific knowledge, research findings and debate on strategies, ideas and innovations. The conference's three themes; People, Systems and Innovation, mark the key investments that governments, civil society and the private sector will have to make to fast-track the attainment of the Sustainable Development Goals (SDGs).

Key highlights of the conference included: the launch of a campaign to integrate Community Health Workers (CHWs) into the formal health workforce across Africa; a ministerial panel on global health security; the Youth Pre-Conference (March 5-6) which was officially opened by First Lady of Malawi Dr Gertrude Mutharika and First Lady of Kenya Margaret Kenyatta; and the Hackathon, dubbed *Innovate4Life*, held between (March 7-8); that injected creativity, resourcefulness and innovation into the conference. We were amazed at the range of brilliant, workable solutions that resulted from the event. Amref Health Africa will support incubation of the three winning ideas and their scale-up so that we can revolutionise health care for mothers and new-borns in Africa. The AHAIC 2017 conference culminated in the reading out of a Communiqué to be shared with governments across the continent. We hope the document will have a far-reaching impact on the engagement and inclusion of communities in general and the youth in particular in health development.

I wish to thank our partners - the Ministry of Health, Kenya, GlaxoSmithKline (GSK) and the City County of Nairobi - for their support in making this conference a great success; and the World Health Organization (WHO) for technical support, guidance and providing keynote speakers.

A special word of gratitude goes to our organising committees, sponsors, government representatives, keynote speakers, oral and poster presenters, media, and every delegate who attended AHAIC 2017 and contributed to its success. Together, we are the custodians of Africa's Health Agenda for achieving the SDGs and universal health coverage. Let's turn the agenda into action.

I wish you all the best in building a healthier Africa. See you at the next AHAIC in 2019!

Dr Githinji Gitahi

Group CEO, Amref Health Africa

Word from the Chair, Amref Health Africa International Board

The Chair of the Amref International Board expressed pride in the success of the Conference, noting the high members and calibre attendance. He called on the participants to back up the conference resolutions with action for the benefit of the approximately 1.2 billion Africans, bearing in mind the link between SDGs and the Africa health development agenda. He underscored community support and ownership as key success factors for Universal Health Coverage and acknowledged Amref Health Africa's lengthy history of strong and authentic linkage with communities in Africa. He noted that the launch of the "Workers and not Volunteers" agenda was one of the greatest outcomes of the Conference.

Mr Issa emphasised the importance of investing in research to inform decision making and policy formulation and reiterated the need to rethink partnerships to ensure UHC. He reminded the participants that the youth must be involved in decision making, adding that they required access to information if they were to meaningfully engage with decision makers. He challenged the participants to consider ways in which citizens could be engaged in PPPs and reiterated the need to build the capacity of government staff to enhance their negotiation skills. This, he said, would help bring parity between the public and private sector in PPPs. In closing, he urged the participants to work to eliminate cultural stereotypes and involve more women in decision making.

Mr Omari Issa

Chair, Amref Health Africa International Board

Introduction

The Africa Health Agenda International Conference (AHAIC 2017) took place from the March 5-9, 2017 at the Radisson Blu Hotel in Nairobi, Kenya. The conference was hosted by Amref Health Africa in partnership with the Ministry of Health, GlaxoSmithKline (GSK) and the Nairobi City County, and was officially opened by Dr Jackson Kioko, Director, Medical Services, Ministry of Health, Kenya (representing the Cabinet Secretary for Health in Kenya, Dr Cleopa Mailu). The World Health Organization (WHO) provided support, guidance as well as keynote speakers. Other sponsors included Takeda, Johnson&Johnson, Philips, PharmAccess, Joint Learning Network, Rockefeller Foundation, Merck, Elsevier, Mpesa Foundation, Terre De Hommes, Advocacy Accelerator, Momala, JICA, Unilever, MHakika, Ipas, Astra Zeneca, Christian Aid and Smile Train.

AHAIC 2017 kicked off with the Pre-Conference Youth Forum held between March 5-6, 2017 following a colourful opening ceremony graced by First Lady of Malawi, Dr Gertrude Mutharika, and First Lady of Kenya, Margaret Kenyatta.

The three-day main conference, held from March 7-9, assembled scientists and researchers, leaders from government, multilateral agencies, the private sector and civil society; and representatives of development partners, youth, advocates for health and the media to discuss, debate and share state of the art scientific knowledge and evidence. Eleven countries were represented at the Conference. The following activities enriched the event:

Pre-Conference Youth Forum

The AHAIC 2017 preconference youth forum provided a 2-day platform for young people to engage, discuss and collaborate with leaders and policy makers from across different health sectors. The purpose was to contribute to strategies, scientific approaches and investments being made on the improvement of the youth's health. This preconference forum brought together 180 young people from 11 countries and 70 adult observers bringing the total delegates to 250. AHAICYouth2017 Facebook garnered 4,121 likes by engaging an aggregate of 5,114 users. Twitter garnered a follower to following ratio of approximately 2:5, 103,000 impressions and 1,376 profile visits.

The opening ceremony was graced by Her Excellency Mrs Gertrude Mutharika: First Lady of Malawi and President of OAFLA, Her Excellency Mrs Margaret Kenyatta: First Lady of Kenya. The preconference youth forum also had the privilege of receiving inspiring speeches from Dr. Githinji Gitahi, Amref GCEO, Ms Shuluni Shirim, Anti-Female Genital Mutilation Ambassador, Amref Health Africa, Ms. Katy Hayward, ViiV Healthcare Global Medical Lead Pediatrics ViiV Healthcare, Ms. Gift Malunga, Acting Country Representative Kenya United Nations Population Fund (UNFPA), Dr Werner Schultink, Country Representative, UNICEF Kenya and Mrs. Sicily K. Kariuki the Cabinet Secretary, Ministry of Public Service, Youth and Gender Affairs. King Kaka delivered a lively performance and Dr Jackson Kioko, Director of Medical Services, Ministry of Health Government of Kenya was the chief guest speaker at the closing ceremony. The pre-conference youth forum received financial and technical support from various organizations including; Amref Health Africa, ViiV Healthcare/GSK, UNFPA, UNICEF, WHO, IPAS Africa Alliance, IPPF, Centre for the Study of Adolescence (CSA), Dance 4 life and YMCA.

The preconference forum acknowledged that majority of the burden of diseases within the region affects young people hence the need to involve them in solving these health challenges. In Africa today, 65% of the total population is below the age of 35 years, and over 35% are between the ages of 15 and 35 years; making Africa the most youthful continent. This was therefore an exciting window of opportunity to harness the demographic advantage through the empowerment and active participation of youth as major stakeholder in health and development. The preconference forum discussed a number of key issues affecting young people with a special focus on sexual and reproductive health & rights and meaningful youth engagement. Other issues included:- Alternative Rites of passage, HIV/AIDS, early marriage, Empowerment of women, Family planning, Empowerment of youth and good governance, Gender Based Violence, Abortion/ Teenage pregnancies, Drug/ Substance Abuse, Stigma and Discrimination.

The preconference forum was vibrant with engaging activities ranging from Edutainment, media interviews, skills building session, panel discussions, photo session, group discussions, the Great Debate, and all culminating to a communiqué (Annex A). The Great Debate focused on contentious issues in society for example; Access to SRHR services, Sexuality education and the role of young people in advocacy. The communiqué highlights the action points and decisions made by young people during the preconference forum and acts as an advocacy tool that brings out the needs of young people to the leaders, development partners and also the youth themselves.

It was resolved that inclusion of youth is necessary for development of Youth-friendly solutions and services. Further, the youth were encouraged to make adults their allies; take an interest in policy making and governance of issues affecting them; ensure a multi-sectoral and multi-dimensional engagement, including parents and teachers in order to achieve the goals of the African Youth Charter and Sustainable Development Goals (SDGs). In addition, the realization that religion and culture plays a big role on how to handle sexual issues necessitates the need to integrate Comprehensive Sexuality Education with all stakeholders. African governments were urged to increase budgetary allocation and prioritize resources towards improving health for young people. It was also noted that many commitments are made at national, regional and global levels on the youth to mitigate youth related problems but are rarely acted upon at country level. To this regard, governments were called upon to issue an official statement on East and Southern Africa and African Union commitments, sign them and implement them in their countries. The preconference youth forum was a great success with the highlight that: Nothing for young people, Without young people (Nothing for Us, Without Us).

Hackathon

The tension-filled 48-hour Hackathon, dubbed *Innovate4Life*, took place on March 7-8. Fifteen innovators, shortlisted from 117 applicants, sought to create innovative solutions to the issues that cause maternal and child deaths. The objectives of the Hackathon were to; create awareness about the plight of women with highlight on maternal health; engage developers and innovators to develop solutions that can help curb maternal mortality; and to inform and activate entrepreneurs and developers to participate in the event.

Three applications (Apps) were selected to move to the next stage. *Help Mum* (Nigeria) is a knowledge App that sends out broadcasts to pregnant women; *Chanjo Plus* (Kenya) tracks vaccination defaulters; and *Wekebere* (Uganda) is a hand-held self-diagnosis App that will be used by pregnant mothers to detect the condition of both the mother and foetus. These three winning innovative solutions will have access to US$3,000 seed funding and a three-month acceleration programme that will support the innovators to refine their solutions and scale up their Apps. Due to the high quality of the solutions presented, an additional 2 runners up innovations were selected to join the acceleration programme that will support innovators to refine their solutions and scale up their Apps. In addition, the team members will receive training and mentorship. The two runners up were: *Pregmum* (Kenya) a simple wearable monitoring gadget that measures the foetal heart rate of a pregnant mother's baby and mother's blood pressure and *Afya Plan* (Kenya) a mobile service that connects groups of mothers together in a chama (welfare/ investment group) to create a pool from where these mothers will get funds for their children's (13 years and below) health care.

Innovate4Life hackathon was successful due to support Amref Health Africa, Takeda and Nailab offered with the stakeholders leveraging on each other's strength.

Campaign Launched

The Opening Ceremony climaxed with the launching of the Workers not Volunteers agenda in support of the critical role played by Community Health Workers (CHWs). The conference acknowledged that to expedite universal health coverage in Africa, the governments must formally recognise and ensure Community Health Workers are an integral part of the formal health workforce.

FGM eradication strategy

Amref Health Africa took advantage of the Conference's critical audience to launch its vision to eradicate Female Genital Mutilation by 2030. This event coincided with International Women's Day celebrations.

Ministerial panel

Amb Dr Mustapha Sidiki Kaloko, Commissioner for Social Affairs at the Africa Union Commission was the lead discussant in this panel on Response to and preparedness for health threats in Africa. The panel had ministers from Kenya, Uganda, Zanzibar and Tanzania.

Media

The conference was extensively covered by more than 15 local and international media houses and proceedings transmitted via TV, radio, newspapers and social media. The in-house Communications team prepared a daily bulletin, ensuring that participants were abreast with the conference highlights.

Conference theme

The theme of AHAIC 2017 Conference was: Towards a Healthier Africa: People, Systems & Innovations. Its objectives were to:

- Bring together researchers, policy makers, practitioners, the private sector, advocates for health and civil society together to reflect on home-grown solutions to achieving the Sustainable Development Goals across the continent.
- Share scientific research findings and best practices addressing health and health systems in Africa.
- Identify and discuss gaps and challenges in implementing the Sustainable Development Goals in Africa.

The objectives were extensively discussed through four sub-themes:

- Community Health Systems Responsiveness and Resilience
- Health Care Financing for Sustainable Development
- Innovation and Technology for Health Systems Strengthening
- Global Health Security Initiatives.

Conference Organisation

The Conference had an Organising committee, chaired by the Amref Group CEO, and a Scientific Committee that coordinated the events (Youth pre-Conference, the Hackathon) and ensured submission of quality presentations and posters. *See Annex F* for committee composition. An Implementation Committee provided logistical and support service structures for the smooth running of the Conference.

AHAIC 2017 hosted nine plenary sessions and 15 track sessions with an average of six oral presentations under each track. Through special invitation, 14 satellite sessions were conducted by organisations including: Amref Health Africa, Japan International Cooperation Agency (JICA), Philips, PharmAccess Foundation, GlaxoSmithKline (GSK), Johnson&Johnson, Elsevier Foundation, Management Development Institute (MDI), Unilever East Africa, Accelerator Advocacy, and the mPesa Foundation. The sessions were guided by the four sub-themes, and were held before or after the main sessions. The conference also facilitated two skills building sessions.

During the three-day conference, a total of 117 posters were presented. The rapporteurs got to review an average of six per day. A summary of key findings and recommendations are included in this Report and the posters are available at **www.ahaic.org**.

An interesting component of the Conference was the creative capturing of highlights using art. This was done by Creative Harvesting from Netherlands during the main conference and Chege Harrison (Bantu) in the Youth Pre-Conference. There were eleven exhibitors at the conference; namely GSK, PharmAccess, Christian Aid, Family Health Company, Bayer, Smile Train, Merck Sharp and Dohme, Philips, Johnson&Johnson, Takeda and Baobab Circle.

Opening remarks

Dr Cleopa Mailu, Cabinet Secretary, Ministry of Health (*represented by Dr Jackson Kioko*)

The Cabinet Secretary acknowledged the high calibre of speakers at the Conference and the potential for effective partnerships to enable accelerated progress towards Universal Health Coverage (UHC). He said: "Health systems in Africa have experienced numerous challenges including coping with the huge burden of disease, sub-optimal public investments and weak resilience to emerging public health threats such as disease outbreaks, epidemics and climate change. Systems, which have been orientated largely towards addressing communicable diseases, are now overstretched by the ever-increasing burden of non-communicable diseases and injuries."

The CS noted that AHAIC 2017 came after the Sixth Tokyo International Conference on African Development (TICAD VI), themed "Advancing Africa's Sustainable Development Agenda", held in August 2016 in Nairobi, Kenya. The CS revisited TICAD VI's concluding framework for action, which focused on expanding coverage of key health services, protecting communities against catastrophic health expenditure and enhancing health security as part of the Universal Health Coverage.

Referring to the theme of AHAIC 2017: Towards a healthier Africa: people, systems and innovations, the CS emphasised the importance of developing inclusive solutions to Africa's unique health challenges. He recognised the marked improvement in the performance of health systems in sub-Saharan Africa, noting that a lot still needed to be done. He called on the participants to focus on engaging communities in health research and identifying evidence to inform policy and practice.

