Implementation Framework for Scaling up Essential Health Interventions in the Context of MDGs (2007 - 2015)

July 2008

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List of acronyms:

ACT	Artemisin based Combination Therapy
AFRO	WHO Regional Office for Africa
AIDS	Acquired Immune Deficiency Syndrome
ANC	Ante Natal Care
ART	Anti retroviral therapy
ARV	Anti Retro Virals
ATM	Division of Prevention and Control of AIDS, Tuberculosis and Malaria
AU	African Union
CAH	Child and Adolescent Health
DHS	Demographic Health Survey
DOTS	Directly Observed Treatment Short-Course
DPM	Director Programme Management
EPI	Expanded programme on immunization
ESA	Eastern and Southern Africa
GAVI	Global Alliance for Vaccines and Immunization
GF	Global Fund to fight against AIDS, Tuberculosis and Malaria
HMIS	Health Management Information System
HIV	Human Immuno-deficiency Virus
HRH	Human Resource for Health
IDSR	Integrated Disease Surveillance and Response
IMCI	Integrated Management of Childhood Illness
IMR	Infant Mortality Rate
IPTp	Intermittent Preventive Treatment during pregnancy
IRS	Indoor residual spraying
IST	Inter-country Support Team
ITNs	Insecticide Treated Nets
MAL	Malaria programme
MDGs	Millennium Development Goals
M&E	Monitoring and Evaluation
MMR	Maternal Mortality Rate
MNCH	Maternal Neonatal and Child Health
MOH	Ministry of Health
NCDs	Non Communicable Diseases
NUT	Nutrition programme
NGOs	Non Governmental Organizations
OPD	Outpatients department

PLWHA	People Living With HIV/AIDS
PMTCT	Prevention of Mother-to-Child Transmission
RC	Regional Committee
RED	Reaching Every District
RPM	Regional Programme Management Meeting
SAM	Service Availability Mapping
SSA	Sub Saharan Africa
STEP	STEPwise survey for Non-Communicable Disease Risk Factors
TB	Tuberculosis
TUB	Tuberculosis Programme in AFRO
ToT	Training of Trainers
U5MR	Under 5 Mortality Rate
UN	United Nations
UNGASS	United Nations General Assembly Special Session
UNICEF	United Nations Children Fund
USD	United States Dollar
WCO	WHO Country Office
WHO	World Health Organization
WR	WHO Representative

Executive summary:

Most of the countries in the WHO Africa Region are not on track to meet health related MDG targets. Health indicators are still poor and the region has the challenge of combating communicable disease at the same time experiencing a growing burden of non communicable diseases. The level of coverage of essential interventions is too low falling short of global targets and further worsened by inequalities in coverage within and between countries.

Efforts in place by countries, WHO and partners to scale up coverage of essential interventions include strengthening health systems, mobilization of additional resources, provision of technical assistance and capacity building. Key challenges to scaling up are system wide constraints, weak coordination and partnerships at all levels and lack of effective community participation. Challenges facing programmes include ensuring utilization of tools, manuals and guidelines, ensuring integrated delivery of a comprehensive package and addressing issues affecting uptake services. WHO's ability to offer timely, harmonized and effective technical support has been hampered by inadequate human and financial resources and poor coordination among programmes.

At the 37th Regional Planning Management meeting, Countries requested WHO to provide technical assistance for development, monitoring, evaluation and resource mobilization for national Road Maps for achieving MDGs on maternal and child health. This calls for new ways of doing things within WHO.

The objective of this framework is to guide WHO and countries on what is needed to scale up essential health interventions and how best WHO can support countries in their efforts to achieve MDG's, based on evidence and practice. Specifically the framework identifies a core set of interventions to be scaled up, ways of strengthening collaboration at country level, modalities of providing technical support to countries, critical health system components that will facilitate scaling up efforts and proposes better modalities of service delivery to improve coverage and reach vulnerable groups. **Countries, WHO and partners** should reach **c**onsensus on the proposed framework among the key stakeholders; revise and harmonize existing plans based on the framework; develop timetable for implementation of the framework and monitor and evaluate the implementation of the framework

1.0 Background:

The current level of coverage of essential interventions is too low to contribute substantially to improvement of population health and meeting health related Millennium Development Goals (MDG) targets. In addition, addressing inequalities in health status and coverage of interventions between and within countries remains a challenge. Social economic determinant like income, housing and education affect health but institutionalization of multisectoral approaches to improving health remain a challenge. Scaling up to improve population health and achieve health related MDGs will take more than expanding services to cover larger geographical areas, there is need to ensure cost effective delivery mechanisms, explore innovative ways of reaching special groups like the poor, women, children and people in rural areas and, institutionalization of a multisectoral response to health.

There are ongoing efforts to meet health related MDG targets. Countries' efforts include increasing investments in health, strengthening health systems and scaling up implementation of essential interventions while partner's support includes mobilization of additional resources for health, participation in policy development and dialogue and supporting capacity building efforts. WHO's support to countries is in line with the normative functions of provision of tools, guidelines, capacity building, evidence for policy and technical assistance.

1.1 Health indicators in the WHO African Region:

All countries signed up to the United Nations Millennium Declaration in 2000 committing to meeting set targets against eight goals by 2015. Current trends show that many countries in the region are unlikely to achieve these targets unless concerted efforts are put in place. Mortality indicators in the region remain high with disparities between and within countries.

Infant mortality rate (IMR): Regional average is 100 per 1000 live births but in 43% of the countries this is over 100 while 4 out of 46 countries have an IMR below 50 deaths per 1000 live births.

Maternal mortality ratio (MMR): Regional average is 910 per 100,000 live births; 35% of counties have a MMR of over 1000 while 4 out 46 countries have a MMR below 300 per 100,000 live births.[1]

Under 5 mortality rate (U5 MR): Regional average is 165 per 1,000 live births and 9 countries have an estimation of over 200 while in 10 of the countries this is below 100 per 1000 live births.[2]

A few countries have registered improvements in health indicators. For example, in Malawi, during the 15 year period preceding the 2004 Demographic Health Survey (DHS), U5 MR declined by 30% while IMR declined by 27%. Other examples include Ethiopia, Madagascar, Mozambique, Rwanda, Tanzania and Uganda as shown in *annex II table 1*.

[1] IMR is 2004 data; source: WHO mortality database; MMR is 2000 data; source: World Health Report 2005

[2] World health report 2006; Working together for health; WHO (uses 2004 data)

Cape Verde, Seychelles and Mauritius showed tremendous progress in reduction of child and Maternal mortality between 1990 – 2005 as shown in table 1. They put in place best practice polices which were backed by good governance, high level political commitment and concrete action at macro and micro levels. At the macro level, favorable allocations were made to the health sector, provision of free health services and education up to secondary level and, improved infrastructure. At the micro level (sector level), realized improved access to health services and emergency obstetric care, community awareness and provision of free ambulance services. Immunization coverage and supervised deliveries in these three countries is above 97%.

Table 1: Indicators for Seychelles, Mauritius and Cape Verde:

Indicator	**U5 MR per 1,000 live births**		**IMR per 1,000 live births**		**Population**	**HIV Prevalence**	**MMR per 100,000 live births**
	1990	2005	1990	2005	2003		
Country							
Seychelles	17 (2000 data)	13	13 (2001 data)	12	81,000		
Mauritius	23	15	21	13	1.2 million	0.6	22 (1990 – 2005)
Cape Verde	60	35	45	26	434,624		

Source: Under-five and infant mortality rates - UNICEF, United Nations Population Division and United Nations Statistics Division;. www.unicef.org/infobycountries; www.who.int/whosis/mort/profile

Mortality indicators have worsened in some countries hit hard by the HIV/AIDS epidemic, for example in Botswana U 5 MR increased from 101 to 116 between 2000 and 2004.[3] Other examples of countries with declining indictors are shown *in annex II table2*.

Looking at inequalities in health outcomes within countries; DHS data has shown that although Malawi's national average annual mortality reduction shows that the country is likely to meet MDG targets; improvement in these indicators is far lower in the poorest 20%. The annual national average reduction in IMR and U5MR was 5% between 1990 – 2004; among the poorest 20% the reduction was only 2.2% and 2.7% respectively. In Uganda, 2006 DHS showed that although the national average for IMR was 76 per 1000 live births, this was over 100 in 3 of the 9 regions.[4] In Benin, U5MR was 198.2 per 1000 live births in the lowest quintile compared to 93.1 in the riches quintile.[5] Similar disparities have also been noted between rural and urban areas and by education status where mortality indicators in urban areas and among the more educated are lower than in rural areas and among the least educated.

