

INTERNATIONAL CONFERENCE ON PRIMARY HEALTH CARE AND HEALTH SYSTEMS IN AFRICA

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1. Opening ceremony

Welcome remarks by the Minister of Health, Burkina Faso

Dr M.B.A. Yoda, Minister of Health of Burkina Faso, welcomed all the ministers of health, delegates and participants to Burkina Faso. He noted that this was the first time in the 30 years since the Alma-Ata Declaration of 1978 that global reflections have focused on the role of primary health care (PHC) in the achievement of the Millennium Development Goals (MDGs). Since the Alma-Ata Declaration, there has been considerable improvement in health indicators and better definition of priority interventions. However, there were new challenges related to HIV/AIDS and avian influenza. He highlighted the relevance of the Ouagadougou Conference in addressing these challenges and expressed the hope that the Conference would give rise to new ideas for using the PHC strategy to strengthen national health systems to achieve the MDG targets.

Statement by Dr Luis G. Sambo, WHO Regional Director for Africa

Dr Luis G. Sambo expressed the apologies and extended the greetings of the WHO Director-General. He acknowledged the presence of the co-organizers. He thanked the President and people of Burkina Faso for hosting and co-organizing the Conference and applauded the personal contribution of the President of Burkina Faso to the cause of public health in Africa. He recounted some of these contributions, including resource mobilization for the global forum of partners for the fight against neglected tropical diseases, advocacy at the last Summit of African Heads of State for better response to the meningitis epidemic in the Sahel region, campaigning for the production of the new conjugate meningitis vaccine, and investment in health care by the Government of Burkina Faso.

Dr Sambo reiterated that the Alma-Ata Declaration was the beginning of a real revolution in public health in the world and that since this Conference comes at the time of the celebration of the 30th anniversary of the Declaration and the 60th anniversary of WHO, there was need for review and redefinition of commitment taking into consideration the lessons learnt and the changes that had occurred since 1978. Some of these changes include globalization and its effects on epidemiological profile, poverty, the food crisis, environmental degradation, health risks related to handling of biological agents, political and economic constraints and the AIDS pandemic. He said that the Conference would provide an opportunity for sharing experiences and good practices as well as difficulties and challenges. For Member States to achieve the health-related MDGs it will require functional health systems with qualified and motivated health personnel providing quality services equitably, based on community needs and with the full participation of the community, including the poorest and the most vulnerable.

Dr Sambo said that the PHC vision was still relevant and was needed more than ever before considering that health was critical for development, a fundamental human right and a crucial factor for poverty reduction. He recognized the efforts made by the countries since 1978 to reduce the burden of morbidity and mortality from HIV/AIDS, malaria, tuberculosis, onchocerciasis and other endemic diseases and maternal and child health conditions. He highlighted the evidence on the reduction in child mortality (including from measles related

causes), polio endemicity, guinea worm cases and leprosy endemicity. He also cited the increase in the number of people living with HIV/AIDS who were on antiretroviral treatment.

Dr Sambo pointed out that despite the fact that the African Region is home to 11% of the world's population, it carried 25% of the global burden of disease and received a relatively limited share of the global resources for health. He indicated that maternal mortality was unacceptably high and required more attention and engagement by all partners. He said that more than 68% of HIV/AIDS infections and 75% of AIDS-related deaths in the world occur in sub-Saharan Africa, and he lamented the emergence of multidrug-resistant tuberculosis.

He noted that 90% of the world's malaria burden was in Africa and that children and pregnant women were the most affected. He called for more investment in the neglected tropical diseases and noncommunicable diseases.

Dr Sambo indicated that health systems were not optimally performing their functions related to governance, production and management of human resources, health financing and provision of quality health services, and as a result they were not able to reduce inequalities in access to health care, especially for the poorest and those in remote areas. This was mainly due to political crises leading to displacement of populations, the structural adjustment programmes of the 1980s and the heavy external debt. There are other factors as well, such as priorities not based on evidence, vertical programme approaches, fragmentation of external aid, insufficient coordination of partners, insufficient planning and management capacity, inadequate housing, limited access to education, and limited water and sanitation coverage. Tackling these challenges requires intersectoral collaboration. He said that PHC was still an effective strategy for improving health, as available global and regional evidence demonstrates.

Dr Sambo noted that, since assuming office, the WHO Director-General had consistently emphasized the health of Africa and strengthening of health systems as her priorities. He reaffirmed the commitment of the UN agencies to the achievement of the MDGs in Africa and underscored the need for increased and harmonized support to countries to accelerate the achievement of the health-related MDGs. He noted the increasing number of innovative financing mechanisms but said that these needed to be harmonized and aligned with national health policies in order to reach the poor. He talked about the initiative "Harmonization for Health in Africa" created by WHO, UNICEF, UNAIDS, UNFPA, the World Bank and the African Development Bank to help countries get value for money from different sources of funding.

Dr Sambo emphasized the need to ensure the realization of the Heads of States' commitment to allocate 15% of their national budgets to health and of the recommendation of the Commission on Macroeconomics and Health (CMH) to allocate at least US\$ 34 per capita to health.

He said that achievement of the health goals required involvement of all members of the community. He encouraged the representatives of the civil society to share their experiences and actively participate in health-related debates. He noted that the private sector had a fundamental

role in health development and this should be taken into account in developing national health policies.

Finally, Dr Sambo said that one of the important outcomes of the Conference was the Ouagadougou Declaration on Primary Health Care and Health Systems. He hoped that its implementation would transform the vision for health development into reality.

Statement by Dr M. Tshabala-Msimang, representative of the African Union

Dr M. Tshabala-Msimang, Minister of Health, South Africa and Chair of the Bureau of African Ministers of Health, gave a statement on behalf of the African Union.

She said that the commemoration of the 30th anniversary of the adoption of the Alma-Ata Declaration was both an acknowledgement that the countries that had adopted its ideals and principles were right to prioritize equity, community involvement and participation, and intersectoral collaboration, and a celebration of the importance of healthy lifestyle programmes for health promotion and disease prevention.

She highlighted the fact that realization of PHC goals was stifled first by selective implementation of the strategy and later by vertical programming. She noted that it had taken almost 30 years to recognize the need for integrated and comprehensive care as well as the importance of strengthening health systems. She underscored the need to stay faithful to the PHC principles and to find ways of designing health systems that provide the best possible options for the poorest of the poor to live full and productive lives.

Dr Tshabala-Msimang noted that it was with the PHC principles in mind that the Third Session of the African Union Conference of Ministers of Health debated and adopted the Africa Health Strategy, 2007–2015 with the theme “Strengthening of health systems for equity and development in Africa”. In order to achieve the goals and objectives of this strategy, the Bureau of Health Ministers developed an implementation plan to be presented to African health ministers at the meeting scheduled for 17 May 2008.

She said that the vision of the African Union (AU) strategy was for an Africa free of the burden of disease, disability and premature deaths. Its mission is to build an effective African-driven response to eliminate poverty and reduce the burden of disease and disability through strengthened health systems, scaled-up health interventions, intersectoral action and empowered communities. She enumerated some of the principles that underpin the AU strategy: health care as a human right and a development concern requiring multisectoral response, equity in health care as a foundation for all health systems, solidarity as a means of facilitating access for the poor, health as a productive sector and not merely a service for consumption, and cross-border cooperation as imperative, since diseases do not respect boundaries.

Dr Tshabala-Msimang cited the various courses of action for strengthening health systems based on the PHC approach, such as those that require (i) increase in allocations to health, prioritization of PHC and development of health insurance schemes that have solidarity as their core and seek to remove user fees, (ii) training of middle-level workers and community health

workers, (iii) recognition and institutionalization of African traditional medicines in national health systems, (iv) development by each country of frameworks for community participation in the health system and creation of an enabling environment for their implementation, and (v) designing, strengthening and implementation of a plan for achieving health literacy and community empowerment to reap the full benefits of community resources.

