



THE STATE OF UNIVERSAL HEALTH COVERAGE IN AFRICA
REPORT OF THE AFRICA HEALTH AGENDA
INTERNATIONAL CONFERENCE COMMISSION

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Citation: Barasa Edwine, Solange Hakiba, Fenny Ama Pokuaa, Omaswa Francis, Moosa Shabir, Bendhaou Karim, Choonara Shakira, Foyeth Eugene, Ralidera Onisoa Rindra, Manthalu Gerald, Dare Oluwafunmilola, Dangana Jonathan, Wanjau Waruguru, Walumbe Rispah, Waithaka Dennis, Oyando Robinson, Otieku Evans, Nyawira Lizah: The State of Universal Health Coverage in Africa: Report of the Africa Health Agenda International Conference Commission. Nairobi. Kenya. 2021

PREFACE

The AHAIC (Africa Health Agenda International Conference) Commission for the State of UHC in Africa was established by Amref Health Africa in November 2020 with the support of Bill and Melinda Gates foundation, as part of the deliberations from AHAIC 2019. The commission serves as an independent body responsible for reviewing Africa's progress towards UHC and providing recommendations that can accelerate this progress. The commission comprises of 11 global health experts from different countries across the continent, drawing on different disciplines across the health sector.

ACKNOWLEDGEMENTS

The AHAIC Commission would like to express its most sincere appreciation for all the individuals and institutions that brought this team together and facilitated the work of the Commission. Our efforts as a team were greatly enhanced by the contributions of our Technical Advisors, Research Assistants, and the Secretariat, and for this we are grateful. We appreciate your dedication to the work. To Amref Health Africa and the Bill and Melinda Gates Foundation (BMGF): we would like to thank you for your continued support and belief in the importance of our mandate. Receive our most sincere gratitude for all the support you so generously provided. Special thanks and acknowledgement to the WHO AFRO and specifically to Dr. Humphrey Karamagi for providing useful data and information, and to the KEMRI-Wellcome Trust Research Programme for technical support. We also would like to thank the global health experts, community members, and various stakeholders across the region for taking their time to share valuable insights into the state of Universal Health Coverage across the continent. Your contributions enriched this report and provided a unique and important perspective. We are looking forward to collaborating with you all and many more as we work towards UHC.



CHAPTER 1: EXECUTIVE SUMMARY

1.0: INTRODUCTION

The immediate post-colonial era in Africa was hopeful, confident and ambitious, and significant progress was registered in many countries. The clarion call by our then-political leaders, and the stated purpose of independence, was to rid Africa of poverty, disease and ignorance. This early progress was reversed by poor governance and economic challenges, occasioned by the collapse of commodity prices and the sharp rise in the price of oil. African countries were mismanaged, impoverished by the collapse of their economies, and reduced to beggars, dependent on foreign aid (Omaswa and Crisp, 2014). This situation promoted a mindset of dependency in African countries not only for money but also for vision, ideas and local solutions. The African self-confidence and the can-do attitude of the immediate post-independence period was accordingly eroded by the imposition of many inappropriate solutions to African problems by external actors, resulting in retarded development and instability.

The derailment of Africa's progress by poor governance and perverse external influence is well typified by the evolution of Africa's health policy. Healthcare policy in the early post-colonial period (1960s to 1980s, approximately) in Africa was driven by independent African governments. Healthcare was considered a human right, underpinned by the guiding principle of universal access to healthcare (Gros, 2016). Healthcare services were predominantly financed by taxes and were mostly offered for free at the point of care. This early post-colonial period was therefore aligned to the global recognition of health as a human right, and the 1978 Alma Ata Declaration to which African countries ascribed (WHO, 1978). It could be argued that had Africa maintained this trajectory, the continent would be closer to achieving Universal Health Coverage (UHC) today. However, collapsed economies that occasioned aid dependence opened the door for external

influence on Africa's health policy. Healthcare policy in the late post-independence period (after 1980) was driven by external actors and was characterised by an imposition of neoliberal policies, in the form of Structural Adjustment Programmes (SAPs) that had devastating long and short-term consequences for the health sector (Omaswa and Crisp, 2014). In the health sector, SAPs translated to a reduction in domestic funding and the introduction of cost-recovery measures in the form of user fees at the point of care. This coincided with a period where Africa faced its greatest healthcare challenges, including the HIV/AIDS epidemic.

The 21st century has seen a renewed commitment by African countries to making advances towards Universal Health Coverage. UHC means everyone has access to the healthcare services that they need, of good quality, without the risk of financial hardship (WHO, 2007). Apart from endorsing the Sustainable Development Goals (SDGs) and UHC resolutions as UN member states, the African continent has made its own reinforcing commitments. For instance, in 2001, the African Union countries met in Abuja and pledged to set a target of allocating at least 15% of their annual budget to enhance sustainable financing for the health sector (the Abuja declaration) (Organization of African Unity, 2001). The 2007-2015 Africa health strategy recognises health as a human right and calls on African governments to guarantee healthcare for all their citizens in an equitable manner, while the 2016-2030 Africa Health Strategy sets a goal for the continent to achieve UHC by 2030 (African Union, 2007, African Union, 2016). In 2019, the AU launched the Africa Leadership Meeting where African leaders made the Addis Ababa call to action on UHC, and later signed a memorandum of understanding (MOU) with the WHO in the same year to support the call's implementation (WHO, 2019).

In this report, the Africa Health Agenda International Conference (AHAIC) Commission on the State of UHC in Africa takes stock of Africa's progress in fulfilling these UHC commitments. The AHAIC Commission was set up in November 2020 to take stock of the continent's progress towards UHC and to make recommendations on what is needed for the continent to achieve this

goal. This was an especially interesting time for the Commission given that the continent, along with the rest of the world, is grappling with the COVID-19 pandemic. The COVID-19 pandemic has highlighted weaknesses in Africa's health systems and reminded us that, indeed, UHC and health security are two sides of the same coin.

The Commission set out to answer three overarching questions:



What progress has been made by African countries towards achieving UHC?



What are the challenges and opportunities that African countries face on the journey towards UHC?



What are the key recommendations for transformative change that African countries should adopt to accelerate progress towards UHC?

To answer these questions, the Commission employed a multifaceted approach that included reviews of literature, analysis of secondary data, qualitative interviews with regional and country level policy makers and implementers, people's stories, and deliberations by the Commissioners.

2.0: AFRICA'S PERFORMANCE ON UNIVERSAL HEALTH COVERAGE INDICATORS

2.1: Effective Coverage with Needed Health Services

- Coverage with essential healthcare services in Africa is low:** Only 48% of people in Africa received the healthcare services that they need. This means that approximately 615 million people in Africa may not receive the healthcare services that they need.
- Quality of healthcare service provided in African countries is inadequate and is considered the least performing indicator of UHC:** When quality of healthcare services is considered (i.e., effective coverage), service coverage scores across African countries are even lower.
- Coverage with essential health services in Africa is inequitable:** For instance, on average, the demand for family planning satisfied among the rich (quintile 5) is four times that among the poor (quintile 1).
- Coverage of services for women and girls is low:** Access to essential services that are needed by women and girls in Africa is particularly low. For example, between 2015 and 2019 less than half (49%) of African women had their demand for family planning (FP) satisfied by modern methods.
- Africa's health systems are poorly attuned to meet the healthcare needs of the poor, the disabled, lesbian, gay, bisexual, transgender and queer (LGBTQ) and other vulnerable groups:** Challenges range from discrimination and stigma to inadequate structural design and provisions to support access to care.

2.2 Financial Risk Protection

1. **The incidence of catastrophic healthcare payments in Africa is high and increasing:** Approximately 97 million people in Africa, representing 8.2% of the continent's population, incur catastrophic healthcare costs at the 10% threshold annually.
2. **The proportion of individuals that are pushed into poverty in Africa is high but is reducing:** About 15 million people, representing 1.4% of the continent's population, are pushed into poverty annually because of out-of-pocket healthcare payments.

2.3: Health Outcomes

Health outcomes in Africa are improving but remain low: While the continent has 17% of the world's population, it accounts for 23% of the global burden of disease.

While the African continent is experiencing signs of progress on each of the UHC indicators, progress is slow, the scores on these indicators remain low and, in some cases, have worsened over time.

3.0: CHALLENGES FACED BY AFRICAN COUNTRIES ON THEIR PATH TO UNIVERSAL HEALTH COVERAGE

Out of many challenges, the Commission has elected to highlight what we deem to be most intractable and representative, and most amenable to solutions. The challenges faced by African countries in their quest to achieve UHC have been grouped into broader contextual challenges, and demand and supply side health system challenges, as follows:

3.1: Broader Contextual Challenges

1. **The legacy of colonisation continues to challenge health system progress:** Examples include the exclusion of African traditional medicine; the prioritisation of curative, hospital care; and the hierarchical, disempowered, and under-resourced district health systems.
2. **Neo-colonial influence of external institutions has affected Africa's progress towards UHC:** These include low prioritisation and underfunding of health systems; promotion of user fees due to externally imposed Structural Adjustment Programmes (SAPs), the verticalisation of healthcare service delivery as a requisite for donor funding for major service areas (immunisation, HIV, TB, and malaria), and the perverse influence of health sector priorities by international development organisations that undermine and ignore local ownership, knowledge and local solutions.
3. **The ability of African countries to mobilise resources for the health sector is affected by inadequate economic**

performance and its attendant high levels of poverty, dependency rates and informality.

4. **An underdeveloped manufacturing sector means that African countries rely on importation of essential healthcare commodities.** This increases the costs of these commodities and compromises their availability for health security.
5. **Political instability and wars continue to directly disrupt healthcare services,** and indirectly affect health systems by disrupting economic activities and all other sectors (such as education, with impacts on social determinants of health) in several African countries.
6. **A high fertility rate and young population yields a high dependency ratio** that strains health system resources and limits the number of people actively contributing to the economy and to pooled health financing in Africa.
7. **Rising and unplanned urbanisation will increase population density in urban areas,** strain social services and infrastructure, and add more pressure on under-resourced health systems.
8. **Climate change poses a threat to population health** and is expected to result in further strain on the already under-resourced African health systems.
9. **Inadequate investment, and specifically domestic funding,** in health research and development.

3.2: Health System Supply Side Challenges

1. **Inadequate and poorly managed health sector resources:** Challenges include inadequate financing that is characterised by low domestic funding of the health sector, high dependence on donor funding and out-of-pocket payments, fragmentation of financing arrangements, passive purchasing arrangements, weak public finance management systems, inefficiency in the use of healthcare resources, inadequate numbers of and poor motivation among healthcare workers, weak and fragmented information systems, and weak health infrastructure.
2. **Weak governance and accountability of health systems:** Challenges include inadequate legal and policy frameworks for UHC, weak management of the political dynamics of UHC reforms, poor leadership and management of the health sector, weak multi-sectoral coordination and health priority setting, poor public-private coordination, under-prioritisation of primary healthcare and quality of care, the scourge of corruption, inadequate community engagement and accountability systems, and discrimination and prejudice against specific

population groups including youth, women, people living with certain chronic conditions such as HIV/AIDS, and LGBTQ persons.

3.3: Health System Demand Side Challenges

1. **A high disease burden:** Challenges include a high burden of communicable diseases such as HIV/AIDS, TB and malaria; physical trauma; the emergence of non-communicable diseases; and recurrent infectious diseases outbreaks and epidemics, with Ebola and COVID-19 as recent and current examples.
2. **Low sense of ownership of and trust in health systems:** Ownership and trust are crucial as the mere presence of the health services does not necessarily translate into their acceptability and use by the community.
3. **Certain societal practices, norms and beliefs continue to negatively affect access to healthcare in Africa, especially for specific population groups:** These include the need for women to seek permission from men in order to seek care, the stigma attached to unmarried women seeking reproductive and maternal healthcare, and the requirement that a healthcare worker of a particular gender attends to a patient of the same gender.

It is apparent that the challenges faced by African countries in their quest to achieve UHC partly relate to legacies of the past, to poor agency, to current circumstance, and to emerging and future challenges. It is also instructive that these challenges not only relate to the health system, but also to the broader societal, political and economic country contexts. It is not all doom and gloom, however, because the continent has immense opportunities that, if leveraged, will accelerate progress towards UHC.

4.0: OPPORTUNITIES THAT AFRICAN COUNTRIES COULD LEVERAGE TO ACCELERATE UHC PROGRESS

The road to UHC for African countries is paved with both challenges and opportunities. Opportunities available for African countries include the following:

1. **Africa's economic growth trajectory was promising pre-COVID-19 and is likely to bounce back.** If this happens, it will offer an opportunity to mobilise additional resources in healthcare and address the social determinants of health.
2. **The Organization of African Unity (OAU) has transformed into the African Union (AU), which is pro-people,** embraces civil society and has zero tolerance for illegitimate governments; it is promoting an African renaissance with pride in African values to reset the mindset needed to achieve UHC. The AU, the WHO's Regional Office for Africa (WHO AFRO) and other members of the UN family that have strong convening, advocacy, and resource mobilisation capacities could be leveraged to provide leadership, governance, political advocacy, technical

support and resource mobilisation for UHC.

3. **The African Continental Free Trade Area (AfCFTA) has the potential to stimulate economic development of African countries** with knock-on effects on the health sector, expand healthcare markets in ways that will incentivise investments in the African health sector, and reduce tariff and non-tariff barriers to the trading of healthcare commodities.
4. **The vast network of African traditional healthcare providers** offers an opportunity to enhance access to primary healthcare services, especially preventive and promotive care.
5. **Political commitments to UHC** need to be utilised to advocate for more investments in UHC-related reforms and for more African countries to enact UHC policies and legislations (not centred on health insurance reforms alone).
6. **The potential for a demographic dividend** presents an opportunity to improve labour productivity, which could have positive outcomes for the health sector.
7. **Africa has a developed private sector** that could be leveraged to complement the public sector in delivering UHC.
8. **Africa needs to leverage its innovation ecosystem,** increasing mobile connectivity and a boom in digital technologies, and more broadly, the potential that the fourth industrial revolution (4IR) holds, in order to transform its health systems.
9. **Africa can leverage the strong civil society** ecosystem to advocate for UHC and to hold governments and other actors accountable.
10. **Africa has a large pool of well-trained and competent health professionals** who have potential to provide the transformative leadership for UHC, instead of being forced to run away to greener pastures abroad.
11. **The health system strengthening efforts made in response to COVID-19** provide an opportunity for African countries to make comprehensive investments in health that will strengthen the foundation for UHC. Further, COVID-19 nationalism in some countries has awoken their populations to the threat of Africa being left out and failing to access lifesaving health technologies and spurred discussions about self-reliance including in local manufacturing of health products such as vaccines.

In the face of the challenges discussed in the previous section, opportunities abound. African countries will, however, have to be decisive and committed to leveraging these opportunities.



African countries need to implement integrated care models of service delivery, contracting, and reimbursement. This will entail developing primary care networks that integrate horizontally across several healthcare providers at the same level and across services to span promotive, preventive, curative, rehabilitative, and palliative care and community health systems, including traditional medicine providers; diagonally with various priority programmes; and vertically with secondary healthcare facilities.



5.0: RECOMMENDATIONS FOR TRANSFORMATIVE CHANGE TOWARDS UNIVERSAL HEALTH COVERAGE

African countries will need to transform their health systems, in ways that address their challenges while taking advantage of prevailing opportunities and building on the rich and positive cultural values to get buy-in and ownership. We highlight recommendations that are in no way comprehensive, but rather, illustrative of the task ahead.

5.1: RECOMMENDATIONS TO AFRICAN GOVERNMENTS

5.1.1: African governments should address health sector specific challenges by:

- 1. Re-orienting health systems and health system priorities to respond to population health needs**
 - Re-orient health sector priorities beyond curative care and to encompass preventive and promotive care. This will require investments in public health and the financing of public goods for health.
 - Prioritise resources to a high burden of disease areas that continue to plague the continent. These include addressing the causes of maternal, child and neonatal deaths and a high-burden of infectious diseases (e.g. HIV/AIDS, TB, and malaria).
 - Adapt service delivery models to provide long term and continuous care, in line with the emergence of non-communicable diseases.
 - Increase investments in strengthening emergency preparedness and health security.
- 2. Re-orienting health systems to prioritise and strengthen primary healthcare (PHC) as the foundation for UHC**
 - Prioritise primary healthcare and a Health in All Policies approach at the highest level of government as an integrating concept for a developmental approach to decentralised government.
 - Reallocate existing health system resources and increase investments to prioritise the strengthening of PHC systems.
 - Strengthen the role of primary healthcare facilities as the first point of contact for healthcare needs. This includes increasing physical access to primary healthcare facilities, employing mechanisms to explicitly assign population groups to primary healthcare units, and implementing robust referral systems.
 - Strengthen PHC delivery by implementing flexible models of non-hierarchical multidisciplinary teams of clinical and non-clinical staff to provide integrated care to defined empanelled populations, and patients coming from them.
 - Implement integrated care models of service delivery, contracting, and reimbursement. This will entail developing primary care networks that integrate horizontally across several healthcare providers at the same level and across services to span promotive, preventive, curative, rehabilitative, and palliative care and community health systems, including traditional medicine providers; diagonally with various priority programmes; and vertically with secondary healthcare facilities.

3. Investing in strengthening health system inputs, especially in primary healthcare

- Invest in boosting the number of skilled health workers through education and skilling, addressing motivation and retention, and ensuring equitable distribution of health workers with a focus on rural and marginalised regions.
- Address health infrastructure gaps with a focus on improving both the availability and quality of care, while focusing on equitable access.
- Boost investment and implement policies to support the availability of essential health commodities in public health facilities.
- Strengthen health information systems in order to monitor and track UHC progress, as well as to provide information for health sector decision making and performance improvement.

4. Investing in system-wide approaches to improve the quality of healthcare delivered to people

- Develop and implement a governance framework that articulates a vision, and accountability, for quality health systems.
- Address health workforce constraints that impact quality of care.
- Address resource constraints that impact quality of care.

5. Reforming health financing systems in contextually appropriate ways to support UHC

- Progressively increase domestic financing of the health sector to an adequate level. This should be guided by an assessment of the resource needs to deliver needed healthcare services to the population. This will require increasing the fiscal space for health in feasible ways such as improving taxation efficiencies and enhancing efficiency in the use of existing resources.
- Restructure health systems to reduce fragmentation of pooling arrangements. Doing this will require considering feasible and context-appropriate pooling mechanisms. For instance, there is overwhelming evidence that voluntary health insurance contributions do not work because of the high informality of African labour markets. Predominantly tax-financed health systems offer better promise but only if the fragmentation of public finance is addressed.
- Implement strategic purchasing reforms that include implementing evidence-based, transparent and inclusive mechanisms for defining service entitlements for populations, and reforming contracting and payment mechanisms to incentivise accountability for quality

and efficiency.

- Reform public finance management systems to reduce operational inefficiencies and align with health system goals.
- Identify and address the causes of inefficiency in country health systems. This will not only unlock additional resources for the health sector, but also enhance health outcomes.
- Reorient financing from a health-systems view, to a systems-for-health view and thus prioritise the financing of public goods for health.

6. Strengthening governance and accountability for health

- Reaffirm political commitment to health as a social goal in which top-level political leadership is committed to improving the health of the people, with demonstrated and visible leadership from the head of state and government. This is the foundation of the statement that “UHC is a political choice”.
- Position health as a priority crosscutting development strategy in all their sectoral plans.
- Develop and implement comprehensive legal and policy frameworks to guide UHC implementation in countries.
- Invest in developing the leadership capacity in the health sector. This should be focused on the identified leadership gaps, which include complex systems thinking, soft skills and political management, and the use of evidence to inform decision making. Further, the role of governments and ministries of health should be strengthened through dedicated capacity development for health ministers and senior government officials.
- Develop and implement political/stakeholder management plans for UHC reforms. Governments should develop skills and capacity to work with an ever-increasing array of players in health including civil society organisations, academia, private sector, development partners and the public, among others, as effective stewards of the health of the population.
- Broaden perspective (priorities, planning, financing, coordination) beyond a narrow “health-system” view, to a broader “systems-for-health” view. Develop and implement a framework to strengthen and govern multisectoral action in addressing health challenges. A multisectoral action framework should also be leveraged to address the social determinants of health.
- Develop and implement a framework to govern and leverage public-private partnerships for health. Such a

framework should clearly define the role of the private sector, ensure that these roles and inherent incentives are aligned with overall health system goals, and govern this arrangement to promote the public good.

- Develop and implement anticorruption strategies to address corruption and strengthen transparency and accountability in the health sector.
- Strengthen community communication, accountability, and engagement mechanisms to promote people-centred and responsive health systems.
- Develop and implement a framework to mainstream equity, gender and intersectionality in all health policies and programmes. African governments should be intentional about addressing inequities in financing and access to health services across all social stratifiers (wealth, gender, age, disability, sexual orientation, location, etc.). This will involve identifying and addressing both structural determinants of these inequities and nurturing cultures that promote equity and fairness for all.

7. Investing in health technologies and take advantage of the fourth industrial revolution (4IR) to enhance the performance of all health system functions

- Invest in the physical infrastructure to support the development and adoption of 4IR technologies in the health sector.
- Invest in country capacity to drive and support innovations and create an enabling business environment.
- Develop and implement a comprehensive policy and regulatory framework to govern the adoption of digital and other technologies in the health sector.
- Leverage digital health solutions to develop and implement UHC reforms.

5.1.2: African governments should address the broader contextual challenges by:

1. Reflecting on, and addressing the undesirable legacy of colonisation and embark on a programme to decolonise health policy and reforms

- Recognise and integrate the traditional health system with the formal health system.
- Reclaim its rightful role as the leader and steward of health policy and reforms. Ensure that policy and reform priorities are country-led and context-appropriate, with external actors playing a supportive rather than leadership role.
- Nurture a change of mindsets from donor dependence to progressive self-reliance and self-determination.
- Restructure health systems to empower decentralised

levels to effectively contribute to healthcare delivery.