Dr Mailu urged African states to prioritise health sector investments to enhance capacities for implementation of interventions that will contribute to realisation of the Sustainable Development Goals (SDGs) and UHC. He expressed hope that through sharing and learning from one another, the Conference would chart a practical way forward for improving health in Africa.

Plenary Sessions

Plenary 1: **Addressing bottlenecks affecting health systems in communities of Africa: Strategies, achievements, challenges and the way forward**

Presenters: **Dr Delanyo Dovlo, Director HSS WHO; Dr Marc-Alain Widdowson, Deputy Director CDC, Kenya; Prof Richard Muga, Uzima University; Prof Francis Omaswa, Executive Director, ACHEST and Dr Davide Mosca, Director of Health Division, IOM**

Chair: **Prof Fred Mangen, Makerere University**

The disparities in economic growth across Africa are likely to skew attainment of Sustainable Development Goals (SDGs). The continent is undergoing transitions in socio- economic, political and epidemiologic trends and health security risks (emerging communicable diseases). The continent's health system remains weak because of years of under-investment, failure to harness emerging opportunities, limited innovation in the delivery of health services, poor disease surveillance, limited interaction between households (communities) and formal health systems, poor capacity of community health systems to carry out health promotion, poor scaling up of evidence-based solutions, limited capacity of health professionals to package and present community-friendly solutions and interventions, leadership, governance and stewardship failures, and global fixes (international standards) that are not necessarily adaptable locally.

Participants expressed the following concerns:

i. Is Africa prepared to harness the demographic dividend (youth bulge) and the health challenges likely to emerge from that social-demographic transition?

ii. The incident of a survivor of the deadly Ebola Virus Disease in Liberia who ended up dying of birth-related complications - "Is this an indication that Africa is investing more on emerging diseases at the expense of basic health education?"

iii. How can health development initiatives can be reconciled with the complexity and dynamism of communities in programme design?

iv. Why are the effects of Leadership Management and Governance (LMG) not felt in the health system despite heavy investments in this area?

v. What is the status of implementation of governments' commitment to the Abuja Declaration on increasing health financing to at least 15% of their annual budgets?

The panellists concurred with the issues raised and decried the low investment in health systems. ACHEST was cited as having developed a handbook on LMG for Ministers of Health. The guide demonstrates ways of strengthening and institutionalising basic management skills at the administrative level of Africa's governance systems. Africa's health systems must address financial, leadership, governance structures that are responsive to disease trends.

Recommendations

The session recommended that African governments need to:

- Invest more in strengthening community health systems, LMG and stewardship of health services.
- Enhance interaction between communities and formal health systems; close the knowledge gap (through investing in data, research and evidence).
- Continue investing in a cadre of CHWs empowered with the relevant skills to initiate change at household level.
- Orient the training and capacity building of health practitioners to focus on community-friendly solutions and service delivery.
- Institutionalise quality improvement at all levels of the health system.
- Document and build strong evidence of scalable interventions.
- Delineate the roles of political, community and technical leaders in governing health systems because competent technical leadership exerts influence on political and community leadership.
- Contextualise Universal Health Coverage in the training of Human Resources for Health and increase communities' awareness of their rights.
- Establish country-specific infection control and outbreak response measures.

Plenary 2: **Towards a healthier Africa: People, Systems & Innovations**

Keynote speakers and panellists: **Dr Githinji Gitahi, Group CEO, Amref Health Africa; Dr Meggy Muoka, Youth representative; Dr Jackson Kioko, Director of Medical Services, Ministry of Health, Kenya (**representing Dr Cleopa Mailu, Cabinet Secretary, Ministry of Health, Kenya**); Mr David Pritchard, Vice-President, GlaxoSmithKline; Dr Matshidiso Moeti, WHO Africa Regional Director**

Master of Ceremonies: **Ms Caroline Mutoko**

Africa's health system is characterised by among other challenges, a huge burden of disease, sub-optimal public investments, low resilience to emerging public health threats, low investment in research and a critical shortage of health workers. Africa carries 70% of the global health burden and only 3% of the global health workforce. More than 50% of Africans do not access the formal health system. Although there is a marked improvement in the performance of health systems in sub-Saharan Africa, a lot remains to be done in key intervention areas such as reproductive, maternal, new-born, child and adolescent health, prevention of violence and injury, and prevention and management of communicable diseases (which cause 70% of deaths in Africa) and non-communicable diseases.

The challenges of health care in Africa are unique and require unique solutions. The importance of Community Health Workers for Universal Health Coverage cannot be overemphasised. They are a critical and necessary part of the continent's health infrastructure, helping to link communities to the health system. Africa can only deploy this vital component once governments institute measures to adequately train and remunerate CHWs as an integral part of the public health service.

Young people comprise 65% of Africa's population and have unique health problems. They should be involved meaningfully in deliberations on strategies, scientific approaches and investments made in the improvement of their health. Commitments to youth should be backed by action at country and continental levels.

The panel of experts recognised Africa's rich experience and potential to form effective partnerships that will accelerate progress towards improved health care delivery and Universal Health Coverage. A partnership approach, marked by acceptance of and respect for each partner's expertise, will be critical to meeting the objectives of the SDGs. Given that political will is necessary in supporting private sector and NGOs to realise SDGs, African governments must put health before political and economic agenda.

Recommendations

- African states must prioritise investments in the health sector to accelerate the attainment of Sustainable Development Goals and Universal Health Coverage.
- Governments must implement policies that are youth-centred and include youth as accountability partners so as to harness the demographic dividend. They should increase budgetary allocation for issues affecting the health of young people even as the latter innovative and take initiative over these issues.
- Partnerships are the preferred model of engagement for development as envisaged by SDG 17. No one can go it alone.
- Community Health Workers are a critical part of the solution to Africa's unique health problems and should be remunerated and integrated into the formal health workforce.

Plenary 3: **Impacting health in Africa through Public Private Partnerships: Lessons, challenges and future actions**

Keynote speaker: **Dr Marijke Wijnrok, Chief of Staff, The Global Fund**

Panelists: **Bruno Witvoet, Executive Vice President, Unilever Africa; Isabel Torres, Senior Director, Access to Medicines Emerging Markets, Takeda Pharmaceuticals; Ian Walker, Corporate Citizenship Director, Johnson&Johnson; Prof Khama Rogo, Head Health Sector Specialist, Head, World Bank Group Health in Africa Initiative; Ashling Mulvaney, Senior Director, Healthy Heart Africa, AstraZeneca PLC**

Chair: **Prof Bitange Ndemo**

Public Private Partnerships (PPPs) are not new in Africa. They began 100 years ago when Faith-Based Organisations began work in Africa. Conceptualising PPPs is challenging when the definition of what is private and what is public is not clear. PPPs have been characterised by lack of appropriate legal, policy and monitoring frameworks or the lack of expertise where these exist. In Africa, for instance, only three countries have the necessary policy and legal frameworks for PPPs. The result has been an imbalance in negotiations, where the private sector is better prepared compared with the public sector. Programmes such as the Global Fund have largely been supported by multinationals with little contribution from African companies. Furthermore, major financing for health is sourced from foundations or individual philanthropy rather than PPPs.

Three main messages emerged from the Conference: First, the quality of PPP transactions must be improved through the guidance of legal and policy experts for successful implementation of PPPs. The capacity of governments to manage PPP agreements should be strengthened to enable them negotiate on equal terms with the private sector. Secondly, private sector involvement should not only be limited to money but must instead reflect the six building blocks of the health system. The engagements must be expanded to cover a number of years. India is a good example of domestic financing. There has been increased funding for health by harnessing the corporate Social Responsibility (CSR) model, high net worth individuals and PPPs.

Participants raised concern that although PPPs have worked in infrastructural programmes where profits are expected, they often fail to deliver the envisaged gains. The response was that for PPPs to succeed, partners have to be flexible, resourceful, committed, organised and should share a strategic vision. They also need to break silos and work with resources that already exist.

Examples of successful PPPs in Kenya include the iodisation of salt that has eliminated incidence of goitre; the National Hospital Insurance Fund (NHIF) which works with the public and private sectors to expand access to health care, and the Global Fund partnership that responds to HIV/AIDS, Malaria and TB globally.

Recommendations

The session recommended that governments should:

- Engage the private sector in dialogue to build trust.
- Enact relevant legal and policy frameworks.
- Explore innovative financing.
- Improve the degree to which the government systems are agile and flexible;
- Start small, document lessons and scale up best practices;
- Develop a business case (s) for conditional funding and avoid working in silos.

Plenary 4: **Implementation of the health SDGs in Africa: strategies and challenges**

Key note speaker: **Mr Arif Neky, Advisor for UN Strategic Partnerships and Coordinator of the SDG Philanthropy Platform**

Panellists: **Neren Rau, Director, External Affairs and Communications, MSD (Pty) Ltd South Africa; HE Mrs Toyin Saraki, Founder President, Wellbeing Foundation, Nigeria; Dr Marc Alain Widdowson, Deputy Director, Centres for Disease Control and Protection (CDC); Dr Delanyo Dovlo, Director, Health Systems Strengthening Cluster – WHO**

Chair: **Edwin Macharia, Partner and Regional Director for Africa, Dalberg East Africa**

The Sustainable Development Goals (SDGs) adopted by 193 countries across the world, are a transformative agenda towards which governments, civil society and the private sector must work together to leverage resources, support implementation and track impact. Attainment of the SDGs may be slowed down despite decline in fertility rates, increase in Contraceptive Prevalence Rate (CPR), decline in infant and maternal mortality, increase in skilled deliveries and increased knowledge of HIV status. To maintain a positive trajectory, all actors must focus on the following enabling factors: political support, public investments, effective coordination, philanthropy, harnessing of the demographic dividend (lesson from the Asian Tigers), capitalising on gains in maternal and child health, gender equality, enabling policy environments and ensuring that budgets are responsive to community needs, strong PPP investment (in risk pooling, maternal and child health, disease management and case follow-up).

The panel of experts reiterated that PPPs were critical for pooling resources to attain the SDGs. Dwindling bilateral funding to Africa means that Africa must be more efficient in the use of development assistance, as well as own funding and leveraging internal resources. The latter includes deploying the public sector's "hidden" assets such as natural and human resources and engaging with communities as equal partners to accelerate the attainment of the SDGs in general and improving health outcomes in particular.

Concern was raised about the level of corruption. The response was that there are multiple mechanisms in place to check corruption, including the use of score cards and direct impact assessments. For example, WHO has observatory units to check how countries are doing. The public must remain vigilant and proactively hold governments accountable.

Recommendations

The session recommended the following actions:

- African governments should transition from dependence on bilateral funding to financing models; scan the operating environment for suitable investment opportunities and prioritise partnerships around already existing initiatives; focus on long-term planning instead of piloting programmes that are not taken to scale; and assess the impact of investments and emphasise accountability.
- The private sector should build the capacity of the public sector to engage in the PPP processes, including clear rules of engagement, disengagement and inclusive participation in designing health solutions.

Plenary 5: **The role of innovations and technology in improving health and services in Africa**

Keynote speakers and Panelists: **Robert Collymore, Chief Executive Officer, Safaricom Limited; Poelof Assies, General Manager, Philips East Africa; Nicole Spieker, Director of Quality, PharmAccess Foundation, Amsterdam; Rita Owino, Marketing Development Manager, Primary & Referral Care, GE HealthCare**

Chair: **Prof Melba Wasunna, Strathmore University**

Innovations are not limited to technology. They cut through a continuum of technology and non-technological solutions. Innovations are vital in providing new solutions to address challenges in health systems, essential services and policies. They also provide novel solutions that increase affordability, reach and quality of health services. Developers must be prepared to test innovations, make mistakes, correct them , scale-up successful solutions or quickly discard what does not work. Technology must be relevant, scalable, sustainable, customised to respond to a problem, easy to use, durable, portable and affordable. The ideal solutions for health matters range from those that enable early detection, clinical decision-making support (protocols), education and training, to diagnosis and health promotion.

The panel of experts observed that while more investment was needed for primary health care in Africa, the private sector was the major investor in health care. The traditional funding mechanisms are ill-suited to the urgency with which the world is moving to develop solutions to emerging problems. There is need for innovation in financing models. The speakers called for collaboration rather than the prevailing fragmented efforts to address similar challenges. The partnerships must be aligned in purpose and begin with the end in mind so that investment is made in solutions that have potential for scale-up and which solve real problems.

Winners of the *Innovate4life* hackathon were announced during this session. Out of 117 applications received, 15 teams were selected to participate in the 48-hour event. The lead sponsor was TAKEDA and the focus was on maternal and child health challenges. The three most promising innovations were:

- **Help Mum (Nigeria)** – developed a knowledge Application (App) that sends out broadcasts to pregnant women;
- **Chanjo Plus (Kenya)** – developed an App that tracks vaccination defaulters;
- **Wekebere (Uganda)** – developed a hand-held self-diagnosis App for use by pregnant mothers to detect the condition of both the mother and foetus.

The Innovative4 Life Fund was officially inaugurated to support rolling rounds of innovations.

Recommendations

The session made the following recommendations:

- The session gave the following recommendations: African governments should increase investments in health, explore options for innovation in financing models and ensure the active involvement of both the public and private sectors. This will ensure scalability and sustainability of the innovations.
- Developers should keep their innovations simple and build solutions from the ground up with input from the end users.
- The government, civil society and private sector should maintain a holistic view of the health system, and ensure collaboration.
- Technology is context-specific; Africa needs technologies that are relevant to the African environment, affordable, energy-efficient and easy to use.

Plenary 6: **Antimicrobial Resistance**

Presenters: **Prof Charles Feldman, University of Witwatersrand, SA; Prof Gunturu Revathi, Consultant Clinical Microbiologist, Aga Khan University Hospital, Nairobi**

Chair: **Dr Zonke Mlokoti – Fikeni, GSK Area Lead, Africa & Asia DC**

The World Health Organization has recognised Antimicrobial Resistance (AMR) as a complex global threat that calls for shared responsibility among countries. Without urgent intervention, it is estimated that there will be 10 million cases of AMR by 2050, coupled with a loss of enormous amounts of economic resources. Evidence has shown that certain treatment protocols promote resistance, for instance the administration of multiple drug combinations without appropriate diagnosis. This poses the risk of a mismatch between antibiotic usage and actual need. In the USA and Europe the annual expenditure on antibiotics is huge, with approximately 70% on non-therapeutic use for animals.