[3] Source: Botswana, Demographic Health Survey Report ; 2006
[4] Source; Uganda Bureau of Statistics (UBOS); 2006.
[5] DHS data; 2001

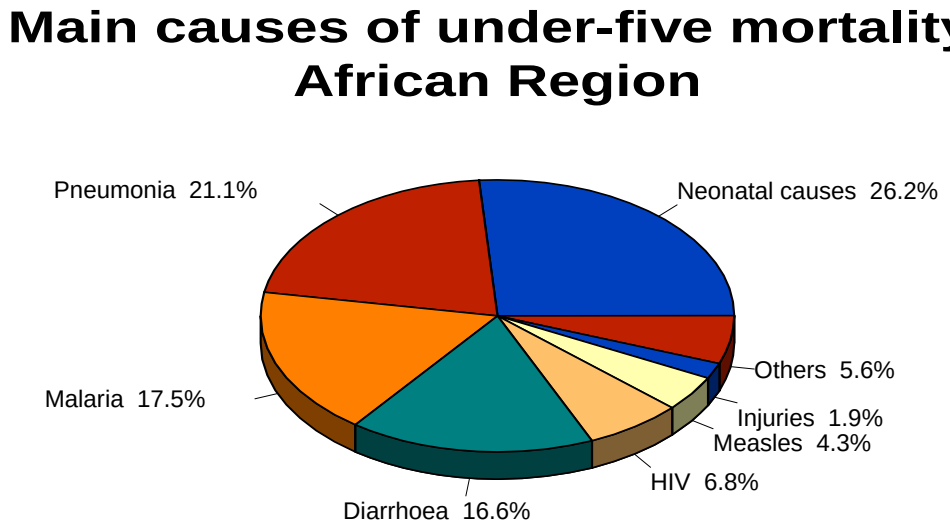
1.2 The burden of disease in the WHO African Region

The region is faced with a double burden of disease; with the challenge of combating communicable diseases while experience a growing burden of non-communicable diseases. There are 25.8 million people living with HIV/AIDS. HIV is the leading cause of death and disease among adults in the region[6]. The most affected countries especially in Southern Africa have prevalence of over 20% while West African countries although less affected, prevalence rates in some countries are creeping up estimated to exceed 5%.[7] Infection among pregnant women is estimated at 20–30% in some countries while mother to child transmission ranges from 25 – 40%.[8] The HIV/AIDS epidemic has contributed to the increased incidence of tuberculosis and currently, there are an estimated 2.4 million new tuberculosis cases and half a million TB related deaths every year. Malaria accounts for 30 – 60% of outpatient visits in health facilities and the region accounts for 60% of morbidity and 90% of mortality occurring worldwide[9]. Malaria accounts for 18% of Under 5 children deaths in Africa.[10]

Children of sub-Saharan Africa face the gravest challenges in terms of survival. The region has 10 percent of the world's population and yet accounts for 44 percent of the world's under-five mortality – 4.6 million children under-five die every year. The main causes of under-five mortality in the region are shown in figure 1:

Figure 1

[6] Source: WHO; Towards Universal Access: Scaling up Priority HIV/AIDS Interventions in the Health Sector—Progress Report, April 2007
[7] HIV and AIDS in Africa ; June 2007
[8] The health of the people: African Regional Health Report, WHO 2006
[9] WHO/ AFRO; World Malaria Report 2005
[10] The health of the people; The African Regional Health Report; WHO, 2006



Source: WHO, World Health Statistics, 2008

Prevalence of low birth weight in Sub Saharan Africa (SSA) ranges from 11 – 52% and 30 – 40% of children under 5 years are stunted. Malnutrition is associated with at least 50% of deaths. Prevalence of iron deficiency anaemia in young children is estimated at 50% and 600,000 children under 5 years die annually in Africa because of vitamin A deficiency.

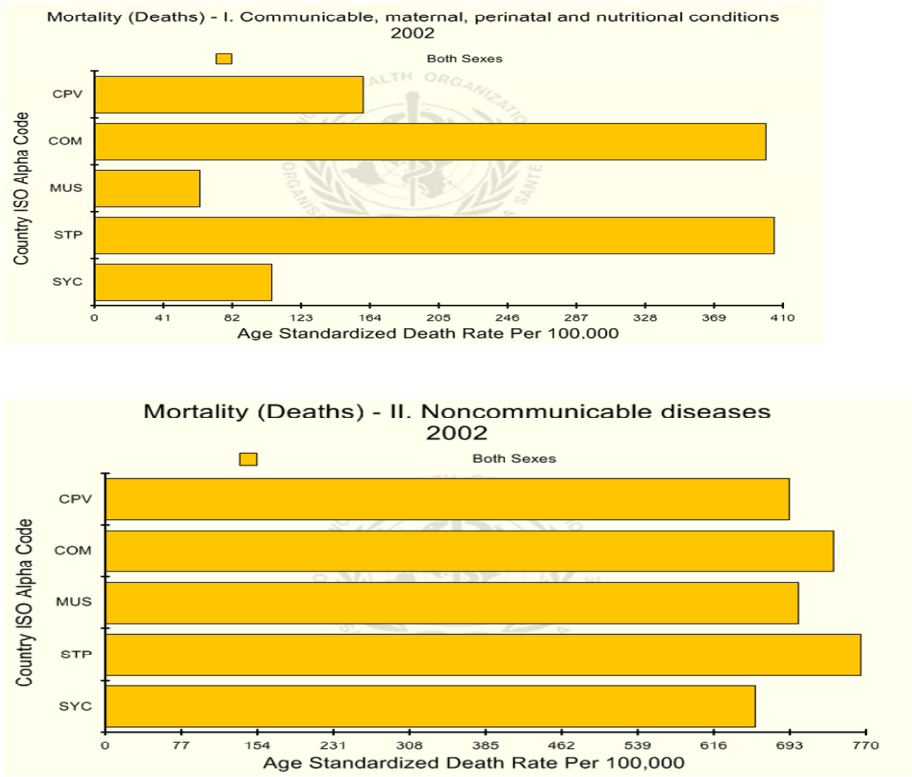
The region continues to experience epidemics; over 50% of countries have reported meningitis epidemics annually for the last six (6) years while over 60% of countries have reported cholera epidemics annually for the last four (4) years.[11]

In the African region in 2005 and in all age groups, chronic disease accounted for over 800 per 100,000 deaths, see figure 2 for mortality due to NCDs compared to communicable diseases. The main chronic diseases such as heart disease, stroke, cancer, chronic respiratory diseases and diabetes are attributable to a few set of common risk factors between man and Women.[12] Regional average prevalence of diabetes ranges from 1 – 20%. It is estimated that 500,000 new cases of cervical cancer occur every year worldwide and 80% of these are in developing countries. Non

[11] WHO/AFRO; IDSR data; 2007
[12] Preventing chronic diseases; a vital investment; WHO, 2005

communicable diseases are also contributing to the high maternal mortality in cases of diabetic and hypertensive pregnant women. Neurological, mental and psycho-social disorders are aggravated by both communicable and non communicable disease conditions including wars, accidents, violence and injuries. Increased consumption of alcohol and tobacco has been reported even among school going children.[13] The Global Youth Tobacco Survey conducted in six countries showed that smoking in 13-15 year olds ranged from 13% in Kenya to 33% in Uganda.

Figure 2: Mortality from communicable and non communicable diseases



Mortality from CD and NCD in the African Small Islands (source:Global Burden of Diseases Project)

[13] Global School-based Student Health Survey; WHO, 2007

CPV: Cape Verde; Com: Comoros; Mus: Mauritius; STP: Sao Tome and Principe; Syc: Seychelles

Neglected diseases such as onchocerciasis, trypanosomiasis and leishmaniansis continue to affect mainly the rural poor communities in Africa impacting negatively on the productivity of these communities. Seventeen (17) out of the 30 countries affected world wide are found in the African Region.[14]

The disease burden exerts an enormous economic burden on governments, communities and families. The linkage between health and other social determinants of health is well documented, health being a means but also an outcome of better income, housing and education. Reduced productivity, school absenteeism and impoverishment caused by disease impede poverty eradication/reduction efforts of many countries in the region.

1.3 Coverage of essential health intervention - situation analysis:

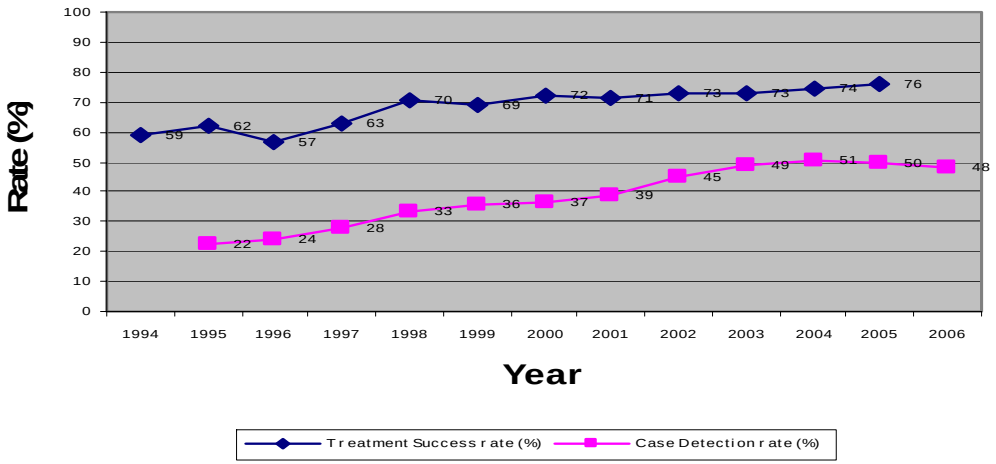
Although essential health interventions to address the burden of disease that contribute towards attainment of MDGs are largely known, coverage in majority of countries remains very low.