She reported that the African Union had launched an initiative called “Africa’s movement to improve maternal health and strengthen child survival in Africa beyond 2015”. The pillar of this initiative was a functioning district-level health system and referral systems to other levels of care.

Dr Tshabala-Msimang added that African health ministers had endorsed the Three Ones approach to partnership in health and the principles of the Paris Declaration, and that the Africa Health Strategy recognizes the importance of social determinants of health and urges the ministers to participate in the development of poverty-reduction strategies and economic empowerment processes to encourage promotion of health options. She surmised that without strong health systems based on the PHC strategy, sufficient human resources with the necessary health skills and motivation, and involvement of communities and families—all which are social determinants of health—it would be a struggle for Africa to achieve the MDGs.

She noted that this was a momentous time that highlighted the importance of the vision of community participation, intersectoral programming, health promotion and disease prevention, but she regretted that PHC was being compartmentalized by people pushing for vertical programmes instead of integrated care.

She observed that the African Union adopted its health strategy in 2006 and that an appropriate implementation plan had been developed. The vision of the strategy was to reduce the burden of disease through strengthening health systems. The strategy was underpinned by guiding principles such as health care as a human right, equity in health care as a foundation for all health systems, use of solidarity groupings as a means of assuring access, cross-border collaboration in disease prevention and control, and the need for coordination of partner support.

Dr Tshabala-Msimang recommended that countries increase allocations to health, prioritize PHC, encourage health insurance schemes, seek to abolish potentially catastrophic user fees and invest in middle-level health professionals such as clinical officers, pharmacy assistants and clinical associates. She noted that since majority of Africans use traditional medicine, there was need for its institutionalization in the health system. She added that South Africa had a policy and legislation on the practice of African traditional medicine, and that the African Union was reviewing the efforts made in institutionalizing traditional medicine and had established a task force for exploring the feasibility of local production of the medicines.

She observed that the African Union’s health strategy proposed that each country develop a framework and plan of action for community empowerment and involvement, with reduction of maternal mortality as an essential objective, strengthening of health systems as the pillar and South-South collaboration as an essential component, and requiring the ministers of health to act as stewards to ensure that the poor are never forgotten.

Dr Tshabala-Msimang noted that the escalation in food and fuel prices and the effects of global warming would especially adversely affect the poor. She said that there was a need to avoid conflict to obviate destruction of health systems and to allow reconstruction of systems that had been destroyed.

She expressed the hope that Africa would achieve the MDGs, but cautioned that this required strong PHC systems to revitalize national health systems.

Statement by His Excellency Blaise Compaore, President and Head of State of Burkina Faso

President Compaore expressed his appreciation for the honour given to Burkina Faso to host the Conference and acknowledged that the Conference both celebrated the 30th anniversary of the Alma-Ata Declaration and commemorated the 60th anniversary of WHO. He congratulated the WHO Regional Director and the Conference organizing agencies—the Scientific Committee, the Expert Committee and the Organizing Committee—for a great conference.

President Compaore recalled that the Alma-Ata Conference of 1978 developed the PHC approach as a strategy to reach the target of the Health for All by the Year 2000 strategy which had been adopted by the World Health Assembly in 1977. This gave hope to Africa because it espoused the universal values of health as a right and community involvement as essential in all decisions related to health that aimed to guarantee to all of a minimum health service package and give special attention to the rights of the vulnerable. He lamented that 30 years after the Alma-Ata Declaration the target of health for all remained elusive. However, he considered the concept and the strategy of PHC as a guide for health matters in the world and noted that it had stimulated a number of initiatives that had achieved significant progress.

President Compaore acknowledged that African leaders had been significantly involved in formulating the Declaration on Health as a Basis for Development during the Twenty-Third Ordinary Session of the African Union (then the Organization of African Unity) in 1987 and were committed to realizing the MDGs by 2015 and to the decision taken by the Heads of State in 2001 during the Abuja Summit to allocate at 15% of their national budgets to health.

He acknowledged the important role of health workers and researchers in the public and private sectors and their devotion to making progress in PHC. In Burkina Faso, the implementation of the national health plan for 2001–2010 required rigorous monitoring of progress. For example, between 1999 and 2008 the national budget allocated to health increased from 7 to 15%, the ratio of health centres to the population grew from 1 to 25 000 persons in 1985 to 1 to 9800 in 2007, and the prevalence of HIV/AIDS dropped from 7.14% in 1997 to 2% in 2006. In addition, with the support of development partners, onchocerciasis, polio and guinea-worm disease were in the process of elimination.

President Compaore lamented that the essential goals of promoting good diet and good hygiene and providing clean water had not been achieved as desired, and that diseases of

epidemic potential and neglected tropical diseases still had very important impact on the health of the people.

He hoped that the Conference's deliberations would go into depth on issues related to health financing, human resources for health, and the crucial problem of brain drain. He said that the deliberations should also cover the new opportunities to redefine the concept of PHC in relation to the attainment of MDGs.

Finally, President Compaore appealed to Member States, partners, the private sector and the civil society to convene a forum for sharing best practices to revitalize PHC and health systems at the continental level.

Statement from UNICEF

Dr Esther Guluma, the UNICEF Regional Director for West and Central Africa, presented her remarks on behalf of the UNICEF Executive Director, Ms Ann M. Veneman.

Dr Guluma reported that since 1978 many important lessons had been learned, among which was that families in the communities we all strive to serve were key and the most important factor in achieving health goals. She emphasized the need to continue supporting and strengthening the expanded programmes on immunization, distribution and use of insecticide-treated bed nets, breast feeding, and use of oral rehydration salts, and strengthening of health systems in general (particularly the production and retention of human resources) and primary health care of the youth. She expressed her conviction that resolve was needed to achieve the targets of the MDGs in Africa, and there was urgent need for governments, United Nations agencies and partners to work together to ensure that the effects of disease, natural and man-made disasters and conflicts were mitigated and that provision was made for the most vulnerable groups in the society.

Statement from UNFPA

Ms Mona Kaidbey, UNFPA's Deputy Regional Director of the African Division, summarized the experiences of African countries in implementing the Alma-Ata Declaration and the progress towards the health-related MDGs. She called for rethinking of health strategies, intensification of responses, augmentation of resources, scaling up of successful interventions and urgent action.

She reiterated that there was adequate expertise and experience in the continent to develop concrete and practical approaches on how to move forward in the implementation of primary health care in Africa to achieve the goal of health for all and specifically the health MDGs. She also noted that progress towards achieving these goals depended on partnerships among communities, governments, the United Nations, the civil society, academic institutions and the private sector.

Finally, Ms Kaidbey reiterated UNFPA's commitment to supporting the implementation of the African Union's Maputo Plan of Action for Reproductive Health and Reproductive Rights

adopted by African ministers of health in September 2006. She stressed that strengthening of primary health care would go a long way in scaling up the implementation of the Maputo Plan of Action.

Statement from UNAIDS

Dr Meskerem Grunitzky-Bekele, the Regional Director of UNAIDS West and Central Africa, delivered these remarks on behalf of Dr Peter Piot, Executive Director of UNAIDS. Dr Grunitzky highlighted the importance of the Conference in creating renewed interest in improving health and promoting development through the PHC approach. She recalled that following the Alma-Ata Declaration, most African countries developed or reviewed their national policies and elaborated national health development plans with the goal of ensuring better health for their populations; however, HIV/AIDS had posed a major challenge in the development of Africa, especially within the health sector. She noted that 3 million people were currently on antiretroviral therapy globally following the implementation of The 3 by 5 Strategy, with 2 million of these in the African region. Where HIV/AIDS programmes were integrated with health service delivery, the funds mobilized by HIV/AIDS were being used to expand other essential health interventions.

Dr Grunitzky noted that there were many challenges confronting the health systems, including the great dependence on external resources, weakness of the health systems and lack of harmonization or alignment with national priorities. She emphasized that now was the time to revitalize PHC in order to address these problems. Dr Grunitzky reiterated the commitment of UNAIDS to collective action to achieve the MDG targets and to active contribution to initiatives at global, regional and national levels under the leadership of its Executive Director. She added that, as an umbrella agency of 10 United Nations agencies, UNAIDS would continue its roles of advocacy, coordination and mobilization of resources, and partnership with governments, the civil society, the private sector and donors.