AMR has also been linked to the use of herbicides as well as dust and metals (and shown to promote resistance). The predicament is why AMR is spreading very fast despite clear guidelines and availability of specialists, especially in the USA. The absence of solutions to medical conditions such as cancer and Alzheimer's disease has increased the demand for alternative medicine in both developed and developing countries. In Africa, patients turn to herbalists due to the lack of accessible and affordable quality healthcare. In Kenya, for example, the factors leading to AMR are: few microbiology laboratories and Infectious Disease practitioners; poorly equipped institutions of higher learning; syndromic management approach due to lack of investment in diagnostics and very poor healthcare infrastructure. There are few new antimicrobials in the pipeline and the likelihood of patients accessing new ones is low.

The other causes of AMR include resistant strains of bacteria, mal-use of antibiotics at both facility and community levels and use of antibiotics to treat plants and livestock. The key to addressing AMR is to coordinate multiple interventions that are aimed at reducing antibiotic usage and the alignment of usage with need. Antimicrobial stewardship is one of the approaches that have been applied to address AMR. This is a multiple strategy approach that guides the use of antimicrobials. It comprises interventions to monitor and direct antimicrobial use by means of standard evidence based approaches. It has been successfully applied in South Africa and uses multiple approaches (agriculture, community, education, prescription, and clinical setting). The approach involves auditing what is being done and targeting quick wins such as the use of multiple antibiotics, drug dosage, duration and frequency. The main components include coordinated action, improved diagnostics, surveillance, infection prevention and the appropriate use of antimicrobials.

It has been noted that vaccination contributes to a reduction in AMR. For example, Pneumococcal Vaccine (PCV 7) has been shown to reduce infection in children and a reduction in pneumococcal resistance among adults.

To curb AMR; antibiotic use should be reduced and aligned with the need; countries should enforce use of prescriptions to access antibiotics; the use of antibiotics in animals should be closely monitored and governments rallied to commit to addressing the issue.

A participant sought to know whether 'fake' drugs can lead to AMR. Whereas there is no hard evidence, drugs with lower than the recommended composition of the active ingredients tend to cause resistance, as does under-dosing. Whereas the Pharmacies and Poisons Boards are responsible for monitoring the use and effect of drugs, they are unable to do this due to inadequate funding. It was noted that that the general public was not aware of AMR and therefore the need for information campaigns. There is need to hold players accountable for reducing AMR, especially the non-therapeutic use for animals.

Recommendations

- A collaborative global response is required to address AMR inclusive of International policy to govern antimicrobial use in agriculture and animal husbandry.
- Stakeholders to implement Antimicrobial stewardship & Diagnostics Stewardship to monitor and direct Antimicrobial use.
- Governments and other partners to invest in research & diagnostics; bring together Science & policy.
- Advocacy and Community education to curb self-medication and antimicrobial use in animals and farms without proper consultation.

Plenary 7: **Universal Health Coverage**

Presenters: **Prof Stella Anyangwe, Hon Prof of Epidemiology, School of Health Systems and Public Health, University of Pretoria; Francis Ukwuije, Senior Health Economist & Head of Health Care Financing, Equity & Investment, Federal Ministry of Health, Nigeria; Dr Amit Thakker, Chairman, Kenya Healthcare Federation**

Chair: **Mr Nathaniel Otoo, Chief Executive Officer, Ghana National Health Insurance Authority**

Despite the pledge by African Union member countries to implement the Abuja Declaration to allocate 15% of their annual budgets to health, only one African country has attained the target. 80% of Africa's population seeks treatment from unregulated, traditional medical practitioners, as opposed to visiting a health facility.

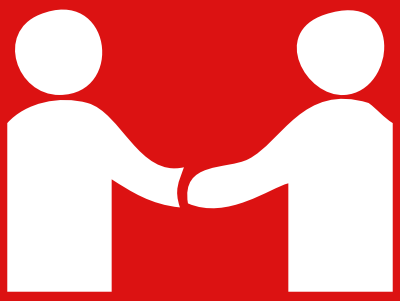
Lack of diagnostic equipment, inadequate capacities, poor attitude of health workers, and weak monitoring and evaluation systems contribute to poor health services in government facilities. The private sector has focused more on Universal Health Insurance rather than Universal Health Coverage, while faith based organisations are not considered within the framework of the health care system and are therefore not factored in the government coverage count. Despite its importance, regulation is poorly implemented because it requires heavy investment in human and financial resources. Self-regulation has not worked well in Africa.

To attain universal coverage, different strategies are needed, key among them; ensuring that health care is available for everyone, adoption of new sets of tools to measure the contribution of both private and public health facilities, regulation to streamline service provision, standardisation and financing, a strong M&E system to ensure quality of services, partnership, leadership and accountability and community awareness to increase health-seeking behaviour.

Recommendation

The session recommended the following to achieve Universal Health Coverage:

- Governments should institutionalise the role of the private sector in finding sustainable solutions.
- All stakeholders should improve health leadership, management and governance and create awareness to ensure that the end users participate and make informed choices.
- Governments should create a policy environment that anchors the principles of UHC to appropriate institutions.
- Governments should abide by their commitments to the International Health Regulations.



CLOSING
CEREMONY

Closing Ceremony

Speakers: **Dr Githinji Gitahi, GCEO Amref Health Africa; Mr Omari Issa,Chair, Amref Health Africa International Board; Dr Nicholas Muraguri, Permanent Secretary, Ministry of Health, Kenya; Dr Evans Kidero, Governor, Nairobi City County (**represented by Dr Benard Muya**); H E Toyin Saraki, Founder President, Well Being Foundation**

Master of Ceremonies: **Ms Carolyne Mutoko**

Dr Githinji Gitahi, Group CEO Amref Health Africa

The Amref Group CEO read out the AHAIC 2017 Communiqué. *See Appendix A.*

Dr Evans Kidero, Governor Nairobi City County (*represented by Dr Benard Muya*)

The Governor of Nairobi said he was pleased that the Nairobi County had identified the important role played by CHWs, who would soon be put on the County payroll. He emphasised the importance of PPPs in health care financing and said the county government of Nairobi was committed to increasing the health budget. Health care financing, he noted, was a key factor in bringing about a sustainable health care system.

Dr NIcholas Muraguri, Permanent Secretary, Ministry of Health, Kenya

The Permanent Secretary noted the unique health challenges facing Africans and said that it was necessary to prioritise the continent's health agenda in order to meet global health targets.

He summarised the issues facing the continent and highlighted the solutions proposed by the Conference, such as a responsive and resilient Community Health Systems, health care financing, leveraging innovation and technology, and addressing Global Health Security threats through preparedness. He reiterated the Conference's recommendation to prioritise investments aimed at realising the SDGs and UHC.

He recognised the key role played by CHWs, the necessity of harnessing the youth demographic dividend, involvement of marginalised populations in decision making, and partnerships, which he said were important vehicles for the attainment of the SDGs and Africa's transformation. Dr Muraguri expressed confidence that the best practices and innovative solutions deliberated upon during the conference would contribute to fostering home-grown solutions to the health challenges facing Africa.

Chief Guest: H E Toyin Saraki, Founder President, Well Being foundation

The Chief Guest observed that the magnitude of challenges posed by communicable and non-communicable diseases in Africa could no longer be ignored. She said that the continent's demographic transition was one of the factors behind the increase in NCDs in Africa and highlighted the need to strengthen Africa's health system to address both existing and emerging disease threats. Africa, she said, needs to put in place mechanisms to respond to public health emergencies and disease outbreaks, citing the Ebola Virus Disease in West Africa.

H E Saraki highlighted the lessons learnt from the Ebola crisis, among them the lack of personnel, inadequate financial resources, ineffective communication, lack of coordination, and lack of community ownership. She urged African governments to restructure their expenditure to achieve the Abuja Declaration target of 15% investment of their budgets into health.

In closing, she emphasised on the importance of maternal and child health programmes including immunisation, family planning, nutrition, public health and safe drinking water. Africa, she said, must prepare itself to address emerging environmental risks particularly climate change, ecosystem degradation and occurrence of natural disasters and emergencies.

Gallery

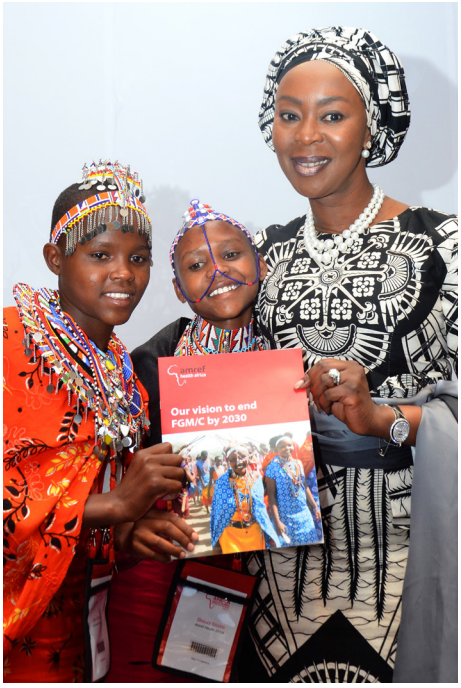
First Lady of Kenya, H E Margaret Kenyatta and First Lady of Malawi, H E Dr Gertrude Mutharika during the Youth Pre conference forum

Delegates at the conference registration desk

H E Toyin Saraki addresses youth at a town hall session

First Lady of Kenya, H E Margaret Kenyatta and First Lady of Malawi, H E Dr Gertrude Mutharika with participants at the launch of the Youth Pre-Conference forum

Carolyne Khamala discusses a poster on enhancing Amref Health Africa's visibility through social media



Youth ambassadors Abigael Sabina, Shilumi Shirim with H E Toyin Saraki

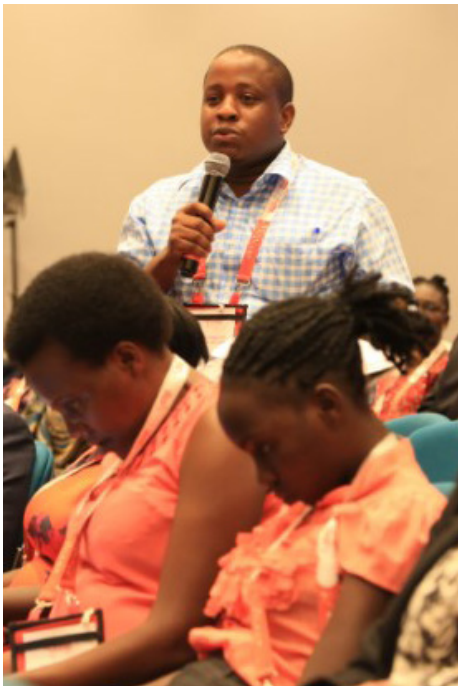
Visual artist Chege Harrison sketches illustrations of one of the town hall sessions

Participants in the 48-hour *Innovate4Life* Hackathon rack their brains for solutions to maternal and child deaths

A visual artist sketching illustrations of one of the sessions

Robert Collymore Safaricom CEO, awards the winners of the *Innovate4Life* Hackathon

A panel discussion on Public Private Partnerships in session



A participant makes a contribution during a session

Delegates at an exhibition booth

Dr Githinji Gitahi during the launch of the Workers not Volunteers agenda

Participants share ideas in a breakout session during the Youth Pre-conference forum

UNICEF Ambassador King Kaka addresses Youth Pre-conference delegates

Oral Presentations

Sub Theme 1: **Community Health Systems responsiveness and resilience**

Community health systems refer to people-led mechanisms and structures through which community members and community-based organisations and groups interact, coordinate and deliver their responses to the challenges and needs affecting their communities. Communities play a key role in increasing the reach and impact of health systems. They have a role to play in strengthening and realising the various components of effective community health systems: sustainable funding, equitable access to care, a strong and efficient health management system and successful behaviour change communication.

Track 1.1a: Best practices and Innovations for increasing access to Reproductive, Maternal, Neonatal, Child and Adolescent Health (RMNCAH) services in communities

Sponsor: **Christian Aid**

Chair: **Sylla Thiam, Amref Health Africa, Senegal**

Co-chair: **Dr Salim Hussein, Ministry of Health, Kenya**

Presenters:

- **John Kitui, Country Manager, Christian Aid, Kenya:** Creating an enabling environment for empowered communities to engage in the achievement of Universal health Coverage.
- **Sherine Athero, Project Coordinator, African Population and Health Research Centre, Kenya:** Combined demand and supply side strategies: community based distribution approach for improving family planning/reproductive health services uptake in Western Kenya.
- **Maureen Olyaro, Christian Aid, Kenya:** Political economy analysis of family planning.
- **Margaret Mugisa, Amref Health Africa, Uganda:** Improved access and utilisation of maternal health services: women's group approach in Gulu and Amuru districts in Northern Uganda.
- **David Ngilangwa, Researcher, Amref Health Africa, Tanzania:** Factors associated with recruitment and retention of Community Health Workers in Maternal, New-born and Child Health Programme in Simiyu Region, Tanzania
- **Yohannes Dibaba, Ipas, Ethiopia:** A decade of progress providing safe abortion services in Ethiopia: results of national assessments in 2008 and 2014
- **Evarine Nampewo, Busia District Local Government, Uganda:** District health team-led supervision of community based family planning services: what do findings suggest and can the results be used to strengthen the community based service delivery system?

In this session, a number of innovations were presented addressing RMNCAH services issues.

To combat maternal and child mortality, scalable and sustainable innovative solutions are needed. Four presentations focused on poor Family Planning (FP) outcomes.

Sherine Athero mentioned that in Kenya, access to Family Planning services is hampered by inadequate knowledge and utilisation of these services, negative attitudes and inadequate capacity among providers to deliver the services. She said that by addressing both supply- and demand-side barriers, her project had improved client-provider interactions and helped to increase Contraceptive Prevalence Rate. Other important outcomes included positive contraceptive switching behaviour and increased male involvement. She attributed the successful outcomes to the consortium approach adopted by the programme, which was useful in leveraging resources.