HIV/AIDS: The regional estimate for access to ARVs is still very low, only 28% of the People Living With HIV/AIDS (PLWHA) needing antiretroviral (ARV) drugs received treatment by the end of 2006.[15] Coverage is much lower for children under 5 at an estimated Sub Saharan Africa average of 13%. Only 3 countries (Botswana, Namibia and Uganda) in the region met the target of treating 50% of PLWHA by the end of 2005. Majority of pregnant women in need of PMTCT services do not receive them, estimated regional average coverage stands at 11% ranging from below 5% in Democratic Republic of Congo and Nigeria to close to 30% in South Africa. Although there has been an increase of more than 100% in the last three years in the number of new HIV testing and counseling sites in some countries such as Botswana, Lesotho, Malawi, Mozambique, Rwanda, Tanzania, Zambia, Zimbabwe among others, the HIV testing and counseling remains unsatisfactory low. Recently completed DHS in 12 high-burden countries in sub-Saharan Africa, showed that the median percentage of men and women who had been tested for HIV and had received the results were 12% and 10% respectively.

TB: Regional TB case detection rate remains very low at only 46% by the end of 2006 (WHO target is 70%) with 11 countries having a case detection rate below 30% while 9 of the countries (Algeria, Angola, Benin, Botswana, Cameroon, Kenya, Lesotho, Namibia and South Africa) are above 70%.[16] By the end of 2006, the regional coverage for TB DOTS was estimated at 91%, but is below 50% in Gabon. Similarly the DOTS treatment success has shown slow progress over a period of 5 years reaching 76% in 2006 which is below the set target of 85%. Only 8 countries (Algeria, Benin, Comoros, DRC, Eritrea, Gambia, Mauritius and Sierra Leone) achieved the 85% target.

[14] Global Buruli Ulcer Initiative.
[15] Towards universal access: Scaling up priority HIV/AIDS interventions in the health sector; AFRO, April 2007.
[16] Global Tuberculosis Control; surveillance, planning, financing; WHO report 2007.

Figure 3: Trend of Treatment success and case detection rates. African Region 1994 - 2006



Source: Global Tuberculosis Control: Surveillance, Planning, Financing. WHO Report 2008, Geneva, World Health Organization (WHO/HTM/TB/2008.393)

Malaria: ITN use by children under five is less than 10% in the region. Some countries have however made impressive gains in ITN use among under-fives such as Eritrea 63% Rwanda 50%, the Gambia 50%, Guinea Bissau 44%, Niger 43% and Togo 40%. In the 2006-2007 malaria season about 19 countries deployed IRS[17]. About 5 million units/structures were sprayed and 21 million people protected with an average operational coverage of 83%[18]. All the 35 countries where IPTp is recommended have adopted the policy but only 20 are implementing country-wide with IPT 2 less than 10% in most countries. However, countries that adopted the policy earlier have higher coverage such as Zambia 61%,

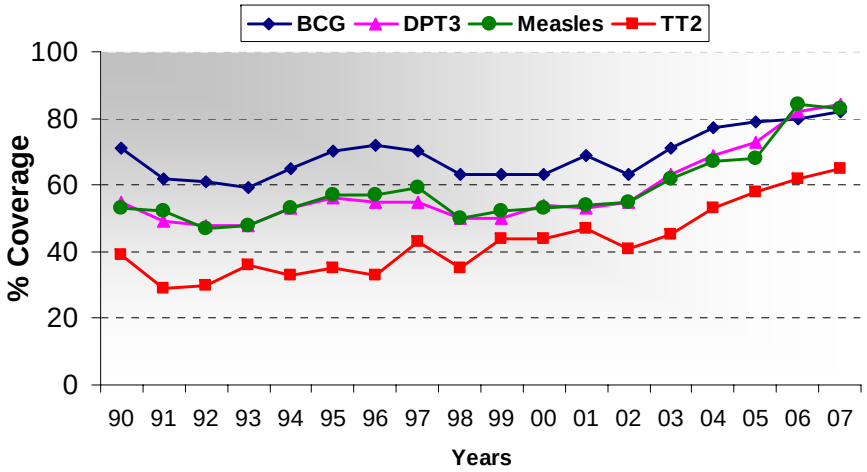
[17] *UNICEF & RBM (2007) Malaria & children progress in Intervention coverage.*

[18] *WHO/AFRO (2007) Overview of the Implementation of Indoor Residual Spraying of Insecticides for Malaria Control in the WHO African Region 2006 - 2007*

Malawi 45% and the Gambia 33%[19]. In some countries, the increase in ANC attendance has not moved in tandem with IPTp coverage[20]. All but 2 countries have adopted the ACT policy, but only 20 are implementing countrywide. In 14 countries with recent data, the median proportion of children under five years with fever receiving an ACT was only 2% (range $\leq$1 to 13)[21].

Maternal and child health: Percentage of births attended by skilled health personnel is above 70% in a few southern Africa countries but below 20% in Chad and Ethiopia with a regional average of 43%. Contraceptive prevalence rate is below 10% in 19 countries in the region. Immunization coverage continues to improve steadily as shown in figure 4 although is still very low in some countries, for example in Equatorial Guinea, it was 34% and 25% for DPT3 and measles respectively in 2006.

Figure 4: Immunization coverage with EPI vaccines African Region, 1990-2007



Source: *Annual WHO/UNICEF Joint Reporting Forms, Administrative coverage*, Ministries of Health

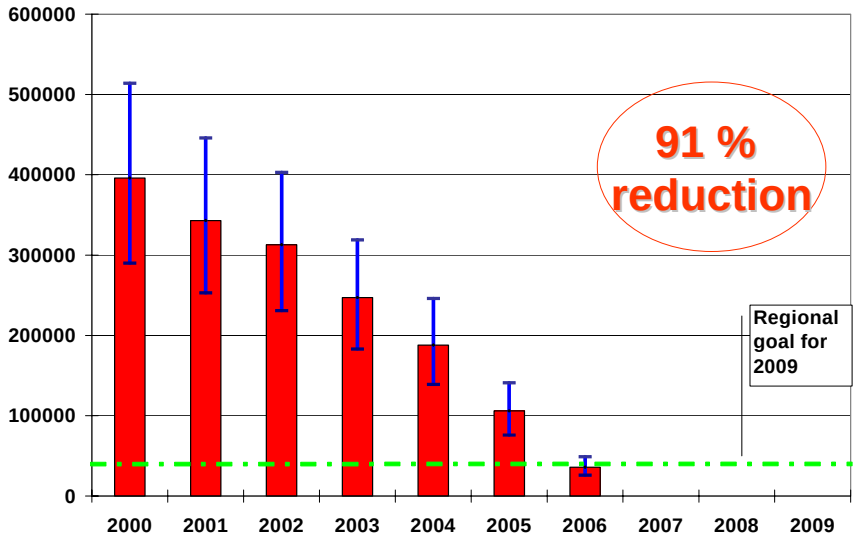
[19] *UNICEF & RBM (2007) Malaria & children progress in Intervention coverage.*

[20] DHS data from Ghana, Kenya, Malawi and Tanzania shows that ANC attendance at least twice is greater than 80% yet IPTp 2 coverage is below 30%

[21] *UNICEF & RBM (2007) Malaria & children progress in Intervention coverage.*

A 91 % measles death reduction has been recorded from 2000 to 2006 as shown in figure 5.

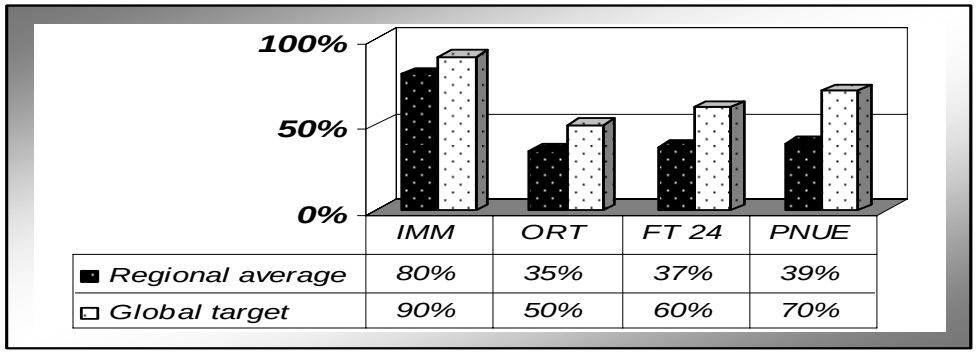
Figure 5: Estimated reduction in Measles mortality (all ages) in the African Region, 2000-2006



Source: WHO/IVB measles deaths estimates

Regional average for coverage with key child survival intervention is below global targets as shown in figure 6.