Statement from the African Development Bank

Mr T.B. Ilunga, Manager, Health Division of the African Development Bank (ADB), noted the significant advances attained in the last 30 years in health even though the goal of the Health for All by the Year 2000 Strategy had not been achieved by many countries in Africa. He confirmed that ADB had adopted the PHC strategy and had incorporated it into the policy and strategy documents that guide its investments in the health sector. In line with this, he noted that three quarters of ADB's resources invested in the last three decades, amounting to US\$ 1.5 billion, went to PHC activities in African countries. These resources had helped strengthen national and district health systems, build health infrastructure and capacity of health workers, and deliver essential health interventions. He noted, however, that a lot more needed to be done, particularly in addressing challenges such as reorienting health systems to the realization of PHC, integrating services, improving governance, ensuring judicious use of resources, sustainably financing health care, reducing inequities and inequalities and improving access to health facilities.

Mr Ilunga expressed the commitment of ADB to engaging with other partners to see the realization of the recommendations of the Conference. He reiterated ADB's continued support to strengthening of health systems and to collaboration between health and related sectors such as water and sanitation, education and infrastructure. He expressed ADB's desire to collaborate in coordination, harmonization and alignment of aid. He concluded by thanking the organizers of the Conference, including the hosting government.

Statement from the World Bank

Representing the World Bank, Dr O. Bangoura said that the African Region had been at the forefront in the PHC movement, devoting important intellectual work by eminent African scientists and financial resources to support countries' efforts to implement the PHC strategy. He regretted that the implementation of the strategy occurred in the context of economic hardship.

He observed that since the launching of the PHC strategy there had been a marked reduction in infant mortality and malnutrition. He lamented, however, that in spite of unprecedented advances in health technologies, millions of children died every year from preventable causes, and maternal mortality rates had not changed much since the 1990s.

He noted that African health systems faced special challenges because of the large unmet need, competing priorities, low expressed demand for preventive services, weak sector governance and accountability, dearth of trained and motivated human resources for health, limited institutional capacity, weak delivery infrastructure (in terms of availability of quality services and access), and weak monitoring and evaluation systems. These challenges are compounded by recurring conflicts, widespread poverty and slow economic growth.

Dr Bangoura said that there was consensus on the urgent need to strengthen health systems if the financial commitments enabled by the new Development Assistance for Health were to succeed in achieving MDG targets. He noted that the new World Bank's health, population and nutrition strategy, "Healthy Development," focuses on strengthening health systems' performance, for example in financial management, utilization of essential health services by the poor, community empowerment and participation, partnerships between the public and private sectors, good sector governance and accountability, recruitment and training of community health workers, and improvement of the health infrastructure. The strategy aims to take advantage of the World Bank's comparative advantage in areas such as its multisectoral approach to country assistance, health financing, insurance, regulation, systemic arrangements for financial management and ability to engage the private sector. Achievement of the targets of the MDGs requires a multisectoral approach.

Dr Bangoura said that the World Bank was committed to contributing to efforts to align and harmonize the activities of the global partners with the countries' needs in order to prevent duplication, economic distortion and excessive administrative costs, and to ensure that development assistance for health was owned and led by the countries. He noted that the World Bank regarded the Conference as an opportunity to identify the strategic orientations for scaling up essential health interventions to achieve the health-related MDGs using the PHC approach

and to agree on benchmarks for both government and development partners' performance, including in allocation of external and domestic resources to health.

2. Overview of Primary Health Care and health systems in the African Region

This plenary session was chaired by Dr Luis G. Sambo, Regional Director, WHO Regional Office for Africa. Professor G.L. Monekosso, Chair of the Scientific Committee, gave a presentation entitled "Overview of Primary Health Care and health systems in the African Region".

Professor Monekosso gave an overview of the progress made in health since the Alma-Ata Declaration, highlighting the strengths, weaknesses, opportunities and challenges. The achievements included (i) creation of health districts and integrated community programmes, (ii) partnering with non-public health providers, community health workers and resource persons, health training institutions and appropriate health cadres, and (iii) development of essential medicines lists.

He cited several reasons for the failure of African countries to achieve the goals of the Health for All 2000 strategy: (i) the resources expected from the governments and partners were not provided, (ii) the health sector monopolized PHC, and (iii) each country was left to decide on its own how it would implement PHC. The economic crisis of the 1980s with the associated structural adjustment programmes led to budget cuts, resulting in shortages of human resources for health, inadequate and inequitably distributed facilities, inadequate basic supplies, and limited health budgets. Recurrent civil wars limited progress, vertical projects diverted health workers from working with communities, and there was little community involvement in health.

The challenges for the future include how to deal with the decreasing expenditure on health, increasing cost of services, insufficient human resources for health, weak capacity at the lower levels after decentralization, heavy burden of disease, weak intersectoral collaboration, and poor community empowerment.

The opportunities include the international focus on MDGs, efforts to put health at the centre of socioeconomic development, development of frameworks for partnerships, recognition of the importance of the social determinants of health and increase in financing of activities in this area, and adoption of the health districts concept.

Three main areas of action essential for revitalizing PHC and strengthening health systems were discussed: stewardship, financing and service delivery. Stewardship was defined as encompassing strengthening of governance, setting of equity goals, provision of oversight and leadership, and strengthening of regulatory frameworks.

The areas highlighted under financing were fairness, increasing allocation to health and social protection from catastrophic expenditures through sharing of health risks.

Service delivery focused on building managerial capacity at the operational level; developing and implementing evidence-based policies for multiskilled, motivated, and equitably distributed health human resources; strengthening procurement and supply chain management to ensure availability of essential medicines and supplies; and strengthening health information management.

The roles and responsibilities of the stakeholders were identified: the communities were expected to be empowered so as to provide oversight over their health systems, the governments were expected to be accountable and committed to upholding health as a basic human right, and the development partners were expected to commit themselves to increasing the level, predictability, flexibility and effectiveness of aid for health to facilitate achievement of the MDG targets.

It was pointed out that the MDGs were complementary to PHC, with MDGs 4, 5, and 8 directly affecting health, while the rest were central to the provision of the necessary environment for health development. The need for continuous and sustainable dialogue with communities and to link this with dialogue at higher levels was pointed out.

As a way forward and to execute the plans developed, the countries need to commit resources, and communities, governments, partners and the civil society, including Africans in the diaspora, need to play complementary roles in confronting the health problems facing Africa.

The discussion following the presentation raised the following issues:

- There is need to involve other sectors when planning for health and to convince governments that investment in health is in itself a wealth-creation undertaking.
- Although money is important, organizational capacity is even more so and more scarce.
- The bottom-up approach is the best way to engage communities for participation in PHC delivery. Experience in this area was being sought.
- PHC is important but usually is placed under the local government, and yet skills are inadequate at that level. Ways to address this problem need to be found.
- There is a high turnover of programmes in the health sector, and often new programmes are introduced without evaluating old ones.
- A balance is needed between provision of universal access to health care taking into account governance, equity and efficiency factors on the one hand, and the desire of politicians to establish large health infrastructure on the other hand.
- Much funding to African countries is from global initiatives, but these initiatives tend to undermine the comprehensive approach to health care since they do not address the underlying factors for example in maternal and child health, tuberculosis, etc.
- There was need to explore the possibility of World Bank supporting human resources and sustainable financing for major disease programmes in Africa instead of funding targeted programmes.

The following recommendations were made:

- The countries were urged to shift from piloting insurance schemes to implementing them fully.
- Emphasis should be on primary care and quality secondary and tertiary care.
- There is need to involve other sectors in health planning in order to address the social determinants of health.
- There is need to strengthen the capacity of lower levels to support and implement PHC.
- Old programmes should be evaluated before being abandoned for new programmes.