Maureen Olyaro noted the vast disparities between regions in Kenya; for instance the Contraceptives Prevalence Rate (CPR) which ranges from 2% to 81%, and the high unmet need for Family Planning, especially among the youth. She analysed this using a socio-political and economic prism, noting the underlying power and governance context within which Family Planning service delivery takes place. She said that communities were ready to fill in the spaces created by devolution of government in Kenya, to engage with government and establish mechanisms to dialogue and hold governments to account. Financing for Family Planning services, she observed, was predominantly driven by donor funding, which eroded the government's ability of governments to take responsibility and therefore remain accountable to communities.

Evarine Nampewo observed that in Uganda, maternal health indicators are among the poorest in the world, with particularly low numbers in northern Uganda. Whereas community-based Family Planning programmes contribute to better health outcomes at the community level, the sustainability of these programmes is hindered by the district health team's limited capacities to supervise these programmes. An intervention centred around women groups led to important findings among them the establishment of by-laws that enforce male involvement in birth preparedness and enhancing access to health services; and the vital role that increased interaction between health workers, secret mothers and Community Health Workers (CHWs) play in improving health outcomes.

Apart from challenges related to Family Planning, the session addressed abortion-related maternal mortality, which led to the revision of the Abortion Law in Ethiopia in 2005. This resulted in improved provision of Safe Abortion Care services while obstetric complications from abortion were dramatically reduced.

The session also discussed the attrition of Community Health Workers (CHWs) in Tanzania as a result of lack of remuneration; a reality that poses a huge challenge in the continuity and sustainability of the important role played by CHWs in connecting communities to the formal health system. The session observed that women CHWs were more at risk of attrition. It was agreed that recognition of the work of CHWs by communities had been shown to be important sources of motivation in addition to financial incentives. The session identified the important role that supervision of the work of CHWs by district health team play in sustaining community-based Family Planning programmes.

In conclusion, innovations for better maternal and child health are manifold and can be developed in various areas, including the legislative sphere, at community-level (women groups, CHWs), and at district level to increase ownership.

Recommendation

All relevant stakeholders must be involved to bring about health systems that foster improved outcomes for maternal and child health.

Track 1.1b: Best practices and innovations for increasing access to RMNCAH services in communities

Sponsor: **Christian Aid**

Chair: **Zahida Qureshi, Board Member, Amref Health Africa in Kenya**

Co-Chair: **Patrick Kagurusi, Amref Health Africa, Uganda**

Presenters:

- **John Kitui, Country Manager, Christian Aid Kenya:** Creating an enabling environment for empowered communities to engage in the achievement of Universal Health Coverage.
- **Kazeem Balogun Christian Aid UK, Nigeria:** Partnering with other international NGOs to deliver health services in hard to reach communities- Christian Aid Nigeria 'fruit bowl' approach experience.
- **Purity Mwendwa, University College Dublin, Ireland:** Assessing the demand for community health workers social support: Perspectives of mothers in rural Rwanda.
- **Ruth Mbugua, Mount Kenya University, Kenya:** Role of community health workers monetary incentives on retention and health service delivery in Kibwezi district, Kenya.
- **Mouhamed El Bachir, Amref Health Africa West Africa, Senegal:** The ICT Device, a major innovation initiated by Amref Health Africa in the health system Senegal?
- **Seminie Nyirenda, Amref Health Africa, Malawi:** Use of social audits to enhance community participation in the improvement of quality maternal health service delivery.

Due to inadequate health funding, communities in hard to reach areas have poorly equipped health facilities and weak health systems. Using the fruit bowl approach, a project implemented by Amref Health Africa empowered communities to be able to work with local health authorities to address social norms that affect the uptake of health services. The project saw the adoption of a number of health seeking behaviour by communities, e g adopting the use of mosquito nets and Vitamin A supplementation. The project reached 6600 women with Family Planning options over an 18-month period.

The community learnt that addressing social norms and gender dynamics helps in driving the uptake of health services and that partnerships helps to pool resources and avoid duplication of effort. Even though the fruit bowl approach is people centred, effective and gives results, the expectation is that the government will take up the activities after the project ends.

The discussion focused on the importance of quality of care provided by community health workers, and its acceptability by communities. The discussion noted that 62 out of 64 young women interviewed had received assistance from a community health worker. Most of these women said the services were very good although emotional support could have been improved.

The young mothers said that the CHWs did not visit them after delivery even though they expected the CHWs to inquire about other issues affecting them over and above the health of mother and child. The CHWs played other roles such as mobilising mothers to set up associations as well as to organise traditional means of transporting the mothers to deliver in health centres where there are no ambulances.

The discussion reiterated the importance of remuneration of community health workers/ volunteers given the critical role they play in the health sector. The discussion noted the difference in performance, attendance of meetings and service provision between CHWs who received incentives compared to those that did not. Attrition rates were also higher for those CHWs not receiving monetary incentives. The meeting noted the lack of a standard incentive package for CHWs, with different partners paying different rates, whereas the government did not remunerate them. Other forms of incentives included bicycles, T-shirts on dialogue days and recognition by communities.

The discussion on ICT devices decried the high maternal and child morbidity and mortality rates in areas of implementation with low skilled birth attendance. The discussion identified the use of telemedicine in one project that led to an increase in the number of people accessing antenatal care, skilled birth attendance at health facilities and child health services. The project has a telemedicine suitcase that serves three districts. This approach will be scaled up to other areas with high mortality rates and integrated with several councils in the district.

The discussion identified social audits as a means of enhancing community participation in the improvement of quality maternal health services. The project trained communities to conduct social audits thereby enabling them to pick out problems such as pilferage of drugs, poor health provider attitudes in health facilities and birth complications arising from a number of traditional birth attendants that were continuing to assist deliveries.

Recommendation

Partnership with other organisations is not a replacement for health providers' responsibilities.

Track 1.2: Addressing gaps in adolescent sexual and reproductive health services and rights

Sponsor: **Ipas Africa Alliance**

Chair: **Maureen Kuyo, Board Member, Amref Health Africa in Kenya**

Co-Chair: **Subbaraman Karthik, Philips**

Presenters:

- **Liza Kimbo, Alliance Director, Ipas Africa Alliance:** Opening remarks from Ipas Africa Alliance, the track sponsor
- **Nyasha Sithole, Zimbabwe Trust, Zimbabwe:** Social media listening: Using new technologies to address gaps on adolescence sexual and reproductive health.
- **Kidi Moses, Ipas Africa Alliance:** Increasing modern contraceptives uptake among adolescents with a particular focus on the uptake of long-acting reversible contraceptives (LARCS) through voucher and referral strategy.
- **Hussein Abdulla, Amref Health Africa, Ethiopia:** Increase safe and informed decision making on sexual and reproductive health (SRH) by young people in North Shoa Zone of Amhara Region, Ethiopia.
- **Meshack Acholla, Kakenya Centre for Excellence, Kenya:** Using education as a tool to end Female Genital Mutilation (FGM) in Trans Mara, Narok County.
- **Sharon Barasa, Center for the Study of Adolescents, Kenya:** Empowering young people to advocate for implementation of policies in Kenya
- **Anke van der Kwaak, Royal Tropical Institute, Netherlands Motivational Intervention for Young Males In Siaya:** Results of an Intervention Study.

Complications in pregnancy and childbirth are the leading causes of death among adolescent girls in Africa and other developing countries. The limited access to sexual and reproductive health and rights (SRHR) information and services among adolescents and youth has been shown to lead to STIs (including HIV), unintended pregnancy, unsafe abortion, and other health and social issues. It has been demonstrated that training both health workers and CHWs on youth friendly service provision is an effective means of increasing demand for SRH services among youth.

In many communities across Africa, there is low uptake of modern contraceptives, high prevalence of FGM, child marriage, school dropout and early pregnancy. The average age of marriage for females is low in many areas (median age in Ethiopia is 15.1), which subsequently leads to high rates of early pregnancy. In many communities, parents disprove of youth accessing SRHS services.

The discussion noted that in order to design projects that increase access to Family Planning (FP) services for young people, it is imperative to first identify the socio-cultural, religious and economic barriers to these services. IPAS shared their experience in the use of the FP voucher model referral system as a good example of models that have led to a 4% increase in the uptake of contraceptives. The meeting noted that despite the influential role played by young men, health workers were still struggling to find an appropriate way to engage young men in SRH programming. Further the use of interpersonal communication strategies at community level has been shown to create demand for FP among young women in an easy-to-replicate approach.

The meeting discussed a number of strategies that have been successfully implemented to enable girls to avoid FGM, early marriage, and stay in school. These include: (i) Establishing girls' boarding schools, (ii) Setting up networks for excellence (form 1-4), (iii) SRH training, (iv) Leadership training, and (iii) Community engagement (including identifying and supporting community champions), and (iv) Nurturing girls as role models. The meeting discussed the girl's boarding school run by Kakenya Centre for Excellence as an example of that was positively received by the target community. This is attributed in part to the school performing very well, engagement of a local community board comprising five community leaders, the fact that the school's founder grew up in the village where the school is based, and zero dropouts. The approach focuses on education as the entry point to tackling FGM issues.

Kenya's vibrant SRHR policy framework is an enabling factor in addressing SRH issues, however youth/adolescent awareness of these policies is low due to low levels of youth engagement in developing, disseminating and implementing processes. Motivational interviewing (MI+) is a goal-oriented, client-centred counselling style for eliciting behaviour change. The approach helps the clients to make safer choices about their sexuality and health resulted issues to increase uptake of SRH services. The Royal Tropical Institute's work in Siaya found that school-based youth groups tend to dissolve after 1-2 years, therefore the need to engage a variety of groups in capacity building activities to address SRHR.

Adolescents and youth are often left out of policy making and implementation processes affecting them. Engaging youth and building their leadership skills is a critical and effective way of addressing gaps in ASRHR. Evidence has demonstrated that youth can effectively engage in advocacy on SRHR topics, as well as research and learning activities related to SRHR advocacy. New and innovative technologies should be embraced to bridge ASRHR gaps. Youth participation in advocacy on increasing SRH services has had positive results at county level in Kenya. In Kisumu County, it resulted in commitments from budget committee to increase budget for SHR services for youth. Empowered young people who are able to voice their rights and engage with decision makers can create positive results (e.g. in terms of increasing budget for youth SRH services).

Recommendations

- Increase access to comprehensive SRH information, services and rights.
- Engage youth in ASRHR advocacy – materials exist via organisations like AfriYAN which are being used to engage government at regional and national levels (e.g. National ASRHR Forum, Technical Coordination Group on the ESA Commitment).
- Invest in developing youth leadership skills and in enabling youth to lead in implementing ASRHR initiatives.
- Public awareness raising activities should target existing CBOs, family members, community leaders and gate keepers whose outlook on youth usage of SRH services to influence the greater community where access to SRH services is stigmatized.
- Scale up effective models for preventing FGM where appropriate; this has multiple positive effects including preventing school dropout, child marriage, early pregnancy.
- Involve young people as advocates for change to ensure progressive implementation of SRH policies. Young people should also be involved as accountability partners, holding ministries and government accountable.
- Collect qualitative evaluation data for ASRHR interventions in order to understand the context of results.

Track 1.3: Approaches to improving nutrition status of communities

Chair: **Joseph Martin Chabi, WHO**

Co-Chair: **Irene Otieno, Toronto, Canada**

Presenters:

- **Samuel Biwott, Save the children, Kenya:** CHBIS chalkboards data for decision making at community level.
- **Sospeter Gitonga, Amref Health Africa:** Increasing diet diversity through school and kitchen gardens.
- **Kevin Mwenda, University of California, USA:** Fine-scale spatial modelling of child under nutrition in Kenya.
- **Edna Ojee, University of Nairobi, Kenya:** Microresearch survey of parents and guardians knowledge and practice on under nutrition of children aged 6 months to 5 years at Mama Lucy district hospital, Nairobi.
- **John Mnandi Ejekwuo, Kampala International University, Uganda:** 'Matoke' (banana) peels: The nutraceutical imperative for fighting diabetes in Uganda.
- **Nancy Mwangi, Population Services Kenya:** Coupling community resilience and Behaviour Change Communication (BCC) towards improved nutrition in Kwale, Kilifi and Kitui counties, Kenya.

Malnutrition is a condition that results from insufficient, excessive or imbalanced consumption or absorption of nutrients. Malnutrition affects the health, education and economic development of a country especially where the community has limited knowledge of what constitutes a balanced diet as well as the timing, duration and benefits of practices such as breastfeeding.

Globally, nearly half of the deaths in children under-5 years of age are linked to malnutrition, while in Kenya it is a leading cause of under-5 mortality. Child undernutrition metrics in Kenya are collected at the household level but reported at the county or national level. The use of localized geo-statistical models to support policy decision making in addressing under-five malnutrition is important due to its accuracy and compared to the global regression method which is not specific to household data and prioritizes malnutrition interventions. Despite this, there is inadequate knowledge of the rates of malnutrition and caregiver knowledge in mixed income communities for example in neighbourhoods such as Eastlands in Nairobi, Kenya. Households in marginalised communities mainly get their food from farming, purchasing, and relief food and lack the capacity and resilience to manage and mitigate man-made and natural shocks at both the community and household levels. The meeting noted that husbands and men in general were keys influencers on procuring a balanced diet.

The meeting discussed the factors surrounding the prevalence of global acute malnutrition (GAM) in Kakuma Refugee Camp was 11.4% in November 2015 while that of Turkana West was 16.7%

in July 2015. The causes of this included severe food shortfalls occasioning total reliance on food distribution and changing climatic conditions. A study on the refugee camp showed that the proportion of households not consuming vegetables, fruits, meat, eggs, fish, seafood and milk products was 57.0% in 2015 (SENS survey report 2015).

The meeting discussed a number of approaches among them (i) Power-mapping - a contextual multifaceted intervention for improving primary level demand, access and utilisation for Maternal and Child Health (MCH) services in three sub-counties, 15 points of care and 25 Community Units in Wajir County of Kenya; (ii) Chalkboards - an approach that is effective for carrying out community dialogues, successful tracing, referral and linkages of community members to health facilities.

Personnel in charge of health facilities use Chalkboards to collect data for decision making. The facility head counter-checks the data and does household spot-checks to verify the quality of data and collected by the CHW. The data is entered into facility DHIS, linked to sub county and county DHIS data and used by the facility Head to decide on discussion points during the dialogue day.