Fig. 6: Regional average coverage for key child survival interventions compared to global targets:



Code: IMM: measles coverage, ORT; proportion of children with diarrhea who receive ORT, FT: proportion of children with fever receiving treatment within 24 hrs, PNUE: proportion of children with pneumonia taken to a provider
Source: Lancet, Child Survival Series; 2006 using 2004 data

Exclusive breast feeding rate ranges from as low as 4% in Sierra Leone to 84% in Rwanda with a regional average of 30%

Coverage on newborn and child health interventions

Repeated evaluations in the African Region have shown that the coverage for preventive interventions that can be provided in a scheduled manner such as antenatal care (69%), immunization (measles: 72%, tetanus toxoid: (77%), vitamin A supplementation (73%) is high.

On the other hand coverage of curative interventions for illnesses in newborn babies and children that require on-demand availability remains low (postnatal care within 2 days: (8%), pneumonia taken to appropriate provider (40%) diarrhea receive ORT (30%), fever receive anti-malarial (34%). This applies also to skilled attendant at delivery (42%) with requires a 24 hr clinical care availability.

Coverage of interventions that require behavioural and social change such as early initiation of breastfeeding: 42%, Exclusive breastfeeding up to 6 months: 30%) is also low. Overall, the progress is insufficient to achieve the MDG4. Missed opportunities for integrated services exist during antenatal care or immunization services.

Urgent action and investment is needed to accelerate progress for coverage of clinical-care interventions, which depend on adequate access, human resources, essential supplies and maintaining the quality of services.

Disease Surveillance: Implementation of Integrate Disease Surveillance and Response (IDSR) is at various stages ranging from introduction in a few districts to nation-wide coverage. Completeness and timeliness of reporting to enable timely detection of outbreak and prompt response as well as use of information for monitoring and evaluation of interventions remains a challenge. Reports received from countries in 2005 showed

a variation of completeness from 40% to 99% with a median of 68% for malaria morbidity and mortality. By 2005, only 57% of countries had malaria preparedness and response plans.

Non Communicable diseases: STEP surveys, a WHO stepwise approaches to chronic disease risk factors surveillance to assess tobacco use, harmful consumption of alcohol, unhealthy diets, physical inactivity, overweight and obesity, raised blood pressure, raised blood sugar and abnormal lipid levels have been completed by only eleven countries.

Health systems: Funding for health is below requirement with 59% of countries in the region having a per capita expenditure of less that US$10, only Mozambique has met the Abuja commitment of devoting 15% of government expenditure to health. Policies and plans are not implemented due to lack of financial resources and other key inputs in the health system.

Weak infrastructure, limited procurement systems and inadequate laboratory services continue to affect provision of services while uptake of services is hampered by social economic and cultural influences. Effective referral is hampered by inadequate funding to operate ambulance services and the inability of referral levels to offer required services due lack of necessary inputs.

The human resource crisis has been a well-acknowledged problem for a while, to date only seven countries seem to have taken concrete steps to try and address the problem by increasing health worker remuneration, developing more favorable contractual arrangements, providing entitlements for those working in remote areas and redefining career profiles.

Health promotion, an approach with the potential for accelerating the realization of specific health targets, increasing social and community participation, contributing to disease prevention and reduction of risk factors associated with specific diseases is under-funded.

Inequalities in coverage exist within countries, for example, analysis of DHS data (1992, 2000 and 2004) in Malawi showed a widening pro-rich inequity in immunization coverage, ARI treatment, utilization of public facilities and access to reproductive health services. In a number of countries for example, Uganda, Lesotho and Namibia, coverage of intervention is higher among the richest quintile, in urban areas and among the more educated.

Majority of countries in the regions are not on track to achieving MDGs and at the 37th Regional Planning Management meeting, Countries requested WHO to provide technical assistance for developing, monitoring, evaluation and resource mobilization for national Road Maps for achieving MDGs on maternal and child health. This calls for new ways of doing things within WHO. The new way of planning within WHO, using strategic objectives as opposed to areas of work offers an opportunity to joint planning.

However, there are few countries in the region that are on track to meeting as shown in table 2:

Table 2: countries on track to meeting health related MDGs:

MDG	MDG description	Countries in the region on track to meeting targets
4	Reduce by two thirds, between 1990 and 2015 the under-five mortality rate	Cape Verde, Mauritius, Seychelles, Algeria, Eritrea
5	Reduce by three-quarters, between 1990 and 2015, the maternal mortality ration	Botswana, Cape Verde, The Gambia, Mauritius
6	Halted by 2015 and begun to reverse the spread of HIV/AIDs, the incidence of malaria and other major diseases	**HIV/AIDS**: Botswana, Uganda, Zimbabwe **Malaria**: Benin, Cameroon, Central African Republic, Comoros, Gambia, Guinea-Bissau, Kenya, Rwanda **TB**: Angola, Gabon, Gambia, Madagascar, South Africa, Swaziland, Zambia

Source: The Millennium Development Goals in Africa: Progress and Challenges, Economic Commission for Africa; August 2005.

2.0 Challenges to scaling up essential health interventions:

Ownership, accountability and the stewardship: these need to be strengthened at all levels in the health system. .

Coordination and partnerships: weak coordination and partnerships at global, regional and national level has led to duplications, inefficient utilization of resources, failure to pursue common priorities and insufficient complementarities in partner's support. At the country level, weak partnerships with the private sector (both for-profit and not-for-profit) have resulted in failure to harness capacities in this sub sector.

Capacity to monitor and regulate NGOs: substantial donor funds are channeled through NGOs whose capacity to contribute to health priorities varies greatly in different countries. Some NGOs have no capacity to deliver services and ministries of health have no capacity to regulate and monitor their activities.

Health financing: Twenty seven (27) countries have a public percapita expenditure of less than US$10 per person per year[22] far below an estimated requirement of US$36-40 to deliver a minimum package of services.[23] Donor projects and Global health initiatives are making

[22] Health financing: A strategy for the African Region; WHO; AFRO 2006.
[23] Investing in health, Macro Economics and Health: WHO 2004

substantial contribution to health; but, the challenge remains aligning these to country priorities and unpredictability. Erratic disbursements and low budget performance has greatly affected implementation of plans.
Flow of funds to operational levels is problematic due to a number of reasons ranging from weak financial systems to lack of capacity in financial management at the decentralized levels.

Essential inputs: Procurement and Supply Chain Management is weak contributing to frequent stock outs of essential medicines and health commodities. There is also lack of necessary equipment and weak infrastructure that hamper service delivery. There are inequalities in distribution of available infrastructure and equipment within countries and expansion of infrastructure with no consideration of required recurrent costs to enable provision of services.

Decentralization: This was meant to render services more responsive to local needs and foster community participation in service delivery. Capacity in planning and management of health services at the decentralized levels is weak. The anticipated improvement in accountability following decentralization is difficult to enforce because making autonomous entities account to central level ministries is a challenge. Occasionally conflicts in priorities have been noted between the central and decentralized levels.
Effective referral systems, between levels of care, are constrained by lack of funds to operate ambulance services and the suboptimal functionality of referral facilities due to weak infrastructure, inadequate laboratory services and lack of essential inputs.

Human resources for health (HRH): These are inadequate in numbers and skills mix and inequitably distributed in countries. Poor remuneration, human resource management and working conditions have led to demotivation of the available workforce, thus the high attrition rates and brain drain. Brain drain is both internal, from the public sector to the private sector or donors in country and external, migration to other countries. Distortions in deployment have been noted where staff are deployed to provide services not in line with their training. Out of the 57 countries with severe human resource crisis globally, 36 are in the WHO African region. Thirteen (13) countries have a policy and plan on human resources but their realization calls for increased investment in human resource.
In order to attract and retain special skills, incentive packages have been designed for specific cadres which, has eroded team work at service delivery levels.

A number of training modules have been developed by programmes and following this short term trainings have been undertaken in areas where new skills had to be imparted. The multiplicity of training modules has overwhelmed both countries and training institutions. In service training has neither been integrated nor rationalized thus keeping health workers away from duty stations for long periods of time. Capacity building has occasionally not translated into improved service delivery due to lack of supervision of those who have been trained and lack necessary inputs e.g. equipment to enable them apply acquired skills. .

Multiplicity of tools, manuals, guidelines and reporting tools: these have been developed by programmes and donors and sent to service delivery levels already facing human resource shortages. Utilization of these is poor in addition to reducing time available for health workers to deliver services.

Community participation: Active community participation is very important in improving uptake of services but in some countries is weak and ineffective. Among the issues is lack of community health workers to deliver services; weak linkages with the formal health system and lack of skills on community participation approaches among health workers. At the central level, very few Ministries of health have established community health departments which ideally should play coordination role. Community activities are under funded and voluntarism tried in several areas has not worked. Supervision of community health workers by the community based health centers is lacking due to human and financial resource constraints. Different stakeholders have implemented short-term community activities in a disjointed manner that has not been sustainable.

Monitoring and evaluation: M & E in many countries is weak at all levels of the health system. There is inadequate capacity for collection of good quality data, analysis, interpretation and utilization in planning and development of strategies.