Maternal and child mortality trends in Africa

Dr Peter Salama, Chief of Health, UNICEF, New York, gave a presentation with two main objectives: to review current data to celebrate the progress made and to critically evaluate the approaches used, for better performance in health delivery. He emphasized that PHC was not only related to MDGs but it was also critical and central to achievement of the MDG targets. He noted that at their current pace of progress, most countries in the African Region would not achieve the MDG targets. He reported that substantial progress had been made in sub-Saharan Africa since the Alma-Ata Declaration, as infant protection had improved from 25% to the current 50%. Even though progress had been made to reverse the overall trend in health delivery, many countries in Africa were still struggling to even stay on track to meet the targets of the MDGs. In addition, at 28%, the level of underweight children was still high in Africa as was the prevalence of poor sanitation. The trend is similar for maternal mortality: sub-Saharan Africa still has one of the highest maternal mortality rates in the world.

Not all is negative in the African Region. Almost one third of the 50 least developed countries (many in the African Region) have reduced their under-five mortality rate by 40% or more since 1990 and immunization coverage rates are high, particularly for measles. Immunization strategies have also been used as vehicles for increasing distribution of insecticide-treated bed nets and vitamin A. In addition the proportion of HIV-positive pregnant women receiving antiretroviral therapy increased from 11 to 31% between 2004 and 2006.

There have been many lessons, particularly in enhancing success of community partnerships and programmes. Some of these lessons relate to the benefits of cohesive, inclusive participation; support and incentives for health workers; adequate programme supervision and support; effective referral systems; intersectoral collaboration; secure financing; and integration of community partnerships with district and national health programmes.

The following actions were proposed to improve programmes, policies and partnerships:

- Take advantage of the well-funded, disease-specific interventions.

- Make maternal, newborn and child health a central tenet of integrated national planning.
- Improve health systems.
- Advocate for sustained political commitment to and harmonization of partnerships.

A number of issues were raised in the discussion following this presentation:

- There is need to involve the other sectors in planning for health and to convince governments that investment in health is in itself wealth creation.
- Although money is important, organization capacity is even more crucial and more scarce.
- To engage the communities in PHC delivery, the bottom-up approach should be the best way to go. Experience in this area is being sought.
- PHC is considered important but it is usually placed under the local government, yet this level is not adequately equipped with a skilled workforce. This problem needs to be addressed.
- There is a high turnover of programmes in the health sector and often new programmes are introduced without evaluating old ones.
- We need to address the imbalance between the need for universal access to health care that encompasses the values of good governance, equity and efficiency on the one hand, and the desire of politicians for big health infrastructure on the other hand.
- Although Africa receives large funding through global initiatives, these tend to undermine a comprehensive approach as none of them is being used to address the underlying factors of maternal and child problems, TB etc.
- The possibility of the World Bank direct funding for disease programmes in Africa going to support human resources and sustainable financing instead of funding targeted programmes should be explored.

The following were the recommendations:

- The countries were urged to shift from piloting the insurance schemes to fully implementing them.
- Emphasis should not be focused only on primary health care but also on quality secondary and tertiary care.
- There is need to involve other sectors in health planning to address the social determinants of health.
- There is need to strengthen the capacity of the lower levels to support and implement PHC.
- Old programmes should be evaluated before being abandoned for new ones.

3. Stewardship

Dr B.M. Ramos, Minister of Health of Cape Verde, chaired the plenary session on governance and equity. Mr B. Ndaw from Senegal gave a presentation on governance, and Professor Rene Loewenson of Equinet (Zimbabwe) talked on equity.

Governance

Mr B. Ndaw made a presentation on governance. Governance is a method by which public institutions, the private sector and civil society participate in exercising political, economic and administrative authority in managing public affairs at all levels, from the global level to the local level. These main actors in governance including technical and financial partners play a specific role in improving the welfare of the populations.

How can a more aggressive strategy of “Revitalizing PHC” be implemented within the old structure with its hierarchy-based model of state decision-making, and its professional ethic differing among the different actors?

The truth is that the institutional framework for PHC implementation in States is in disrepair. The ministry of health remains a simple department with directorates that are hardly dynamic and have a weak capacity for political management of PHC.

Strengthening the capacity for stewardship of the health sector will require strengthening also the capacity of local government to participate more effectively in resource management and large-scale community action. It would be expedient to integrate good governance in various sectors with innovative reforms for implementing the principles underpinning the “Paris Declaration”, adherence to human rights and basic values, and establishment of a high level of transparency and accountability to help scale up best practices of modern management.

Implementing the PHC strategy with the ultimate objective of achieving the MDGs and improving health system performance requires development of the PHC implementation structure and ownership of the principles of good governance.

The discussion on this presentation raised these issues:

- Organization is more important than money in ensuring good governance for effective PHC. Leadership, management and a functional health structure down to the community level are as essential as funding in PHC.
- The social determinants of health lie outside the health sector. There is need, therefore, to convince other sectors to be involved in planning and implementing PHC.
- Health is a productive not a consuming sector. There is a need to convince governments that preventing disease and keeping the workforce healthy will lead to savings, increased productivity and wealth creation.
- The level of government responsible for PHC should receive adequate resources in order to deliver the service required of it.

- There is need to focus on building efficient health systems rather than big buildings for political visibility.
- The current global funds that are mostly for vertical programmes (for specific diseases) tend to undermine the comprehensive approach to health. Such funds should also be used to address the underlying determinants of health and other priority health issues, such as maternal, newborn and child health.
- Many new donor-driven initiatives are being introduced in countries without assessing the outcomes of old initiatives. Governments should define their own agenda and coordinate support.

Equity in African health systems

Professor Loewenson’s presentation was entitled “Equity in African health systems”. She noted that socioeconomic inequalities lead to persistent though avoidable inequalities in health, disadvantages in access to health care among those with the greatest need in African countries and limited achievement of national and global development goals, even under conditions of economic growth. Africa is particularly disadvantaged in a context of significant global inequality. While many actions to address this lie outside the health sector, this sector can play a vital role in improving health equity through comprehensive, PHC-oriented systems. Although commitment to this exists in the policy of African countries, there are gaps in specific strategic plans, resource allocation, target setting to address disparities, and linkages to wider poverty-reduction strategies.

Besides widening the availability of quality services in disadvantaged areas, health systems need to provide leadership for action across sectors to improve physical, economic and social environments for health, including by collecting and organizing evidence, promoting efficiency in the delivery mechanisms and dedicating budgets for this. Within the health system, equity is improved by redistribution of resources to prevention and underserved areas, particularly for free service to clients at the point of use at community, primary and secondary levels. Needs-based resource allocation formulas support this with explicit annual allocation targets that set a reasonable pace of change, as do the reduction of the currently high out-of-pocket spending on health and implementation of equitable financing options such as dedicated health taxes and social health insurance. Voluntary and community-based insurance schemes need to be assessed for their benefits to poor communities.

Addressing equity also implies strengthening the power and ability people have to direct resources to their health needs; integrating health services with social structures and cultural systems; involving users and communities in planning and running the services; promoting respectful and “equal” relationships among providers, users and health personnel; and providing information to encourage action on health and effective use of services. Joint community health service mechanisms exist, but there is need for guidelines on roles, earmarked and sustained resources, capacity-building and health worker orientation and incentives. Experience in and methods for community monitoring and participatory processes for organizing community preferences and experience exist, but there are gaps in systematic integration of these methods in health planning. The civil society and community-based organizations can support such

processes, while parliaments can raise policy awareness and foster public debate in support of health equity through their representative, legislative and oversight roles.

While there has been progress in implementing such measures, liberalization policies, health policy choices, resource constraints and bureaucratic cultures have undermined their implementation. Promoting equity demands a strengthened health public sector supported by at least 15% of government spending; international delivery on debt cancellation; official development assistance commitments; inclusion of health rights and obligations in national constitutions and laws; and a strong alliance of public interests in health, particularly involving the state, the civil society, the parliament and health workers. Equity needs to be vigorously championed and, in addition, context-relevant goals, targets and indicators of equity should be set, monitored and reported within development policy.