- De-verticalise health systems: African countries should take advantage of planned donor transitions to reintegrate existing vertical programs with the rest of the health system in ways that improves efficiency while guarding the gains made.

2. Investing in the manufacturing of healthcare commodities within the continent to increase access to affordable healthcare commodities

- Invest in education and human capital development for the manufacturing of healthcare commodities.
- Invest in research and development in health as a foundation for industrial development in health.
- Improve the infrastructure (such as energy, transport and technology).
- Improve regional- and country-level policy and regulatory barriers to local manufacturing and strengthen African institutions to implement AU Resolutions such as the African Medicines Agency and African Medicines Manufacturing Plan.
- Leverage the AfCFTA to negotiate regional markets and promote pooled procurement to create markets that can incentivise and sustain local manufacturing.

3. Implementing policies that take advantage of the demographic dividend

- Strengthen investments in adolescent, youth and women's health, including sexual and reproductive health and family planning.
- Invest in education for adolescents, youth and women. Achieving the demographic dividend requires that over 60% of the population have attained good quality tertiary education.
- Promote economic policies that target the expansion of employment opportunities for youth and women.

4. Developing policies and investing in the implementation of the Paris agreement on Climate action

- Develop and implement a framework for mitigating the emission of greenhouse gases.
- Develop and implement a framework for adapting health systems to make them resilient to climate change.

5. Support research and development broadly, and in the health sector

- Prioritise and increase domestic funding for research and development for health.



African professional associations and other CSOs, through their members should be socially accountable for applying their knowledge and skills to pursue equity and social justice; demonstrating leadership for excellence; and rejecting unethical, intolerable social, economic and political situations, rather than ignoring and accepting them as “normal” without comment or outrage from African experts and their populations.



5.2: RECOMMENDATIONS TO NON-STATE ACTORS

1. The African Union Commission (AUC), Regional Economic Communities (RECs), professional associations, civil society organisations (CSOs), academia, and private sector in Africa should popularise and scale up the campaign to re-capture and restore the spirit of the independence movement, self-confidence, ambition and the mindset that is required to generate and sustain political will and social action for achievement of UHC in Africa.
2. The WHO, the UN Family and other actors should translate Universal Health Coverage into simplified operational language within the principles of Primary Health Care as articulated in the Alma Ata Declaration and reconfirmed in Astana.
3. The AUC and WHO should provide leadership to all actors to maintain the visibility of PHC principles and balance the current pre-eminence of commoditisation of UHC.
4. All actors should promote and monitor UHC, and update its indicators to emphasise people’s ownership and participation using available resources at the various stages of economic development of societies.
5. The AUC, RECs, professional associations, CSOs, academia, and private sector in Africa should organise structured capacity development programs for health and other ministers and senior government officials to provide them with stewardship, leadership and governance and accountability competencies. Such programs should be conducted in Africa and near where they live and work.
6. African professional associations and other CSOs, through their members should be socially accountable for applying their knowledge and skills to pursue equity and social justice; demonstrating leadership for excellence; and rejecting unethical, intolerable social, economic and political situations, rather than ignoring and accepting them as “normal” without comment or outrage from African experts and their populations.
7. Civil society should advocate for the prioritisation of UHC and for increased inclusivity, dialogue, and accountability that puts the people at the centre of UHC reforms.
8. Private sector should play a complementary role to governments and increase investments in expanding access to services and local manufacturing of healthcare commodities.



CHAPTER 2: INTRODUCTION

2.1: COVID-19 AND THE NEED TO REFOCUS ATTENTION ON UNIVERSAL HEALTH COVERAGE

At the time of writing this report, the COVID-19 pandemic globally has infected and killed millions of people, and triggered what is arguably the greatest economic recession in a century with devastating impacts on lives and livelihoods. While the direct health impact of the pandemic has been less severe in Africa compared to the rest of the world, the continent has not been spared. Over 4 million COVID-19 infections and 100,000 deaths have occurred in Africa thus far, and it is estimated that COVID-19 was responsible for a contraction of African economies in 2020 and the impoverishment of huge numbers of people. This context is crucial because the pandemic has exposed the weak 'underbelly' of health systems and highlighted the critical role that health systems play in not only promoting population health but wider socio-economic development.

It is against this backdrop of a world and continent reeling under the devastating shock of the COVID-19 pandemic, that we reflect on the state of Universal Health Coverage in Africa. In this report, we define UHC as a *state in which individuals and populations have equitable access to, and benefit from quality preventive, promotive, curative, long term management, and palliative health interventions, including health security, without experiencing financial hardship*. This definition is particularly important because COVID-19 has reminded us that

beyond a biomedical focus on individual curative healthcare services, health systems must pay attention to preventive and promotive population and public health interventions and invest in capacities to bolster health security in anticipation of future health shocks. The link between UHC and health security is clear; country capacity to respond to epidemics is contingent on systems reforms and capacities for UHC. It is no wonder, then, that UHC and health security are considered two sides of the same coin. Therefore, rather than divert attention, COVID-19 should serve to refocus the world's and indeed Africa's attention on reforming its health system to accelerate progress towards UHC.

2.2: HISTORY OF UNIVERSAL HEALTH COVERAGE

The quest to promote the health of populations in ways that protect them from financial hardship has a long history. Scrolls dating back over 3,000 years reveal that some workers had state sponsored healthcare in ancient Egypt (Austin, 2015). In the 19th century, Germany and later other parts of Europe began providing health insurance to workers in response to their agitation for social security (Bärnighausen and Sauerborn, 2002, Savedoff et al., 2012). While these prior initiatives were country focused, the evolution of UHC as a global health priority is perhaps best captured by the declarations and resolutions adopted by United Nations' member states (Table 2:1).

Table 2:1: UHC milestones as a global initiative

YEAR	MILESTONE	DETAILS
1948	United Nations General Assembly Universal Declaration of Human Rights	The right to a universal minimum standard of health outlined in international agreement
1948	World Health Organization Constitution	The WHO is established, with its constitution recognizing the highest attainable standard of health as a fundamental human right of every human being
1978	Alma Ata Declaration	A landmark declaration of the principle of working for “health for all” at a global conference on primary health
2005	World Health Assembly Resolution 58.33	Universal health coverage endorsed by the World Health Assembly for sustainable health care financing
2008-2013	2008, 2010, 2013 World Health Reports	These reports promote UHC and emphasize prepayment and pooling systems as essential for UHC
2012	United Nations Resolution A/67/L.3	This resolution emphasizes UHC as important to human development and recommends its inclusion in the post 2015 development agenda
2015	Sustainable Development Goal 3.8	UHC is included as a health-related sustainable development goal (SDG)
2018	Astana Declaration	Heads of States participating in the Global Conference on Primary Health Care in Astana made a new declaration emphasizing the critical role of primary health care around the world.
2019	World Health Assembly Resolution	Member states at the World Health Assembly passed a resolution on UHC with a focus on PHC and the role of community health workers

Understanding the history of health policy in Africa is relevant in appreciating the position of UHC in Africa’s health agenda, and the challenges that the continent faces.

2.3: HISTORY OF HEALTH POLICY IN AFRICA AND ITS LINK TO THE PRESENT

The immediate post-colonial era in Africa was hopeful, confident and ambitious, and significant progress was registered in many countries: The clarion call by our then-political leaders, and the stated purpose of independence, was to rid Africa of poverty, disease and ignorance. This early progress was reversed by poor governance and economic challenges, occasioned by the collapse of commodity prices and the sharp rise in the price of oil. African countries were mismanaged, impoverished by the collapse of their economies, and reduced to beggars, dependent on foreign aid (Omaswa and Crisp, 2014). This situation promoted a mindset of dependency in African countries not only for money but also for vision, ideas and solutions. The African self-confidence and the can-do attitude of the immediate post-independence period was accordingly eroded by the imposition of many inappropriate solutions to African problems by external actors, resulting in retarded development and instability.

The derailment of Africa’s progress by poor governance and perverse external influence is well typified by the evolution of Africa’s health policy: Healthcare policy in Africa has gone through several iterations since pre-colonial times. Pre-colonial health policy during the exploration period was

focused on protecting European explorers from disease (Gros, 2016). Colonialism transformed this pre-colonial approach from a fragmented, explorer-driven endeavour, to a more state-centric approach to health policy (Gros, 2016). Both explorer and colonial medicine were heavily biomedical and prioritised curative care, which during the colonial period was initially provided by mission hospitals (Gros, 2016, McPake, 2009). Healthcare in both eras was also characterised by a disregard and marginalisation of African traditional medicine; a presentation of western contemporary medicine as the right alternative, rather than complementary, to African traditional medicine; and a prioritisation of the healthcare needs of Europeans (explorers and colonisers) bolstered by a view of Africans as less than human (Gros, 2016).

Healthcare policy in the early post-colonial period in Africa (approximately between 1960 and 1980) was driven by independent African governments (Gros, 2016). Healthcare was considered a social and human right rather than a private good, and universal access to hospital care was the guiding principle (Gros, 2016). Healthcare services were predominantly financed by taxes and were mostly offered for free at the point of care. This early post-colonial period is aligned with the global recognition of health as a human right, and the 1978 Alma Ata declaration to which African countries ascribed. It could be argued that had Africa maintained this trajectory, the continent would now be closer to achieving UHC.

However, the late post-colonial period, starting from the late 1970s through the 1980s and 1990s and to the current

period, witnessed a radical shift in health policy in Africa that has had significant implications for UHC (Gros, 2016). Health policy became significantly influenced by external actors and acquiesced to a neoliberal ideology embodied in structural adjustment programs (SAPs) of the 1980s that were introduced and championed by the World Bank and the International Monetary Fund (IMF) (Gros, 2016). SAPs required countries to implement cost recovery policies and reduce investments in social sectors including health, as a precondition to lending by the World Bank and the IMF. Cost recovery in the health sector translated to the introduction of user fees as the major health financing mechanism and thus compromised earlier endeavours to guarantee healthcare as a right while removing financial barriers. The Bamako initiative of 1987 is thought to be an awkward fusion of the earlier desire to expand access to healthcare for all, while at the same time abiding by the prevailing neoliberal ideals of the SAPs (Gros, 2016). The Bamako conference was sponsored by the WHO and UNICEF, and brought together African health ministers in Bamako, Mali (Pangu, 1997). While the conference reaffirmed Africa's commitment to the Alma Ata declaration of 1978, it proposed cost recovery through the selling of generic medicines at low cost to healthcare users to finance PHC, and thus aligned itself with the SAPs (Gros, 2016).

The 21st century, however, has seen a renewed commitment by African countries to make advances towards UHC: Apart from endorsing the UHC resolutions as part of the UN member states, the continent has made its own reinforcing commitments. For instance, in 2001, the African Union countries met in Abuja and pledged to set a target of allocating at least 15% of their annual budget to improve the health sector (the 'Abuja Declaration') (Organization of African Unity, 2001). The 2007-2015 Africa Health Strategy recognises health as a human right and calls on African governments to guarantee healthcare for all their citizens in an equitable manner, while the 2016-2030 Africa Health Strategy sets a goal for the continent to achieve UHC by 2030 (African Union, 2007, African Union, 2016). In 2019, the AU launched the Africa Leadership Meeting where African leaders made the Addis Ababa Call to Action on UHC, and later signed a memorandum of understanding (MOU) with the WHO in the same year to support the Call's implementation (WHO, 2019).

2.4: ABOUT THE AHAIC COMMISSION ON THE STATE OF UHC IN AFRICA

The Africa Health Agenda International Conference (AHAIC) is a biennial conference convened to reflect on the key health issues affecting the African continent and to chart a way forward. AHAIC 2019 resolved to achieve UHC in Africa by 2030 through increasing access to health services; improving the effective delivery of quality health services; establishing mechanisms to guarantee adequate and sustainable publicly led financing; and lastly, strengthening accountability to safeguard transparency and efficiency at all levels, and specifically people-led accountability. Underlying this is the requirement to improve health systems performance, leadership, governance and return on investment.

The AHAIC Commission on the State of UHC in Africa was set

up in November 2020 to take stock on the continent's progress towards UHC and make recommendations on what is needed for the continent to achieve this goal. The Commission is an independent body comprising of 11 members drawn from diverse backgrounds regarding country, professional discipline, expertise, and experience. The Commission set out to answer three overarching questions:

1. What is the progress made by African countries with regards to UHC?
2. What are the challenges and opportunities that African countries face on the journey towards UHC?
3. What are the key recommendations for transformative change that African countries should adopt to accelerate progress towards UHC?

To answer these questions, the Commission employed a multifaceted approach:

- a. **Literature reviews:** The commission carried out comprehensive literature reviews focused on UHC in Africa.
- b. **Analysis of secondary data:** The Commission collated secondary data from online data repositories that were relevant to answer the Commission's questions.
- c. **In-depth Interviews:** The Commission interviewed individuals at the national and regional level that had in-depth knowledge on the Commission's questions. Interviewees ranged from regional and national level public sector, private sector, and development partner policy makers; implementors; and key opinion leaders.
- d. **People stories:** The Commission issued an online call inviting the public across Africa to submit short stories that capture their experiences and perception on the state of UHC in their countries. This was meant to capture the lay perspective that would complement the often-technocratic perspective that are captured through traditional methods.
- e. **Commissioner deliberation:** The 11 members of the Commission held several meetings in regular intervals (bi-weekly) where they deliberated on the Commissioner questions and reflected on data that emerged from the other 4 approaches.

This report presents the findings of the Commission's work. The report has six chapters. Chapter one presents an executive summary, followed by chapter two, which sets the stage by discussing UHC within the African context. Chapter three tackles the first Commission question by articulating findings on the state of UHC in Africa. Chapters four and five address the second Commission question by delving into the challenges and opportunities that African countries face in their quest to achieve UHC. Lastly, Chapter 6 addresses the third and last Commission question by articulating the recommendations for measures that African countries should adopt to accelerate their progress towards UHC.



CHAPTER 3: STATE OF UNIVERSAL HEALTH COVERAGE IN AFRICA

3.1: INTRODUCTION

This chapter discusses the state of UHC in Africa drawing on quantitative and qualitative evidence. The chapter draws quantitative evidence from key UHC indicators from the 2019 WHO/World Bank global monitoring report on UHC (World Health Organization, 2019b), Demographic and Health Survey (DHS) data repository, as well as from other complementary literature. Qualitative evidence is drawn from stakeholder interviews, people stories, as well as Commission deliberations. The chapter focuses on three key indicators of UHC: (i) service coverage; (ii) financial risk protection, and (iii) health outcomes, and also considers the equity dimension of UHC.

3.2: COUNTRY LEVEL UHC COMMITMENT

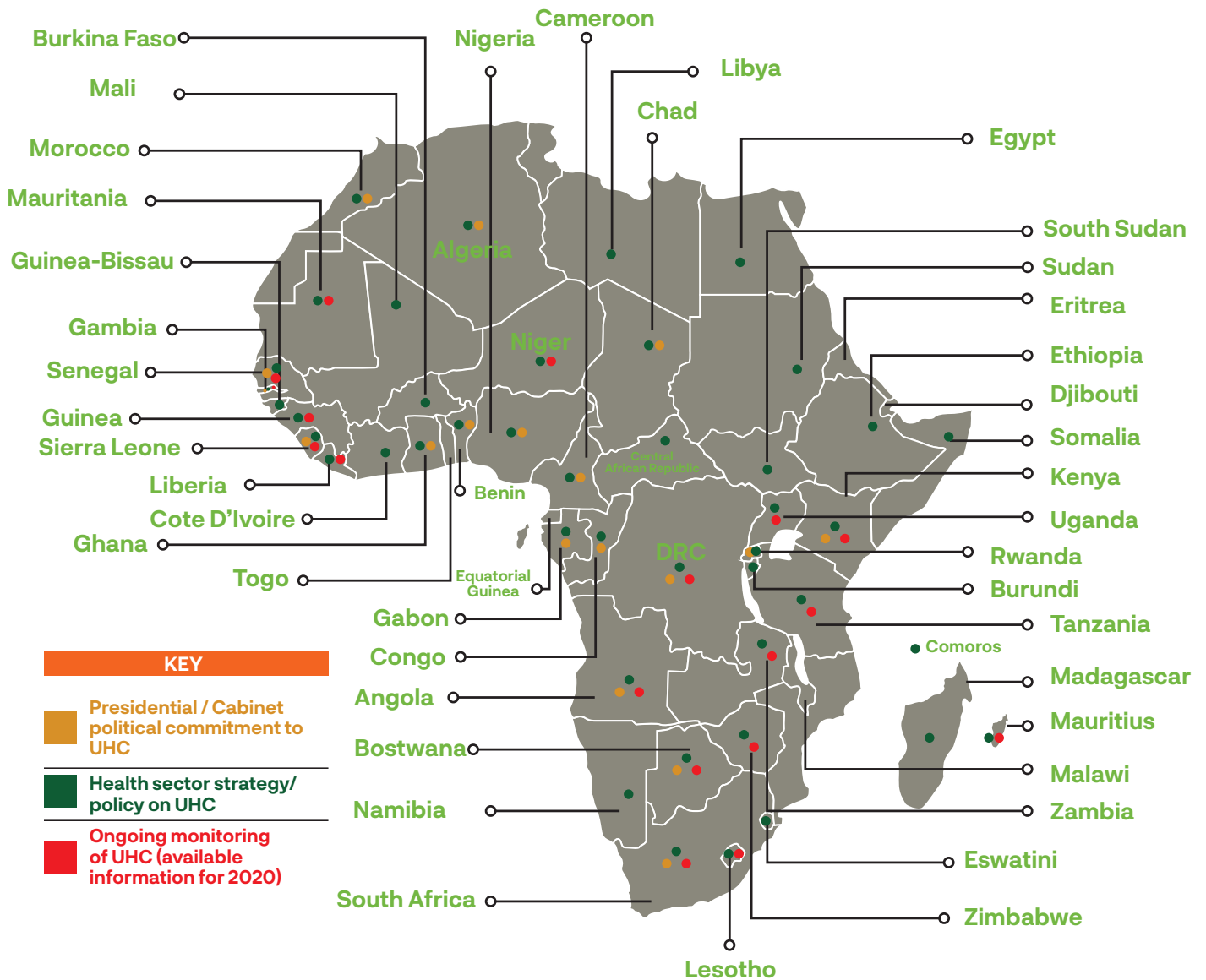
It is apparent from the previous chapter that the global commitment to UHC has been translated to a regional commitment in Africa. At country level, many African countries have made commitments to achieve UHC. As at 2020, 50 out of 54 (93%) African

countries either had a health sector UHC policy or had included UHC as a goal in their health sector policies and strategies. However, only 20 out of 54 (37%) African countries had a formal political commitment, beyond the health sector, by the president or cabinet to prioritise UHC as part of their development agenda. Further, 21 out of 54 (38%) of African countries had active monitoring processes for UHC (Figure 3:1).

3.3: SERVICE COVERAGE

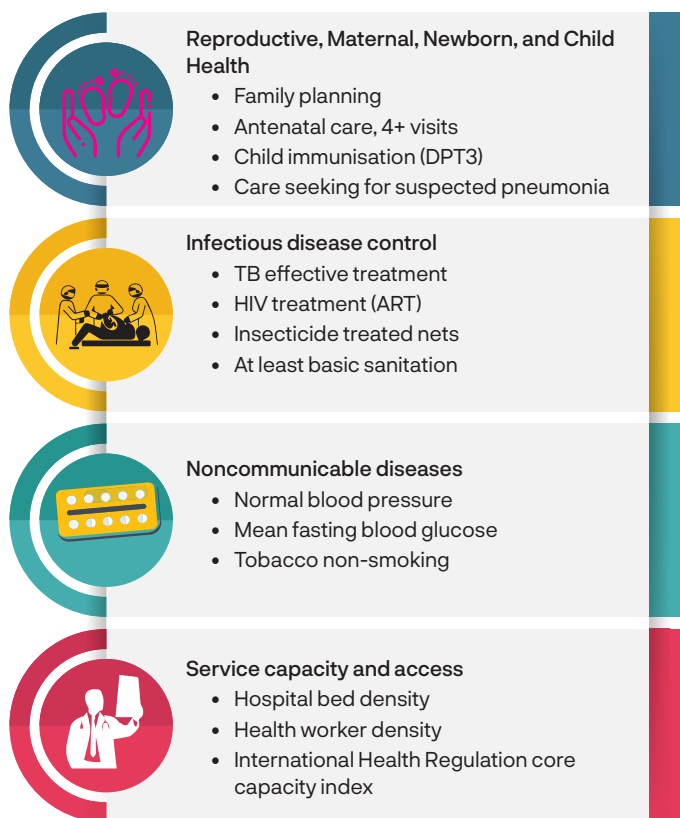
To quantitatively assess service coverage, we adopted the 16 indicators used by the WHO/World Bank UHC Global Monitoring Report. The 16 indicators span four key areas: (i) reproductive, maternal, new-born, and child health (RMNCH); (ii) infectious diseases; (iii) non-communicable diseases; and (iv) service capacity and access (Figure 3:2). The UHC Global Monitoring Report develops the UHC Service Coverage Index (SCI) as the geometric mean across these indicators. A glaring omission in the WHO/World Bank framework is an indicator for community engagement and accountability.

Figure 3:1: Status of UHC commitments in African countries



As at 2020, **50** out of **54 (93%)** African countries either had a health sector UHC policy or had included UHC as a goal in their health sector policies and strategies. However, only **20** out of **54 (37%)** African countries had a formal political commitment, beyond the health sector, by the president or cabinet to prioritise UHC as part of their development agenda.