Integration: Although integration has efficiency gains and can improve coverage of intervention substantially, it has not been implemented effectively. Progress in co-implementation is noted in areas like ANC and IPTp; HIV/AIDS and TB, provision of ITNs alongside immunization services and integrated delivery of MNCH interventions. However, many opportunities are still missed for country-wide roll-out of integrated interventions.

Other challenges: include recognizing the burden of certain disease conditions e.g. non-communicable diseases, resistance to available drugs, adaptation of proven cost effective interventions, implementation of agreed policies, lack of a favorable policy environment and, weak linkages between prevention, treatment, care and support interventions. Widespread denial with stigma and discrimination against PLWHA has affected uptake of HIV/AIDS interventions.

Resources: Challenges faced by WHO include inadequate human resource in some WHO country offices to offer timely technical assistance to ministries of health and partners. Inadequate funding for WHO hinders ensuring that evidence based guidelines and tools are adopted by countries.

In summary, key challenges to scaling up are system wide constraints, weak coordination and partnerships at all levels and lack of effective community participation. Challenges facing programmes include ensuring utilization of tools, manuals and guidelines, ensuring integrated delivery of a comprehensive package and addressing issues affecting uptake services like stigma. WHO's ability to offer timely, harmonized and effective technical support has been hampered by inadequate human and financial resources and poor coordination among programmes.

3.0 Examples of good practices:

There are some countries in the regions that have attempted to overcome these challenges and subsequently reported improved coverage of interventions.

Government leadership and ownership:
In 2003, the government of Malawi took a decision to provide highly subsidized ITNs to under – fives and pregnant women and mobilized funding for at least one million nets a year and mass net re-treatment on a yearly basis. This improved ITN coverage to 35% and 31% in under – fives and pregnant women respectively, although evaluation of it's impact on morbidity and mortality is yet to be undertaken.

Partnership between public and private to improve coverage of health services:
Management of TB cases in the private sector is not adequately captured in national TB control programme contributing to a low case and treatment success. Kenya involved private practitioners in provision of DOTS services to increase case detection and treatment success rates. Following involvement of private practitioners, treatment success rates continue to improve and by mid 2004, the private sector in Nairobi had registered 3,000 patients. Efforts are underway to scale up to other towns.

In Uganda, involving traditional healers in the fight against HIV/AIDS increased access to care and prevention services. This partnership bridged the gap between the traditional and biomedical health systems. Traditional healers worked as effective community educators and counselors addressing key issues like stigma, which greatly increased uptake of HIV/AIDS services.

Sustained government efforts:
Sustained vector control efforts in Swaziland over the years have yielded significant reductions in the burden of malaria. High coverage using indoor residual house spraying (IRS) has been achieved with funding mainly from the government. Within a period of five years (2000 – 2005), 400% reduction in confirmed malaria cases was registered and a similar trend was achieved in reducing malaria deaths.

Strengthening health systems to improve health outcomes:
An integrated research project was implemented in two districts in Tanzania beginning in 1997. The approach used was to strengthen the heath system to improve service delivery. Evidence based tools for planning and management were developed using district HMIS and sentinel Demographic Surveillance Systems data, capacity of the district management team was build in planning and management, community participation was ensured and burden of disease data was used in priority setting and guided resource allocation. The evaluation done in 2003 showed a 55% decline in under 5 mortality in Rufiji district and 56% decline in Morogoro district. Reductions were also registered in adult mortality.

In Mali, local communities and their authorities are able to recruit health professionals and able to attract them by paying good salaries and provide incentives such as free housing and utilities. This approach allowed most of the community health facilities to have the minimum health

staff required according to national standards to provide health services to the communities.[24] Zambia has introduced an incentive scheme for rural based doctors by providing them salary supplementation and this has enabled national authorities to post doctors in rural areas where it was not possible to do so before.

Strengthening community participation to improve uptake of services:
In Namibia, Omaheke region, the TB treatment success of less that 30% in a highly mobile population living in a sparsely populated area was posing a big challenge to patient follow up. DOTS was introduced in 1999, community treatment supporters were trained on treatment observation and health workers trained in supervision of community volunteers. Treatment success improved to 89% in 2003 up from 30% in 1999 and proportion of defaulters fell to 0.5%. In Senegal, trained, supported and supervised community health workers were able to treat and refer children with pneumonia.

In Ghana, Wassa district, access to IMCI and reproductive health services was improved through empowering communities to manage their health as an integral part of development. Communities were empowered to reduce the three delays; delays in deciding to seek appropriate care through creating awareness on danger signs, delay in reaching appropriate facility through provision of communication and use of local transport initiatives and delay in receiving care at the health facility through provision of door step services by community based health workers in hard to reach areas. This improved coverage for ANC and measles immunization and, reduced malaria case fatality and under 5 mortality rates.

Integration of services and subsequent increase in coverage of interventions:
Rapid increase in ITN coverage was realized in Niger where ITN distribution was integrated with polio campaigns undertaken using GF funds. Mass distribution of more than 2 million nets to all children under 5 was achieved increasing household ownership to 61.1% and 68.7% of households with children under 5 owned an ITN. In addition, the equity ration between the rich and the poor rose from 0.74 to 0.81. In Togo Distribution of ITNs with the immunization campaign delivered more than 90% of ITNs to eligible children.[25]

In Malawi strengthening TB/HIV coordination[26] increased access for TB patients to HIV services and access to TB services for HIV patients. HIV testing and counseling was offered to all patients with TB and HIV patients screened for TB. Within a period of a year (from July 2003 to end 2004) all hospitals in the country were implementing these interventions. Twenty six percent (26%) of TB registered patients were tested for HIV; 97% of HIV positive TB patients received cotrimoxazole treatment and 24 ART sites started 6,796 new patients on therapy during the year.

[24] Source: Promising Practices in human resources for health development in the who African region. 2004. Unpublished
[25] WHO/AFRO (2006) The Africa Malaria Report 2006.
[26] This was done through establishing a national TB/HIV coordination committee with focal person in the NTB program and in the National AIDS programme. The collaboration wasn't implemented as a vertical programme but joint national NTB and National AIDS programme joint efforts.

An evaluation of IDSR in 7 countries showed that IDSR implementation improved detection, reporting, investigation, laboratory confirmation and response to outbreaks. Coordination mechanisms were instituted and technical support for implementation was provided by programmes and several partners in a coordinated and complimentary manner

These good practices have shown that:

- Integrated service delivery and partnerships between public and private sector improve access to services and help overcome key barriers like stigma, substantially increasing coverage of essential interventions in an efficient manner. Blanket targeting through mass distribution can address equity issues in the short term given the challenges associated with reaching the poor and failed attempts in identifying them.
- Government leadership and ownership of programmes is very crucial. Commitment by governments and preferential allocation of resources for key interventions can increase access to services even without substantial increases in donor funding. Improving health outcomes requires more than short-lived projects, as governments take up short-term projects funded by donors and global initiatives, plans should be put in place to ensure long-term sustained efforts.
- Sustained coverage and scaling up cannot be realized when the health system is very weak, therefore, investing in the health system is part of scaling up efforts. Evidence based priority setting; planning and resource allocation can lead to a significant impact with minimal increments in resources thus relevant capacity must be built especially at the decentralized levels. Supervision by health workers must be ensured if community resource person are to deliver acceptable quality services.

4.0 General objective:

The objective of this framework is to guide WHO and countries on what is needed to scale up essential health interventions and how best WHO can support countries in their efforts to achieve MDG's, based on evidence and practice.

4.1 Specific objectives:

The specific objectives of this implementation framework include:

a. Identify a core set of interventions to be scaled up
b. Identify ways of strengthening collaboration of programmes at regional and country level
c. Propose improved modalities of providing technical support to countries
d. Propose critical health system components that will facilitate scaling up efforts
e. Propose better modalities of service delivery to improve coverage and reach vulnerable groups.

4.2 Expected outcomes:

The expected outcomes from countries, WHO and other partners are the following

a. Accelerated improvement in coverage of essential health interventions

b. Core interventions for scaling up identified
c. Improved collaboration and strengthened partnerships at global and regional levels
d. Improved modalities of providing technical support o countries

5.0 Guiding principles:

The following principles will guide scaling up priority health interventions:

1) **National stewardship and accountability:** Governments should guide all investments in health and ensure accountability and transparency of at all levels of the system including the community.
2) **Ownership:** The scaling up process should be owned by governments, communities, civil society and the private sector in countries.
3) **Sustainability**: Efforts should involve sustained investments and implementation. Where short projects are implemented governments should plan for long-term investments to enable continued implementation of interventions.
4) **Human rights:** All persons have a right to health, including access to an effective and integrated health system which is responsive to national and local priorities and accessible to all. Every person should have access to essential health interventions, which are appropriate, relevant and of acceptable quality.
5) **Equity and sustainable universal access:** Countries should factor in the planning, resources allocation and implementation processes innovative ways of improving access to health services for the poor and vulnerable groups and, taking gender consideration into perspective.
6) **Life course approach** (pregnancy, child birth, early infancy, childhood, adolescence, adult life)**:** A life course approach to delivering CAH and NCD interventions should be embraced
7) **Inter-sectoral collaboration:** Interventions to be undertaken by the relevant sectors should be clearly outlined and coordination efforts to ensure their implementation put in place by appropriate authority.
8) **Partnerships:** Strong and effective partnerships should be developed at the global, regional, national, district and community levels in order to enhance coordination of program activities, avoid duplication of efforts and maximize the use of resources. At the country level, partnership with the private sector in service provision should be strengthened. An enabling environment should be provided through favorable policies, provision of subventions, sharing of information and capacity building opportunities.
9) **Community participation:** Mechanisms to ensure active community participation in planning and management of health services, harmonization of culturally acceptable community packages and delivery strategies should be put in place.