Two issues were raised in the discussion following the presentation:

- The list of equity principles should include geographical equity.
- There is need to strengthen comprehensive PHC-oriented health systems of all providers, redistribute resources within the health system, and recognize the central role of people in health systems and invest in them.

3.1 Community ownership and participation

Professor Miriam K. Were, Chair of the National AIDS Control Council of Kenya and member of the AMREF Board, chaired the panel discussion on community ownership and participation. The panellists were Dr P. Salama, Dr H. Remme, Professor O. Akogun, Dr S. Sanou, Mr Missanga and Dr Omar Khatib.

Integrated community-directed interventions: results of a multicountry study

Dr Oladele Akogun and Dr Hans Remme gave a presentation entitled “Integrated community-directed interventions: results of a multicountry study” on behalf of CDI (community-directed interventions) research teams. They underscored the urgent need to improve access of poor populations to existing health interventions. One programme that is based on community participation—a core principle of primary health care—and that has a track record of success in improving access is community-directed treatment with ivermectin (CDTI). CDTI is ensuring sustained and wide treatment coverage for 60 million people in rural Africa and will reach 100 million people by 2010. The success of CDTI prompted the African Programme for Onchocerciasis Control (APOC) to request the Tropical Disease Research initiative to undertake a study to find out whether CDI could be used to combat other diseases.

In 2005, a three-year, multicountry study was launched to establish to what extent the CDI process could be used for integrated delivery of other health interventions with varying degrees of complexity alongside ivermectin. Four interventions were selected to examine this question. They ranged in complexity from relatively “simple”, such as vitamin A supplementation, to complex interventions, such as distribution of insecticide-treated bednets, directly-observed

treatment short-course (DOTS) for tuberculosis and home management of malaria. The results from seven research sites in Cameroon, Nigeria and Uganda are reported here.

Each research site included five health districts—four districts for the trial and one for comparison—for a total of 35 districts covering of 2.35 million people. All the sites already had several years of experience with CDTI. A new intervention was added in each trial district in the first and second year of the study. During the third year, all five interventions (including the ongoing ivermectin treatment) were delivered through the CDI process in all trial districts. In the comparison districts, all the interventions continued to be delivered in the conventional manner.

The CDI approach was shown to be much more effective than the currently used delivery approaches for all interventions except DOTS.

- **Malaria treatment:** More than twice as many children with fever received appropriate antimalaria treatment in CDI districts than in comparison districts, with the treatment levels in the trial districts exceeding the target of the Roll Back Malaria Partnership of 60%.
- **ITNs for malaria prevention:** Possession and utilization of ITNs were two times higher in the CDI districts than in the comparison districts despite shortages of ITNs at most research sites.
- **Vitamin A coverage** was significantly higher in the CDI districts than in the comparison districts, with 90% of eligible children receiving the supplements.
- **DOTS treatment for TB** saw no significant differences in completion rates between CDI districts and comparison districts.
- **Ivermectin for onchocerciasis:** The addition of multiple interventions to the CDTI package boosted ivermectin treatment by an additional 10%.
- **Integrated delivery of interventions:** At least four to five interventions could effectively be implemented through CDI strategies. The coverage with the different interventions generally increased over time in the CDI districts, reflecting “maturation” of the CDI process.

With respect to costs to the health system, CDI was more efficient than conventional delivery systems. Without any increase in implementation costs at the health district and first-line health facility levels, the CDI process achieved higher coverage than conventional treatment. At the community level there was an increase in “opportunity costs” with CDI, reflecting the greater time commitment by community implementers. Intrinsic incentives, such as recognition, status and knowledge and skills gain, were perceived as more powerful motivators than material incentives.

No technical limitations affected community implementation of any of the interventions. When given the necessary training and support, community implementers demonstrated that they could effectively implement each of the five study interventions irrespective of its level of complexity and were eager to use and sustain the approach over the required period. The main challenges were social constraints related to acceptability and appropriateness of the intervention

and the health system's constraints such as shortage of supplies, reluctance of health workers to train community implementers to manage TB drug administration and, in some isolated cases, health policies restricting distribution of antimalarials by anyone other than certified health services staff.

The conclusion from this study was that integrated delivery (also called co-implementation) of different interventions through the CDI process was feasible and was greatly facilitated by engagement of the communities and willingness and ability of community implementers to deliver multiple interventions. Health workers, policy-makers and other stakeholders also displayed significant support, and their buy-in increased over time. The important factor that hindered effective integrated delivery of interventions through community-directed strategies was poor supplies of drugs and other intervention materials.

Based on this study, it is recommended that in areas with experience in community-directed treatment for onchocerciasis control, the CDI approach should be used for integrated, community-level delivery of a broader range of appropriate health interventions. This may include the interventions tested in this study, especially for malaria, or other packages of interventions chosen on the basis of the criteria developed in the study for defining the interventions appropriate for CDI.

The CDI approach builds on the core principles of PHC, notably true community participation and empowerment. The study indicated that CDI can significantly contribute to the reinforcement of PHC by bringing the investment by APOC in community empowerment for onchocerciasis control to bear fruit in the delivery of other priority health interventions to poor and underserved rural communities.

Follow-up of implementation of community-directed treatment with ivermectin (CDTI) for river blindness control in River Assin, Bougouriba, Burkina Faso

Dr S. Sanou, Director-General of the Ministry of Health, Burkina Faso, gave a presentation on his country's experience with community participation in PHC.

Burkina Faso has had different types of experience with community participation in PHC, including community involvement in the management of village health and implementation of the Bamako Initiative, and with community members' working as health auxiliaries. Through the community-based laboratory programme, a minimum package of priority interventions (such as the Bazéga community laboratory) was implemented and community members were trained. Community involvement is critical to both accessibility and affordability of PHC in Burkina Faso. Nevertheless, there are challenges in terms of training, motivation, mobilization and sensitization of the community and coordination.

Experience in community participation in the implementation of Primary Health Care: the case of CDTI in the fight against onchocerciasis, Mr Ohanndja B. Missanga, community representative, Cameroon

The district of Monatele, Cameroon is hyperendemic in onchocerciasis and is eligible for community-directed treatment with ivermectin, which involves annual mass treatment. The district's population is about 70 000. At the beginning of the programme, ivermectin was distributed mainly by health workers assisted by members of the community. Between 1998 and 2002 coverage went from 25% to 46%, which was far below the target, mainly due to community misconceptions of the effects of the drug.

Improvement in community participation changed the results dramatically: therapeutic coverage reached 73% and 90% of the geographic area in 2004. Through community self-monitoring, the critical problem of motivation of community distributors was resolved. Training more distributors solved workload problems.

Following the successful experience using CDTI, similar techniques were used to improve coverage of other health priority programmes such as immunization.

This experience with community-directed strategies should be used for implementation of priority health programmes to achieve the MDGs.

Enhancing community preparedness for response to and recovery from emergencies within PHC

Dr Omar Khatib of Emergency and Humanitarian Action, WHO African Regional Office gave a presentation on "Enhancing community preparedness, response and recovery to emergencies within PHC". He noted that more than 70% of the countries in the African Region had already reported an emergency in 2008. In real population numbers, this means that about 589 million people had been affected directly or indirectly by an emergency since the beginning of the year. Large proportions of the population are displaced and live in chaotic situations and they end up as passive recipients of "humanitarian aid". They usually have no power to determine the nature or administration of this support. Their resilience and preparedness to cope with or face up to the challenges brought about by these emergencies or by displacement are usually nonexistent. Government support for this population is also minimal and sometimes nonexistent, untimely or inefficient. The stewardship role of governments in these situations is very much compromised, especially when the PHC system and general governance were weak even before the emergency.

The presentation reflected on the way to improve community resilience, preparedness, response and recovery in emergencies and disasters using the PHC approach, as health systems in the Region embark on revival and strengthening of the PHC concepts of community participation, equitable service delivery and multisectoral participation. It highlighted the use of integrated PHC as a practical approach to strengthen health systems. Health Action in Crisis (HAC) proposes to reflect this in the interaction between primary health care and emergency preparedness and response.