Figure 3:2: Tracer indicators used to generate UHC Service Coverage Index



Coverage with essential healthcare services in Africa is low:

Only 48% of people in Africa received the healthcare services that they need (Table 3:1). This means that approximately 615 million people in Africa do not receive the healthcare services that they need. There is substantial country variation in service coverage in Africa, ranging from 25% in Somalia to 78% in Algeria. Most African countries (67%) had service coverage scores below 50%, with Somalia (25%), Chad (28%) and Madagascar (28%) having the lowest scores (Figure 3:3). It is evident that Northern African countries (Egypt, Algeria, Morocco, and Tunisia) feature among the countries with high service coverage.

Among the components of the health service coverage index, Africa performed better in coverage with non-communicable disease services (mean 67%) and lowest in the service capacity and access indicator (mean 36%). This highlights the significant capacity gaps that African countries face in their quest to deliver needed healthcare services, something that we will come back to in the next chapter.

Table 3.1: Essential health service coverage in 2017

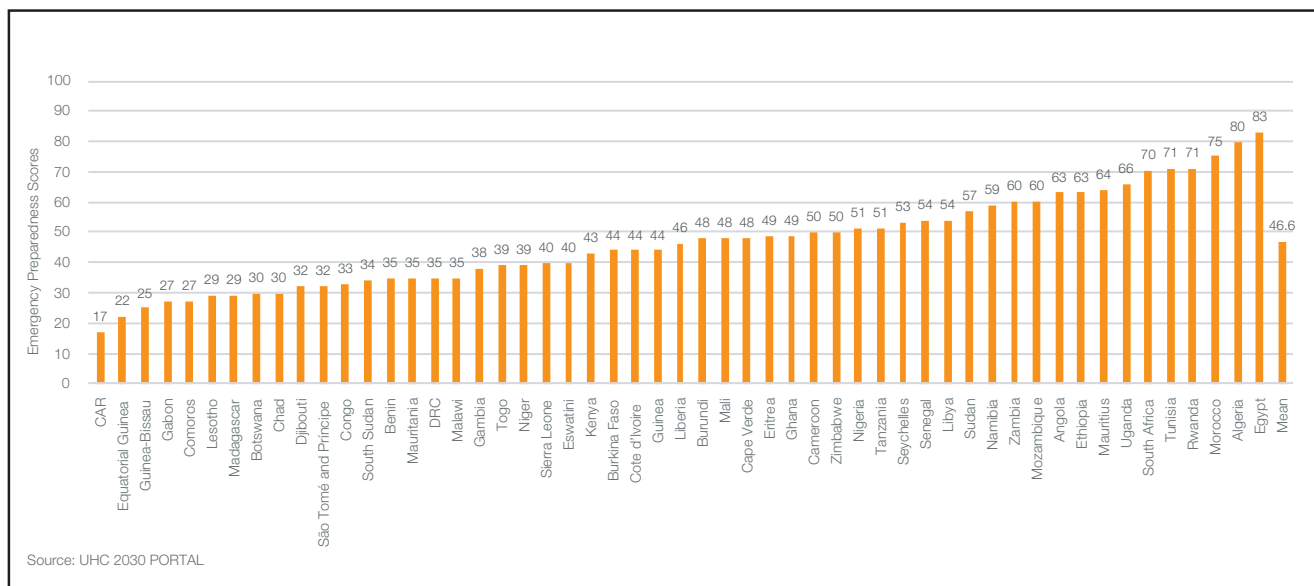
	UHC SCI components: Reproductive, maternal, newborn and child health	UHC SCI components: Infectious diseases	UHC SCI components: Non-communicable diseases	UHC SCI components: Service capacity and access	UHC index of service coverage (SCI)
Number of African countries	53	53	53	53	53
WHO African mean (SD)	58.3 (14.8)	44.8 (14.4)	66.8 (5.6)	35.9 (24.1)	48.1 (12.5)
WHO Americas mean (SD)	80.0 (10.7)	63.0 (11.4)	71.4 (8.8)	72.5 (20.2)	70.8 (10.4)
WHO European mean (SD)	83.4 (13.0)	71.4 (8.6)	59.5 (8.5)	89.9 (12.2)	74.8 (8.5)
WHO South-East Asia Region mean (SD)	72.4 (11.0)	53.4 (11.4)	62.4 (7.6)	53.8 (17.9)	59.1 (9.6)
WHO Western Pacific mean (SD)	78.3 (10.2)	65.3 (12.1)	57.0 (19.0)	75.2 (22.7)	67.2 (14.5)
WHO Eastern Mediterranean mean (SD)	70.3 (15.5)	59.4 (16.6)	63.4 (6.0)	75.1 (27.2)	66.0 (14.9)
World mean (SD)	73.6 (16.3)	59.6 (15.9)	64.0 (10.7)	66.3 (29.2)	64.0 (15.6)
Minimum (Africa)	15	11	52	12	25
Maximum (Africa)	90	78	81	95	78
Top 3 Africa	South Africa, Cape Verde, Egypt	Botswana, Morocco, Algeria	Nigeria, Ghana, Ethiopia	Egypt, Algeria, Seychelles	Tunisia, Seychelles, Algeria
Bottom 3 Africa	Somalia, Chad, South Sudan	Madagascar, Angola, Gabon	Mauritius, Central African Republic, Lesotho	Chad, Burundi, Sierra Leone	Somalia, Chad, Madagascar

Source: [UHC Index of service coverage \(SCI\) \(who.int\)](https://www.who.int/teams/global-health-promotion-and-prevention/essential-services/essential-health-services-coverage)

The International Health Regulation (IHR) score is particularly interesting at a time when Africa and the world are dealing with the COVID-19 pandemic. This indicator provides a summary measure of country performance across 13 IHR areas. The mean emergency preparedness score for Africa is 46.6, ranging from 17 in the Central African Republic to 83 in Egypt (Figure 3.3). Overall, these findings show that the African continent has inadequate capacity to prevent and respond to health security threats. More fundamentally, the COVID-19 pandemic has exposed the weaknesses of existing health security and pandemic preparedness metrics. Specifically,

it has become apparent that existing metrics are biased towards *hardware* aspects of health systems such as availability of infrastructure, and neglect *software* aspects of the system, such as leadership and governance. The COVID-19 pandemic has demonstrated globally, and in Africa, that leadership and governance are significant determinants of country preparedness and response to health crisis, and that future iterations of health security metrics should endeavour to incorporate or enhance the representation of these software aspects of health systems.

Figure 3:3: Emergency preparedness scores in Africa- average of 13 core capacities in 2019



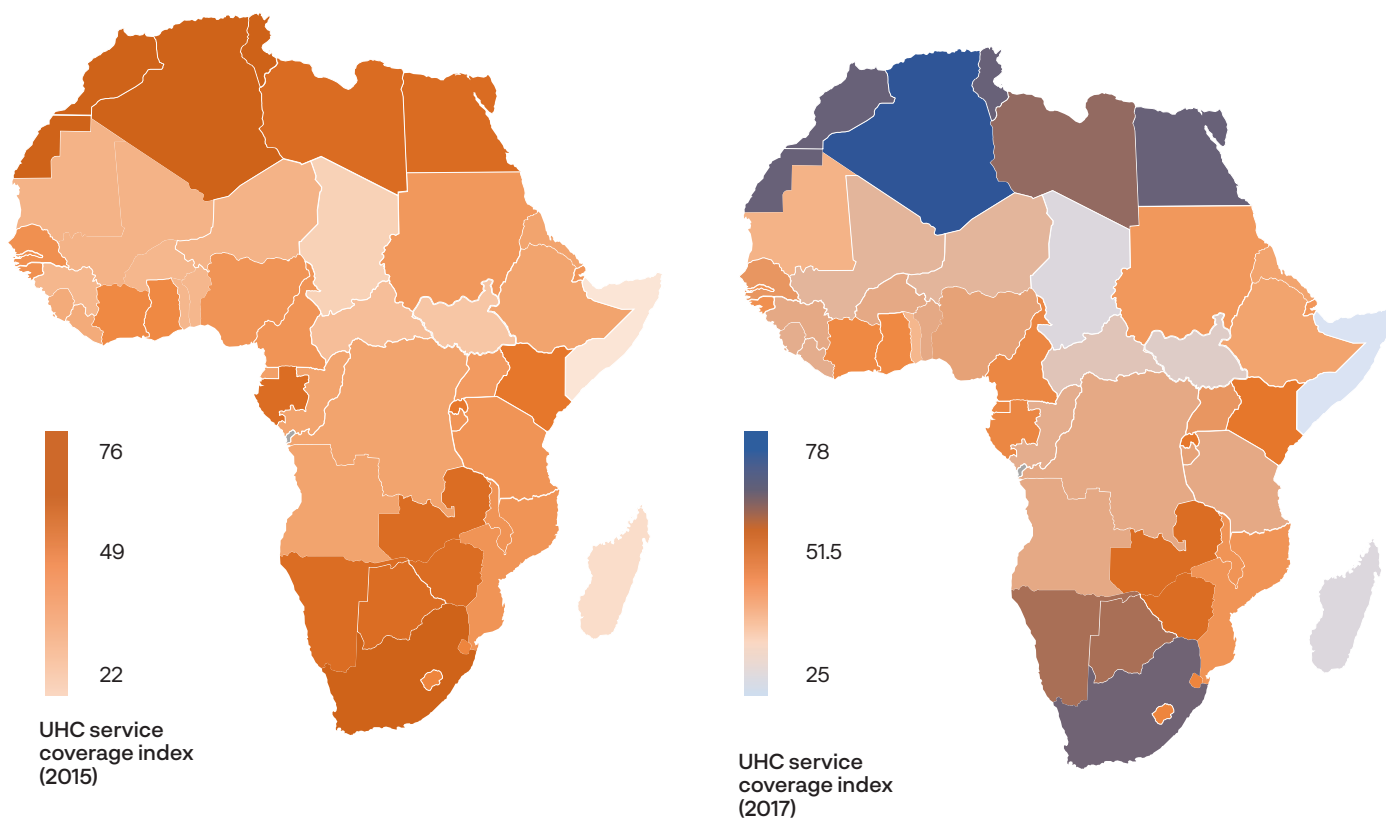
Notes: CAR – Central African Republic; DRC – Democratic Republic of Congo

Quality of healthcare service provided in African countries is low and is considered the poorest performing indicator of UHC:

When quality of healthcare services is considered (i.e. effective coverage), service coverage scores across African countries are even lower (Hategeka et al., 2020, Nguhiu et al., 2017, Yakob et al., 2019). For instance, a study in Rwanda found that while crude coverage for maternal and child health services was 57%, when quality of care is considered, effective coverage was only 33.2% (Hategeka et al., 2020). A study by Giorgio and colleagues that aimed to assess the quality of healthcare across 10 African countries based on health providers’ clinical knowledge, their clinic attendance and drug availability, found gaps in clinical knowledge to be the main hindrance in care readiness (Di Giorgio et al., 2020). For example, whereas 64% of clinical vignette cases were diagnosed correctly by healthcare providers across

all conditions and countries, less than a third (27%) of the providers correctly diagnosed and provided the appropriate treatment for the two common causes of death (i.e. diarrhoea and pneumonia) among under-fives (Di Giorgio et al., 2020). In addition, 30% of the healthcare providers were not at their duty posts in the facilities to provide care according to their work schedule. Overall, this study estimated that the probability of a health facility having at least one competent healthcare worker present with the critical inputs required to provide neonatal, child and maternity care that meets the minimum quality standards was only 14% (Di Giorgio et al., 2020). Interviewed policy makers generally felt that quality of care was the least performing UHC indicator in Africa and cited structural capacity gaps as a key reason for this. This was also reflected in the stories shared by people (Box 1).

Figure 3:4: Trends in UHC essential service coverage in Africa, 2015 to 2017 (Source [UHC Index of service coverage \(SCI\) \(who.int\)](https://www.who.int/teams/global-health-promotion-and-prevention/essential-services))



Coverage with essential health services in Africa is characterised by inequality: Coverage with essential health services is not only low in the African continent, but also characterised by inequality. Table 3:1 outlines the socioeconomic distribution of selected essential service coverage indicators in Africa. For instance, the mean high-to-low ratio (i.e. the ratio of richest and poorest quintiles) score for demand of family planning satisfied

by modern methods was 4.2 in Africa, ranging from 0.9 in Ghana to 77.0 in Mauritania. This implies that the wealthiest individuals are more than four times likely to receive modern family planning methods compared to the poorest individuals. Overall, relative to the rest of the world, Africa is more inequitable for the assessed indicators (Table 3:1).

Table 3:2: Socioeconomic distribution of essential service coverage indicators globally and in Africa

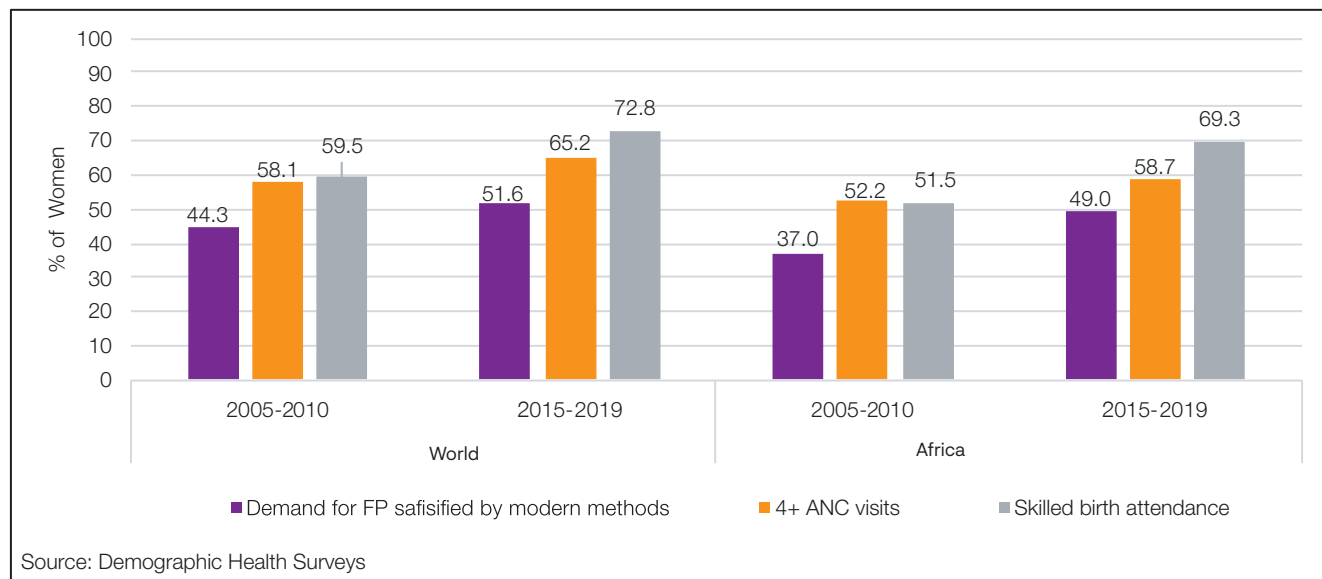
	Skilled birth attendance (Q5/Q1 ratio)	Demand for family planning satisfied by modern methods (Q5/Q1 ratio)	Children with symptoms of ARI taken to a health facility (Q5/Q1 ratio)	Availability of basic sanitation - handwashing facility with soap and water (Q5/Q1)
Number of African countries	45	44	38	31
WHO African mean (SD)	3.1(2.7)	4.2(11.9)	1.5(0.5)	16.2(44.5)
WHO Americas mean (SD)	2.1(1.4)	1.4(0.3)	1.4(0.3)	2.2(1.1)
WHO European mean (SD)	1.2(0.5)	1.3(0.3)	1.5(0.6)	2.3(1.9)
WHO South-East Asia Region mean (SD)	2.6(2.0)	1.1(0.2)	1.2(0.2)	3.3(2.7)
WHO Western Pacific mean (SD)	2.0(1.0)	1.2(0.5)	1.4(0.3)	6.6(6.8)
WHO Eastern Mediterranean mean (SD)	2.7(1.5)	1.7(0.9)	1.3(0.2)	5.3(1.8)
World mean (SD)	2.6(2.2)	2.8(8.8)	1.4(0.5)	11.4(35.4)
Minimum (Africa)	1.1	0.9	1.0	1.3
Maximum (Africa)	14.7	77.0	3.0	253
Top 3 Africa	South Africa, Malawi, Rwanda	Eritrea, Angola, Mauritania	Guinea, Mauritania, Angola	Democratic Republic of Congo, Chad, Gambia
Bottom 3 Africa	Nigeria, Togo, Eritrea	Ghana, Morocco, South Africa	Gambia, Malawi, South Africa	Egypt, Sierra Leone, Comoros

Notes: Results are based on latest data available; ARI – Acute Respiratory Infection. Source: STAT Compiler

Coverage of services for women and girls is low: Access to essential services that are needed by women and girls in Africa is particularly low. For instance, less than half (49%) of African women had their demand for family planning (FP) satisfied by modern methods between 2015 and 2019. Of the three services targeted at women, demand for FP sat-

isfied by modern methods performed poorly compared to the other two indicators in Africa and at global levels. On the other hand, skilled birth attendance was the best performing indicator among the three assessed indicators in Africa and at global level (Figure 3:5).

Figure 3.5: Trends in gender inequalities in service access



Notes: Findings presented for countries with data for reference years; FP – Family Planning; ANC – Antenatal care



Access to essential services that are needed by women and girls in Africa is particularly low. For instance, less than half (**49%**) of African women had their demand for family planning (FP) satisfied by modern methods between 2015 and 2019.

Box 1: Stories from the Frontline

My Experience with the UHC in Africa

Fredrick Majiwa

Samburu County is one of the marginalised counties in Kenya. A painful incident that happened a few months ago has remained etched at the back of my mind. As a project officer working for a local NGO that supports the health facilities within the county, my team and I, had made our duty call to a particular facility on that day. Right in the middle of our meeting, one of the nurses had to step out to take care of an emergency.

A premature baby, hardly weighing 1000gms, had been brought to the facility and required emergency newborn care. The parents of the baby had travelled almost 40 kilometers after the baby's home birth the previous night to reach this health facility. Despite being worn out from the stressful journey, they were quite hopeful that help would be at hand. What followed next has got to be one of the most heartwrenching experiences of my life. Due to an ongoing power shortage, the resuscitator was not operational, yet the baby badly needed warmth.



There are people, many people, who are cut off from accessing primary healthcare services like this family. When they struggle and arrive at health facility, the quality of care required is still not available and they have to fumble. | Fredrick Majiwa

A decision to refer the baby to the nearest public facility was met with the grim news that the health workers there were not available as they were on strike. The next available option was a non-public facility which happened to be a daunting 70 kilometers away. It was a dire situation that was only made worse by the news that the only ambulance the hospital owned had broken down. This effectively meant that there was no available means for the family to transport their baby quickly. I watched the helplessness



on their faces as they tried to make calls to beg relatives for money to be able to transport their baby by taxi. I felt the pain deep in my heart. We made a quick decision to offer our project vehicle to transport them despite going against our organisations' policy. We would deal with the consequences later. Silently, each of us prayed that the baby would make it as so much time had already been wasted. Needless to say, we were exasperated to later learn that the baby never made it.

For me, Universal health Coverage in Samburu was laid bare from that particular incident. There are people, many people, who are cut off from accessing primary healthcare services like this family. When they struggle and arrive at health facility, the quality of care required is still not available and they have to fumble. Financing for individual birth plans is also a challenge since there is no stable source of income for the majority of the population in the marginalised counties.

3.4: FINANCIAL RISK PROTECTION

To quantitatively assess financial risk protection, we relied on two indicators: the proportion of the population that incurs catastrophic health expenditure, and the proportion of the population that is impoverished annually because of out-of-pocket healthcare payments. We assumed that households incur catastrophic health expenditure when their annual out-of-pocket healthcare costs are greater than 10% of their total annual household expenditures. We used the international poverty line (US\$1.90) to assess impoverishment.

The incidence of catastrophic healthcare payments in Africa is high and increasing: Approximately 97 million people in Africa incur catastrophic healthcare costs, representing 8.2% of the continent's population. This percentage has increased from 6.6% in 2000. The incidence of catastrophic healthcare costs varies across the continent ranging from 0.2% in the Gambia to 54.2% in Sierra Leone (Figure 3:5). The incidence of catastrophic healthcare expenditure in Africa is slightly lower than the global average (8.8%) and is the least across the six WHO Regions of the world. This observation could be interpreted in two ways. One, that Africa is doing better than the rest of the world with

regard to financial risk protection. However, this interpretation is improbable when taken together with the observation in the next section, that more people are pushed into poverty by out-of-pocket healthcare payments in Africa compared to the rest of the world. A likely explanation, therefore, is the inherent weakness of the indicator of catastrophic healthcare expenditure, which can be low because most people cannot afford to seek healthcare in the first instance. The story shared in Box 2 illustrates the potential benefit of implementing a prepayment financing system that removes financial access barriers to citizens in a country.

It is curious that some of the countries that recorded high service coverage (Egypt, Morocco, Tunisia), score poorly on this financial risk protection indicator. This could be because these countries have well-developed service delivery mechanisms that are not matched with equally well-developed financial risk protection mechanism. This is a reminder that UHC reforms are intended to be whole-system reforms rather than narrow reforms focused on only one dimension. A good demonstration of this is Rwanda, which performs well on both financial risk protection and service coverage. Rwanda's whole-system approach to health reform is also illustrated by a submitted people's story (Box 3).

Box 2: Stories from the Frontline

My Experience with the UHC Pilot in Kenya



By Jane Wanjiru from Kenya

I am Jane Wanjiru, a 55-year-old resident of Nyeri County in Kenya. Nyeri County is one of the four counties selected for the UHC pilot program in 2018 in my country. For many years, I suffered from severe back pain and had sought multiple treatment options, exhausting all my savings. However, there was no improvement and I was

left sick and with a financial burden. This left me no choice other than to resort to home remedies and over-the-counter drugs. I had little or no hope left until a ray of sunshine gave me a lifeline through the UHC pilot program. I was enrolled by a community volunteer who showed up at my doorstep, registered me and later gave me a card which allowed me access to a health centre of my choice without any out-of-pocket payment required.