5.1 Prerequisites for successful scaling up:

To successfully scale up in the African region, WHO should provide an effective oversight and policy guidance to enforce collaboration among programs. Ensure joint technical missions to countries, development of integrated guidelines, tools and training modules and institute an internal review mechanism for all documents that are sent to countries. Effective and institutionalized joint planning amongst programmes and Divisions for priority strategies and activities programmes should be more proactive in ensuring collaboration through consultations and sharing information in a timely manner. WHO Representatives should play an active role in ensuring collaboration at country level. WHO should be more proactive in collaborating with regional networks that develop health initiatives and support countries to implement health programme.

Partners:
Partners should build upon country priorities and plans as well as consensus on core interventions to be scaled. They should provide predictable funding in a sustained manner and show flexibility in utilization of funds provided by donors and global initiatives.

Countries:
Countries are strongly required to (i) provide effective stewardship and ownership of scaling up essential interventions, (ii) appreciate the need for scaling up essential interventions, (iii) develop evidence based, prioritized, realistic and costed strategic and operational plans, (iv) strengthen the health system and build required capacity at all levels, and (iv) ensure availability and equitable distribution of competent human resources that are supported to offer servicese and are supervised.

6.0

6.0 Scaling up implementation of essential interventions:

Scaling up essential health intervention in both scale and scope to achieve universal coverage and contribute towards attainment of MDGs, will require effective collaboration at the regional and national levels, integration at health facility and community levels and coordination of all actors and activities. *See glossary for definitions*. Vulnerable communities and groups including, the poor, women, children, conflict and post conflict situations and hard to reach areas should be targeted.

Scaling up will make use of lessons learnt from good practices, previous attempts within AFRO to integrate communicable diseases programmes at the district level and build on ongoing efforts to strengthen collaboration, see *Annex III for details.* Support will be provided within the framework of existing policies and strategies of countries where these exist and building on efforts and exisiting regional strategies to accelerate attainment of MDG targets. *See Annex IV for details*. Efforts by Inter country Support Team for East and Southern Africa (IST/ESA) in a document entitled “IST Framework for harmonized country support to accelerate achievement of the Health related MDGs” still in draft form, are acknowledged and taken into consideration in the development of this document.

6.1 Core set of interventions to be scaled up

The proposed priority activities by programme are highlighted in table 3.

Table 3: Proposed essential health package activities for countries in the African Region: 2005 - 2009

Program	Key interventions:
HIV/AIDS	• Strengthening HIV testing and counseling • Maximizing the health sector's contribution to HIV prevention • Accelerating the scale-up of HIV/AIDS treatment and care • Accelerate the scale up of PMTCT interventions • Investing in strategic information to guide a more effective response
Tuberculosis	• DOTS expansion • Improve quality of Lab diagnostic services • Improve case holding and treatment success • Prevention and management of multi-drug resistant TB • Strengthen Collaborative TB/HIV activities
Malaria	• Scaling up case management with quality and affordable antimalarials • Universal access to ITN and IRs for those at risk of malaria • Scaling up malarial prevention and control in pregnancy interventions • Strengthening systems for Malaria Epidemics Preparedness and Response
Maternal Health	• Improving the provision of, and access to, quality MNH care including FP services. • Strengthening the referral system.
Child and Adolescent Health	• Integrated management of common childhood illnesses and treatment and care of children exposed to or infected with HIV. • Newborn care • Immunization of mothers and children
Nutrition, infant and young children feeding	• Infant and Young Child Feeding, including micronutrien supplementation and deworming
Non communicable diseases	• Implementation of STEPS in all countries • Scaling up integrated primary prevention efforts targeting al

Program	Key interventions:
	majors risk factors • National NCD programs in all countries including oral health, sickle cell disease, injuries and mental health • Scaling up secondary and tertiary prevention of all NCDs including disability & mental health management • Research on socio-economic impact of NCDs to emphasize multisectoral approach
Disease surveillance and epidemic response/IDSR	• Extending IDSR to all health facilities in each district • Enhancing surveillance data reporting and use of information for action at health facility and district levels • Establishing and train district rapid response team • Conducting supportive supervision to mentor and orient health care facility staff
Health System Strengthening and health promotion as a cross cutting components for scaling up. Strengthening health systems will be done through the six building blocks (service delivery, health work force, health information, medical products, vaccines and technologies, health financing, leadership and governance for health) using Primary Health Care Approach in order to achieve equity of access, increase coverage, improve quality and ensure safety for better health outcomes.	

6.2 Ways of strengthening collaboration of programmes at regional and country level:

Countries, WHO and partners **should build** consensus on an affordable package of essential health interventions to be scaled up defined for each level of care including the community, bearing in mind the concept of optimization as opposed to maximization and the resource constraints faced by countries. They should ensure joint planning and integrated service delivery. They should also develop an agreed framework on how collaboration and joint planning will be ensured. At the planning stage, programmes should discuss and agree on collaborative activities which should be clearly reflected in the Plans of Action of each with a budget allocated to them e.g. review and integration of tools and guidelines, joint Technical Assistance missions. Schedules for these collaborative activities should be agreed between programmes and regular reviews of implementation of the collaborative activities have to take place.

6.3 Proposed modalities of providing technical support to countries:

WHO:

a. Provision of simplified, rationalized and integrated tools, manuals and guidelines for strengthening policy development, planning, supervision, M&E, advocacy and communication skills.
    - Take an inventory of all tools, manuals and guidelines developed by WHO, review for appropriateness and integration (programme specifics to be added as addendums).
    - Institute an internal review mechanism that reviews all developed guidelines, tools, training modules and manuals to ensure harmonization and integration
b. Provide funding to support key activities that enhance adaptation of appropriate guidelines and tools at country level.
c. Ensure availability of minimum required competencies within WCOs; (through re-profiling & Capacity building where necessary)
d. Supporting capacity building by:
    - undertaking an inventory of existing training modules developed by WHO with an intention of rationalizing and integrating them. Programme specifics could be included as addendums where justified.
    - providing updates and new evidence for continual improvement of training and service delivery.
e. Provide technical assistance to countries to adapt and implement Regional Strategies and Road Maps:
    - Use more innovative ways of offering technical assistance in addition to missions:
    - Interaction with WCO's should be a regular activity for Regional offices and HQ. These could focus on discussing progress reports and other key issues during the implementation period.
    - Systematic approach to technical missions and integrated as much as possible.

6.4 Critical health system components that will facilitate scaling up efforts:

WHO and Partners are required to strengthen partnerships at a Global and Regional levels and mobilize resource through advocating for and mobilizing more predictable funding for health. They should support governments to strengthen health financing monitoring and, improve allocative and technical efficiency in use of resources. They should also participate and provide guidance in country processes, development of policies and strategic plans, implementation based on comparative advantage and support capacity building in areas of identified gaps.

Countries are required to provide effective leadership, coordination and stewardship in scaling up essential interventions. and ensure implementation of long term, sustained programs as opposed to short term projects. This requires building capacity to coordinate partners and donor assistance and, creation of mechanisms for making decentralized levels accountable for the results,, They should .strengthen management of health services at all levels through ensuring availability of competent managers, good support systems and a good working environment and ensure availability of comprehensive and rationalized national Health Policies, Health Sector Strategic and operational Plans integrated into the overall development processes. Countries are required to ensure access to essential medicines including building capacity in forecasting and quantification., institute therapeutic committees, strengthen logistic and procurement systems; improve access to quality laboratory services and adequate and appropriate infrastructure.

1) Strengthen Monitoring and evaluation; development of Health Information Policies, strategic plans and indicators, promote utilization of information in planning and development of strategies, undertake Service Availability Mapping (SAM) to guide planning and strengthen community information systems.
2) Capacity building should be built in countries to:
    - Undertake skills review by level of care to ascertain gaps and develop capacity building plans to address them including curriculum review to strengthen the pre service training.
    - Use of training institutions for in service training including programme managers conducting trainer of trainers (TOT) workshops organized for tutors, lectures and to orient them on the new integrated modules to reduce duplication and time taken of work of health workers

3) countries should improve productivity of available human resource by;
    a. Undertaking workload assessments for health teams at the different levels to show relative and absolute shortage in human resource and design appropriate strategies.
    b. Identifying innovative ways of addressing human resource challenges borrowing from good practices in the region.
    c. institutionalizing retention and motivation packages should be provide in a holistic way to motivate whole teams rather than individuals.
    d. Ensuring availability of necessary inputs for optimal productivity of health workers.
4) For Health financing countries are required to:
    a. Develop comprehensive health financing policies in order to reduce reliance on out of pocket payments where they are high, by moving towards prepayment systems involving pooling of financial risks across population groups.
    b. Advocate for increased allocation to the health sector including fulfilling the Abuja commitment of 15% of government expenditure allocated to health
    c. Improve allocative and technical efficiency in resource utilization through needs based resource allocation, undertaking efficiency studies to identify areas of efficiency gains, explore ways of improving absorption capacity and; strengthening health financing monitoring.