The meeting noted that there is currently no completely effective treatment for diabetes mellitus other than insulin therapy, glyburide, which is used in the management of the condition. Insulin therapy is associated with side effects such as weight gain and other cardiovascular risk factors. In Uganda, matooke, a staple food made by boiling the peeled bananas is used in the management of diabetes mellitus whereas in Eastern Nigerian, the same conditioned is managed through eating bananas boiled in the peels. The meeting was informed that these traditional treatments had not undergone clinical trials.

The meeting observed that a multi-sectoral approach that includes partnerships and collaborations with line ministries, and key actors to address malnutrition in Turkana was essential. Community ownership and involvement in making decisions on household and school kitchen gardens, the type of crops and vegetables to be grown is important for sustainability; as is the promotion of locally available nutrient-rich foods, proper selection, preparation and ideal cooking methods to enhance dietary diversity as well as promote good nutrition.

In conclusion, the meeting agreed that data collection and utilization by the stakeholders plays an important role in the allocation of nutrition resources, evidence based decision making and policy formulation; while nutrition interventions should carry out community awareness and capacity building to increase the utilisation of these services.

Recommendations

- Promote production and consumption of locally available foods that are culturally acceptable to improve the nutritional status of the population.
- Organisations to invest in nutrition monitoring, evaluation and research to inform interventions that are evidence based, sustainable and replicable.
- Integrate nutrition interventions to other health programming areas such as water and sanitation, reproductive maternal, new born and child health, HIV, TB and malaria.
- Encourage innovations that will improve food production, preservation and storage.

Track 1.4: Best practices and models for training health workers

Chair: **Peter Ngatia, Amref International University, Kenya**

Co-Chair: **Patricia Vermeulen, Amref Health Africa, Netherlands**

Presenters:

- **Belayneh Lemma, Amref Health Africa, Ethiopia:** Perception on teaching learning practice among upgrading Health Extension Workers in Shashemane Health Science College, Oromia Region.
- **Agnes Gatome, Abt Associates Inc, Kenya:** A comparison of clinicians knowledge of Sexually Transmitted Infections (STIs) and Anti-Retroviral Treatment at cross-border areas in East Africa.
- **Alfred Wise, Living Goods, Uganda:** Leveraging incentives to deliver better health outcomes: Results of a randomized controlled study.
- **Linnet Sang, Moi Teaching and Referral Hospital, Kenya:** Evaluation of Clinical Nurse Educators' Program in Moi Teaching Referral Hospital, Kenya.
- **Mathew Thuku, IntraHealth International, Kenya:** IntraHealth's experience on best practices and models for training health HR managers in Kenya.
- **Jackline Kiarie, Amref Health Africa in Kenya:** Secret sauce to training frontline health workers effectively for improved health service delivery.

Over four million people worldwide lack access to health services and healthcare. This is primarily due to the enormous shortage of health workers and mal-distribution of available health workers between rural and urban areas especially in sub-Sahara Africa. When there are no health workers, lives are lost. The numbers of health workers, skills and commitment are crucial components to providing quality health services. Health worker training must strike a balance between theoretical and practical training to ensure quality performance by health workers. All clinicians including health workers must always use updated protocols and guidelines so that they can attend to diseases that may be facilitated by the movement of people across borders.

The meeting discussed the many models of training for community health workers, nurses and managers; face to face, e-learning, mobile learning, mentoring and coaching that are applicable to deliver content efficiently and effectively. The discussants observed that these models must be anchored on best practices around needs assessments to identify the needs, selection of trainees, developing of curricula and curricular materials, follow-ups, and a high impact performance management system with Key Performance Indicators to measure the impact of training.

Recommendations

- Partnerships, including with the private sector are key. This enhances sustainability and easy scale-up of the solutions, such as mobile learning where trainees bring their own devices.
- Involve top leadership of institutions for buy-in.
- Make use of standards, guidelines and evidence based practices at all times.

Track 1.5: **Refocusing healthcare systems to prevent and manage NCDs**

Track sponsor: **AstraZeneca**

Chair: **Florence Temu, Amref Health Africa in Tanzania**

Co-Chair: **Joseph Kibachio, Ministry of Health, Kenya**

Presenters:

- **Ashling Mulvaney, Senior Director, Heathy Heart Africa, AstraZeneca Plc London:** The Healthy Heart Africa programme; an example of multi-stakeholder approach to prevent and manage NCDs in Africa
- **Wanjiru Mathenge, Population Services, Kenya:** Targeted demand creation strategies increase uptake of screening for hypertension amongst Kenyan males.
- **Annie Njenga, Philips, Kenya:** Improving care for NCDs by providing mental care.
- **Bara Ndiaye, Amref Health Africa, Senegal:** Decentralisation of cervical cancer screening and treatment of early stages in rural area in Senegal.
- **David Onchonga, County Government of Samburu, Kenya**
- **Gabriel Waari, Jomo Kenyatta University of Agriculture and Technology, Kenya:** Prevalence and factors associated with poor medication adherence among type 2 diabetes mellitus patients on follow-up at Kenyatta National Hospital.
- **Roselyne Okumu, Kenyatta National Hospital Kenya:** Association between socio-economic and psychological experiences of parents with children on leukemia treatment in Kenyatta National Hospital, Kenya.

Africa is facing the double burden of non-communicable and communicable diseases which is straining the health systems in the region. NCDs are overtaking communicable diseases and posing the biggest health challenge in African countries. Chronic diseases are a huge burden for patients because of the lifelong dependence on medication. Mental disorders such as Depression and Anxiety are the single largest contributor to global disability. It has been said that there is no health without mental health (*Lancet* & WHO). The co-morbidity of depression and NCDs is becoming a big health problem world-wide, especially because patients may not seek help for mental conditions.

The combined health outcomes for NCDs and depression are worse compared with those of each of these conditions considered independently. This challenge has been compounded by the scarcity of professional (psychiatrists) whose services are quite expensive and often not covered by medical insurance companies. Kenya only has 88 psychiatrists.

A number of innovative approaches have been successfully piloted in Kenya and Zimbabwe. The approaches have included; (i) It has been proven that Problem Solving Therapy for mental health can be delivered by non-specialist workers; (ii) Trained lay people such as Community Health

Volunteers (CHVs) have been used to assist clients to identify problems and develop smart actions plans to address the same; (ii) The Healthy Heart Africa Program, funded by AstraZeneca, has successfully reached men with behaviour change messages promoting hypertension screening. (iv) The explosion of mobile phone access can be leveraged to deliver these services. A mobile based anonymous chat platform (Inuka) has been developed to target clients with depression and anxiety with messages.

In Senegal cervical and breast cancer are the leading causes of cancer deaths among women. However cancer screening and treatment services are centralized meaning that the majority of the population in rural areas cannot access these services. Amref Health Africa in Senegal carried out a pilot project to decentralise early treatment for cervical cancer in 3 rural districts in Senegal. This intervention involved capacity building of nurses and midwives, community awareness, screening and treatment of pre-cancerous lesions. At the end of the pilot, 1680 had been screened and 110 were found to be positive.

In Kenya, the prevalence of diabetes ranges between 1.2 and 10.5 % (rural-urban). An analysis of clients with Type 2 diabetes receiving medication at Kenyatta National Hospital found that only approximately 40% had good adherence and 37% of clients had good glycaemic control.

Children with leukaemia undergo different experiences compared with adults, a fact that puts a heavy psychological and socioeconomic burden on the care givers. Some of the psychological experiences include shock, worry, anxiety, loss of control, fatigue, confusion, anger and fear of recurrence. The socioeconomic effects emanate from the fact that the majority of patients earn less than US$ 100 per month, the bulk of which is channelled into treatment. Psychological stress was higher when undergoing procedures such as bone marrow aspirates, chemotherapy and phlebotomy.

To reverse these trends, innovative and integrative approaches to health care service delivery are needed. There is need to reform healthcare systems to enhance their responsiveness to NCDs.

Recommendations

- Community Health Volunteers are critical in addressing the challenge of Non Communicable Diseases.
- Decentralisation of NCD services is critical in improving access and follow-up.
- Lay workers (including CHVs) can be trained to address mental in illnesses using techniques such as Problem Solving Therapy.
- Addressing adherence among diabetes patients should go beyond taking medication and look as other factors such as socioeconomic status.
- Pre-treatment counselling for cancer patients including caregivers of children with cancer is important.

Sub Theme 2: Health care financing for sustainable development

The grim health situation in Africa is partly a result of the crisis in healthcare financing on the continent. Only 1% of the world's health expenditure is used in Sub-Saharan Africa, countries in the region are ill-equipped to adequately address their health problems. In April 2001 African governments committed to dedicate at least 15% of their annual budgets to the health sector; however, only six countries have met the pledge with 60% of countries still spending less than 10% of their total budgets. While donor support is important in reducing harm from the current health crisis, it is not sustainable and encourages dependency. With the advent of the SDGs, Global Financing Facility is beginning to take centre stage to catalyse national resource mobilization for health.

Track 2.1: Community-based healthcare financing solutions for vulnerable populations

Chair: **Moses Alobo, GlaxoSmithKline, Kenya**

Co-Chair: **Nzomo Mwita, Amref Health Africa in Kenya**

Presenters:

- **Ernest Okyere, Christian Aid, Ghana:** Integrating revenue mobilization in maternal health projects at the local level.
- **Rosalind McCollum, Liverpool School of Tropical Medicine, Great Britain:** Exploring the impact of devolution on health equity in Kenya.
- **Heri Marwa, PharmAccess, Tanzania:** Creating sustainable Community Health Insurance Schemes by leveraging from national social schemes.
- **Lawrence Auma, Save the Children International, Kenya:** Influencing access to reproductive health services through incentivizing of community health volunteers (CHVS) in Bumula Sub-County.
- **Dorothy Muroki, FHI 360, Kenya:** The policy context and health service delivery to key and vulnerable populations at cross border sites: Experience from CB-HIPP project, Kenya.
- **Thu Vu, Amsterdam Institute of International Development (AIID), Netherlands:** Social protection programs in health and transmission pathways to inclusive growth: The case of Kenya.

40% or more of total health expenditure in Africa comes from out of pocket expenses. This is in a context of weak health systems, limited access to quality primary health care services, poor heath seeking behavior and poverty. Given that the majority of households in sub-Saharan Africa are poor means that they are not resilient in the face of health shocks. Often, such shocks lead to catastrophic health expenditures that continue to drive many households into increased vulnerability to diseases and a vicious cycle of more devastating health shocks.

The challenge of under-investments in health by African governments means that locally generated funding or risk pooling (community-based healthcare financing schemes) become important options. The removal of user fees in countries like Tanzania, while being credited to an increased in the utilisation of health services, still leaves the poorest households struggling to access hospital services.

The meeting explored options for minimising out-of-pocket payments and options for shielding families from health shocks. Some of the options explored were innovative risk-pooling financing mechanisms such as community insurance and the health wallet, creating sustainable community health insurance schemes by leveraging from National Social Health Schemes, using tax as an entry point whereby taxpayers are mobilized to actively demand for services at their local health center, and regional cooperation and integration of health insurance schemes.

Recommendations

- Revenue mobilization is a good entry point for participatory governance. The civil society should exercise transparency to build the trust of local authorities.
- Local authorities have an opportunity to build trust through introducing a taxation system complemented by a strong advocacy for the utilisation of services.
- Transform community health financing into a viable and sustainable Micro insurance scheme, where CHVs increase enrolment in community based insurance schemes.
- Build capacity among technical and political decision makers around delivering equitable health services.

Track 2.2: National social health insurance schemes and their impact on accessing quality healthcare

Chair: **Prof Joseph Wang'ombe, Amref Advisory Board, Kenya.**

Co-Chair: **Christophe Sauboin, GlaxoSmithKline**

Presenters

- **Bashiru Jumah, SEND, Ghana:** Is the National Health Insurance Scheme Pro-Poor? The need to make inclusive progress on health outcomes.
- **Nanlop Ogbureke, Christian Aid, Nigeria:** A review of Community-Based Health Insurance Schemes (CBHIS): Lessons from Nigeria And Ghana.
- **Uwineza Clarisse, University of Rwanda:** Women's Health View in a National Health Insurance Scheme: A case of a developing country, Rwanda.
- **Lilian Otiso, LVCT Health, Kenya:** Assessment of acceptability and willingness to pay (WTP) for HIV services among patients in a Kenyan HIV clinic.
- **Hillary Omala, Community Health Association of Kenya, Kenya:** Disparities in health care access.
- **Reuben Mutuura, Moi University, Kenya:** Factors influencing Willingness and Ability to pay new NHIF premiums amongst the self-employed In Nairobi, Kenya.

Across Africa, insurance schemes have been implemented to achieve better health outcomes for all people. The discussants highlighted the various challenges that come with these schemes. In **Ghana**, the question is the extent to which the national health insurance scheme (NHIS) can enable the poor to access health given that only 38% of the population is registered with NHIS. The implementation of the country's FMH (Free Maternal Healthcare) policy is characterised by a number of challenges including low subscription and unapproved charges. The low subscription is because of distance to the registration centres, high premiums, and inability to afford the registration charges.

The meeting discussed the research question around how Community-Based Health Insurance Schemes (CBHIS) in **Nigeria** can be used as a tool to achieve Universal Health Coverage (UHC). The government of Nigeria has allocated approximately 5% of its annual budget to health, while two thirds of health care financing is out-of-pocket. The discussants pointed out significant gaps in the CBHIS system, key among them: (i) Lack of clarity in the role of NHIS role as a regulator and an implementer of CBHIS, (ii) Unsustainable implementation of the CBHIS schemes, (iii) The socio-economic status of the rural population influences community participation in NHIF, (iv) Lack of financial security, (v) Fragmented federal structure, (vi) Lack of clear delineation of responsibilities across the different tiers of government in Nigeria which makes the tax-funded model an inefficient and impractical way of funding health care, (vii) Inadequate partnership with the government, which is imperative for establishing CBHIS.

A study from **Rwanda** assessed the contribution made by the CBHIS to the improvement of women's health outcomes; given that women CBHIS enrolment reached 94.1% in 2014. The status of women's health indicators improved between 2005 and 2014: maternal mortality rates (MMR) came down (from 1071 to 210), Total Fertility Rate (TFR) came down (from 6.1 to 4.2), contraceptive use increased (from 17% to 53%), antenatal care by a skilled provider increased (from 94% to 99%), use of skilled birth attendance increased (from 28% to 91%). and life expectancy of women increased (from 49 to 66 years). The National Health Insurance Scheme (NHIS) is a good strategy for women's health improvement because it addresses financial barriers, reduces out of pocket expenditures and cover the most vulnerable population.