I attended a nearby health centre where, after medical examination, they (medical staff) referred me to the Level-5 hospital for further investigations and specialised treatment. Here, I got to be seen by an orthopaedic consultant who prescribed intense tests such as X-rays, including an MRI. All these tests made it easier for the doctors to come up with a diagnosis; a dislocation of my backbone discs. I got prescriptions followed by

weekly physiotherapy sessions and by the beginning of 2020 I could stand, walk and even carry on with my daily chores, just as before my illness began. All this was possible because UHC had come through for me. Furthermore, I did not spend any money on this intense healthcare journey and for that I'm full of gratitude to UHC.

My prayer is that this type of treatment is availed to the majority of my country's population who are suffering from such illnesses, or even worse than mine. If you walk into an emergency room or even a waiting room of many hospitals in this country, you will find many cases that are even worse than mine. Yet many of them do not have the means to pay for the treatment that they require. I hope the government scales up the pilot program to the rest of the country to alleviate people's suffering, just as it did for me.

The proportion of individuals in Africa that are pushed into poverty by healthcare costs is high but is reducing: About 15 million people are pushed into poverty annually in Africa because of out-of-pocket (OOP) healthcare payments, representing 1.4% of the continent's population (Figure 3:6). This percentage has come down from 2.8% in 2000. The level of OOP impoverishment var-

ies across countries, ranging from 0.01% in Zimbabwe to 13.42% in Sierra Leone. The percentage of people pushed into poverty because of out-of-pocket healthcare payments in Africa is higher than the global average (0.7%) and is highest across the six WHO Regions of the world.

Box 3: Stories from the Frontline

Improving Access to Primary Healthcare Services and Strengthening Health Systems: Evidence from the Introduction and Scale-up of Health Posts in Rwanda

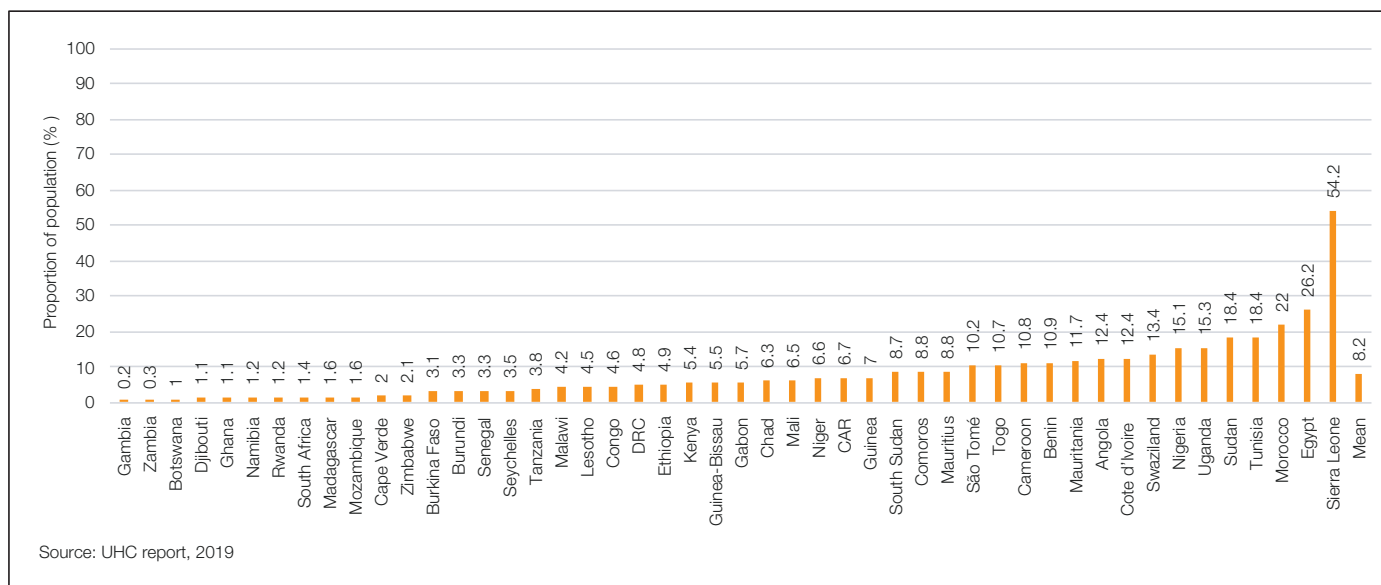
By Nyandwi Alypio, Parfait Uwairaye and Natasha Salant

In 2010, five years after the successful establishment and national scale-up of the community-based health insurance (CBHI), Rwanda registered dramatic improvements in the utilization of primary healthcare services (PHCS). Looking at maternal health, for instance, data from the Rwanda Demographic and Health Survey found that the use of any modern contraceptive method increased from 10 percent to 45 percent, delivery at a health facility increased from 28 percent to 69 percent, and the number of women who had a live birth and respected the standard of at least four antenatal care visits increased from 13 percent in 2005 to 35 percent in 2010. The improvement in access to maternal healthcare services is believed to have contributed to the decrease of maternal mortality ratio, from 750 per 100,000 live births in 2005 to 476 deaths in 2010. A deeper analysis of the access to primary healthcare services, as presented in the Rwanda Health Sector Strategic Plan 2012–2018 concluded that while CBHI was actively reducing financial barriers to the primary healthcare services, further improvements on PHCS coverage were going to depend on improvement in geographical accessibility, measured by the reduction of the average time needed to reach the nearest health facility. To that end, the new policy orientation adopted was to increase the number of existing levels of public health facilities, emphasizing in particular the scale-up of health posts in administrative cells without any other level of health facility. The immediate impact of the investments made in the construction of health posts has been seen in a 47% improvement in geographic accessibility, such that the average time needed to reach the nearest health



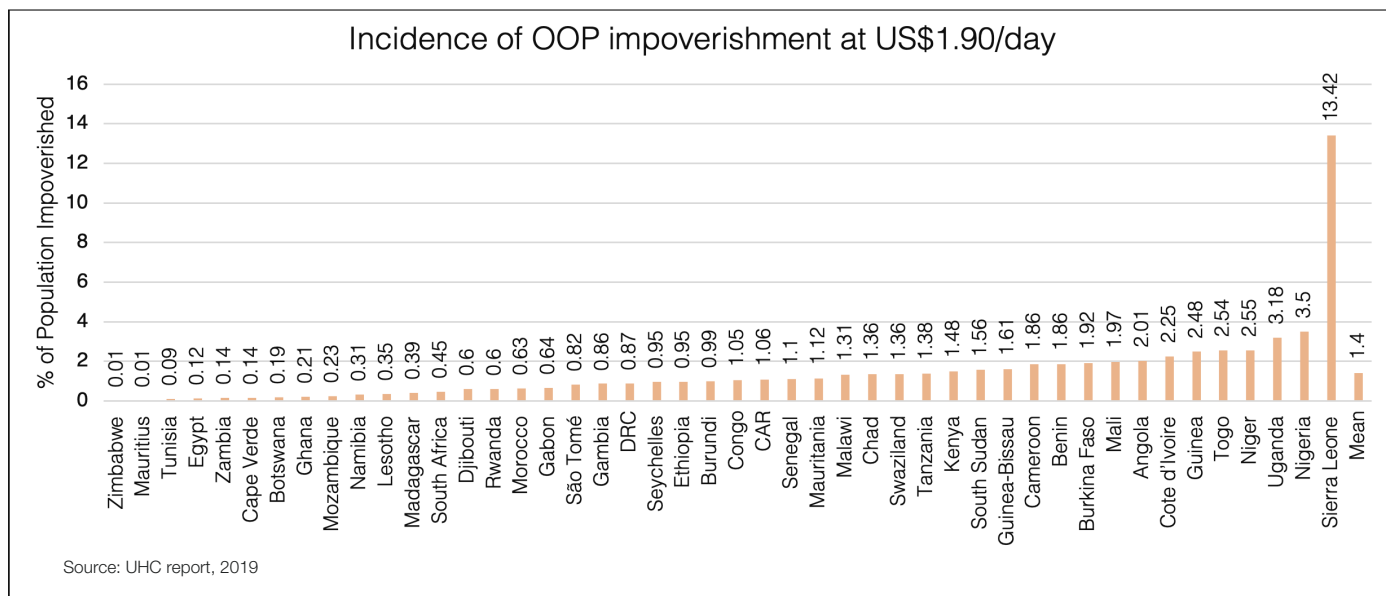
facility on foot decreased from 95 minutes in 2005/2006 to 50 minutes in 2016/2017. Since then, other indicators have supported the finding that access and coverage of PHCS have improved. For instance, vaccination coverage among children aged 12-23 months has increased from 90% in 2010 to 96% in 2020; and the use of any modern contraceptive method has increased from 45% in 2010 to 58% in 2020. Recently, during the COVID-19 pandemic, health posts acted as the shock absorber of disruptions to services caused by the lockdown. While outpatient department (OPD) consultations at health centres and hospitals went down, they increased by 260% in health posts, suggesting that services were still accessible to those seeking health services despite travel restrictions and other consequences of the pandemic. The story of the scale-up of health posts in Rwanda demonstrates that primary healthcare remains a key component of Universal Health Coverage even when the resilience of health systems is challenged. Investments like these in other African countries could make Africa's path to UHC more realistic and sustainable.

Figure 3:6: The state of catastrophic health expenditure in Africa



Notes: DRC – Democratic Republic of Congo; CAR – Central African Republic

Figure 3:7: Impoverishing out-of-pocket healthcare payments in Africa



Notes: CAR – Central Africa Republic; DRC – Democratic Republic of Congo

3.5: HEALTH OUTCOMES

Health outcomes in Africa are improving but remain low: Africa has a mean life expectancy of 65 years. While this has improved from 56 years in 2000, it ranges from 51 years in Lesotho to 77 years in Algeria in 2019. Africa's life expectancy is low compared to the global average (73 years) and is on average 9.4 years lower when compared to other regions of the world. This low life expectancy is explained by the high disease burden in Africa. While the continent has 17% of the world's population (World

Atlas, 2021), it accounts for 23% of the global burden of disease (i.e. Disability-Adjusted Life Years) (IHME, 2021). For instance, the under-5 mortality rate in Africa was 60 per 1000 live births in 2019, ranging from 12 in Libya to 117 in Somalia and Nigeria, compared to the global average of 27. Further, in 2017, the maternal mortality rate was 413 per 100,000 live births, ranging from 37 in Egypt to 1150 in South Sudan, compared to the global average of 161 deaths per 100,000 live births. The continent consistently underperforms when compared to other world regions on the selected health outcome indicators (Table 3:3).

Table 3:3: Selected health outcomes globally and in Africa

YEAR	Life expectancy (years)			Neonatal mortality rate (per 1000 live births)			Under-five mortality rate (probability of dying by age 5 per 1000 live births)			Maternal mortality ratio (per 100 000 live births)		
	2000	2010	2019	2000	2010	2019	2000	2010	2019	2000	2010	2017
Number of African countries	54	54	54	52	52	54	53	53	53	53	53	54
WHO African mean (SD)	55.6(8.3)	61.1(6.9)	65.1(5.4)	34.7(12.2)	28.1(10.0)	23.7(8.6)	123.0(54.6)	82.1(38.3)	59.9(29.1)	694.7(466.3)	489.8(311.5)	413.0(280.0)
WHO Americas mean (SD)	71.8(6.1)	73.1(8.2)	75.1(4.0)	14.2(6.5)	11.8(6.0)	10.1(5.8)	27.9(19.1)	24.1(42.5)	16.5(10.7)	102.6(89.3)	86.0(86.6)	75.8(81.1)
WHO European mean (SD)	73.8(4.9)	76.4(4.6)	78.4(3.9)	8.5(8.3)	5.4(5.4)	3.9(4.2)	18.6(21.1)	10.5(11.3)	7.4(8.2)	31.5(77.4)	19.5(43.3)	14.2(26.8)
WHO South-East Asia Region mean (SD)	66.5(4.0)	70.6(3.7)	73.1(3.6)	28.8(12.7)	19.7(9.3)	14.5(6.9)	60.1(31.4)	38.0(19.2)	26.2(13.4)	296.8(214.5)	171.8(91.4)	131.7(70.8)
WHO Western Pacific mean (SD)	68.4(7.7)	71.1(7.4)	72.6(7.4)	15.8(10.7)	12.5(8.3)	10.0(6.6)	35.4(29.3)	10.5(11.3)	19.2(13.5)	165.0(212.7)	116.1(180.2)	61.7(54.1)
WHO Eastern Mediterranean mean (SD)	69.3(6.1)	72.0(5.5)	73.6(5.1)	21.1(18.4)	15.3(15.6)	13.7(13.1)	40.4(39.5)	28.2(28.2)	22.6(22.2)	203.7(388.6)	134.6(252.0)	86.9(166.2)
World mean (SD)	66.7(9.8)	70.0(8.8)	72.5(7.1)	19.8(14.9)	15.3(12.2)	12.6(10.4)	55.2(55.8)	37.5(39.4)	27.3(27.8)	276.7(396.9)	192.9(271.0)	160.8(233.5)
Minimum (Africa)	43.8	47.4	50.8	5.8	8.7	6.5	13.8	14.1	11.5	53	45	37
Maximum (Africa)	74.4	76.1	77.1	56.0	46.8	42.8	227.7	160.5	117.2	2480	1360	1150
Top 3 Africa	Algeria, Tunisia, Libya	Algeria, Libya, Tunisia	Libya, Tunisia, Algeria	Mali, Guinea-Bissau, South Sudan	Somalia, Guinea-Bissau, Central African Republic	South Sudan, Central African Republic, Lesotho	Angola, Niger, Sierra Leone	Chad, Somalia, Sierra Leone	Chad, Somalia, Nigeria	Chad, South Sudan, Sierra Leone	South Sudan, Chad, Sierra Leone	Sierra Leone, Chad, South Sudan
Bottom 3 Africa	Burundi, Zambia, Central African Republic	Lesotho, Eswatini, Central African Republic	Lesotho, Central African Republic, Somalia	Botswana, Seychelles, Mauritius	Seychelles, Mauritius, Libya	Libya, Cape Verde, Seychelles	Seychelles, Mauritius, Libya	Seychelles, Mauritius, Libya	Libya, Seychelles, Cape Verde	Seychelles, Mauritius, Egypt	Egypt, Tunisia, Libya	Egypt, Tunisia, Seychelles



3.6: CONCLUSION

Findings from this chapter reveal that overall, the African continent is experiencing signs of progress on each of the UHC indicators: service coverage, financial risk protection, and health outcomes. However, scores on these indicators remain low and, in some cases, sub-components of the indi

cators, such as the impoverishment indicator of financial risk protection, have worsened over time. Quality of care remains a key challenge that was not only highlighted by the quantitative evidence, but also by stakeholder interviews, people stories, and Commissioner engagement. The findings also re-emphasise the fact that UHC requires whole-system, rather than narrow, one-dimensional reform.



CHAPTER 4: CHALLENGES FACED BY AFRICAN COUNTRIES ON THE PATH TO UNIVERSAL HEALTH COVERAGE



We see this for instance during the COVID-19 pandemic, where concerns have been raised about the justifications for Western-style lockdowns that are not calibrated to the contextual realities of high informality, the prioritisation of advanced critical care (intensive care unit (ICU) beds and ventilators) while ignoring gaps in essential care.

4.1: INTRODUCTION

In this chapter, we address the second question posed by the Commission on the challenges that the African continent faces on the path towards UHC. It is impossible to outline and comprehensively discuss all possible challenges. Rather, we have elected to highlight what we deem to not only be the most intractable and representative, but also the most amenable to solutions. We have grouped these challenges into contextual, health system supply side, and demand side challenges, respectively.

4.2: CONTEXTUAL CHALLENGES

4.2.1: History and Path-dependence

The legacy of colonisation continues to challenge health system progress: The legacy of colonial structures continues to shape African health systems in ways that have consequences for service coverage and equity (Agyepong et al., 2017, Tumusiime et al., 2019). We highlight three such examples. First, the introduction of Western contemporary medicine in Africa during the colonial era was accompanied by a disregard for and vilification of African traditional healthcare systems (Agyepong et al. (2017). This is despite the contextual reality that traditional healthcare providers were, and still are,

typically the first point of contact for the majority of the rural and poorest populations in Africa (Kasilo et al., 2019, Nabyonga-Orem et al., 2019). This traditional health system had, and still has, extensive reach to the population and has the potential to expand equitable access to care if integrated into the formal system. Second, colonial medicine had a preference for curative, hospitalised care, over preventive and promotive care. This preference has persisted in Africa, being path-dependent on health infrastructure (investments in hospitals) and healthcare professional training foundations that were established during colonisation. Third, the hierarchical, disempowered, and under-resourced district health systems are currently functioning, as they were designed during the colonial times, to be “subordinate” to the central government, thereby limiting their potential to foster a localised, sustainable and equitable UHC (Tumusiime et al., 2019).

Neo-colonial influence of external institutions has affected Africa’s progress towards UHC: Post-colonial African health systems have been shaped by a mix of influence by international development organizations and the actions of local actors (see chapter 2). Three external influences deserve mention. First, neoliberal policies embodied in Structural Adjustment Programmes (SAPs), introduced and championed by the World Bank and the International Monetary Fund are responsible for the reduction in government spending on healthcare in the 1980s and 1990s at a time when Africa faced its greatest health challenges (HIV/AIDS, TB, malaria, etc.) and for the promotion of regressive user fees as a solution for sustainable financing. Second, the verticalisation of healthcare service delivery as a requisite for donor funding for major service areas (immunisation, HIV/TB, malaria) has introduced inefficiencies, undermined integrated financing and service delivery, and compromised a whole-system view in the health sector. Third, aid dependency disempowered African governments and compromised their agency (Omaswa and Crisp, 2014). As stated by Omaswa and Crisp (2014; page 10), “Africans went to the Bretton Woods’ institutions and to other institutions and countries begging for advice and for money and we got both, but in exchange for certain core values. Africans lost self-respect, self-confidence, and self-determination”. As a result, Africa has a mindset problem; there is a sense in which Africans have externalised problem solving and accountability for actions. Fourth, and related to the loss of self-determination and agency by African governments, international development organizations continue to influence health sector policy choices, leveraging their role as major funders of healthcare reforms (Paul et al., 2018, Gautier and Ridde, 2017).

This influence is problematic when proposed reforms are at odds with the contextual realities of African health systems. Specifically, external solutions may be incongruent with the local priorities, and with contextual capacities to effectively

deploy them. For example, health insurance (public or private) is gaining attention in Africa as a prepayment health financing mechanism and is championed by several international development organisations. However, the experience in several African countries is that these mechanisms fail to achieve scale because of the problems associated with substantial informality of African labour markets and that they are characterised by substantial inequalities (Fenny et al., 2020, Barasa et al., 2021). Another recent externally driven reform that appears to be at odds with the contextual realities of African health systems is performance-based financing (PBF). PBF has been introduced in several African countries as a payment mechanism that incentivises quality and coverage of services. However, ignorance of context (budget constraints, poorly paid health workers, significant gaps health system inputs) has led to mixed results at best and the lack of adoption and integration of PBF initiatives into the health system. It has been said, for instance, that PBF is meant to be “the cherry on the cake”, and if so, what’s the use of the cherry when there is no cake? The emasculated African often perpetrates these context-inappropriate solutions. We see this for instance during the COVID-19 pandemic, where concerns have been raised about the justifications for Western-style lockdowns that are not calibrated to the contextual realities of high informality, the prioritisation of advanced critical care (intensive care unit (ICU) beds and ventilators) while ignoring gaps in essential care (e.g., oxygen availability), and the prioritisation of supplies of hand sanitisers while paying little attention to investments in clean running water and soap given the reality of serious gaps in access to clean water in Africa and the cost-effectiveness of sanitation (Kelley et al., 2020, Barasa et al., 2020, Baker et al., 2020).

4.2.2: Economic Challenges

The ability of African countries to mobilise resources for the health sector is affected by inadequate economic performance, and attendant high levels of poverty and informality: The African continent has a mean GDP per capita of US\$2,794, ranging from US\$261 in Burundi to US\$17,448 in Seychelles (World Bank, 2021c). Twenty five (46%) African countries are classified as low income, 21 (39%) as lower middle income, six (11%) as upper middle income and only two (4%) as high-income countries (World Bank, 2020b). 34% of the continent’s population lives below the international poverty line (World Health Organization, 2021b), 9.1% are unemployed (World Bank, 2021d), and about 89% of available jobs are in the informal sector (Bonnet et al., 2019). All these factors combine to constrain the fiscal space for health in Africa, and the feasibility of mobilising additional resources for health.

Underdeveloped manufacturing sector: The COVID-19 pandemic exposed Africa’s inadequate capabilities to manufacture and supply essential drugs and personal



protective equipment needed to curb the disease. While some countries, such as Kenya, South Africa, Egypt and Morocco have capacity to manufacture pharmaceutical products, Africa is said to import more than 80% of its pharmaceutical and medical consumables (African Union, 2012). Across the 54 African countries, only 4 countries (South Africa, Senegal, Tunisia, and Egypt) have set up local vaccine manufacturing plants, and out of this, perhaps only Senegal manufactures a WHO-approved vaccine (UNIDO et al., 2017). As a result, Africa imports 99% of its human vaccines. The vaccine nationalism witnessed during the COVID-19 pandemic (Beaton et al., 2021) has highlighted the vulnerability that results in overreliance on importations and underlined the need for the African continent to prioritise the development of local continental manufacturing capacity for vaccines (Bright et al., 2021). Countries with local manufacturing capacity for vaccines have prioritised domestic needs with the result that Africa has been late in initiating COVID-19 vaccination and lags in scaling up coverage with this essential vaccine. Africa faced similar challenges with supply of personal protective equipment and COVID-19 testing laboratory reagents. The continent has an underdeveloped manufacturing sector (Signé, 2018). This has been attributed to several reasons and we highlight a few here. First, infrastructural gaps in the energy sector lead to high energy costs (Signé, 2018). Similarly, capitalisation of regional economies at scale continues to be hindered by weak transport networks across African countries. Second, underinvestment in skills development has led to a shortage of qualified workers in the local labour market (Signé, 2018). Third, African countries have chronically underinvested in research and development, which forms the foundation of industrialisation. Fourth, intellectual property protection has created a barrier to local manufacturing of patented essential health commodities (pharmaceuticals, vaccines, etc.). Fifth, market fragmentation and the attendant trade and non-trade barriers have disincentivised investments in local manufacturing on the continent since individual country markets are often too small to justify massive investment in manufacturing. Sixth, African countries often have policies that are not supportive of local manufacturing, combined with weak regulatory frameworks. Seventh, corruption that leads to burdensome port and tax burdens continues to contribute to high direct and indirect costs of international trade in Africa.