5) In ensuring an all inclusive process where all stakeholders are enabled to participate fully, countries should put in place mechanisms to enable effective engagement of NGOs in service delivery. .

6.5 Proposed modalities of service delivery to improve coverage and reach vulnerable groups.

The following modalities of service delivery aiming to improve coverage, particularly among the poor are suggested

Countries

Countries should undertake programme reviews regularly and strengthen weak programme areas.
Countries should adapt and implement Regional Strategies and Road Maps. They should also adapt tools, guidelines, training modules and manual for strengthening policy development, planning, supervision, M&E, advocacy and communication skills.
Countries are required to review and integrate guidelines and promote their utilization at the relevant levels. A dissemination strategy should be part of the guideline development. A "clearing house" at the national level that reviews all new protocols, guidelines and training modules to incorporate them in existing systems should be instituted.
Countries should ensure that decentralized levels prepare good evidence based comprehensive and integrated annual operational plans (including community activities) that are well costed, consistent with national policies and strategic orientations and, are responsive to local priorities. Implementation of these plans must be monitored regularly. Countries should reorganize services through outreaches, use of community resource persons who are supported and supervised and, involve the private sector to ensure total coverage of all population. . In addition, countries should explore ways on how the " Reach Every District Strategy" used for EPI could apply to all programmes and interventions and could be added sequentially.
Countries should develop a harmonized and comprehensive approach to community participation and partnerships with community organizations to scale up service delivery. They should explore new ways to involve communities in the oversight, planning and operations of health services. Countries should invest in health promotion to stimulate community participation, empowerment, improve uptake of services and address broad determinants of health. The home should be looked at as an implementation level and will need information, education and communication messages translated into local languages

WHO:
WHO will pursue its support to countries to undertake programme reviews and strengthen weak areas. WHO will also disseminate best practices to countries for guidance in developing national strategies and will support operational research in prioritized areas.

AFRO will work closely with the IST to implement this document and countries will be supported in phases. The IST/ESA has already drafted a framework for harmonized country support and other ISTs will identify core IST activities in line with this overall framework.

7.0 Opportunities:

There are enormous opportunities at global, regional and national level to scale up implementation of interventions in countries. These include (i) global commitment for accelerating the attainment of the MDGs; (ii) recognition of the importance of strengthening of health systems in scaling up interventions; (iii) increased financial commitment to strengthen health systems from Global Fund for AIDS, Tuberculosis and Malaria, Global Alliance for Vaccines and Immunization, Alliance for Human Resources, Health Metric Networks, debt relief initiative, and Paris Declaration on donors' harmonization and aid effectiveness.
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8.0Implications for countries, WHO and Partners

Countries, WHO and partners should reach **c**onsensus on the proposed framework among the key stakeholders; revise and harmonize existing plans based on the framework; develop timetable for implementation of the framework and monitor and evaluate the implementation of the framework.

WHO and various partners will formalize collaboration for policy guidance and mobilize adequate resources that are required to implement identified activities.

9.0Way forward/recommendations:

This implementation framework is expected to accelerate coverage of essential health interventions contributing towards improving population health and attainment of MDGs. The success of this framework will depend on fulfilling the prerequisites for countries, WHO and partners and implementation of the identified tasks for each stakeholder.

Glossary:

Essential health care package: Defined to comprise of health interventions (promotive, preventive, curative and rehabilitative) including required inputs, selected on the basis of their ability to have the greatest impact on diseases burden reduction at various levels in the country. Interventions are selected after taking into consideration issues such as cost effectiveness and equity.[27]

Scaling up: Geographical expansion of intervention and/or diversification of the range of services.[28]

Accessibility of health care: A measure of the population that reaches the appropriate health services.[29]

Collaboration: The acting together of two or more people from different programs either within the same or different agencies to deliver a service which neither can deliver alone.[30] Collaboration should be emphasized at higher levels, global, regional and national levels. See *Annex I. 1.1* for examples on collaboration.

Coordination: The act of working together harmoniously which is built in a deliberate manner involving a strong will to make a system operate, and organize the behavior of the stakeholders involved.[31]

Integrated services: availability of multiple health services through a single facility or at a single visit.[32] See *Annex I. 1.2* for examples on integration.

[27] Source: Planning and implementation of District health systems; WHO AFR/DHS/03.04
[28] Source: Framework for universal access to HIV/AIDS Prevention, Treatment and Care in the Health Sector; WHO 2005
[29] Source: "The European Observatory om Health systems and Policies", the glossary of health systems related terms used at WHO. Available at http://www.euro.who.int/observatory/Glossary/TopPage?term=1
[30] Source: The integration of health care: Dimensions and implementation; working paper; Andre-Pierre Contandriopoulos et at; University of Montreal; 2003
[31] Source: Andre-Pierre Contandriopoulos et at; University of Montreal; 2003
[32] Source: http://www.who.int/reproductive-health/publications/rtis_gep/glossary.htm

ANNEX I: Examples of collaboration and integration:

1.1 Examples of collaboration:

- Joint planning on PMTCT, Sexual and Reproductive health, nutrition, health promotion, TB interventions;
- Joint meetings between WHO and UNAIDS, UNICEF and UNFPA among other partners.
- Joint planning of TB/HIV activities in 34 countries
- Joint planning on PMTCT and HIV
- Divisional approach to introduce primary prevention of NCDs including injuries and mental health course at IRSP
- Joint planning of surveillance activities by different programmes
- Joint planning of maternal and child health

1.2 Examples of integration of activities:

a. Integrated child survival intervention (Immunization, and distribution of ITNs, Vit A, Zinc and treatment of minor illnesses)
b. Integrated delivery of malaria control interventions with Neglected Tropical Diseases
c. Integrated activities at country level with Mal and EPI (RED Approach, Integrated campaigns, ITNs distributions, re-treatments)
d. Integrated MNCH Monitoring and supervision tools
e. Framework for integration of FP, MIP, PMTCT and NUT into MNCH services
f. Integrating malaria prevention in ANC and child welfare clinics
g. Rapid investigation of outbreaks using AFP/Polio surveillance officers
h. Integrated disease surveillance (Integrated data collection tool for epidemic prone diseases and diseases targeted for eradication)
i. Integrated support supervision (Integrated supervision tool and teams)
j. Implementation of DPAS with NUT HPR CDP (NCD)
k. HIV testing in TB patients
l. TB screening for people living with HIV/AIDS
m. Integrated primary prevention measures of NCDs including oral health, injuries and mental health.

ANNEX II: Countries that have registered improvements in health indicators

Table 1: Countries that have registered improvements in health indicators (years in brackets):

Country	**IMR per 1,000 live births**		**U5MR per 1,000 live births**		**MMR per 100,000 live births**	
Mozambique			207 (’98)	156 (’03)		
Madagascar			129 (’97)	94 (’04)		
Rwanda			217 (’99)	152 (’05)		
Ethiopia	92.4 (’00)	79.7 (’05)	150.6 (’00)	127 (’05)		
Uganda	88 (’00)	76 (’05)	152 (’00)	137 (’05)	505 (’00)	435 (’05)
Tanzania	100 (’99)	68 (’04)	156 (’00)	112 (’04)		

Source: country Demographic health survey reports:

Table 2: Countries with deteriorating health indicators:

Country	IMR per 1,000 live births		U5MR per 1,000 live births	
Botswana	50 (’95)	74 (’00)	101 (’00)	116 (’05)
Namibia			58 (’95)	71 (’04)
Zimbabwe	73 (’00)	78 (’04)	117 (’00)	129 (’04)
Lesotho	81 (’01)	91 (’04)		113 (04)

Source: country Demographic health survey reports:

ANNEX III: Efforts and lessons at WHO/AFRO

1. Project on integration of communicable disease programmes at district level was implemented between 2003 – 2005 in five pilot countries.
2. Collaboration efforts:
   - CAH and EPI coordinating a meeting took place in August 2007 in Ouidah, Benin . The meeting involved key programmes (HIV/AIDS; MAL; EPI; CAH) and partners ( ) and reviewed available management modules and work out ways of integrating them.
   - DES coordinating development of a comprehensive occupational health package involving; TUB, MAL, HIV/AIDS, MNH and Health promotion.
3. Guidelines provided to shape up and strengthen collaboration between IMCI and malaria programmes at regional, national and sub-regional levels.
4. The ATM division has agreed on common modalities of strengthening common areas like monitoring, laboratory services and partnerships
5. Guidelines for developing national health policies and plans, draft, World Health Organization, Regional Office for Africa , Brazzaville, 2005