Dr Khatib emphasized that PHC was essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community with their full participation and at a cost that they and

the country can afford to maintain at every stage of development in the spirit of self-reliance and self-determination. Emergency preparedness, on the other hand, is a programme of long-term development activities to strengthen the overall capacity and capability of a country to efficiently manage all types of emergencies and bring about an orderly transition from relief through recovery to sustained development.

Dr Khatib concluded with the statement that a well-prepared country or community will have a strong emergency preparedness and response programme and will be able to mitigate the effects of an emergency and return to sustainable development.

The following were raised in the discussion as affecting community involvement in health:

- For the past 12 years, communities have been responsible for managing the community-directed treatment with ivermectin. Coverage increased from 1.5 million in 1998 to 4.8 million people in 2006.
- In Uganda, “health is made in homes but repaired in health facilities”.
- Malawi has trained health-surveillance assistants drawn from and working with the communities to identify their difficulties.
- Guinea-Bissau proposed that analysis of maternal and child mortality rates should take into account the level of poverty in the community.
- Many community-based success stories are not recorded.
- Caution should be used when referring to typical rural communities, and peri-urban communities should also be considered.

Professor Miriam Were summarized the recommendations and the way forward for community ownership and participation in health development as follows:

- Communities can be involved, and do actually participate, in provision of some services for improved health outcomes.
- Empowered communities tend to be more demanding. There is need to identify and utilize the processes that ensure community involvement and participation and to define how best to involve communities.
- Poverty is the underlying cause of increased child mortality.
- Communities should be empowered to achieve improved health outcomes.

3.2 Intersectoral collaboration

Honourable Emmanuel Otaala, Minister of Health of Uganda, chaired the panel discussion on intersectoral collaboration. The facilitator was Professor Firmino G. Mucavele of the New Partnership for Africa’s Development (NEPAD). Country experiences were presented from Madagascar and Cape Verde.

Professor Mucavele's presentation was entitled "Multisectoral collaboration in the process of revitalizing primary health care and health systems in Africa". He said that in Africa, the evidence base remained thin and health systems research was often limited and marginalized. The demand for health systems research is low and hence there are limited funding opportunities for interested researchers. Equally, the use of research results in policy change is limited.

Countries in Africa face serious challenges in mobilizing, allocating and managing financial resources in the face of increasing disease burdens. Two thirds of African countries are classified as low income and have limited potential for economic growth or inadequate general revenues. Health service management systems in most countries in Africa are weak. The combined effect of these problems is a serious recurrent expenditure crisis, as well as inadequate capital expenditure.

In many African countries, health systems at the district or local level are under-resourced and inefficiently managed. Resource constraints often require health services to generate and utilize locally raised revenue with little financial support from the central government. Planning and management skills are often inadequate and, in some countries, close to 50% of the health facilities are headed by unqualified staff who have limited capacity to plan or organize health activities, provide efficient orientation to health systems, monitor or supervise health institutions or evaluate the effectiveness and efficiency of operations and strategies. Staffing levels are low, facilities are poorly equipped and there are frequent shortages of essential supplies, including drugs. Consequently, the achievement of PHC and MDG targets is compromised.

African countries should institutionalize the preparation of National Health Accounts (NHAs) as a tool to determine financial flows to the health sector. African countries that have undertaken NHA exercises have demonstrated that they are a useful tool for understanding financial flows and expenditure patterns, helping to make wise integrated choices on health, education, agriculture and public works. PHC objectives and overall socioeconomic objectives complement each other rather than compete. Therefore, multisectoral evaluation of alternative ways of financing and allocating resources must include PHC and health systems. The development of efficient and effective ways of providing health services must be part of the national development plan. Institutionally, governance programmes must incorporate clear monitoring and evaluation mechanisms in health.

Despite the usefulness of NHAs, few countries have undertaken them to date. Amongst other things, this means that although African Heads of State have committed their countries to allocating 15% of public expenditure to health, there is no ready source of evidence to establish whether there is progress in achieving this on the continent. There is a need to strengthen the quality and completeness of NHAs, the technical capacity within countries to undertake NHAs and training institutions to support NHA activities in Africa.

PHC envisaged universal coverage of basic services such as education on methods of preventing and controlling prevailing health problems; promotion of food security and proper nutrition; adequate safe water supply and basic sanitation; maternal and child health care, including family planning; vaccination against major infectious diseases; prevention and control

of locally endemic diseases; appropriate treatment of common diseases and injuries; and provision of essential drugs. Since the Alma-Ata Declaration, other elements have been added to this list by individual countries. For example, mental health has been added by most countries. Africa must look for integrated ways of addressing PHC and including it in national health systems.

While discussing various mechanisms that could be employed to strengthen collaboration among partners, Professor Mucavele underscored the need for national health systems to use the mechanisms that ensure effective collaboration with partners. The focus must be on the countries' integrated systems, which must be strengthened, harmonized and synchronized with systems in the subregions and all over Africa through NEPAD and the African Union.

Implementation of the mechanisms should include increased funding for operations and health systems research, including community-based interventions, to strengthen the evidence base for public health decisions and to enable health research to become an integral part of the health system.

The regional economic communities should be used as coordinators, harmonizers and synchronizers of PHC and health systems. This will entail dissemination and discussion of good practices and experiences of the countries, with a view to accelerating the achievement of the MDGs.

The WHO regional offices for Africa and Eastern Mediterranean, in collaboration with NEPAD and the African Union, should work with UNICEF, UNFPA, UNAIDS, FAO and UNECA to mainstream PHC into all sectors of development. This includes organizing training sessions for technical officials and NHA briefings for policy-makers at regional and continental levels. They should also be responsible for providing direct technical support to countries to implement NHAs and supporting the regional economic communities in synthesizing country data in order to provide regional and continental summaries of findings and lessons on methodologies and their application.

NEPAD is essentially a catalysing, coordinating, mobilizing and promoting agent. Judging by the rapid increase in the number of government ministries adopting NEPAD policy frameworks and programmes for their respective sectors, as well as the recent increase in the number of countries signing the African Peer Review Mechanism, NEPAD has consolidated its role as the vehicle for effective socioeconomic renewal in Africa. NEPAD's added value is derived from the fact that it brings together dedicated political champions, development partners and leading African scientists. The fact that NEPAD is relatively flexible and little constrained by protocol and bureaucratic practice allows it to provide a forum for open and frank dialogue.

Professor Mucavele explained that mainstreaming PHC in other sectors was necessary to enhance synergism and concurrent achievement of MDGs. PHC is regarded as a cost-effective approach, and its principles include social justice, equity, human rights, universal access to services, community involvement and giving priority to the most vulnerable and underprivileged. Therefore, all sectors of development must include specific contributions to the improvement of

health in Africa. Education, food, agriculture, natural resources and water and sanitation sectors should be integrated into the PHC strategy.

Country-specific plans and the role of the various players must be recognized. Because of country variations, it is not possible to make in a generic strategy definitive statements about the specific roles of public services, the private sector, NGOs, community-based organizations and other players that make up the diverse group of health-care providers. All sectors need to work in a coordinated fashion towards achieving a country's health and health service goals. Also, each sector has particular strengths, such as the national base of the public sector, the responsiveness of private providers and the unique ability of NGOs to reach high-risk and often marginalized groups.

Health provision is a labour-intensive and labour-dependent sector; therefore, human resources should be central to any strategy aiming for an effective health system. All country strategies will therefore need to adopt a comprehensive approach to, and prioritize the implementation of, the range of factors influencing human resource availability and performance.

Madagascar's experience

Dr Dieudonné Rasolomahefa, Director-General of Health, Ministry of Health, Family Planning and Social Protection, made a presentation entitled "Intersectoral collaboration using the Champion Municipality Approach—an opportunity for revitalizing Primary Health Care". The presentation contained the following sections: challenges and genesis; challenges of the Champion Municipality Approach in Madagascar local language; key elements; Champion Municipality process; outcomes of the health Champion Municipalities; monitoring indicators; qualitative results achieved after the implementation of the Champion Municipality Approach; new challenges and way forward; and conclusion.