4.2.3: Instability and Fragility

Political instability and wars continue to directly disrupt healthcare services, and indirectly affect health systems by disrupting economic activities: 20 out of 54 African countries are classified as fragile (World Bank, 2021d). Political instability and wars disrupt healthcare service delivery and slow any progress in financing, coverage, and outcomes. For example, in the Democratic Republic of Congo, Central African Republic and Somalia, healthcare provision has been greatly affected by “overt and endemic” armed violence (Pavignani et al., 2013). It is no wonder, then, that politically unstable countries feature prominently among the African countries with low UHC scores in the previous chapter.

4.2.4: Demographic Challenges

A high fertility rate and young population yields a high dependency ratio that strains health system resources in Africa: The average fertility rate in Africa is 4.7 births per woman, ranging from 1.4 in Mauritius to 6.9 in Niger (World Bank, 2021a). This results in a high dependency ratio that places a resource strain on Africa's health systems (World Bank Group, 2016, United Nations, 2019b). Pressures on the health system are likely to increase in the future as it has been projected that even with anticipated reductions in fertility rate, sub-Saharan African countries could account for more than 50% of the growth of the world's population (i.e. an increase of about 1.05 billion people) between 2019 and 2050, and the population growth is expected to continue through the end of the century (United Nations, 2019b).

Rising and unplanned urbanisation has added more pressure on the under-resourced health systems: In Africa, the proportion of people living in urban areas rose from about 35% in 2000 to almost 45% in 2018, and the number is expected to increase to almost 60% by 2050 (United Nations, 2019c). The rapid and unplanned urbanisation has resulted in, among other things, a high number of slum dwellers, increased environmental pollution, inadequate public transportation, and poor water supply and sanitation, which are all associated with increased morbidity and premature death.

4.2.5: Climate Change

Climate change poses a threat to population health and is expected to result in further strain on the already under-resourced African health systems: Africa is most vulnerable to the impacts of climate change due to its low adaptive capacity to respond economically, politically and geographically (NEPAD, 2017). Climate change poses both direct and indirect threats (United Nations, 2015). For example, studies done in Botswana have shown associations between higher temperatures and increased mortality especially among the under-five (Agyepong et al., 2017). Indirectly, climate change has been linked to increased morbidity and mortality through epidemiological transitions (Ota et al., 2018, Ibeneme et al., 2020, Agyepong et al., 2017), and the emergence of hostile environmental conditions, such as the 2010-2011 famine in Somalia, which led to roughly 250,000 deaths especially among under-five children (Agyepong et al., 2017).

4.3: HEALTH SYSTEM SUPPLY-SIDE CHALLENGES

4.3.1: Inadequate and Poorly Managed Health Sector Resources

African health systems are underfunded: The mean public expenditure on health as a share of country GDP in Africa is 2%, ranging from 0.2% in Cameroon to 5.4% in Lesotho. This level of public spending is less than half of the 5% level that has been recommended as the minimal required by LMICs

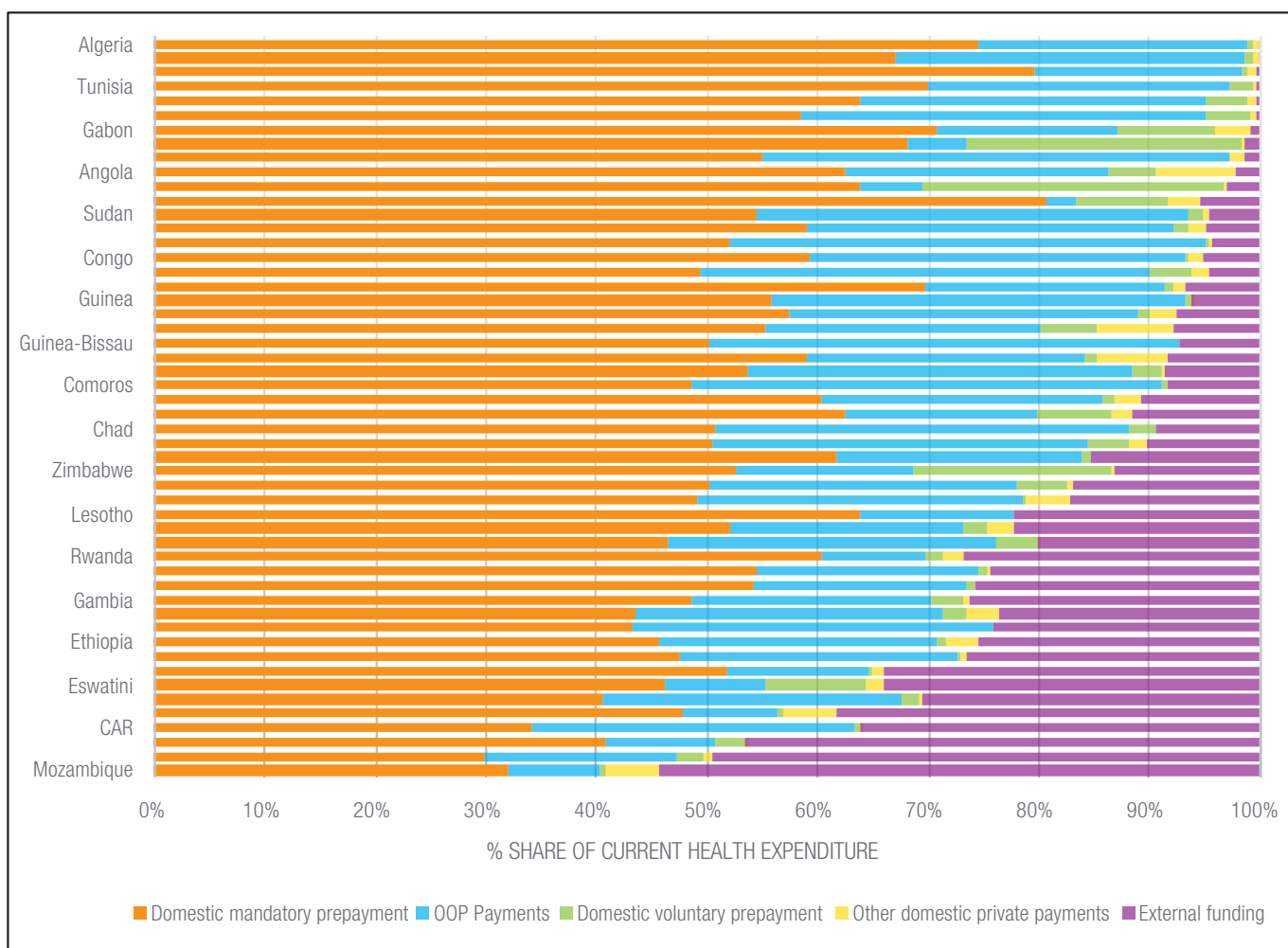
to improve health outcomes and financial risk protection (Mcintyre et al., 2017). As a result, Africa's health systems are characterised by chronic underfunding (Foyeth, 2015). Further, the mean current health expenditure (CHE) per capita was US\$133 in Africa in 2018, ranging from US\$19 in the Democratic Republic of Congo to US\$833 in Seychelles, which is much lower than the global average (US\$1138) and the lowest across the six WHO world regions. 83% of African countries spend below the recommended US\$86 per capita which is estimated to be the minimal required to deliver a basic package of care (Mcintyre et al., 2017).

In addition to fiscal constraints occasioned by multiple factors and structural challenges such as weak public finance management systems, a key challenge that African countries face is the place and prioritisation of the health sector in development. There is a sense in which the health sector has found it difficult to shed the tag of being a cost centre, rather than an investment centre that yields direct and indirect economic returns to countries.

Health systems continue to rely on out-of-pocket payments: The mean of out-of-pocket payments as a share of current health expenditure (38%) is high, ranging from 3.3% in Botswana to 76.6% in Nigeria. It is no wonder then, that many African countries experience high levels of catastrophic healthcare payments and impoverishment as shown in the previous chapter.

Reliance on donor funding, and the threat of donor transition: There is considerable variation in the extent to which different African countries rely on external funding for health services; the share of external funding for health in current health spending ranged from less than 1% (in Algeria, Morocco, Seychelles, Tunisia, Mauritius and Egypt) to 62.9% (in Mozambique), with 50% of African countries obtaining more than 15% of their current health spending from external sources. Even where external funding is not the major source of current healthcare financing in an individual country, such funding may dominate specific healthcare programs. For example, about 85% of HIV/AIDS activities in Kenya in 2005/2006 were funded by donors. Reliance on external funding in sub-Saharan Africa has increased significantly over the past one-and-a-half decades (Figure 4:1). Such reliance is understandable as some sub-Saharan African countries lack adequate domestic funds to meet even the basic health service needs of their populations. However, there are concerns about whether increased donor funding is effective in improving health services in the recipient countries (Foyeth, 2015, Mao et al., 2020). This is related to the potential "fungibility" of donor funding, whereby a recipient government offsets increased donor funding for the health sector by reducing its allocations from domestic tax revenue to the health sector, thereby making donor funding a substitute for, instead of a supplement to, domestic funding of health services.

Figure 4-1: Distribution of health financing across source in Africa (2018) Source: [Global Health Expenditure Database \(who.int\)](https://data.who.int/global-health-expenditure-database/)



The problem of reliance on donor funding is worsened by the planned donor transition as countries graduate from low income to middle income status. Reductions in donor funding in a context of constrained fiscal space and no clear alternative financing plans threatens to erode the gains made by African countries on key health outcomes including HIV/AIDS, TB, malaria, and childhood immunisations.

Fragmented health financing pools: Most African health systems are financed from multiple separate pools (e.g., government tax pool; donor pool such as global fund for HIV, TB and malaria; national health insurance pool; multiple private and community-based health insurance pools) with different management structures and lack of, or poor, coordination (Saleh et al., 2014, Marten et al., 2014). This results in inequitable access to healthcare, inefficiencies, and concerns about financial sustainability of UHC reforms due to reduced cross-subsidisation of income (rich to poor) and risks (healthy to sick) across populations, which is key to equitable and sustainable financing of UHC.

Inefficiency in the use of healthcare resources: Against a background of constrained fiscal space for health, it is im-

perative that available resources are used efficiently. Evidence shows that there is substantial wastage of healthcare resources in Africa. An assessment of the country efficiency in delivering UHC reported a mean technical efficiency score of 76% for Africa, implying a 24% wastage of available health system resources (Jordi et al., 2020).

Shortage of skilled health workers: Despite bearing 25% of the global disease burden, sub-Saharan Africa only had 3% of health workers globally (Dalton, 2014). Many African countries are yet to achieve the 23/10,000 (number of health workers per population count) threshold target recommended by the WHO. For instance, the mean density of doctors is lower (4.8/10,000) compared to the mean for nurses and midwives density (13.9/10,000) (Table 4:1). Moreover, while the mean density for nurses and midwives ranged from 1.1/10,000 in Somalia to 81/10,000 in Seychelles, more than half (68%) of the countries have nurses and midwives density below the mean. It is also telling that the mean density of health workers for both cadres is way below the global levels (Table 4:1).

Table 4:1: Health workforce density in Africa by health worker cadre

	Doctor density/10,000 (2010-2018)	Nurses and midwives density/10,000 (2010-2018)
Number of countries	53	53
Mean for Africa (SD)	4.8 (10)	13.9(14.8)
Mean for World (SD)	19.2(18.5)	42.7(41.7)
Minimum	0.1	1.1
Maximum	65.3	80.8
Top 3	Seychelles, Botswana, Ghana	Seychelles, Botswana, Ghana
Bottom 3	Somalia, Guinea, Madagascar	Somalia, Guinea, Madagascar

Source: [UHC Data Portal - UHC2030](#)

Factors that explain this include: 1) limited investments in training, leading to a supply that does not meet the needs; 2) poor retention of health workers within the public system, and the country more broadly (brain drain); and 3) maldistribution (e.g., over 90% of dentists and pharmacists practice in urban regions); 4) low motivation and poor human resource management manifested as staff absenteeism ranging from 20% (in Senegal) to almost 50% (in Uganda) (World Bank Group, 2016). We are, however, concerned that the existing data and indicators used to monitor human resources for health do not comprehensively capture the diverse range of healthcare professionals in African health systems. It is imperative that these indicators are updated to adequately

capture the diversity and range of health workers in African health systems.

Weak health infrastructure: There are stark health infrastructure disparities at the sub-national levels in many African countries. For example, a study that assessed availability of services (defined as the number of hospitals per 500,000 population) in sub-Saharan Africa found that while most countries (90%) attained the service availability targets at the national level, more than half (58%) of sub-Saharan African countries did not meet the availability targets at the province level and 95% did not meet them at the district level (Figure 4:2) (Wigley et al., 2020).

Figure 4:2: Maps showing where the service availability targets have been met, at i) national, ii) province, and iii) district levels. Source: Wigley et al. 2020. Notes: Regions shaded in grey were not included.

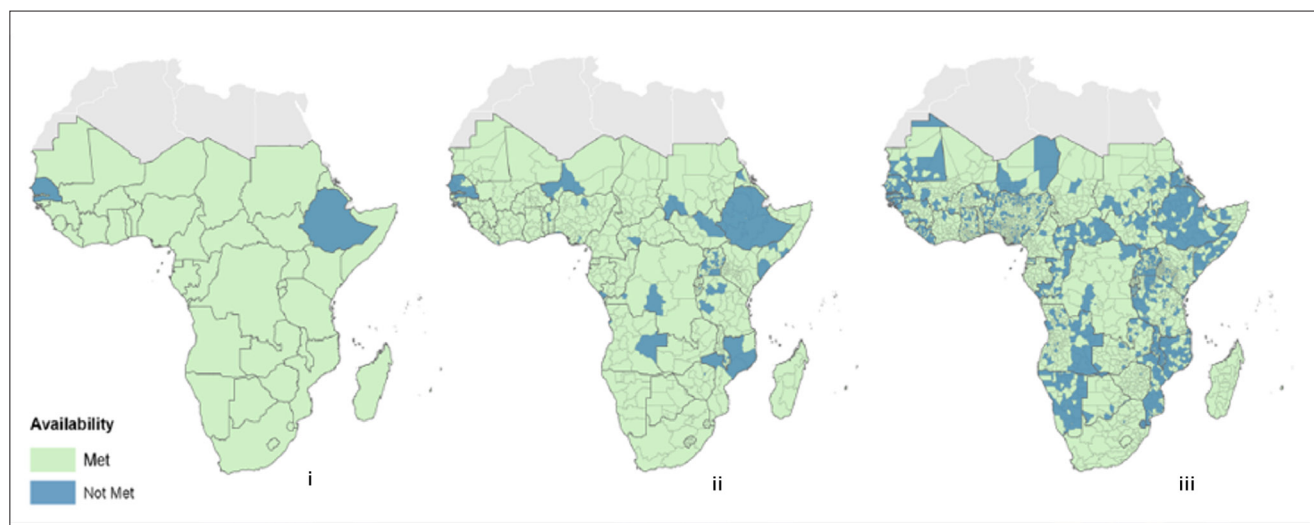
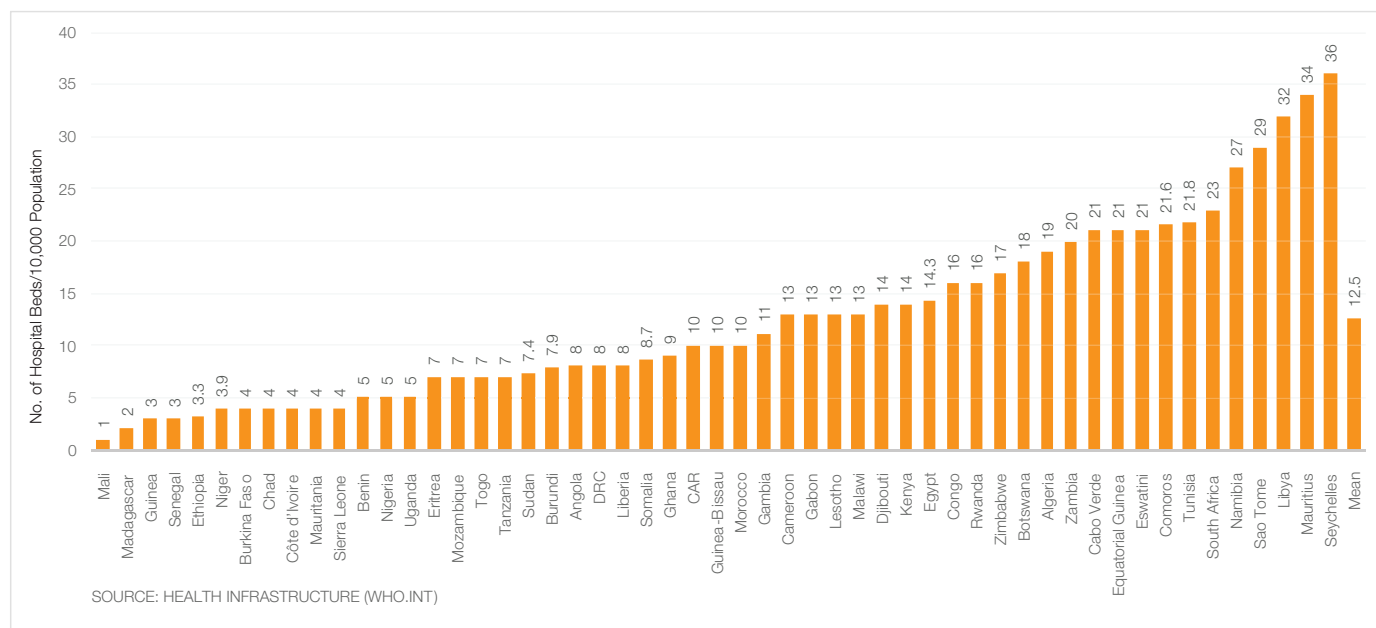


Figure 4:3 further shows the infrastructural gaps in Africa's health system. The mean hospital bed density per 10,000 population count is 12.4, ranging from 1 in Mali to 36 in Seychelles. More than half of the countries (55%) had hospital bed density below the mean. In addition, the mean hospital bed density in Africa is way below the global mean (28 beds per 10,000 population) and is the lowest of the six WHO world regions.

Africa's infrastructural weaknesses were exposed during the COVID-19 pandemic. For example, at the start of the COVID-19 pandemic in 2020, Uganda, Rwanda, and Tanzania were estimated to have 55 (for a population of 40 million people), 50 (for a population of 12 million people), and 38 (for a population of 58 million people) functional ICU beds, respectively (Asiimwe and Kache, 2020), which is vastly insufficient.

Figure 4:3: Hospital bed density in Africa



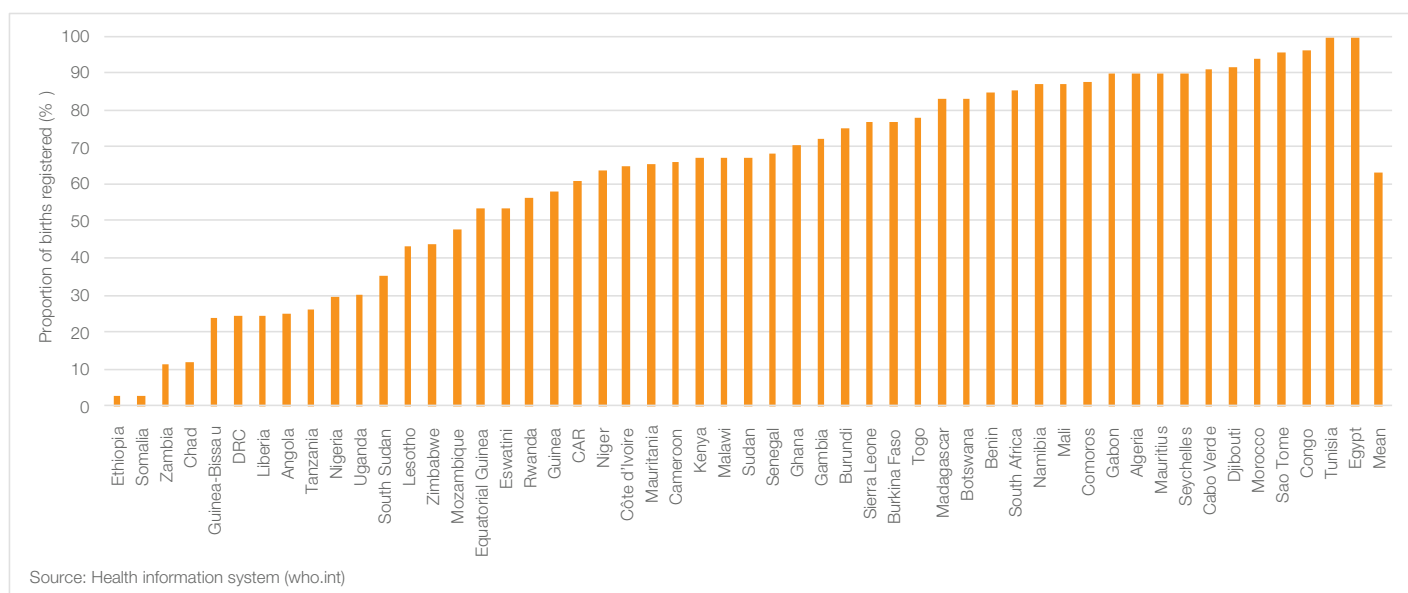
Notes: CAR – Central African Republic; DRC – Democratic Republic of Congo

Weak and fragmented health information systems: Although progress has been made over time, the routine health information systems of many African countries are still at nascent stages of development and are not yet reliable enough to inform service delivery decision making (World Health Organization, 2021c). For example, on average, only 62% of births are registered in Africa, ranging from 3% in Ethiopia to 99% in Egypt (World Health Organization, 2021a) (Figure 4:4). This weakness in information systems has also been demonstrated by the COVID-19 pandemic during which there remain gaps in documentation of deaths and cause of deaths to aid in quantifying

the true extent of the pandemic's impact on the continent.