The meeting discussed a study on the acceptability and willingness to pay for HIV services among patients in Kisumu and Nairobi counties of Kenya. In **Kenya**, 1.5 million people are living with HIV, which is one of the major causes of mortality. The study explored the perceptions of people living with HIV/AIDS regarding their willingness to pay for services in a context where HIV care lasts a lifetime and is heavily funded by donors. Whereas 16.3% of respondents found it acceptable to be charged for HIV services, 57.3% of the group said it would only be acceptable if donors withdrew funding. Reasons for this included poverty; the fact that the government and donors are paying for the service and perception that HIV treatment is a human rights issue.

People who were paying for HIV services said they were willing to continue paying. Other factors that showed a positive correlation with willingness to pay (WTP) were income, education, private insurance. Preferred payments method were cash (in Nairobi) followed by NHIF (in Kisumu). The discussants noted that the client's unwillingness to make payments using insurance suggested fear of stigmatisation by insurance companies or employers. The meeting reiterated that the poor should not be charged because this would affect their access to services. The meeting noted that health insurance was a viable option for domestic financing for HIV services, even though stigma must be addressed.

The discussants highlighted the fact although 99% of all respondents had heard about NHIF; only 19.5% were registered while 59% said they were willing to register in future. The study found that those not willing to register were unaware of the benefits. Factors such as age, marital status, income, poverty and presence of children and awareness of the benefits played a significant role in the willingness to pay.

Recommendations

- For **Ghana**: strengthen institutional capacity of implementing agencies, review the definition of indigents by parliament, harmonise national definition of core poor.
- For **Nigeria and Kenya**: assure long-term financial support and create awareness on the benefits of CBHIS.

Track 2.3: Models of public/private sector collaboration in healthcare financing

Chair: **Frances Longley, Amref Health Africa, UK**

Co-Chair: **Elkana Ong'uti, Ministry of Health, Kenya**

Presenters:

- **Klaus Thieme, SolidarMed, The Swiss Organization for Health in Africa, Zambia:** Improving Attrition and Retention of Rural Health Workers: Building up a Sustainable and Cost-Effective Housing Cooperative in Zambia.
- **Boniface Mbuthia, Options, Kenya:** Performance Based Financing Intervention in Public and FBO Primary Healthcare Facilities in Bungoma County in Western Kenya.
- **MaqC Eric Gitau, UNICEF & dance4life Liaison, Kenya:** Engaging young people for better health and development.
- **Christophe Sauboin, GSK, Kenya:** Can the Kenyan government afford rotavirus vaccination after GAVI graduation?
- **Maurice Siminyu, Busia County, Kenya:** Strengthening Community Health through Public/ Private Partnerships.
- **Stephen Karuntimi, IntraHealth International, Kenya:** The Afya Elimu Fund: Increasing student access to training fees through a sustainable Revolving Loans Fund.

There is evidence of increased coverage of privately provided health insurance in many countries. Private firms are increasingly investing substantial resources in health development though corporate social investment. The level to which these private players fit into national health strategies and plans could be improved.

Governments and private sector entities have previously not worked closely in promoting the health of populations. The meeting discussed ways of enhancing public/private sector relationships to improve resources for health.

Recommendations

- Public Private Partnerships (PPP) should be implemented holistically for effectiveness
- Communities should be highly involved in PPPs
- PPPs that support young people have been shown to bring about a high impact

Sub Theme 3: Innovation and technology for health systems strengthening

Health systems comprise all people, institutions, resources and activities whose primary purpose is to promote, restore and maintain health. Globally, the technology ecosystem has proven to be a key enabler in developing innovative solutions that have the potential to transform the quality of service delivery in all pillars of the health system. To meet the ambitious international health goals articulated in the Sustainable Development Goals, Africa needs to explore use of ICT driven innovations.

Track 3.1: Appropriate technologies for improving healthcare at community level

Chair: **Steven Wanyee, Kenya Health Informatics Association**

Co-Chair: **Danny Dubbeldeman, Amref Health Africa, Netherlands**

Presenters:

- **Imad Agi, United Nations Non-Governmental Liaison Service & UN Foundation, ECOLOO, Senegal**: A Sustainable Toilet Solution for Urban & Rural Areas
- **Erick Yegon, Ipas Africa Alliance, Kenya:** Closing the loop: Designing a mobile referrals platform for Community Health Volunteers to improve access to reproductive health care in Western Kenya
- **Caroline Mbindyo, Living Goods, Kenya:** Leveraging smart mobile tools to motivate and strengthen community health worker programs
- **Mable Jerop, Amref Health Africa, Kenya:** Evaluating adherence to testing and treatment procedures by community health volunteers in community case management of malaria, Bungoma County, Kenya.
- **Maarten van Herpen, Philips (Africa Innovation Hub), Netherlands:** Improving healthcare at community level through innovation by the private sector.

Community Health workers and volunteers are key agents for patient referral, disease detection and treatment. A study by IPAS has shown that 89% of clients who sought Reproductive Health services were referred by CHWs. The meeting discussed a number of tools and innovations that increase communication between clients, CHW and facilities and that have also improved the quality and efficiency of the CHW's. The meeting discussed these in the context of how CHW can be supported to contribute to improved reproductive health outcomes.

ECO Loo developed an ecological latrine that has a two-tier box that helps to protect water resources.

Living Goods works with local and national governments to develop systems that enable CHWs to deliver services. They have developed smart mobile tools, which are open source, have a Global Positioning System, data management capabilities, can support performance-based financing schemes, patient referral and treatment.

The system allows the user to assess the performance of CHWs. The model adopted by Living Goods has been shown to reduce under-5 mortality by 25%.

Philips uses its subsidiary company, Internal Venturing, to develop new products and business models targeted for the primary health care level. Philips has co-developed and scaled up a number of solutions that support health workers at the facility to improve maternal health outcomes.

Recommendation

Governments in Africa should invest in community health workers and implement task shifting to address the shortage of human resources for health. The private sector has a huge potential to contribute to improvements in Primary Health Care and to enhance the impact of CHWs.

Track 3.2: Innovations for increasing numbers and skills of health workers

Chair: **Janet Muriuki, IntraHealth International, Kenya**

Co-Chair: **Serafina Mkuwa, Amref Health Africa in Kenya**

Presenters:

- **Joachim Osur, Amref Health Africa in Kenya:** Regional response to the challenge of health worker migration in Africa.
- **Deborah Kioko, Amref Health Africa in Kenya:** Sub-county health management teams leadership development programme for improved maternal and child health service delivery in Makueni County.
- **Robert Nguni, IntraHealth International Kenya:** Implementing HRIS to track health workforce training through a peer-to-peer-model.
- **Andrew Wabwire, Amref Health Africa in Uganda:** Barriers to increasing numbers and skills of health workers in Uganda through eLearning.
- **Kehinde Jimoh, Abt Associates, Nigeria**: Automated-feedback generated in smartphone for supportive supervision enhanced performance of TB facilities and community health workers in Nigeria.
- **Anke van der Kwaak, Royal Tropical Institute, Netherlands:** Motivational intervention for young males in Siaya; results of an intervention study.

Only 1.7% of physicians live in sub Saharan Africa despite the sub region's high burden of disease. The migration of physicians to other countries and/or to the private sector in search of better remuneration, allowances, recognition, promotion or career development continues to further weaken Africa's health systems. Health worker associations and governments in Africa need to be in constant discussions and governments supported to implement appropriate policies to mitigate against health worker migration. One way of doing this is to strengthen the data systems that track health workers migration, training, supportive supervision, impact of e-learning, and leadership management and governance. Protocols that monitor this data could play an important role in coordinating and managing the health workforce. African governments should not only provide an oversight role over these data repositories but also use it for policy formulation and implementation.

Leadership and management are vital components of the health system. The challenge is often the lack of appropriate training in the two areas. In many countries, Physicians are often appointed to management positions despite their lack of management skills and experience. To effectively achieve impact in service delivery, it is imperative for health managers to be holistically trained.

The meeting discussed the use of e-learning training to upgrade midwives as a strategy to addressing the inequitable distribution of trained midwives, particularly in the rural areas. Contrary to assumptions, the e-learning programme uses mentors and tutors with occasional face-to-face sessions between students and their tutors. E-learning is more cost effective compared to traditional learning approaches, (students do not need to pay for accommodation and upkeep) while the use of electronic data management systems for supportive supervision enhances performance and accelerates indicators of interest. The meeting agreed that there was need to raise awareness about existing e-learning programmes.

Recommendation

Governments in Africa should take the lead in health workforce management and ensure the sustainability of on-going interventions.

Track 3.3: Innovations for improving quality of health care

Chair: **Sarroukh Eddine, Philips, Kenya**

Co-Chair: **William Muraah, County Government of Meru, Kenya**

Presenters:

- **Yaya Mbaoua, GlobalMed Africa & The Mbaoua Group, Cote d'Ivoire:** Improving access to medical care in Africa via telemedicine: A case study of Cape Verde.
- **Patrick Igunza, Amref Health Africa in Kenya:** Kenya Patients perspectives on use of mobile phones in HIV Patient-Care Support: A descriptive study at Kibera and Baba Dogo Health Centers, Nairobi.
- **Tara Talvacchia, Maternity Foundation, United States:** How an App is improving quality of care during childbirth in Kenya and Ethiopia.
- **Isabirye Paul, University Research CO., LLC USAID-ASSIST Project, Uganda:** Reducing perinatal mortality by over 15% in Northern Uganda; Focusing on using improvement methods to scale up simple high impact lifesaving interventions.
- **Stephen Mburu, University of Nairobi, Nairobi:** Improving Quality of Care in health facilities through implementation of an Integrated Electronic Health Records System (EHRS).
- **Mark Achola, Access.Mobile, USA:** Beyond Bulk SMS: Using an Intelligent Patient Engagement Platform.

Lack of access to medical care in Africa is a major concern. This is because of a number of gaps, among them, shortage of medical facilities, drug stock-outs, poor adherence to drugs such as antiretroviral drugs for HIV positive patients, sub-optimal health system management, inadequate number of qualified health professionals and high levels of poverty.

The Safe Delivery Application can play an important role in reducing maternal and new-born mortality, especially when used by health care workers who have undergone Basic Emergency Obstetric and New-born Care (BEmONC) training. The App provides skilled birth attendants with direct and instant access to evidence-based and up to date clinical guidelines on BEmONC. This is because simple interventions such thorough check-ups during the antenatal visits and have been shown to contribute immensely to improved MNCH outcomes. The main barrier to scaling up the use of the App remains getting trainers to adopt the new routines.

The meeting discussed a number of challenges to implementing an integrated electronic health records system (EHRS) such as the high cost of software, poor connectivity, the information flow across health facilities in low-resource settings, and the lack of skilled staff.

If used consistently, Innovations in ICT, for instance mobile technology can play an important role in healthcare delivery in low resource settings. For it to be efficient there is need for a cultural shift between patients and health facilities.

The use of a targeted Short Message Service system to engage patients and influence health seeking behaviour can address gaps in patient engagement. Technology such as Telemedicine can now connect specialists to patients across borders and vast geographical locations. Telemedicine has worked in Cape Verde; making it a good example of how the technology can be adopted and expanded all over Africa.

Recommendation

Governments should harness innovative technology and scale it up in the management of chronic illnesses.

Track 3.4: **Approaches to making surgery safe and adherence to ethics in research.**

Track sponsor: **Smile Train**

Chair: **Prof Jelle Stekelenburg, Board Member, Amref Health Africa, Netherlands**

Co-Chair: **Mohammed Karama, Umma University, Kenya**

Presenters:

- **Esther Nyambura Njoroge, Vice President and Regional Director, Africa Smile Train.** Opening remarks from Smile Train, the track sponsor: Safe, quality and timely surgery for cleft lip and palate; The Smile Train Partnership Model
- **Ntacyabukura Blaise, University of Rwanda:** Developing a model of advancing research culture in young African health professionals: The case of Rwanda.
- Edwin Macharia, Safe Surgery 2020 & Dalberg Global Development Advisors: Safe Surgery 2020: A collaborative partnership in Global Health.
- **Richard Muwanika, Makerere University, Uganda:** Anti-Tetanus Antibody Responses among Men Seeking for Safe Medical Male Circumcision Services in Uganda.
- **Lilian Mutegi, Gertrude's Children's' Hospital, Kenya:** Safe Cleft Surgery in Gertrude's Children's Hospital.
- **Asrat Mergia, NaPAN, Ethiopia:** Amref Health Africa/ Smile Train Cleft Lip Palate Repair Epidemiological Findings Compared to Worldwide Epidemiological Reports.
- **Joseph Lelo, Amref Flying Doctors, Kenya:** Improving access to tertiary care by use of air ambulances in Africa: A subscription model.

The meeting discussed the following approaches to making surgery safe:

Safe, quality and timely surgery for cleft lip and palate; The Smile Train Partnership Model: The model promotes access to safe, timely surgical care and a culture of research and adoption of evidence-based initiatives. Smile Train is an international children's charity that focuses on providing surgery for children with cleft lip and palate. The approach (i) provides funds, training, equipment and other resources; (ii) Optimisation of patient selection, ensuring qualified human resources, equipment; and (iii) thorough quality review processes to ensure provision of safe surgery. Smile Train and Gertrude's Children's Hospital have entered a partnership to study factors that ensure the safety and effectiveness of cleft surgery using a multidisciplinary approach, including dentistry and speech therapy. The study identified infections and anaemia as key reasons for cancellation of cleft surgery operations. Late post-operative failures were traced to illiteracy and poor diet; while poor self-image was identified as a factor requiring psychological support.

Amref Health Africa/ Smile Train Cleft Lip Palate Repair Epidemiological Findings Compared to Worldwide Epidemiological Reports. This study looked at the epidemiological findings of cleft lip palate repair performed between 2006 to 2016 in nine countries under the Amref Health Africa Smile Train project, and compared these against global figures. Of the 6,972 surgeries performed; the median age was 10 years but gradually decreased showing that the backlog of adult cases was being reduced. There were differences in male to female ratios, more females were affected in the study group and more single compared to multiple cleft surgeries. These findings point to a reluctance to treat female children, and to treat cleft surgery as risky. It was noted that the data was collected from health facilities and may reflect a selection bias.