Challenges of the Champion Municipality Approach: promoting local development through multisectoral collaboration; promoting community participation; inducing change of behaviour; improving performance of actions carried out in the municipalities.

Key elements: community participation; development of deconcentrated and decentralized structures; strengthening prevention and health promotion programmes.

Champion Municipality process: a simple, modular and motivating working methodology; provide a menu of indicators that are easy to understand and assist the municipalities to choose indicators matched to their priorities; set objectives for the municipality and sign binding contract; implement actions on sustained basis; hold celebrations and reward the municipalities for their efforts; implementing the Champion Municipality Approach in 303 municipalities targeting a population of over 3.9 million; priority to maternal and child health; increasing awareness through information, education and communication; strengthening collaboration among basic health centres, local authorities and the communities.

Outcomes of the health champion municipality: 186 municipalities given awards out of 383 involved in the approach; one health district awarded the *Mendrika* out of the 46 involved in the approach; significant progress in good governance at the local level; greater accountability; increase in tax revenue at local level; notion of social accountability.

New challenges and perspectives: support the Champion Municipalities to continue and improve their performance; strengthen ownership of the approach and accelerate its scaling up; strengthen civil society at the grassroots by institutionalizing the network of community workers; popularize the Champion District Approach; promote the concept of social accountability as a basis for the Champion Municipality Approach; strengthen multisectoral integration of the approach; motivate development partners to rally to the approach.

Cape Verde's experience

Dr Jacqueline Manuela Pinto Rocha Pereira gave a presentation on “Multisectoral collaboration in health: the experience of Cape Verde in relation to the achievement of the MDGs”.

Cape Verde has considerable experience in multisectoral collaboration in the health sector. The policy of Cape Verde government has placed the individual at the centre of development. The country's health delegations that work with municipal health committees have representation from various other sectors, such water and sanitation, education and the Ministry of Infrastructure and Transport. At the central level there is a national multisectoral health council chaired by the Minister of Health.

There are various models of collaboration:

- Spontaneous collaboration of populations during public health related celebrations;
- Participation by institutions in ad hoc health events;
- Contribution by the Ministry of Education to health development through school health programmes, school curriculum development, Expanded Programme on Immunization campaigns and reproductive health activities;
- Contribution by the Ministry of Infrastructure and Transport to water and sanitation and health infrastructure development, which has allowed tremendous development of basic health infrastructure such as health centres and basic health units;
- Multisectoral collaboration in HIV/AIDS control.

The participants raised the following issues:

- There is need to improve economic costing of various diseases—to take into account direct and indirect costs—in order to demonstrate the importance of health in development and the need for more investment in the sector. There was an appeal to WHO to support the countries in estimating the economic cost of diseases to generate evidence for use in sensitization and advocacy.

- The question of financial responsibilities, which becomes important in a multisectoral environment, must be resolved.
- The countries should follow a multisectoral approach to provision of PHC.
- Models of the multisectoral approach need to be developed to be used to persuade other sectors and partners join.
- The presentation on rural communities raised questions about how peri-urban settings would be organized and how investment in health at the local government would be captured. South Africa's experience with multisectoral cabinet committees on health, environment, etc. was used to demonstrate the need for the ministries of health to be as competent as the ministries of finance. Also the NEPAD health strategy, which has been adopted by the Heads of State, includes an infrastructural development fund and appeals for more South-South collaboration.
- The Public Health Association of Burkina Faso underlined the importance of strengthening PHC through a strategy featuring five pillars: (i) efficient use of resources, (ii) strengthening of research for monitoring health determinants, (iii) the need for Member States to develop mechanisms for sharing health-care financial risks, (iv) organization and mobilization of communities, and (v) recognition of the importance of the subregional organizations as well as NEPAD in fostering health development.
- There is need to reorient financing modalities to make them more results based in order to implement the comprehensive packages for maternal and child health that have shown good results. The Madagascar experience of fostering championship is important and should provide lessons.
- The question of involvement of other sectors in the forums organized by the health sector was raised.
- The experience of Chad shows that using the Alma-Ata principles succeeded in dramatically reducing the number of patients attending formal hospitals and resulted in sustainable financing.
- Since the countries cannot manage to allocate 15% of their health-care expenditure to PHC given the other competing needs, there are questions about the kind of flexibility that could be brought into the coordination of the partners. At times the partners' demands are not aligned with national health development priorities.
- Cape Verde emphasized the importance of making the 15% Abuja target relative, depending on a country's context and on whether other sectors such as health insurance or infrastructure and transport were contributing.
- The good collaboration among the UN agencies during various crises in the Democratic Republic of Congo was mentioned and its dynamics was cited as worth emulating.

In response to the issues raised, Professor Mucavele indicated that the 15% contribution set from the governments could be taken as an indicator of what was expected of countries, but the

actual contribution would be relative to a country's ability. However, what was more important was that the national accounts must capture the contribution to the health sector.

Multisectoral collaboration and the primary health-care approach have produced good results in reproductive health, malaria control and HIV/AIDS. One difficulty is that health matters remain strictly under the Ministry of Health. The main challenges are related to coordination of health partners and the emerging epidemics of noncommunicable diseases that require much more multisectoral approach.

Honourable Emmanuel Otaala, Minister of Health of Uganda and Chair of the panel discussion on intersectoral collaboration, summarized the recommendations and the way forward as follows:

- More resources to be allocated to results-based interventions;
- PHC to be aligned with national and local policies;
- A multisectoral approach should be adopted or strengthened;
- Health sector resources should be better distributed;
- A formal policy framework to improve transparency and efficiency needs to be developed;
- More involvement of all the stakeholders of the health sector is required;
- Contract arrangements should be used as a tool for strengthening performance and complementarity.

4. Service delivery

4.1 Service delivery and decentralization

This session was chaired by Honourable A. Tou, Minister of Health of Algeria, and had two presentations: "Service delivery", by Professor E. Alihonou and "Decentralization", by Mr Bamba Cheick Daniel.

Service delivery

Professor Alihonou defined service delivery as an essential and integral part of health systems because it underlies the carrying out of health interventions by giving the health-care provider the mandate to provide health, and the government and the society the mandate to guarantee continuity and sustainability. He noted that in Africa, it was still a challenge for health services to guarantee these two prerequisites because quality care cannot be provided without quality services and sustainable service provision was not guaranteed.

The presentation was in two parts: the first part dealt with the general considerations in service delivery and the second part responded to the Conference objectives. It covered direct service delivery to satisfy the immediate health needs of beneficiaries and indirect service

delivery, which permits direct service delivery to be rendered. An enabling environment would include existence of a health policy and institutional framework, training of health-care workers, health financing and management, operational research services, etc.

The presentation also dealt with the nature of service delivery based on the level and location of the health system and the domain of the intervention. The strategy to improve delivery of decentralized health services is based on creation of adequate health centres and mobile units, and provision or improvement of outreach activities and home visits.

Professor Alihonou said that the scaling up of essential health interventions and development of the ways and means to implement integrated interventions must be achieved using a minimum essential health package. He highlighted the increasing burden of noncommunicable diseases like diabetes, cancer, mental health disorders, cardiovascular disease and obstetric emergencies, and the need to address them within the essential package. He mentioned some prerequisites for effective delivery of the essential package, including developing administrative guidelines, training, providing equipment, and establishing a structure and mechanism for verifying and checking the standards.

Professor Alihonou illustrated through the TANASH model the level of service utilization that was required to attain the health-related MDGs. He said that improvement of service coverage and service performance was key in responding to the demand for care, even for vulnerable populations.

He concluded by highlighting four tenets of effective service delivery: good management, change of culture, appropriate strategies and equity.