Further, fragmentation of health information systems is manifested in a multiplicity of health information tools and systems, lack of Ministry of Health (MoH) institutionalised data collecting and sharing procedures, and poor quality of data. For example, in Mozambique, each non-governmental organisation funded by PEPFAR fed into a global PEPFAR database through their own parallel data collection system, using separate forms, data entry, data transfer systems, and analysis (Pfeiffer and Chapman, 2019).

Figure 4.4: Civil registration of births in Africa



Notes: CAR – Central African Republic; DRC – Democratic Republic of Congo

4.3.2: Governance and Accountability of Health Systems

Inadequate legal and policy frameworks for UHC: The stewardship role of government on UHC on the African continent has been called into question. Governments are supposed to play a critical role in demonstrating commitment, leading the agenda, and putting in place a policy and regulatory framework for UHC. However, only 7.4% (n=4) of African countries (Algeria, Congo, Gambia and Botswana) have made legislation on UHC compared with 37.6% (n=73) in the rest of the world (UHC 2030, 2020). There is also limited awareness of existence of specific national law or policy on UHC in African countries (UHC 2030, 2020).

Weak management of the political dynamics of UHC reforms: UHC reforms in Africa are replete with examples of internal and external stakeholders with varying interests exerting their power to influence specific reforms. This has either slowed down the progress of reforms or affected the nature and outcomes of reforms. For instance, while South Africa's National Health Insurance (NHI) reforms were first proposed in 2007 as part of an election manifesto by the African National Congress, political dynamics and opposition by key interest groups have stalled progress and it was not until 2011 that a Green Paper outlining proposals for a single-payer NHI was published by the South African government and piloting began in 11 districts across all the nine provinces (Matsoso and Fryatt, 2013, Schaay et al., 2011, van den Heever, 2016). Kenya has failed to develop a health financing strategy despite several attempts since 1989 because of non-

alignment between key actors that include the private sector, the trade unions, international development organisations, and national and local level bureaucrats.

Poor leadership and management of the health sector: Poor leadership and stewardship have been highlighted as a stumbling block to UHC progress in Africa. Some specific gaps in health sector leadership that have been highlighted relate to: 1) proactive systems thinking (Agyepong et al., 2017, Tumusiime et al., 2019); 2) creativity and innovation (Agyepong et al., 2017, Tumusiime et al., 2019); 3) "soft skills" such as investing in, and managing, behaviours and relations (Agyepong et al., 2017, Tumusiime et al., 2019, Omaswa and Boufford, 2010a); and 4) use of data to inform decision making and to monitor and evaluate performance (Agyepong et al., 2017). This weakness in leadership has been attributed to: 1) a lack of institutionalised strategies for leadership capacity building (Agyepong et al., 2017, Chigudu et al., 2018, Kwamie et al., 2016, Foster et al., 2018); 2) selection and training of leadership that is focused on technical competence rather than on soft skills (Agyepong et al., 2017); 3) weak capacity to hold leaders accountable for their (in)actions and health systems performance (Agyepong et al., 2017); and 4) bureaucratic processes and procedures that stifle learning, creativity and innovativeness by health managers particularly at the district and local government levels (Tumusiime et al., 2019, Chigudu et al., 2018).

Weak multi-sectoral coordination: Africa's pressing health chal-



The private sector plays key roles in, among others, procurement and distribution of essential health commodities, and in the delivery of healthcare services in Africa. A weak policy and regulatory environment, and poor coordination between the public and private sector have hampered the extent to which African health systems can leverage the capacity available in the private sector.

allenges require effective multisectoral action (Oni et al., 2019, Ota et al., 2018, Sanders et al., 2019, Tumusiime et al., 2020, Olu et al., 2019, Agyepong et al., 2017, World Bank Group, 2016). However, multisectoral approaches in Africa are weak, curtailing efforts to, for instance, respond to health emergencies, and prevent and control communicable and non-communicable diseases. The inadequacy in multisectoral approaches is occasioned by, among others, weak leadership and governance structures, and capacity challenges. Government ministries are highly hierarchical, emphasise vertical authority, and have poorly developed structures and incentives for horizontal communication across ministries (Tumusiime et al., 2020, Ota et al., 2018, Nabyonga-Orem, 2017).

Poor public-private coordination: The private sector plays key roles in, among others, procurement and distribution of essential health commodities, and in the delivery of healthcare services in Africa. A weak policy and regulatory environment, and poor coordination between the public and private sector have hampered the extent to which African health systems can leverage the capacity available in the private sector (Nabyonga-Orem et al., 2019, Olu et al., 2019, Rao et al., 2018, Maluka et al., 2018, Chirwa et al., 2013). Poor coordination has also led to incoherence of public and private sector approaches, sometimes at the expense of the public good. Examples include fragmentation of health financing pooling arrangements because of poorly regulated health insurance markets.

Under-prioritisation of primary healthcare: African countries have typically prioritised tertiary and secondary, often hospital-based care, at the expense of primary healthcare (Fusheini and Eyles, 2016, Mbogo and McGill, 2016). This not only limits geographical access and coverage, but also compromises the efficiency and equity of African health systems since primary healthcare is more affordable and cost-effective and its local delivery avenues are better positioned to serve those who are worse off in society.

The scourge of corruption: High levels of corruption continue to result in substantial wastage of resources that are much needed by the African health systems sector (Uzochukwu et al., 2018). A culture of corruption also presents barriers to accessing healthcare. For example, it is estimated that the paying of bribes in order to access healthcare services in Africa is associated with a four-fold increase in difficulties to access healthcare services (Hsiao et al., 2019). According to the latest estimates from the UHC 2030 portal, Africa's mean corruption perception index is 32.5, ranging from 9 in Somalia to 66 in Seychelles, compared to the global mean index of 43 (a low (high) score means that a country's public sector is perceived as highly (less) corrupt) (UHC 2030, 2021). A good example of the consequences of corruption in the health sector is the corruption in the procurement of COVID-19 supplies that has worsened the unavailability of personal protective equipment for healthcare workers in Kenya (Chesoli and Kimosop, 2020) and South Africa (de Villiers et al., 2020).

Inadequate community engagement and accountability systems: People stories identified challenges in community engagement by the health system. It is instructive that this challenge was highlighted by people stories rather than by interviews with health system stakeholders. Several submitted stories identified poor communication to the public about UHC reforms and policy as a key challenge that has contributed to reduced demand for healthcare. Submitted stories also highlighted that the channels available for the public to give feedback to the system on their experiences and expectations were inadequate.

Discrimination and prejudice: Some of the people stories submitted to the Commission highlighted the prejudice and stigma that individuals face. This discrimination can be based on age and gender: young women are denied access to reproductive health services, including family planning because prevailing gender norms are at odds with a young woman being sexually active (Box 5). The discrimination can also be based on stigma attached to disease: individuals denied reproductive health services because they are living with HIV/AIDs and hence are not expected to be sexually active. Stories also highlighted discrimination on the basis of sexual orientation because prevailing social norms do not consider LGBTQ persons "normal" (Box 4).

Box 4: Stories from the Frontline

Worse than pigs and dogs!

Story submitted from Zimbabwe

I am tired of telling sad stories, but really that is what almost everything about my life has been, sadness, gripping sadness, a sadness that envelopes you like the shroud of death. I could never say it with the sauce and unmasked hate that our former Zimbabwean President said it! But, I'll try, arhem, "We are not gays." It was during the burial of a national hero back home, and what brought more tears to my eyes, and I believe a 1000 more like me, was the President declaring on national TV, "Gays are worse than pigs". So, whenever everyone speaks of free access of universal health coverage, I struggle to break off the shackles of oppression. I am sick, probably dying but I cannot dream of setting foot in a public hospital. Really, I'd rather die at home. There is no way I can bear that nasty, disgusted expression on the nurse's face each time I tell her I am gay. Man, I am tired of being a crime, of being told it's my fault, or that I have syphilis, and of doctors and nurses and other healthcare workers telling me I am a disease vendor.



4.4: HEALTH SYSTEM DEMAND-SIDE CHALLENGES

4.4.1: High Disease Burden

Africa's high burden of disease hampers efforts to achieve UHC: Sub-Saharan African countries have made notable progress in containing the burden from major infectious diseases like HIV/AIDS, tuberculosis (TB) and malaria over the years. For instance, the number of TB deaths reduced to 1.8 million deaths in 2019 from a high of 2.1 million in 2003 (World Health Organization, 2019a). Also, a 22% reduction in malaria incidence, that is, from 294/1000 to 229/1000, has been recorded between 2010 to 2018 (World Health Organization, 2019c). Nevertheless, compared to other world regions, the African region still bears a disproportionate burden of HIV, malaria and TB. For instance, out of the 1.7 million new HIV infections reported globally in 2019, more than half (57%) of these new infections occurred in Sub-Saharan African countries (UNAIDS, 2020). Also, in the wake of diminishing donor funding and emerging epidemics such as the COVID-19 pandemic that disrupted service delivery due to lockdowns and other restrictions, prog-

ress is fragile, and additional concerted efforts are required if critical global targets set for these conditions are to be met (Saleh et al., 2018, Rogerson et al., 2020, Weiss et al., 2021).

The emergence of non-communicable disease presents a double challenge: Africa is experiencing an epidemiological transition characterised by a surge in non-communicable diseases (NCDs). For example, whereas in 2000, NCDs contributed to 18% of the total Disability Adjusted Life Years (DALYs) in Africa, in 2015, they contributed 28% of DALYs (Ota et al., 2018). It has been estimated that NCDs will be responsible for about 5 million deaths by 2030 (Ota et al., 2018).

Recurrent disease outbreaks and epidemics have direct and indirect impacts on health systems: It has been estimated that annually in Africa, there are over 100 infectious disease outbreaks resulting in high disability, morbidity, mortality and economic losses (Olu et al., 2019). For example, the 2014-2016 Ebola outbreak in West Africa infected nearly 30,000 and killed over 11,000 individuals in the three most affected countries (Guinea, Liberia, and Sierra Leone) (Kamorudeen et al., 2020).

Box 5: Stories from the Frontline

Nurses who shout

Story submitted from Malawi

One day I went to a health facility to collect my antiretroviral therapy (ART) and the emergency pill. I met a 75-year-old nurse who was there to assist me. When she was about to hand me my pills, I asked for condoms and pregnancy pills. She looked at me and asked for my age and I told her, "I am just 19". She started shouting at me. I told her I still need the condoms and pregnancy emergency pill. She then told me they don't have condoms and emergency pills in stock. Let's think about an adolescent girl living with HIV and pregnant. The stigma and challenges are just too much.



More recently, in Africa, the COVID-19 pandemic has infected over 4 million individuals and resulted in over 100,000 deaths one year after the introduction of the virus on the continent. The ongoing COVID-19 pandemic has resulted in about 1.4 million children missing their Bacillus Calmette–Guérin vaccine (BCG) vaccine, and a further 1.3 million missing their first measles dose between January and August 2020 (Tumusiime et al., 2020).

4.4.2: Low Sense of Ownership and Trust in the Health System

A sense of ownership and trust in the health system is crucial as the mere presence of the health services does not necessarily translate into their acceptability and use by the community: This is evident within the context of the COVID-19 pandemic where inadequate trust in the safety of COVID-19 vaccines and the intentions of government and external actors is threatening the success of the vaccine roll-out (Vergara et al., 2021, Bhopal and Nielsen, 2021, Verger and Dubé, 2020). Lack of trust in the health system by communities in Africa has contributed to reduced community cooperation in preventive and promotive services; increased use of informal care; and in extreme situations,

attacks on the health system (Woskie and Fallah, 2019). Distrust in the health system is strongly associated with perceptions of persistently poor health sector performance (i.e. poor quality of services and poor health infrastructure) (Woskie and Fallah, 2019), as well as, broader contextual issues such as a history of civil war and weak state capacity, creating perceptions of neglect by the government and outside world (Woskie and Fallah, 2019, Nature, 2019).

4.4.3: Societal Norms and Beliefs

Certain societal norms and beliefs continue to affect access to healthcare in Africa especially for specific population groups.- For instance, norms that require women to get permission from men to seek healthcare services (Paul et al., 2020), and the stigma and prejudice that hinder unmarried women to seek reproductive health and maternal healthcare (Foster et al., 2018) affect access to care by girls and women. Box 6 shares a story that highlights the consequences of norms that prohibit one gender to be attended to by a healthcare worker of another gender.


Box 6: Stories from the Frontline

UHC in Northern Nigeria: Increasing rural women's access to education and health

Dr. Adetoro Adegoke

For a pregnant woman or newborn, rural communities in Northern Nigeria are among the most dangerous places to live in sub-Saharan Africa. Women face a one-in-nine lifetime risk of dying during pregnancy or in childbirth. Not only does the region have an acute shortage of trained health workers, but social norms mean that women are often not allowed to be attended by men and cannot train as health-workers. These challenges stand in the way of Nigeria's efforts to achieve Universal Health Coverage (UHC).

Hauwa, a woman from Katsina state, suffered the consequences of this situation. She started bleeding when pregnant and needed to be checked by a trained health worker. The community's only one was a man and Hauwa's husband refused to allow her to see him. Eventually, Hauwa was taken to the hospital, but she lost her baby. Her husband later divorced her because she was cared for by a man.

 Health workers are one of the WHO's six essential building blocks for a functioning health system – and are crucial to delivering UHC. W4H has enabled Northern Nigeria to make significant progress towards UHC, contributing to its achieving nine of the 13 milestones of the WHO's Global Strategy on Human Resources for Health. | **Dr. Adetoro Adegoke**

Hauwa's experiences made her want to become a midwife and help women receive appropriate, timely care in their own community. But as a rural woman without the necessary education, finances and support, Hauwa's chances of becoming a trained midwife were almost non-existent.

It was to help women like Hauwa that the Women for Health



(W4H) programme was launched in 2012. Funded by UK-Aid and delivered by DAI Global Health, the programme transformed the supply of female health workers to rural communities in six states in Northern Nigeria. The programme worked with nearly 1,000 communities to change social norms so rural women could go away to study as nurses and midwives and return to serve their people.

Hauwa was one of these – a beneficiary of the Foundation Year Programme (FYP) established to help rural women make up gaps in their education. By October 2020, when the programme ended, some 2,801 rural women had been recruited of which 556 had so far graduated as qualified professionals. Training colleges in the region are today transformed – their capacity to produce health workers has more than doubled, and women now make up around 60% of the students in many colleges.

Health workers are one of the WHO's six essential building blocks for a functioning health system – and are crucial to delivering UHC. W4H has enabled Northern Nigeria to make significant progress towards UHC, contributing to its achieving nine of the 13 milestones of the WHO's Global Strategy on Human Resources for Health. State governments have taken over funding and governance of all the programme's activities – and six neighbouring states are establishing their own FYP. The national regulator for nursing and midwifery training is scaling up elements of the programme across the whole of Nigeria. A Human Resources for Health Centre of Excellence has been set up to share learning and support scaling up. W4H leaves a sustainable legacy and marks significant progress towards UHC for underserved communities in Northern Nigeria.



4.5: CONCLUSION

While African countries have made a commitment to achieve UHC, it is apparent that this commitment faces substantial challenges. These challenges reside within the broader context as well as within the health sector. Some of these challenges relate to legacies of the past (colonialism and neo-colonialism), some to current challenges (e.g. size and structure of African economies, health sector resource

constraints, poor governance, and a high disease burden), and some to emerging and future challenges (e.g., population growth, climate change, and the emerging burden of non-communicable diseases). However, it is not all doom and gloom; the African continent is endowed with immense opportunities that may be leveraged to surmount some of these challenges and accelerate progress towards UHC. This is the subject of the next chapter.



CHAPTER 5: OPPORTUNITIES THAT AFRICAN COUNTRIES SHOULD LEVERAGE TO ACCELERATE PROGRESS TOWARDS UNIVERSAL HEALTH COVERAGE

5.1: INTRODUCTION

The road to UHC for African countries is not only paved with challenges, but also with opportunities. The African continent is endowed with current and emerging opportunities that could be leveraged to overcome some of the challenges and accelerate the continent's progress towards UHC. In this chapter, we highlight these opportunities and call on African countries to seize them.

5.2 MAPPED OPPORTUNITIES


5.2.1: Economic Growth and Development

Africa has registered positive and strong economic growth recently, except for the disruption occasioned by COVID-19. For instance, Africa's real GDP growth rose from 2% in 2016 to 3.5% in 2019 thanks to increased investments and net exports (African Development Bank, 2020). Further, despite the impact of the COVID-19 pandemic, the economic growth in Africa is expected to resume at an average rate of about 3% in 2021-2022

(World Bank, 2021b). A growing economy presents immense opportunities for the health sector by expanding the fiscal space for health and improving the social determinants of health (e.g., employment, education, and poverty).

5.2.2: Strong Regional Organisations

Africa has several regional organisations that include the African Union (AU), the Africa Centres for Disease Control and Prevention (Africa CDC), and the WHO's Regional Office for Africa (WHO AFRO). The organisations have immense convening power, technical capacity, and capacity for advocacy. The Organization of African Unity (OAU) has transformed into the African Union, which is pro-people, embraces civil society and has zero tolerance for illegitimate governments; it is promoting an African renaissance with pride in African values to reset the mindset needed to achieve UHC. The AU, the WHO AFRO and other members of the UN family that have strong convening, advocacy, and resource mobilisation capacities could be leveraged to provide leadership, governance, political advocacy, technical



Recent and projected reductions in the fertility rate in Sub-Saharan Africa means that the working age population is growing at a faster rate than other age groups. This will create an opportunity for accelerated economic growth referred to as demographic dividend thanks to, for example, an increase in the working age population (those 25 to 64 years of age) relative to the non-working age, thereby creating a lower dependency ratio.

support and resource mobilisation for UHC. Africa could leverage these regional organizations to advocate for UHC, provide policy leadership, facilitate country capacity development, and mobilise resources for UHC. For instance, we have seen this happen during the COVID-19 pandemic where the AU has mobilised resources and developed a pooled procurement mechanism for vaccines, diagnostics and personal protective equipment.

5.2.3: Regional Integration

Africa has several regional integration and cooperation initiatives, but the most ambitious and extensive one is the Africa Continental Free Trade Area (AfCFTA). AfCFTA is a regional agreement that aims to eliminate trade barriers (such as import quotas and tariffs) between the 54 African countries, and allow free movement of people, goods and services across the African countries. AfCFTA has established the largest free trade area in the world by the number of participating countries and will create a market with 1.3 billion people across 54 countries in Africa (World Bank, 2020a). AfCFTA presents a huge opportunity for the health sector that could be leveraged to promote UHC (Awowusi, 2019). For instance, AfCFTA is said to have the potential to boost economic growth across Africa and elevate over 100 million Africans out of poverty, thanks to, for example, increased employment opportunities and income levels for unskilled labour (World Bank, 2020a). These will have knock-on effects on the health sector by improving the fiscal space for health and addressing social determinants of health. The huge market created by AfCFTA is also likely to attract investments in Africa including in the health sector and improve efficiencies of intra-Africa trade in ways that will benefit the health sector.

5.2.4: Vast Network of Traditional Health Systems

Africa boasts a vast network of African traditional providers that are an important part of the African culture and that are locally recognised and accepted (Kasilo et al., 2019). In Sub-Saharan Africa, the average ratios of traditional health providers and medical doctors per population are 1:500 and 1:40 000 respectively (Kasilo et al., 2019). Thus, it is perhaps not surprising that they are usually the first point of contact for majority of the rural and poorest population in Africa (Kasilo et al., 2019, Nabyonga-Orem et al., 2019). However, this vast network of traditional healthcare providers is currently not being utilised as part of the UHC reforms in most African countries. Given the acute shortage of health workers and facilities particularly in rural and remote areas, this vast network of African traditional healthcare providers offers an opportunity to enhance access to primary healthcare services especially preventive and promotive care. This can be achieved through the inclusion of well-trained and regulated African traditional providers (such as traditional midwives) into the PHC system as part of the efforts towards achieving UHC (Kasilo et al., 2019).

5.2.5: Political Commitments to UHC

The endorsement of UHC at the global, regional, and country level presents several opportunities for African countries. This political commitment can be leveraged to mobilise additional resources for UHC as well as mobilise support for comprehensive health system reforms.

5.2.6: Demographic Dividend

Recent and projected reductions in the fertility rate in Sub-Saharan Africa means that the working age population is growing at a faster rate than other age groups. This will create an opportunity for accelerated economic growth referred to as demographic dividend thanks to, for example, an increase in the working age population (those 25 to 64 years of age) relative to the non-working age, thereby creating a lower dependency ratio (United Nations, 2019a). In addition, in 2019, sub-Saharan Africa had the third-largest number of youth population (between 15 and 24 years of age) at 221

million compared to central and southern Asia at 361 million and eastern and southeastern Asia at 307 million (United Nations, 2019a). However, sub-Saharan Africa is expected to experience an increase of 89% in youth population, which is the largest globally (United Nations, 2019a). To take advantage of the demographic dividend including the young population, African governments need to invest more in human capital by ensuring that everyone has access to healthcare (through, for example, investing more in health systems including UHC-related reforms) and education, and creating opportunities for employment.