6. Joint mission on health policy formulation and health strategic plans development
7. Joint meetings on proposals development (GAVI, GF) to strengthen health systems

ANNEX IV: Regional strategies to accelerate attainment of MDGs:

1. The Regional Child Survival Strategy;
2. Scaling up Interventions against HIV/AIDS, Tuberculosis and Malaria in AFRO AFR/RC56/12, 2003;
3. The Road map for Accelerating the Attainment of MDGs related to Maternal and New born Health in AFRO AFR/RC54/INF/R9, 2004,
4. Maternal and New Born Health: Framework for the promotion and Implementation of Community based interventions; AFR/MPS/04.01; 2004.
5. Strategic Framework for Integrating Additional Child Survival Interventions with Immunization in the Region, August 2006;
6. The Strategic Framework for Malaria Prevention and Control during Pregnancy in The African region,
7. Revitalizing Health Services using the Primary Health care (PHC) Approach in AFRO AFR/RC56/12, June 2006
8. Health System Strengthening in the African Region: Realities and opportunities; AFR/RC57/PSC/8, July 2007.
9. WHO/AFRO. Health Financing: A Strategy for the African Region. AFR/RC56/10 Brazzaville; 2006
10. Framework for the Implementation of the Ouagadougou Declaration on Primary Health Care and Health Systems in Africa: Achieving Better Health in Africa in the New Millennium, WHO AFRO May 2008, draft

ANNEX V: Activities to implement the framework by level:

	CSR	CAH	MAL	HIV/AIDS	VPD
WHO	- Produce a file manual on integration - Capacity building - Provision of Technical Assistance	- Joint planning within AFRO - Strengthen collaboration within AFRO - Strengthen M & E to monitor coverage - Capacity building in programme management[33] - Provision of TA - Support countries adapt the Regional Child Survival Strategy-	- Joint planning within AFRO - Strengthen collaboration within AFRO - Strengthening partnerships - Provision of simple adapted tools and guidelines to facilitate integrated planning; M & E - Capacity building - Develop better methods of assessing burden of disease - provision of TA - development of advocacy and communication and social mobilization tools Resource mobilization	- provision of tools, guidelines - advocacy - strengthening partnerships and providing WHO's orientation in line with it's technical mandate. - Capacity building - Provision of TA - Strengthen M&E	- Provision of guidelines - Provision of capacity building modules - Provision of TA - advocate for Investing in public health
Country	- Implemented IDSR	- Adaptation and Implementation of the Child Survival Strategy. - Capacity building - Implement the Strategic Framework for Integrating Additional Child Survival Interventions with Immunization in the African Region	- Implementation of activities - Extend the RED strategy to all districts - Capacity building	- Implementation of programme activities - Capacity building	- adapt the Regional Child - Survival Strategy - Implement the Strategic Framework for Integrating Additional Child Survival Interventions with Immunization in the African Region

[33] The training module developed includes strategic planning, quantification, M & E, implementation, negotiation skills and supervision. This is intended for programme managers.

	SRH	TUB	Organization and management	Health Information	Human resource
WHO	- Provision of tools and guidelines - Strengthen country M & E for the Road Map. - Provision of TA - Support countries to implement the "Road map for accelerating the attainment of the MDGs related to maternal and new born health in AFRO'	- Joint planning within AFRO - Provision of tools - Provision of integrated TA - Support DOTS scale up	- AFRO should institute an internal review mechanism that reviews all developed guidelines, tools, training modules and manuals to ensure integration and harmonization. - Strengthen partnerships at a Global level and with Regional networks.	- Support countries implement Priority interventions for strengthening national health information systems; AFR/RC54/12 REV.1 - provide an integrated support supervision tool' programme specifics could be added as addendums.	- Undertake an inventory of existing training modules developed by WHO with an intention of rationalizing them. Integrated modules should be developed although programme specifics could be included as addendums where justified. - Provide updates and new evidence for continual improvement of training.
Country	- Adaptation of the Road map for accelerating the attainment of the MDGs related to maternal and new born health and Implementation of activities - Ensure availability of competent staff - M&E	- Implement DOTS - Implement TB/HIV collaborative activities	- Institute a clearing house that reviews all new tools, guidelines and training modules to incorporate them in existing systems. - Strengthen partnerships	- Undertake Service availability mapping (SAM) to map services and availability of other inputs.[34] - Develop and implement plans to strengthen health and all health related information system using the HMN framework. - Strengthen the community component of health information. - development of policies, indicators, - NHIS strategic plans; - Promote use of IT, - web page for sharing data,	- Undertake skills review by level of care to ascertain gaps and develop capacity building plans to address them. - Undertake workload assessments for health teams at the different levels to show relative and absolute shortage in human resource and design appropriate strategies. - Curriculum review should be undertaken to devise means of strengthening the pre – service curriculum.

[34] AFRO has secured funding for 6 countries to undertake SAM, this exercise should involve all programmes. Countries include Angola, Niger, Burkina Faso, Kenya, Tanzania and Malawi.

				- promote utilization of information in planning and resource allocation.	- Use of training institutions for in service training is suggested. These could organize in service training for an agreed number of times a year[35] at the same time incorporate new strategies in pre-service curriculum. A trainer of trainers (TOT) workshop could be organized for tutors, lectures and programme managers to orient them on the new modules. - Training should focus more on public health needs and basic competencies which are more relevant especially in rural areas as opposed to specialist training. - Retention and motivatio options should be designe for health teams a opposed to motivatin specific cadres. - Ensuring availability of necessary inputs is key for optimal productivity of health workers. - Supervision and follow up of trained health workers.

[35] Integrated training could be organized to take 6 days where the first three days are spent on integrated module and allow three days for issues specific to programmes.

	Health promotion	NCDs	EDM	HFS	Nutrition
WHO	- Capacity building for WCO (HIP) and focal points in MoH. - Advocate and support countries to implement "Health promotion: A Strategy for the African Region AFR/RC51/12 Rev.1; 2003	- TA and orientation to countries to undertake STEPS survey - Guidelines for developing policies and legislation on NCDs - Support countries put in place surveillance systems to generate data for advocacy. - Provide standards for efficacious drugs - Best practices to guid countries.	- Provision of guidelines to strengthen procurement - Provision of TA - Provision of tools to improve rational use of drugs (generic medicines list, standard treatment guidelines, community tools on rational use of drugs) - provide tools to support training on drug management - Advocate for strengthening the logistic system - Capacity building	Support countries implement the Health Financing Regional Strategy (HFS/RC56)	- Capacity Building - Strengthen pre-service curriculum - Advocacy - promote integration of nutrition interventions with other programmes; EPI and CAH
Country	- Develop comprehensive multisectoral plans on health promotion.[36] - Adapt and implement the "Health promotion: A Strategy for the African Region AFR/RC51/12 Rev.1; 2003	Implementation - STEPS survey - integrated NCD control programme - surveillance	- Strengthen procurement system - Institute therapeutic committees - strengthen the logistic system	- Develop comprehensive health financing policies. - explore ways of how available funding can be stretched to provide more services - Fulfill the Abuja commitment of 15% of government expenditure allocated to health - Strengthen health financing monitoring - Improve allocative efficiency - Resource mobilization - Ensure harmonization and alignment of resources -undertake efficiency studies and ensure efficient utilization of resources - Reduce transaction costs	- implemented integrated nutrition interventions

[36] Plans should elaborate empowerment, supportive environment and advocacy.

ANNEX VI: Monitoring indicators for programmes for the framework

Indicator	Source of data	Frequency of reporting
HIV/AIDS	HIV prevalence among 15 – 24 year olds	Annual data from countries
TB	Number of countries that have scaled up DOTS in all districts.	Countries providing annual routine data
Malaria	Number of countries implementing effective treatment policies in all districts	Countries providing routine data annually
RH	Number of health facilities providing family planning as a proportion of total health facilities in the country.	Countries providing annual routine data
CAH	Proportion of children with diarrhea who receive ORT	Countries providing annual routine data
Nutrition	Prevalence of under weight	Countries providing annual routine data
NCD	Number of countries with effective integrated NCD programmes	Countries providing annual routine data
IDSR	Proportion of districts submitting weekly or monthly surveillance reports on time to the next higher level	Countries providing monthly routine data
	Proportion of suspected outbreaks of epidemic prone diseases notified to the next higher level within two days of surpassing the epidemic threshold	Countries providing monthly routine data
MPS		
VPD		
Health systems	Number of countries with an increased number of and improved distribution of health facilities / service delivery points per 10,000 population	Countries providing annual routine data
	Number of children under-5 years' out-patient department (OPD) visits per 10,000 children under 5	Countries providing annual routine data
	Number of countries that have in the last 5 years implemented at least 80% of the essential health services at 75% coverage	Countries providing annual routine data

Commentaire [J1] : the two rows to be completed by indicated units to complete the table