Developing a model of advancing research culture in young African health professionals: The case of Rwanda: Rwanda University has developed a model of advancing research which offers global health courses, provides training on scientific research, establishes research groups, and organises research workshops. The meeting agreed that the formation of strong partnerships, a critical thinking approach, good researchers, evidence-based practices, and good global health actors are necessary to ensure sustainability.

Safe Surgery 2020: A collaborative partnership in Global Health. Surgical conditions constitute one third of the global disease burden and cost US$ 3 trillion annually. Up to 33 million people fall victim to catastrophic health expenditures from having to pay for surgery. The Safe Surgery 2020 initiative is a multi-partner initiative that designs country-level and hospital-level solutions to make surgery safe, affordable and accessible. There are four anchors: national surgical planning; developing cohorts of local surgical leaders to transform surgery; testing and scaling up innovative programmes; and advocacy. Currently the initiative is being implemented in Tanzania and Ethiopia. There is need to share and learn from other countries. Safe Surgery 2020 plans to expand to one other country in Asia in 2018.

Anti-Tetanus Antibody Responses among Men Seeking for Safe Medical Male Circumcision Services in Uganda. Uganda adopted Voluntary Medical Male Circumcision (VMMC) strategy in 2010 as an additional approach to preventing HIV infection. VMMC has been shown to reduce the risk of HIV transmission by 60%; with policy focusing on the 10 – 49 age group. Between 2007 and 2013, although 3.2 million circumcisions were performed, quality and safety have remained a challenge with six deaths having been recorded and attributed to infections. In 2015, a WHO study looked at mitigation measures including wound care and vaccination. The study conducted in hospitals in Rakai and Nkozi Districts sought to determine the proportion of clients with minimum anti-tetanus antibody levels before and after tetanus vaccinations. Whereas the risk of tetanus infection was high at only 34% in the baseline; the study found that one tetanus injection provided sufficient immunity at 14 days of 86% and 97% at 28 days.

Improving access to tertiary care by use of air ambulances in Africa: A subscription model. Amref Flying Doctors Is a social enterprise whose objective is to generate income for Amref's programmes as well as provide emergency evacuations, and charity evacuations for those who cannot afford to be airlifted. Approximately 1,000 patients are evacuated each year. In 2016, there were 139 lifesaving charity evacuations. Given that and time saving is a crucial factor, the median

time of presentation to a hospital after injury is 12.5 days. This is despite the fact that 50% of patients will die in the first hour after an accident; 30% within hours and 20% within the first few weeks, often from infection. Maisha is an air ambulance scheme that covers two evacuation flights per year; and two ground ambulance transfers. Subscriptions start at $25 per annum and cover the eastern Africa region. Infrastructural challenges include state of airstrips and insecurity.

Comprehensive approaches to safe surgery include attention to pre-operative; intra-operative; post-operative phases of care; and routine use of checklists and guidelines. Using surgical checklists routinely can prevent up to 50% of surgical complications. There is an acute lack of data on the surgical burden in countries and regions; data that are available are under-utilised.

Cleft surgery does not just correct disfigurements but also extends life expectancy (study from cleft patients in China). Cleft repair has up to 500% returns for individuals reaching their potential and contributing to the economy (this is published data).

In summary, the meeting noted the critical shortage of surgeons being trained; and the fact that those that are working could improve their efficiency and effectiveness. Further, Africa needs good researchers, improvements in data collection and analysis, evidence-based practices and support of global health actors.

Recommendations

- Conduct routine data collection and analysis to determine the surgical burden in countries/ regions.
- Countries need to train more surgeons and existing surgical teams need to be more effective.
- Routine use of surgical checklists must be mandatory.
- National emergency medical services should be supported by governments.
- Cleft surgery should be multi-disciplinary. The approach should include parent education and specialist teams.
- Provide tetanus vaccination and clean surgical care at the time of VMMC.
- Encourage and support research and produce evidence-based initiatives in all health issues.

Sub-Theme 4: Global Health Security Initiatives

Communicable diseases remain the most common health conditions in resource-limited settings and result in huge social, economic and quality of life losses in African countries. From addressing increasing antimicrobial resistance to making sure every last child is vaccinated against polio; from eradication of guinea worm to putting malaria diagnosis and treatment into the hands of communities; countries are developing innovative ways of tackling the continent's communicable disease burden. Today's global health security risks include the emergence and spread of new microbes; globalization of travel and trade; rise of drug resistance; and the potential for accidental release, theft or illicit use of microbes. The Global Health Security agenda is a strategy rooted in science and global partnerships based on three widely accepted concepts: prevent, detect and respond. Community-based disease surveillance and the active engagement of communities has therefore proven critical for the early detection and containment of diseases with outbreak potential.

Track 4.2: **Addressing challenges in the prevention and treatment of communicable diseases**

Chair: **Marten van Herpen, Africa Innovation Hub, Philips**

Co-Chair: **Nathan Bakyaita, WHO**

Presenters:

- **Themba Ginindza, University of KwaZulu-Natal, South Africa:** Prevalence of and associated risk factors for high risk Human Papilloma Virus among sexually active women, Swaziland.
- **Rebecca Kivumbi, Mildmay Uganda:** Targeted HIV testing to close the adult-paediatric treatment gap in 6 districts of central Uganda.
- **Rita Noronha, Amref Health Africa in Tanzania:** Community Health Workers in Improving Treatment Adherence and Retention among HIV Positive Pregnant Women in Tanzania: A cluster-randomized trial.
- **Edward Chilolo, PharmAccess International, Tanzania:** Improved Paediatric Tuberculosis (TB) Case Finding at Mwenge Military RCH Facility, Dar es Salaam Tanzania.
- **Benson Otieno Ulo, Amref Health Africa, Kenya:** Characteristics and Treatment Outcomes of Extra Pulmonary TB Patients in Kenya.
- **Ntambara Nelson, University of Rwanda:** Environment or Our Behaviours, What To Fear: 2016 Cholera Outbreaks in Rwanda.

Despite limited or inadequate data, high-risk Human Papillomavirus (hr-HPV) infection and the dual burden of HIV remain a huge challenge in some Low Income Countries (LICs) such as Swaziland. The prevalence of hr-HPV infection is high among sexually active women and is significantly associated with HIV infection. Women who are HIV positive are five times more at risk of HPV.

In women, when the pre-cancer cells are not treated they develop in to cervical cancer. Despite the concerted interventions a large gap exists between the number of children, adolescents and adults accessing Anti-retroviral Treatment (ART). More than 75% of all estimated HIV+ adults are on ART, compared to only 61,000 (32%) children.

Targeted testing (entry points) is an effective strategy in closing the adult-paediatric treatment gap. Scaling up paediatric HIV counselling and testing requires innovations in capacity building, human resource support, and continuous mentorship at all entry points and linkage to care services.

The meeting discussed the Tanzania case where proper diagnosis of children with Tuberculosis (TB) remains a challenge despite the high TB burden. TB prevalence rate is at 295/100,000, with the National TB and Leprosy Programme estimates showing that children contribute 15-20% of National TB case notification, if proper measures for paediatric TB case finding are in place.

The meeting agreed that Community Health Workers (CHWs) have the potential to enhance the uptake of Prevent Mother-to-child Transmission of HIV services and improve women's adherence to ART and retention in care after delivery. The meeting was informed that a study that showed that the use of CHWs had the strongest effect on increasing ART adherence among postpartum women in care. The meeting agreed that this evidence should inform policy and planning on incorporating CHWs in treatment adherence and retention among HIV positive pregnant women.

Recommendations

- Conduct studies with a longer invention period for comprehensive understanding and promoting intervention.
- Governments, development partners and other stakeholders should invest in health systems and services to improve access to health and health research.
- Community mobilisation and sensitisation should be an integral part of all health interventions.

Track 4.3: Addressing emerging diseases and strengthening community disease surveillance

Chair: **Anne-Marie Kamanye – Amref Health Africa, Canada**

Co-Chair: **Irene Otieno, Toronto, Canada**

Presenters

- **Sylla Thiam, Amref Health Africa, Senegal:** Acceptance of the Ebola virus vaccine by the community in Guinea.
- **Job Mogire, Institute for Global Health and Development, Queen Margaret University, Kenya:** It's as though Ebola infected the health system itself.": Experiences of Kenyan health workers who volunteered in West Africa during the 2014/15 Ebola outbreak.
- **Arancha Aramendia, Mundo Sano Foundation /Institute of Health Carlos III Madrid, Spain:** Prevalence of Strongyloides Stercoralis in a rural community of North-Western Ethiopia.
- **Manpreet Singh, Dalberg Global Development Advisors, Kenya:** Lessons learned and best practices in establishing National Emergency Operations Centers (EOCS).
- **Vinnce Onserio, Young Women Christian Association of Kenya:** Decentralizing health services, a strategy to strengthening disease surveillance: A case of community based TB care in Kisii County, Kenya.
- **Joyce Onsongo, WHO Kenya; Dr Joan Karanja, PHEOC Ministry of Health:**Best practices in establishing the Kenya Public Health Emergency Operations Centers (PHEOC).

The meeting discussed the degree of health system preparedness surrounding emerging disease outbreaks such as Ebola Virus Disease (EVD); neglected tropical diseases such as Soil Transmitted Helminthiases (STH) and community-based management approaches of infectious diseases such as Tuberculosis (TB).

Fragile health systems with inadequate staff and infrastructure in the context of complex health needs negatively impacts effective response to emergencies. The Ebola Virus Disease (EVD) in West Africa exposed the dire vulnerability of Africa's health systems. The battle against EVD exposed the poor state of compliance with International Health Regulations (IHR); weak knowledge management, inadequacies in the emergency response systems, limited capacity to follow-up on cases and the lack of accountability.

The discussants highlighted gaps in the preparation and coordination of health care workers, especially at field level. Ill-preparedness fosters fear of death and worses an already tense situation. The meeting discussed the issue of the Ebola vaccine noting that in the context of a deadly epidemic, acceptance rates of vaccines are generally high (80%) especially amongst affected relatives. The meeting highlighted the enabling factors that increase the vaccine uptake such as information on its availability and effectiveness; while the factors hindering its performance include concerns over the quality of the vaccine, lack of information on the side-effects, and fear of contamination during vaccination.

The meeting discussed key lessons learnt; among them the establishment of Emergency Operation Centres (EOCs). The discussants noted that EOCs should have the capacity to respond to all potential hazards (environmental, biological, social and technological). Whereas there is no single, correct model for setting up an EOC, all EOCs must have top-down support and a strong mandate to ensure effective operations. EOCs have varying structures informed by political, social and economic considerations. Technology significantly improves the efficiency of an EOC by ensuring active surveillance and prompt reporting of outbreaks. The EOC plays an important role in coordination, preparation, operations, data collection, communication and convening. To be effective the National Emergency Response structure should acknowledge the critical roles played at sub-national and community levels and build the capacity of health facilities and systems including well trained staff.

The meeting discussed Soil Transmitted Helminthiases, a neglected tropical disease whose disease burden is generally underestimated and therefore under-diagnosed. Treatment is also undertaken using less effective drugs such as Albendazole and Mebendazole. The meeting underscored the vital role that adequate diagnostic protocols using combinations of methodologies should play to increase diagnosis of STH.

Recommendations

- The public should be given information on new vaccine and reasons for non-acceptance ought to be carefully managed.
- Establish emergency operation centres with a national capacity to detect, prevent and response to emergencies.
- Conduct further studies to strengthen control measures for STH.
- Develop an integrated community-based multi-disease management approach.

Posters

Posters

117 high quality posters were presented during the three-day conference (47 day 1, 24 day 2, 46 day 3). The following are the key findings and recommendations:

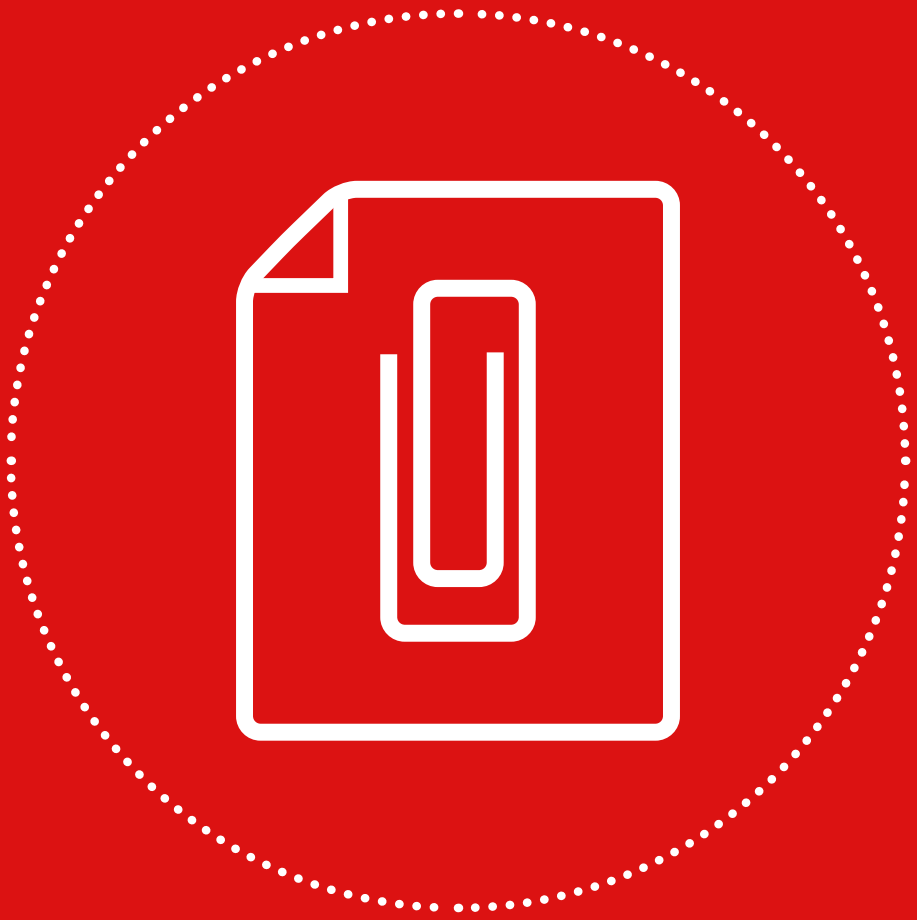
Key findings

- Devolution in Kenya has provided opportunity for expansion of universal coverage through community health services – McColllum *et al*. **TUPE30**
- Contact investigation contributes to the identification of missing TB cases – Kiptai *et al*. **TUPE75**
- Comprehensive sex education training significantly reduces early pregnancy. TUPE58 – Rudia *et al*. **TUPE58**
- Health Workers lacked evidence to facilitate appropriate decision making. Data was shared regularly and used to analyse issues - Peter Kagurusi. **TUPE21**
- The youth lack platforms to get information on sexual health - Gezahegn et al. **TUPE13**
- HIV patients who do not attend clinics seldom adhere to medication, leading to increased morbidity and mortality - Kipkelwon *et al*. **WEPE22**
- Peer mentorship is a cost effective, efficient and convenient approach to improving data documentation and reporting among data clerks in health facilities - Kinara et al. WEDE
- Establishment of food banks and Quality Improvement Teams at community level improve access to food for people living with HIV - Akulima *et al*. **WEPE53**
- Functional handwashing facilities, involvement of teachers and sustained practice of handwashing by the pupils reduces incidences of diarrhoea from 5 to one in a week - Namata T. **WEPE26**
- Communities play a big role in early detection, reporting, prevention and basic management of disease. They are active and willing to participate in community disease surveillance if given incentives - Machache E. **WEPE74**
- Reducing waiting periods for clients and setting up an appointment system for non-emergency clients reduced waiting time, depending on the client volume - Hlabano et al. THPE84
- There is higher use of maternal shelters established through community led initiatives - Githiaka *et al*. **THPE51**
- E-learning as a method of instruction leads to a higher pass rate compared to traditional classroom learning - Wabwire. THPE63
- Increasing male involvement to enhance use of maternal services requires community engagement and interpersonal networks - Kagurusi P. **THPE62**
- Developing an intelligent m-Health requires a model with the following characteristics; agility, flexibility and responsiveness to changing environments and customer demands, cost effectiveness, efficiency and easy to use - Xavier L. **THPE08**
- Sharing information on family planning at community level increased men's engagement - Ojanduru L *et al*. **THPE36**
- Green tea can be used to fight larval development in malaria mosquitos - Mwema J. **THPE29**

Recommendations

- Counties should adopt and promote the community health approach coupled with quality improvement.
- Comprehensive Sexuality Education curricula should be introduced in schools to equip teachers and students with information on sexuality issues and platforms created for youth to discuss their sexual and reproductive health issues.
- Schools must adapt an integrated approach to ensure consistent hand washing practice by pupils.
- Clinic appointments for HIV patients should factor in their work schedule; while patient appointment systems for non-emergency cases can help to reduce congestion and long waiting periods at health facilities.
- Health education targeting TB patients and family members at the household level has been shown to increases treatment success rates and case identification.
- Community partnerships need to adopt QIT structures to strengthen food and nutrition systems at community level.
- Communities must be involved at all stages of setting up maternal shelters.
- Governments should adopt e-learning to up-skill and upgrade health care workers.
- Investing in m-Reporting and community-based disease surveillance systems will improve global health security.
- M-health solutions should be compatible with the advances in mobile technology used locally.
- The innovative use of green tea in reducing malaria infections should be tested and scaled up.
- All the poster presentations made at the conference are available at: **www.ahaic.org**

Annexes



Annex A: **AHAIC Communiqué**

Africa Health Agenda International Conference Declaration on accelerating the achievement of a healthier Africa

Nairobi, Kenya, 5-9 March, 2017

WE, the organisers, keynote speakers, panellists, scientists and researchers, leaders from government, multilateral agencies, the private sector, civil society, development partners, youth delegates, advocates for health and the media, came together at the Africa Health Agenda International Conference held in Nairobi between 5-6th (Youth Pre-Conference Forum) and 7-9th March 2017 (main conference) to discuss, debate and share state-of-the art scientific knowledge, evidence, policy and practice.

The Sustainable Development Goals provide a new framework for global health. The Africa Health Agenda must be a distinct part of this global agenda for change. We therefore focused on:

1. Generating home grown solutions to achieving the Sustainable Development Goals across the continent.
2. Sharing scientific research findings, evidence and best practices addressing health and health systems in Africa.
3. Identifying and discussing gaps and challenges in implementing the Sustainable Development Goals in Africa.

Over the past five days, we have once again seen the power of home-grown innovation in addressing the unique challenges of achieving universal healthcare in Africa.

WE, understand that Africa's health system remains weak and fragmented due to decades of under-investment: with 11% of the world's population, it accounts for 24% of the global disease burden, has an emerging and high burden of infectious diseases, poor women's and children's health and the increasing burden of non-communicable diseases.

Whereas community based healthcare has the potential to contribute to better health outcomes, the gap between the community health and formal health systems remains wide. 50% of Africans still do not have access to quality healthcare.

OUR CALL TO ACTION

The Africa Health Agenda International Conference 2017 has discussed these challenges under three threads: People, Systems and Innovation.

PEOPLE

1. **Human Resource:** We must employ the 'tools of our time' to formulate and implement appropriate policies to mitigate the impact of the significant health worker shortage in Africa. This includes the issues of skewed distribution, brain – drain and migration. We must tailor and develop our health worker training to address the gaps in both health worker numbers and competencies.
2. **Community Health Workers:** Community participation and ownership must be at the centre of primary health care and universal health coverage, given the critical role that the community health system plays in linking households to the formal health system. We call on governments the civil society, and the private sector to formally recognise and make Community Health Workers an integral part of the formal health workforce.
3. **Our Young People:** We must meaningfully involve young people to co-create strategies, scientific approaches and investments to improve their health and implement policies that are youth-centred. Nothing for the youth without the youth!
4. **Strong, Visionary Leadership:** We must build our strengths in leadership, management and governance at political, technical and community levels.

SYSTEMS

1. **Universal Health Access:** We recognise that community-based health insurance, integration of national Health Insurance Schemes and use of Community Health Workers to increase enrolment are potential avenues for mitigating the challenges in access to national health insurance funds.
2. **Global Health Security:** We recognise that successful health systems require good systems for health. We must significantly increase investments in Primary Health Care as the backbone of global health security and universal health coverage. This must be supported through increased capacity for surveillance; strengthened systems to detect outbreaks with short reporting time; enhanced community engagement for early detection and response; and legislation of frameworks for epidemic response.
3. **Public, Private and Community Partnerships:** We need appropriate and robust legal, policy and regulatory frameworks that recognise and are respectful of the value systems of state and non-state actors to create partnerships between equals. We call on governments, civil society and the private sector to engage in dialogue to build trust; we urge the Private sector to embed PPPs in the main business of companies as opposed to their charitable foundations; and the civil society to engage governments in translating evidence into action.

INNOVATION

1. **Evidence and Resources:** We must create the platforms that ensure that research and innovations are translated into evidence-based policy-making and actions. We call on governments in Africa to enact policies and legislation and to allocate the requisite resources to generate and use evidence.
2. **Technology:** We must harness the unlimited possibilities offered by technology in general, and particularly mobile technology and telemedicine, to address health challenges and achieve improved health outcomes. Governments must put in place policies and legislation for effective integration of technology in the health system.
3. **Scale and Sustainability:** We must be bold and have confidence in our home-grown, relevant innovations, bringing them to scale and creating more synergy. We must ensure more of our continent's great ideas reach the widest possible population.

This week we have created a blueprint for health in Africa. But a beautiful document is not enough. We call on governments to live up to their commitments and implement the global, regional and local instruments they have already signed. We too must do our part. Let us now go out and do what it takes to create lasting health change in Africa.

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Annex D: **Organising & Scientific Committee**

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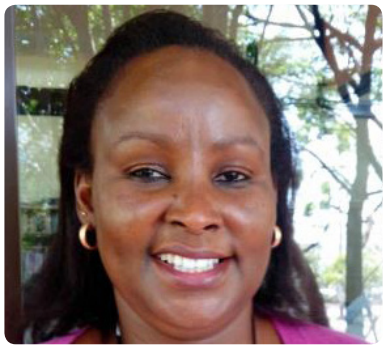

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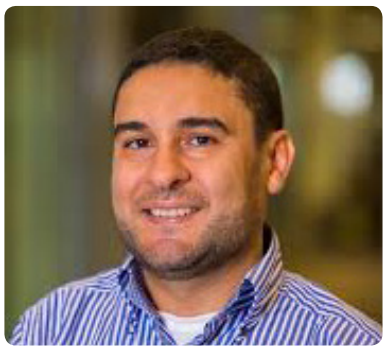

Dr Eddine Sarroukh, Philips

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	Rapporteurs
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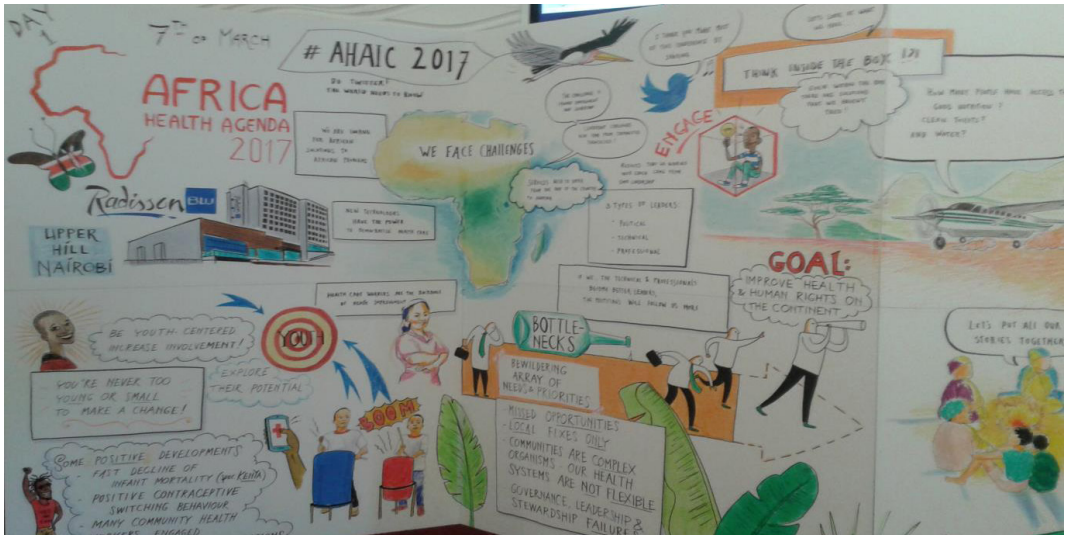
Tracks sessions	Rudia Ikamati, Kulule Mekonnen, Mores Loolpapit, David Kawai, Jane Carter, Dorieke Kuijpers, Prudence Komujinya, Helen Walker, Hajra Mukasa, Bertine Pries, Veerle Ver Loren van Themaat, Andrew Wabwire, Mirre van Veen, Gilbert Wangalwa, Tamene Chaka, Paul Gabula, Graham Atkinson, Michael Kimuyu, Lilian Mbau, Astrid van Rooij, Patrick Bigirwa, Bertine Pries Deborah Kioko, Colleta Kiilu, Kevin O'Neill, Vincent Ouma, Paul Gabula, Mirre van Veen–Anley Haile.
Poster presentations	Kevin O'Neill, Amos Nyirenda, Daniel Kurao, Margaret Mugisa, Anley Haile, Astrid van Rooij, Prudence Komunjuni, Veerle Ver Loren van Themaat, Jennifer Gatebi, Tony Kapsandui, Mirre Van Veen, Hajra Mukasa, Andrew Wabwire, Miriam Chege, Sheba Odondi, Samuel Muhula, Yeshitila Hailu, Rudia Ikamati, Evaline Karijo, Shiphrah Kuria, Kassahun Negash.
Chief rapporteur	Donald Odhiambo
Lead rapporteur	Aileen Ogolla

Graphical representations of AHAIC



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80	Bashiru	Juma	KE	Send Ghana
81	Baye	Denekew	ET	Amref Health Africa, Ethiopia
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84	Beatrice	Gacengo	KE	Terre des Hommes
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113	Boniface	Kariuki	KE	Amref Health Africa
114	Boniface	Mbuthia	KE	Options Kenya
115	Boniface	Hlabano	ZA	Amref Health Africa- South Africa
116	Bonnie	Munyalo	KE	Amref Health Africa, Kenya
117	Bosco	Lemarkat	KE	Baobab
118	Boum	Yap	KE	MSF/Epicentre
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120	Brenda	Werema	KE	Danone Baby Nutrition
121	Brian	Ngure	KE	Surgical Society Kenya
122	Bridget	Wachira	KE	GlaxoSmithKline
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124	Bruno	Witvoet	KE	Unilever Africa
125	Bryan	Wesonga	KE	Safaricom Limited
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130	Caroline	Mbindyo	KE	Living Goods
131	Caroline	Mulandi	KE	Smile Train
132	Caroline	Kyalo	KE	Phillips
133	Caroline	Mulandi	KE	Smile Train
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142	Charles	Oyaya	KE	HSAP
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147	Charles	Maina	UG	Amref Health Africa Uganda
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151	Christine	Kisia	KE	WHO-Kenya
152	Christine	Ngwawe	KE	Amref Health Africa
153	Christine	Odwogi	KE	GlaxoSmithKline
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172	Daniel	Onyango	KE	Amref Health Africa
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618	Nicholas	Muraguri	KE	MoH, Kenya
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632	Nzomo	Mwita	KE	Amref Health Africa

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634	Omari	Issa	KE	Amref Health Africa, Board
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650	Patrick	Bigirwa	UG	Amref Health Africa, Uganda
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654	Paul	Mukundi	KE	Philips Pharmaceuticals
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662	Peter	Nguura	KE	Amref Health Africa, Kenya
663	Peter	Ofware	KE	Amref Health Africa, Kenya
664	Peter	Kimuu	KE	MoH, Kenya
665	Peter	Cherutich	KE	MoH, Kenya
666	Peter	Otieno	KE	Amref Health Africa
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670	Peter	Waiganjo	KE	Amref Health Africa
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694	Reuben	Mutwiri	KE	Moi University
695	Rheena	Wanjiku	KE	Amref Health Africa
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