5.2.7: Well-developed Private Sector

Africa's health systems have a well-developed and vibrant private sector. African governments can take advantage of this through effective, well-managed and regulated partnerships (Abiuro et al., 2014, Blecher et al., 2016, Michel et al., 2020, Rao et al., 2018, World Bank Group, 2016, Ssenyonjo et al., 2018, Maluka et al., 2018, Chirwa et al., 2013). Forging partnerships with private organisations (non-healthcare providers) has proven useful in terms of providing resource support and/or innovations (World Bank Group, 2016, Olu et al., 2019). The reported use of Coca-Cola's distribution channels to address challenges within the national drug distribution network provides an example of leveraging private sector capacities (World Bank Group, 2016). The scope of private sector investment opportunities in the health sector is wide and includes health worker training; manufacturing and distribution of health commodities, devices, and equip-

ment; and health service provision. This, however, needs to be supported by fit-for-purpose policies, regulatory frameworks, and incentives.

5.2.8: Digital Technologies and the Fourth Industrial Revolution (4IR)

Recent advancements in technology in Africa can help facilitate UHC efforts and build health systems' resilience and security. In Africa, mobile usage increased to 73.5% and internet usage to 20.7%, while global average levels are 96% and 43% respectively (Ota et al., 2018). This growth can be used to facilitate healthcare decision making and responses to challenges through, for example, conducting surveillance of diseases and vulnerable populations. Beyond digital health technologies, Africa can take advantage of the fourth industrial revolution (4IR) to develop solutions to address the most challenging health system problems. 4IR encapsulates new technologies such as cloud computing, artificial intelligence, robotics, the internet of things, 3D printing and nanotechnology, among others that traverse biological, digital, and physical systems (Ndungu and Signe, 2020). These technologies can be leveraged to advance diagnostics, the development of therapeutics, improving information systems and surveillance, and support decision making, among others. However, the deployment of digital technologies will need to take into consideration equity implications to ensure that digital technologies do not introduce or exacerbate existing inequalities. African countries will also need to develop appropriate policy and regulatory frameworks to bestow



supportive but accountable governance onto the use of digital technologies in healthcare.

5.2.9: Pool of Competent health workforce

Africa has a large pool of well-trained and competent health professionals who have the potential to provide the transformative leadership for UHC, instead of being forced to run away to greener pastures abroad. This results in substantial wastage in the health system. Africa could unlock this potential by prioritising the strengthening of human resource management, to ensure that their distribution, tooling, and motivation is optimised to unleash their potential.

5.2.10: Strong Network of Civil Society Actors

Africa has a well-developed and strong civil society ecosystem. When brought together, these civil society actors can play a pivotal role in advancing the UHC agenda by sustaining political commitment through advocacy for UHC reforms that truly “leave no one behind,” and by holding governments to account. In addition, through their activities within communities and their particular focus on poor and marginalised populations, civil society organisations are well-positioned to also contribute to the UHC agenda through service delivery (Rosenquist et al., 2013). Together, these reasons highlight the importance of involving civil society organisations in the decision-making processes for the design, implementation, monitoring and evaluation of UHC reforms (Rosenquist et al., 2013).

5.2.11: Health System Strengthening in Response to COVID-19

COVID-19 has exposed Africa’s health system weaknesses and prompted efforts to strengthen health systems to boost their resilience to the pandemic. African countries have mobilised resources to fill gaps in the availability of health workers, essential health commodities such as oxygen, essential breathing interventions such as pulse oximeters, and emergency care. Further, COVID-19 nationalism in some countries has awakened the threat of Africa being left out and failing to access lifesaving health technologies and spurred discussions about self-reliance including in local manufacturing of health products such as vaccines. For instance, the African Union and Africa CDC launched the Partnerships for African Vaccine Manufacturing (PAVM) framework in April 2021 in response to COVID-19 vaccine access challenges (AU and Africa CDC, 2021). COVID-19 may also cause a paradigm shift in which governments move away from viewing investing in health not as a cost but as essential for wellbeing and socio-economic development. African countries can take advantage of these investments in health to create a strong foundation to reenergise UHC efforts.

5.3: CONCLUSION

This chapter demonstrates that in the face of the challenges discussed in the previous chapter, opportunities abound. African countries will, however, have to be intentional about leveraging these opportunities. We discuss key recommendations for building upon these opportunities, in the next chapter.





The trajectory of African development in health and other sectors following the attainment of independence some 60 years ago has been shaped by the quality of governance.

CHAPTER 6: RECOMMENDATIONS FOR TRANSFORMATIVE CHANGE TO ACCELERATE AFRICA'S PROGRESS TOWARDS UNIVERSAL HEALTH COVERAGE

6.1: INTRODUCTION

There is no doubt that the African continent has made a political commitment to achieve UHC (African Union, 2007, African Union, 2016). However, the evidence gathered by this Commission reveals substantial gaps in Africa's progress towards UHC. While we identify challenges that explain the current state of UHC in Africa, we also highlight opportunities that African countries could leverage to accelerate progress. Ultimately, if the continent is to make progress, African countries will need to transform their health systems, in ways that address their challenges while taking advantage of prevailing opportunities. In this final chapter, we highlight recommendations that are in no way comprehensive, but rather illustrative of the task ahead.

6.2: RECOMMENDATIONS TO AFRICAN GOVERNMENTS

6.2.1: African governments should address health sector specific challenges by

1. Re-orienting health systems and health system priorities to respond to population health needs

- Reorient health sector priorities beyond curative care and to encompass preventive and promotive care. This will require investments in public health and the financing of public goods for health.
- Prioritise resources to high disease burden areas that continue to plague the continent. These include addressing the causes of maternal, child and neonatal deaths, and high-burden infectious diseases (e.g. HIV/AIDS, TB, malaria).
- Adapt service delivery models to provide long term and continuous care, in line with the emergence of non-communicable diseases.
- Increase investments in strengthening emergency preparedness and health security.

2. Re-orienting health systems to prioritise and strengthen primary healthcare (PHC) as the foundation for UHC

- Prioritise primary healthcare and a Health in All Policies approach at the highest level of government as an integrating concept for a developmental approach to decentralised government.
- Reallocate existing health system resources and increase investments to prioritise the strengthening of PHC systems.
- Strengthen the role of primary healthcare facilities as the first point of contact for healthcare needs. This includes increasing physical access to primary healthcare facilities, employing mechanisms to explicitly assign population groups to primary healthcare units, and implementing robust referral systems.
- Strengthen PHC delivery by implementing flexible models of non-hierarchical multidisciplinary teams of clinical and non-clinical staff to provide integrated care to defined empanelled populations, and patients coming from them.
- Implement integrated care models of service delivery, contracting, and reimbursement. This will entail developing primary care networks that integrate horizontally across several healthcare providers at the same level and across services to span promo-

tive, preventive, curative, rehabilitative, and palliative care and community health systems, including traditional medicine providers; diagonally with various priority programmes; and vertically with secondary healthcare facilities.

3. Investing in strengthening health system inputs, especially in primary healthcare

- Invest in increasing the number of skilled health workers through education and skilling, addressing motivation and retention, and ensuring equitable distribution of health workers with a focus on rural and marginalised regions.
- Address health infrastructure gaps with a focus on improving both the availability and quality of care, while focusing on equitable access.
- Increase investment and implement policies to support the availability of essential health commodities in public health facilities.
- Strengthen health information systems in order to monitor and track UHC progress, as well as to provide information for health sector decision making and performance improvement.

4. Investing in system-wide approaches to improve the quality of healthcare delivered to people

- Develop and implement a governance framework that articulates a vision, and accountability, for quality health systems.
- Address health workforce constraints that impact quality of care.
- Address resource constraints that impact quality of care.

5. Reforming health financing systems in contextually appropriate ways to support UHC

- Progressively increase domestic financing of the health sector to an adequate level. This should be guided by an assessment of the resource needs to deliver needed healthcare services to the population. This will require increasing the fiscal space for health in feasible ways such as improving taxation efficiencies and enhancing efficiency in the use of existing resources.
- Restructure health systems to reduce fragmentation of pooling arrangements. Doing this will require considering feasible and context-appropriate pooling mechanisms. For instance, there is overwhelming evidence that voluntary health insurance con-



tributions do not work because of the high informality of African labour markets. Predominantly task-financed health systems offer better promise but only if the fragmentation of public finance is addressed.

- Implement strategic purchasing reforms that include implementing evidence-based, transparent and inclusive mechanisms for defining service entitlements for populations, and reforming contracting and payment mechanisms to incentivise accountability for quality and efficiency.
- Reform public finance management systems to reduce operational inefficiencies and align with health system goals.
- Identify and address the causes of inefficiency in country health systems. This will not only unlock additional resources for the health sector, but also enhance health outcomes.
- Reorient financing from a “health-systems” view, to a “systems-for-health” view and thus prioritise the financing of public goods for health.

6. Strengthening governance and accountability for health

- Reaffirm political commitment to health as a social goal in which political leadership is committed to improving the health of the people, with demonstrated and visible leadership from the head of state and government. This is the foundation of the statement that “UHC is a political choice”.
- Position health as a priority cross-cutting development strategy in all their sectorial plans.

- Develop and implement comprehensive legal and policy frameworks to guide UHC implementation in countries.
- Invest in leadership development of the health sector. This should be focused on the identified leadership gaps, which include complex systems thinking, soft skills and political management, and the use of evidence to inform decision making. Further, the role of governments and ministries of health should be strengthened through dedicated capacity development for health ministers and senior government officials.
- Develop and implement political/stakeholder management plans for UHC reforms. Governments should develop skills and capacity to work with an ever-increasing array of players in health including civil society organisations, academia, private sector, development partners and the public, among others, as effective stewards of the health of the population.
- Broaden perspective (priorities, planning, financing, coordination) beyond a narrow “health-system” view, to a broader “systems-for-health” view. Develop and implement a framework to strengthen and govern multisectoral action in addressing health challenges. A multisectoral action framework should also be leveraged to address the social determinants of health.
- Develop and implement a framework to govern and leverage public-private partnerships for health. This includes fit-for-purpose policy and legal frameworks. Such a framework should clearly define the role of the private sector, ensure that these roles and inherent incentives are aligned with overall health system goals, and govern this arrangement to promote the public good.

- Develop and implement anticorruption strategies to address corruption and strengthen transparency and accountability in the health sector.
- Strengthen community communication, accountability, and engagement mechanisms to promote people-centred and responsive health systems.
- Develop and implement a framework to mainstream equity, gender and intersectionality in all health policies and programmes. African governments should be intentional about addressing inequities in financing and access to health services across all social stratifiers (wealth, gender, age, disability, sexual orientation, location, etc.). This will involve identifying and addressing both structural determinants of these inequities and nurturing cultures that promote equity and fairness for all.

7. Investing in health technologies and take advantage of the fourth industrial revolution (4IR) to enhance the performance of all health system functions

- Invest in the physical infrastructure to support the development and adoption of 4IR technologies in the health sector.
- Invest in country capacity to drive and support innovations and create an enabling business environment.
- Develop and implement a comprehensive policy and regulatory framework to govern the adoption of digital and other technologies in the health sector.
- Leverage digital health solutions to develop and implement UHC reforms.

6.2.2: African governments should address the broader contextual challenges by:

1. Reflecting on, and addressing the undesirable legacy of colonisation and embark on a programme to decolonise health policy and reforms

- Recognise and integrate the traditional health system with the formal health system.
- Reclaim its rightful role as the leader and steward of health policy and reforms. Ensure that policy and reform priorities are country-led and context-appropriate, with external actors playing a supportive rather than leadership role.
- Nurture a change of mindsets from donor dependence to progressive self-reliance and self-determination.
- Restructure health systems to empower decentralised levels to effectively contribute to healthcare delivery.

- De-verticalise health systems: African countries should take advantage of planned donor transitions to reintegrate existing vertical programs with the rest of the health system in ways that improves efficiency while guarding the gains made.

2. Investing in the manufacturing of healthcare commodities within the continent to increase access to affordable healthcare commodities

- Invest in education and human capital development for the manufacturing of healthcare commodities.
- Invest in research and development in health as a foundation for industrial development in health.
- Improve the infrastructure (such as energy, transport and technology).
- Improve regional- and country-level policy and regulatory barriers to local manufacturing and strengthen African Institutions to implement AU Resolutions such as the African Medicines Agency and African Medicines Manufacturing Plan
- Leverage the AfCFTA to negotiate regional markets and promote pooled procurement to create markets that can incentivise and sustain local manufacturing.

3. Implementing policies that take advantage of the demographic dividend

- Strengthen investments in adolescent, youth and women health, including sexual and reproductive health and family planning.
- Invest in education for adolescents, youth and women. Achieving the demographic dividend requires that over 60% of the population have attained good quality tertiary education.
- Promote economic policies that target the expansion of employment opportunities for youth and women.

4. Developing policies and investing in the implementation of the Paris agreement on Climate action

- Develop and implement a framework for mitigating the emission of greenhouse gases.
- Develop and implement a framework for adapting health systems to make them resilient to climate change.

5. Support research and development broadly, and in the health sector

- Prioritise and increase domestic funding for research and development for health.

6.3: RECOMMENDATIONS TO NON-STATE ACTORS

1. The African Union Commission (AUC), Regional Economic Communities (RECs), professional associations, civil society organisations (CSOs), academia, and private sector in Africa should popularise and scale up the campaign to re-capture and restore the spirit of the independence movement, self-confidence, ambition and the mindset that is required to generate and sustain political will and social action for achievement of UHC in Africa.
2. The WHO, the UN Family and other actors should translate Universal Health Coverage in simplified operational language within the principles of Primary Health Care as articulated in the Alma Ata Declaration and reconfirmed in Astana.
3. The AUC and WHO should provide leadership to all actors to maintain the visibility of PHC principles and balance the current pre-eminence of commoditisation of UHC.
4. All actors should promote and monitor UHC, and update its indicators emphasise people ownership and participation using available resources at the various stages of economic development of societies.
5. The AUC, RECs, professional associations, CSOs, academia, and private sector in Africa should organise structured capacity development programs for health and other ministers and senior government officials to provide them with stewardship, leadership and governance and accountability competencies. Such programs should be conducted in Africa and near where they live and work.

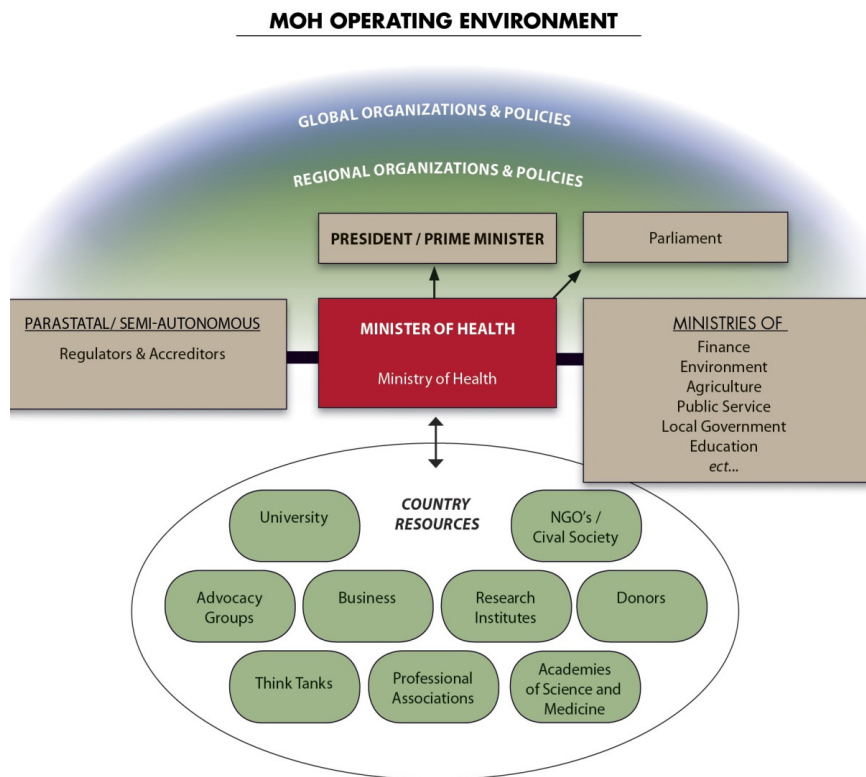
6. African professional associations and other CSOs, through their members should be socially accountable for applying their knowledge and skills to pursue equity and social justice; demonstrating leadership for excellence; and rejecting unethical, intolerable social, economic and political situations, rather than ignoring and accepting them as “normal” without comment or outrage from African experts and their populations.
7. Civil society should advocate for the prioritisation of UHC and for increased inclusivity, dialogue, and accountability that puts the people at the centre of UHC reforms.
8. Private sector should play a complementary role to governments, and increase investments in expanding access to services and local manufacturing of healthcare commodities.

6.4: GOVERNANCE, ACTORS AND THEIR ROLES

The trajectory of African development in health and other sectors following the attainment of independence some 60 year ago has been shaped by the quality of governance. The quality of governance is the single most important determinant of social and economic outcomes in undertakings in every setting; be it global, national, subnational, or institutional. One key determinant of governance in general, and of the effective implementation of the recommendations we outline in this report, is the effective execution of the roles of the various actors in the health ecosystem. The operating environment in which UHC is governed is shown in Figure 6:1 (Omaswa and Boufford, 2010b).



Figure 6:1: Health Sector Actors



At the centre is the Ministry of Health, the Health Minister, and their teams. These are surrounded by the Head of State and Government, Parliament, and other government sectors. Another group of actors are the Health Resource Partner Institutions (HRIPs) who are in the country outside the Ministry of Health and play key roles in the health system. They include academic institutions, civil society organisations, professional associations, development partners, and the business or private sector, among others.



6.4.1: Central role of Governments and Health Ministries

Most international agreements, conventions, and treaties regard governments as responsible for ensuring the conditions under which their people can have the maximum opportunity for health. Governments are also responsible for country compliance with the health regulations of international organisations, such as the UN and WHO, and those of regional bodies, such as the African Union and the Regional Economic Communities governed by member states. Within the government, the Minister of Health is the leader of the health sector and the advocate for the health of the population within government and with non-state actors; engages on behalf of the health sector with international organisations, donors, and regional and global bodies affecting health; and champions the national health agenda among the general population. The capacity of Health Ministries and Health Ministers is therefore critical to the achievement of UHC in the countries. Governments have certain roles that cannot be delegated. Most determinants of health in the home are bestowed by the government and the health system through public education, legislation, inspection, facilitation, or service provision. These include safe water and sanitation; facilitation of people's participation in decision making; education; and political prioritisation of health. Others are enacting and enforcing healthy lifestyles including motor vehicle seatbelts, alcohol consumption, tobacco smoking, and healthy food regulation (on content of animal fat, sugar and salt, among others). No individual, family or community can create such a package without a key role being played by the national government.

Though there are evolving international standards of effective government, "governance" is almost always context-specific, because it must reflect the ways in which all stakeholders interact with one another in a particular set of societal circumstances taking account of culture, history and resources in order to influence the outcomes of public policies. Therefore, of necessity, actions needed to strengthen leadership and management for this increasingly complex role will vary from country to country. Health Ministers and senior officials in Ministries of Health therefore need preparation and capacity building to enable them to play their stewardship and leadership roles for health. The turnover of Health Ministers in Africa is high, and many come to their jobs without prior orientation or technical health knowledge. A dedicated capacity building program for Health Ministers and senior officials is needed to enable them to effectively lead - up towards the Heads

of State, across to other sectors and partners, down to the central ministry and decentralised health actors and out to the general population.

The demand for democracy, citizen participation and accountability has put pressure on governments to decentralise governance, including for health services delivery:

Supporting and sustaining the engagement of citizens and action for local level development calls for capacity building in leadership and management, for decentralisation to work effectively. It must be emphasised that effective decentralisation can only succeed when all actors (central and local governments, civil society, private sector, and international development partners) have the same vision and commitment, as well as required capacities. The central government has to issue clear service standards, avail the resources, and build capacity to provide supportive supervision for the quality of decentralised services.

6.4.2: The Role of Individuals, Families and Community Health Systems

First and foremost, it is the individuals, the ordinary person everywhere, together with their households and communities who should be empowered to own and take responsibility for maintaining their own health, which in most cases is inborn and self-regulated. The internal environment of each person's body is scientifically very carefully self-regulated, creating a harmonious physiological balance that gives the feeling of wellness and wellbeing. It is very often the behaviour of people, as well as individuals' households and communities, that disorganise this "milieu interior" originally described by Frenchman Claude Bernard (Bernard, 1986). We introduce substances into our bodies and treat our bodies in ways that disturb this well-balanced internal environment resulting in the loss of wellness.

A wellness-based health system can only work if it is owned and driven by individuals in the way they live out their daily lives. It is therefore the most important duty of the health system to provide the population with information that creates a high level of health literacy and empowers people to possess and apply knowledge for making lifestyle choices that maintain and promote individual and community health and wellness. Empowering individuals to maintain wellness should create in the population a sense of ownership of the health system, as was envisioned in the Alma Ata Declaration where one of the tenets was the 'active participation of the people themselves'. In addition, this should also empower the population to demand quality health

services and to drop their own sweat in contributing to the better performance of “their” health system. This is also a realistic entry point for getting the balance right between the illness-based and wellness-based health services. Establishing community health systems as described in the Commentary in this Commission report (see Appendices) and in publications in the Africa Health Journal is the way forward, so that people everywhere can organise themselves into committees where they live to take care of their own health (Omaswa, 2020).

6.4.3: The Role of Non-State Actors

The WHO has adopted a Framework for Engagement with Non-State Actors (FENSA) (WHO, 2016). All countries have institutions outside governments that are part of the health system environment. In the Strong Ministries study, these non-state actors were termed Health Partner Resource Institutions (HRIPs) (Omaswa and Boufford, 2010b). They have capacity and potential to support and hold governments accountable. They also create a culture that produces and uses evidence-based policy and programs for health. These institutions are the vehicles for ensuring that the visibility of the health agenda remains high, relevant and acceptable within context. These institutions need to be supported and decentralised to be as close to households as possible, as an integral component of the well-governed health system.

The role of professionals and professional associations: is singled out because these are constituted by members with a deep understanding of the technical aspects of health matters. They have the capacity to support better governance of health in Africa. However, their presence is not always visible and many have left their countries for green pastures abroad (Omaswa and Crisp, 2014). A special effort should be made to strengthen the roles of health professional associations in the governance of health systems in Africa as is the case in other regions of the world.

6.4.4: The Role of Development Partners

In the foreseeable future, African countries will continue to need support from international bilateral and multilateral partners of country governments, global health initiatives, philanthropy and the UN system. Maximising the benefits from these partnerships is heavily dependent on the quality and capacity for leadership and stewardship of beneficiary countries. Donors (as they are sometimes referred to) are looking for leadership from countries and the better the leadership, the more the support. These relationships

should be governed by the agreed Partnership Principles enshrined in the Paris Declaration on Aid Effectiveness, as updated.

6.5.5: The Role of Regional and Sub-Regional Groups

Other critical players who can facilitate convening and joint learning are regional and sub-regional intergovernmental groups including the UN family and financial institutions. These include the African Union and the Regional Economic Communities such as the West African Health Organization and the East Central and Southern African Health Community.

6.5: CONCLUSION

The implementation of SDGs and UHC is taking place during an era of new hope underpinned by the following African and global movements. First, the OAU has transformed into the African Union which is pro-people, embraces civil society and has zero tolerance for illegitimate governments and is promoting an African renaissance with pride in African values to reset the mindset (Kufour, 2015). The AU Commission works alongside regional intergovernmental agencies that convene governments and non-state actors. Second, there is a global movement on social justice and equity that is rolling back impunity and promoting the rights of women and of all people. Third, the current disconnect between economic growth and people’s wellbeing in African countries and globally is now challenged. Greed and wealth accumulation by a few is now recognised as a root cause of global unrest characterised by populism, terrorism, rising poverty, and mass migration. As a result, there are loud calls for new metrics such as the “happiness index,” apart from GDP measurement that includes both economic and human development (Collier, 2018). Fourth, the SDGs as a global compact present an opportunity to Africa in the new era that we must grasp. SDGs are interdependent and call for a movement that promotes global thinking and local solutions, as well as action. Strong societal values of equity, gender, political participation, and community involvement are essential for success. To achieve the SDGs, governments and the people must work together. Fifth, human progress is dependent on innovation and technological innovation. The world is now at the start of the 4th industrial revolution driven by artificial intelligence. Africa must not miss out on this revolution which is projected to have far-reaching impact on the quality of human life.

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COMMENTARY 1: DIGITAL HEALTH AS AN ENABLER OF UHC IN THE AFRICAN REGION

Waruguru Wanjau, Onisoa Rindra-Ralidera

What is Digital Health and what can it achieve?

Digital health is the intersection of technology and health to improve the efficiency of healthcare delivery and make medicine more personalised and accurate. It has a wide scope. In considering digital health the Commission also included health data, social media and wearables. In the African region it offers potential to make care more accessible, improve quality of care, and better reach vulnerable and rural communities. With specific regard to universal healthcare (UHC), digital health has the double potential to address the constraints of providing UHC and to enhance the already existing enablers of UHC.

The challenges of digital health in the context of UHC

Despite its potential to accelerate the realisation of UHC, digital health is not yet integrated as an essential part of health systems in the African region. Digital health is still seen as an optional discretionary complement to UHC and not as a key element of UHC that is to be integrated into the core of the health systems.

Reliable access to infrastructure is necessary to enable the implementation of complex digital health solutions. Yet, access to reliable electricity is poor in many countries, particularly in rural areas. Network connectivity is improving but remains highly variable, with broadband access being particularly scarce (USAID 2016). For digital

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health to be most effective, particularly in the context of UHC, people, healthcare institutions and providers need access to basic connectivity infrastructure, including mobile phones and reliable internet connectivity.

In the past, health in the region has mainly taken a vertical approach based on diseases and Millennium Development Goal (MDG) priorities. With the shift to the Sustainable Development Goals (SDGs), which includes a target on UHC, there is a need to integrate healthcare. The benefits of digital health will be better realised in integrated health systems as opposed to separate digital health systems and solutions for a specific vertical disease.

How can digital health best be integrated into UHC systems?

Given the potential of digital health, the region's interest in achieving UHC and the potential challenges of digital health in the context of UHC, it is important that stakeholders integrate digital health into the systems for UHC in the African region in a thoughtful, sustainable way. Digital health should be mainstreamed in UHC in a way that maximises its potential and enhances the deployment of UHC in the context of the different health systems in the region.

Approaches and Considerations for digital health integration in UHC

Given the importance of context-specific, sustainable, and integrated use of digital health in UHC we propose two main aspects to be considered by policy makers and health practitioners in integrating digital health in UHC in the African region: 1) How digital health can be used in the health system with a UHC lens; and 2) Considerations and approaches of digital health integration that will enable increased impact and sustainability of UHC.

How digital health can be used in the health system with a UHC lens

In considering how digital health can be integrated into a health system to improve UHC, it will be necessary to consider the following elements: health communication, service delivery, product and technology management, monitoring and evaluation, and health financing.

For **communication** from primary care towards higher levels of care, digital health solutions can help to disseminate information, raise awareness, refer to a higher level of care, plan consultations and/or follow-up. It can also facilitate communication with the population, between providers and

between beneficiary providers. The use of digital health for communication can be designed to increase patient engagement in their care journey by ensuring a participatory patient-centred design (Birnbau et al 2015).

In **service delivery**, digital health can guide decision making, assist in diagnosis and thus facilitate the reduction of errors. It can enable better planning by reducing the overload of consultation services by scheduling consultations according to the availability of health workers. For **product and technology management**, digital health can be used for product safety, purchasing, transport, stock management, thus ensuring quality, availability and potentiality of the commodities required to provide care.

For **monitoring and evaluation** in a fully digitised system, patient needs and outcomes can occur remotely and instantaneously to avoid travel. Multi-level healthcare data can also be used for decision making, system improvement and advocacy. With a digitised system collecting data on a large scale, it will be possible to have a synoptic view of all health systems in a country. In order to maximise the use of health data for UHC it is important to ensure that data included in current digital recording systems is accurate, timely and standardised to support decision making (NIH 2013). In evaluating the impact of digital health solutions, it is important to measure whether a digital health solution has achieved its intended outcome. For example, a digital health application that aims to facilitate the patient experience between different sections of a health facility should be evaluated by measuring whether the patient actually spends less time between consultation and pharmacy.

With regard to **health financing**, digital health considerably reduces the resources required to provide care by creating efficiencies in healthcare delivery (Blackmore et al 2020). Digitisation of a health system can be considered an investment because the provided expenses of its implementation can generate income with the facilitation of demand generation, providing increased access to services, analysis of the system to increase efficiencies, and elaboration strategies.

Considerations and approaches of digital health integration that will enable increased impact and sustainability of UHC

Beyond the areas of health service delivery that digital health can improve, the following approaches will lead to greater success and overall strengthening of the health system.

Allocating resources: the implementation of digital health

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Digital solutions must take into account existing disparities in access to infrastructure, literacy, access to finance, access to health and health decision making based on gender, rural and urban areas and age. Therefore, it is important to address these disparities to achieve equal access to health by accentuating them.

platforms requires dedicated resources to ensure appropriate and robust implementation of a good quality digital health system. These resources include a specific monetary allocation and time resources. Dedicated time is needed to consult users during the design phase and to train and orient them on using digital health solutions within the health system. Specialised and qualified local human resources will need to be trained and hired to ensure the maintenance and continuous improvement of digital health platforms as the UHC systems continue to mature and evolve.

Digital health should be a **key component of UHC** in the African region. As different countries integrate UHC and create different models for integrating digital health into UHC, this will enable the region to have different models and use cases, through which countries can learn from each other and improve their own national UHC digital health systems.

Digital health can be used as a **lever to systematise and integrate healthcare** and strengthen health systems. The benefits and effectiveness of digital health will be best seen in integrated health systems and although health in the region has previously been approached in a disease-specific vertical approach, the integration of a digital health approach offers a unique opportunity to facilitate and accelerate the integration of health systems in line with the principles and objectives of UHC.

While **digital health has great potential to make health more accessible**, it will be important to ensure that the uptake of digital health in the CHU is equitable. The digital divide, defined as the inequality of access or ability to engage in healthcare using technology, already exists and steps must be taken to reduce it as digital health is integrated into the CHU (Wood 2020). Digital solutions must take into account existing disparities in access to infrastructure, literacy, access to finance, access to health and health decision making based on gender, rural and urban areas and age. Therefore, it is important to address these disparities to achieve equal access to health by accentuating them.

Digital health solutions created with local context in mind are likely to be more accepted and better adapted to local circumstances. It is important to ensure that digital health is locally adapted and, where possible, developed at the local level in order to grow the capacity for digital health solution creation across the region.

Pilot projects are undermining many digital health solutions (PATH 2017). In order to ensure that the digital health used for UHC produces the desired results, it will be important to start with sustainability and scale in mind. During the design phase, digital health solutions need to be tested and re-tested, with sustainability and adaptability built into the design of the solution, in order to avoid multiple pilot projects that cannot be used at scale, as the UHC is by nature a population-wide solution.

Implementation approaches are essential, as scale can only be determined by the government and will be best achieved when innovators, usually found in start-ups, have clear pathways to collaborate with larger entities, in this case the government (WEF 2018), and their work is integrated into a more centralised population-based digital health work. For the development of digital health at the governmental level, it will also be important for policy makers to integrate digital health into their broader public health strategies. In order to ensure that large-scale implementation is not seen as a complex undertaking, governments can identify feasible starting points such as moving from paper to digital and implementing electronic health records (EHRs) that have proven valuable in Africa: easy to use, scalable, inexpensive and cost-effective (Oluyemi et al., 2020).

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COMMENTARY 2: PRACTICAL STEPS TOWARDS ACHIEVING UNIVERSAL HEALTH COVERAGE FOR PERSONS WITH DISABILITIES

Shakira Choonara

It is estimated that close to one billion people across the world live with some form of a disability (WHO, 2020). There is no reliable data on how many people with disabilities reside on the African continent. In the absence of available data, key health system processes such as planning are ineffective in our countries. While several countries globally have adopted the Convention on the Rights of Persons with Disabilities (CRPD), there has been limited to no traction reported. Without the evidence and a clear breakdown of the different types of disabilities that exist (mental health, hearing, visual impairment, and physical, e.g. facial deformities) and without knowing whether those disabilities are permanent or temporary, tailoring healthcare services is next to impossible.

Often, we pay minimal attention to the causes of disability, which can be congenital and preventable. Increased tobacco consumption, harmful alcohol use, unhealthy diets, and physical inactivity are all contributing factors to

the rise in non-communicable diseases (NCDs) (Gouda et al., 2019). The

rise in chronic conditions is associated with rising levels of disability; for example, visual (deteriorating eye health due to diabetes), physical (strokes), and obesity (body image, bullying and mental health issues).

Addressing the needs of persons with disabilities is one of the most pressing intersectional equity and human rights issues within universal health coverage (UHC). Where data is available (Tanzania, Uganda and Malawi), the proportion of persons with disabilities living under the national or international poverty line is higher than that of persons without disabilities (United Nations Department of Economic and Social Affairs, 2019). There are heightened and intersectional barriers to accessing health services, such as limited access to education, problems entering the workplace, and unaffordable assistive technology

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to be able to navigate transport systems and healthcare facilities. Situations of severe economic hardship translates into issues such as to food insecurity which also affects health by resulting in malnutrition (Talk Poverty, 2014). Often, these socio-economic vulnerabilities extend to and affect the entire household/ family that includes a person with a disability.

The barriers to accessing healthcare are well-evidenced and well-understood (e.g. costs of transport and out-of-pocket expenses). Barriers to accessing healthcare services are exacerbated for persons with disabilities; they are unable to pay for health services, access transport or walk to facilities (e.g. stroke patients in Malawi highlight how they are unable to walk to access healthcare) (Harrison et al., 2020). Disabled patients who require advanced care (referrals to institutions which are further away) are unlikely to pursue this given the inability to afford any additional costs or reach healthcare services that are further away (Harrison et al., 2020).

The socio-economic intersectionality and the actual plight and realities of persons with disabilities needs to be unpacked practically at a policy and implementation level. If we are to really ensure that “no one is left behind” within the UHC agenda, practical steps are essential. Understanding and addressing the causes, for example by tackling NCDs, is important. Below is a list of practical steps that can and should be taken:

- Addressing the social determinants of health is crucial, including the provision of social protection measures (cash transfers, food programmes), to address the dire socio-economic conditions for persons with disabilities. We need to ensure that persons with disabilities face no barriers in accessing social protection programmes, such as having to stand in long queues or be subject to bureaucracy and inefficiency.
- National Health Insurance Schemes (NHIS) should have access to data via social protection programmes and should automatically capture patients to be registered within the schemes. There is a need for interoperability of patient systems.
- There is a need for developing practical tools which can be used by national Governments, for example for budgeting/ financing healthcare services for persons with disabilities.

- National governments need to prioritise and invest in conducting regular disability surveys at least every five years. This is essential for planning and responding to the needs of persons with disabilities, including a health system response, and for understanding intersectional socio-economic issues.
- Other than a focus on rehabilitative care which is also weak, there is a lack of understanding of the nuances and complexities involved in meeting the needs of persons with disabilities. Ministries of Health require investments and dedicated staff capacity. They need disability experts who have a strong understanding of disability issues to advise, plan services and monitor implementation. Hand-in-hand, there needs to be a targeted strategy to include non-governmental organisations (NGOs) that work in the disability sphere within health system processes in policy dialogues and engagement on planned health interventions. This will drive persons with disabilities’ involvement in decision making and UHC processes.
- The stigma and discrimination people with disabilities face in healthcare facilities is rife, coupled with the fact that healthcare providers are not adequately trained to deal with patients who have a disability. Quite simply put, a hearing-impaired participant in Uganda recommends, *“All these health service providers should learn sign language. It will be easy for anyone who is deaf to access services. For example, a pregnant woman would easily communicate to any person in maternity. She can be helped when a doctor knows simple signs,”* (Mac-Seing et al, 2020).

The reality is that we are leaving persons with disabilities behind. The right to health has clearly not been realised at the practical level. The neglect to take steps to address the glaring data gaps in Africa, the limited skills of health providers to deal with disabled patients and the exacerbated barriers to access healthcare are indicative of the lack of progress on social justice and health equity within the UHC agenda. The steps outlined are practical.

The defining questions are: 1) what other practical steps can we take within this decade of action for achieving the sustainable development goals (SDGs) to improve the lives of persons with disabilities by meeting their healthcare needs; and 2) who will advocate on these issues and 3) is there political commitment and financing to truly realise the agenda of *leaving no one behind*?

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COMMENTARY 3: COMMUNITY ENGAGEMENT: THE ROLE OF PEOPLE IN ACHIEVING UNIVERSAL HEALTH COVERAGE (UHC)

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Background

The relevance and need to engage people and communities in health development is undisputed and well documented. However, there are few countries in Africa where clearly, visible actions have been taken to build community health systems (CHS) with people at the centre owning and driving the agenda. CHS is a subset of the national health system, defined by the World Health Organization (WHO) in simplified form as “all the activities whose primary purpose is to promote, restore and/or maintain health” (WHO, 2003). In other words, health

systems are “the arrangements that society makes to take care of the health of its people”. Community is defined for the purposes of this discussion as “a group of people living together in a catchment area and geographic location within a larger region or country” (Omaswa, 2020).

Despite the time pressure to achieve the Sustainable Development Goals (SDGs), the repeated calls from WHO Director-General Dr Tedros and the adoption of the African Union’s Health Strategy 2016-2030, there is no palpable movement in Africa towards translating this vision of people participation into reality. This lack of commitment and action to engage communities and people in health development at national, regional and



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global level is illustrated by the fact that there is not a single indicator, goal or target among the Universal Health Coverage (UHC) Indicators that measures the level of people engagement and participation in achieving UHC (Haas et al, 2012).

Today, what is visible is much advocacy on COVID-19 for people to follow Standard Operating Procedures (SOPs), such as hand washing, social distancing, and for governments to provide oxygen and pulmonary ventilators. There are, regrettably, no public education messages reflecting the challenges people face in accessing water and soap for washing hands. "If health development does not happen in African communities, it will not happen in African nations (Omaswa & Crisp, 2014)," according to Prof. Miriam Were.

Foundations of people participation in health development

The starting point is that 94% of human beings are born completely normal and healthy and can live in good health until old age without losing their health. This is because the human body is capable, on its own, of making highly informed choices on how to maintain well-being and defend itself from health risks. In physiology, we learn about homeostasis, by which the body's internal environment is maintained in a steady state through tightly regulated feedback mechanisms (Holmes, 1986). For example, when it is hot, we sweat, which evaporates so that it cools us; when we are short on water; we feel thirsty and the kidneys produce urine to get rid of excess water. Throughout the life cycle, the body's state of health and well-being is maintained through these in-built mechanisms.

It is evident that the primary responsibility, ownership and accountability for maintaining uninterrupted healthy life throughout the life course rests on the shoulders of individuals, households, families and communities. Each individual should be encouraged and supported to collaborate with their body's internal homeostatic mechanisms and ensure that their healthy status is not lost. The primary role of the health system is to ensure that individuals continue to remain healthy, do not lose their health and will not need avoidable healthcare. This is achieved by promoting health seeking behaviour in the population, highlighting health risks, removing them and creating environments that favour health. It is for this reason that the definition of health by WHO (WHO Constitution, 2006) and the UN Declaration on Human Rights (United Nations, 1948) is broader than absence of disease. It is about well-being, mental, physical and social; including access to basics of life such as food, shelter, security and medical care.

Health promotion, disease prevention and treatment of lost health

The pressures to pay more attention to the needs of repairing lost health are stronger than those to promote and protect existing health. For example, an injured person or a convulsing child have to be immediately attended to and rushed to a health facility. As a result, the drama of providing healthcare is the more visible face of the health system receiving more attention and more resources than promoting and maintaining individual and population health.

APPENDICES

Community Health Systems (CHS)

In order to get the balance right in health system development, there is need for the people together with their government and other partners to build CHS with clearly defined roles for each player. There are entry points for governments and other actors in support of the protection and maintenance of individual and community health. Even when individuals know what to do, they still need access to healthy food, clean water, housing, education and other determinants of health which only governments can provide. Governments are legitimately called upon to shoulder the ultimate responsibility for assuring the conditions in which people can be as healthy as possible. This is achieved by building - in partnership with the people - responsive, integrated, people-centred national, sub-national and CHS.

The need for responsive health systems has two foundations. First, the health of people is a precondition for their well-being and for living productive lives. The right to life is also a right to health and to a responsive health system. The second foundation is our innate humanity of feeling for each other so that the pain and suffering of one is shared and addressed collectively so that “no one is left behind” to suffer alone. On top of these moral arguments comes new evidence that shows that health is no longer perceived just as a cost but is an investment with high economic returns. The health economy on its own contributes to economic growth, employment and Gross Domestic Product (GDP) (High Level Commission on Health Employment and Economic Growth). This is evidence that investing in population health is the best investment. The purpose of all Sustainable Development Goals (SDGs) is to contribute to the health and well-being of people and the protection of our planet. Last but not least, voters value their health and investing in the health and wellbeing of the population has political implications.

Guiding principles for building CHS for people-centred primary healthcare (PHC)

UHC is a political choice made by governments to provide citizens with the health services that they need without financial embarrassment (WHO). Strong government leadership is essential to create the conditions that enable people to maintain inborn health. This includes marshalling actors from across all sectors of government and the whole of society to deliver integrated people-centred PHC by

enacting enabling laws and regulations, providing access to information, healthy food, clean water, decent housing, quality education and resources, among others.

The key elements needed for building sustainable integrated people-centred PHC are:

- (i) local health committees that meet regularly for open community dialogue and governance. These should be led by recognised administrative cadres to ensure government leadership, and have elected representatives from the community, cultural and religious leaders, representatives of relevant government sectors and Community Health Workers (CHW) as their members.
- (ii) a defined package of health services to be provided, derived from a community diagnosis together with financing arrangements,
- (iii) skilled, motivated and supported CHWs who can deliver the defined package of services by visiting households and keeping their health records, distribute health commodities and information with digital tools, and link households with the nearest health facilities and the community health committee. CHWs achieve their best results when the CHS is led through an integrated whole-of-government and whole-of-society approach which empowers and legitimises their technical work.

Conclusion

There is growing evidence that the global movement on UHC is gaining momentum. COVID-19 has illustrated how community health systems are critical to outbreak control. The Elders Forum has issued a report calling for accelerated action on UHC (The Elders, 2019) and the message that ‘*Health is made at home and repaired in hospitals*’ (Crisp, 2020) is being popularised. Africa needs a new dedicated effort on CHS, which will be inspired and accelerated by the AHAIC Commission Report on UHC, to ensure that every person in every village in Africa has the support to maintain the inborn health as well as to access the quality health services that they need. The African Union and its organs, Regional Economic Communities, Financing Institutions, Professional Associations, civil society organisations, the private sector, the WHO, UNICEF and the UN family of organisations should work urgently and cohesively with national governments to make this happen by 2030.

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