Several issues were raised in the discussion relating to service delivery:

- There is a conflict between the call for community participation as advocated in PHC and the introduction of vertical programmes.
- PHC requires sustainable financing systems that include financial risk-sharing mechanisms such as health insurance.
- There is need to identify the source of financing for PHC and therefore use of national health accounts should be promoted.
- Previously, implementation of PHC did not adequately emphasize secondary and tertiary health care. To revitalize PHC, it will be necessary to strengthen the referral system, including defining and strengthening delivery of essential health packages at secondary and tertiary health-care levels.
- The global reform agenda does not take into consideration the health development needs of national governments.
- The role of men in health care and the involvement of the youth in public health care should be promoted in implementation of PHC.

The response from the presenters consisted of these points:

- The health worker has an obligation to provide care when needed and the State has an obligation to ensure continuous health service delivery.
- Community care has now become a platform in health provision, but people should avoid turning it into a political platform;
- Communities have to be allowed to control their health systems. For example, community banks set up for the community fund should be given an institutional framework to enable the communities to invest money in the banks.
- National education systems should be involved to provide literacy programmes.

Decentralization, health systems and development of PHC in Africa

Mr Bamba Cheick Daniel highlighted the link between the decentralization process and development of PHC, with the aim of demonstrating the importance of territorial decentralization in health provision.

He defined administrative deconcentration as a management system in which administrative services are provided in the entire national territory and are hierarchically related to a central administration. These services are rendered at the different administrative levels.

He defined decentralization as a management system in which the real power is conferred to an entity distinct from the central administration. He mentioned two types of decentralization: technical or functional and territorial or geographical decentralization. Decentralization offers the possibility to better adapt public services to local needs and preferences and to reinforce good governance. It also allows for transfer of power, competences, goods and resources from the central level to regional and local levels. It contributes to strengthening of local capacity and development of community initiatives. This achieves political, administrative, socioeconomic and infrastructural development.

Mr Bamba noted that the key issues of decentralization remained transfer of competence and skills along with the transfer of power and resources, limited local capacity and impoverishment. He reminded the participants that the Bamako Initiative aimed at revitalizing PHC based on two strategies, namely health districts and community participation. Twenty years later, however, although much had been done, much more still remained. The development of PHC in Africa in the 21st century will continue to be hampered by a number of factors: rapid urbanization, poor economic performance by countries, civil strife, inadequate community managerial capacity and lack of effective ownership of PHC by the countries. He emphasized that decentralization helps getting decision making closer and responsive to expressed needs.

Mr Bamba regarded the following as constraints to decentralization: inadequate complementarity between decentralized administrations and public health services; nonconformity of health districts to administrative districts; decentralization of responsibilities without decentralization of resources and decision-making power; and often not attending to the need to restructure service delivery and develop capacity.

To achieve an effective interrelation and interaction between decentralized service provision and PHC, the following are necessary: decentralization of decision-making capacity at the district level, harmonization of health districts with administrative districts, provision of a PHC budget at the community and district levels, a legal framework for community participation and a unified budget system.

The following issues were raised in relation to decentralization of health services:

- The role of health as a contributor to development is not appreciated.
- No criteria exist for allocation of funds at the local level, leading to inappropriate use of funds.
- Decentralization of health-related functions should be implemented gradually and be preceded by awareness creation at the grassroots.
- Although the importance of the health-district approach in implementation of the PHC strategy is well acknowledged, it is not adequately funded.
- Release of funds is too slow, and there is need for innovative systems to deliver services to the local population.
- Ownership, management and construction of health facilities, as well as control of human resources, remain under the central Ministry of Health in some cases of decentralization. These should be decentralized.

The presenter made the following comments in response to the issues raised:

- There is need to ensure that taxes and charges collected by the state are ploughed back into PHC.
- Decentralization is not a panacea; all other mechanisms to support PHC should be sought and used.

This plenary session was followed by four parallel sessions: decentralization and management of health services, essential health services, quality of health services, and public partnerships in health management.

4.2 Decentralization and management of health services

The parallel session on decentralization and management of health services was chaired by Honourable Bintu Myers, of the Parliamentary Health Committee of Sierra Leone. The facilitator was Dr D. Egger of WHO Headquarters. Country reports came from Ghana, Mauritius and Rwanda.

Decentralization and management strengthening at the operational level

Dr Egger's presentation was entitled "Decentralization and management strengthening at the operational level". Since the Alma-Ata Declaration on Primary Health Care of 1978, many

countries have adopted some form of decentralization, establishing intermediate levels of public health institutions. A common issue in decentralization and scaling up of health services is the lack of capacity, including quality leadership and managerial capacity, especially at the operational level of both the private and public health sectors. A recent review by WHO of management strengthening in low-income countries, which was complemented by three country case studies, showed that the current management development repertoire presents some strengths and a number of weaknesses. In 2007, WHO convened an international consultation to draw lessons from past efforts in strengthening health leadership and management in low-income countries and to agree on future directions. A simple framework for strengthening health leadership and management in the countries was agreed on. The proposed framework addresses the question “What conditions are necessary for good leadership and management at the operational level?” The framework has a variety of uses, including mapping current activities, assessing needs, planning leadership and management development strategies, and monitoring and evaluation. The consultative meeting also endorsed a set of good practice principles for strengthening health leadership and management.

Ghana’s experience

Dr Frank Nyonator described the Community-based Health Planning Services (CHPS) programme developed in response to the need to address the health system’s challenges in rural Ghana. CHPS links to the local government and involves shifting resources from the national to the district level, with community health workers providing services to households. A community decision-making system with regular feedback from the communities involved has been implemented. Successes include ownership of care of every pregnant woman by the community. It was noted that community members preferred knowledgeable individuals to advise them on their health before seeking care in hospitals. Although CHPS could reduce maternal and child mortality, it faces several challenges, including leadership lapses, resource constraints and lack of essential drugs.

Rwanda’s experience

Dr Claude Sekabarage made the presentation on Rwanda’s experience. He listed the innovations in his country’s health services as financial transfers to decentralized units based on performance, increased coverage of health insurance and improved management of health facilities and delivery of services. A process of comprehensive planning also was instituted. The results show improvements in family planning uptake, antenatal attendance, assisted deliveries, immunization, insecticide-treated bed nets coverage, utilization of curative services, tuberculosis detection rate, number of persons tested for HIV, and uptake of antiretroviral therapy and PMTCT (prevention of mother to child transmission of HIV) services. Up to 80% of the population is covered by community health insurance. Demographic and health surveys showed positive trends in maternal mortality ratio, and infant and under-five mortality rates between 2000 and 2005.

Mauritius' experience

Dr K. Pauvaday reported that Mauritius decided in the late 1980s to decentralize health services and created six health regions each headed by a regional health director and with a public health superintendent responsible for primary health-care services. Governance structures include regional health advisory boards and health committees. The Ministry of Health retained responsibility for policy making. There is a delivery point for every 8759 inhabitants. Health screening and education have been initiated in schools and workplaces using mobile services. Excellent health outcomes have been achieved. The challenges include problems associated with climate change and globalization, food insecurity, migration of health professionals, emerging diseases, HIV/AIDS, noncommunicable diseases and soaring petrol prices.

The discussion on the presentation raised the following issues:

- Decentralization is not an end in itself but a means to achieve specific goals, including reaching vulnerable groups.
- Active community involvement in decision-making about health services could improve health indices.
- Capacity building is not just about training but ensuring availability of basic services and mechanisms that enable communities to organize themselves and participate fully to ensure bottom-up planning.
- Lack of managerial skills at the district level is a major challenge, since the majority of technicians are clinicians and not managers.

The Chair of the session summarized the recommendations and the way forward for decentralization and management of health services as follows: bringing health services closer to communities requires the capacity to deliver and support adequate health services at all levels. Details of the key issues and the recommendations are provided below.

The following recommendations were made:

- Capacity building is not just about training but ensuring availability of resources, adequately trained health workers, and trained health managers in planning, budgeting, resource management and monitoring and evaluation, and creating better critical-support systems and an enabling working environment.
- There is need for well-planned services and decentralization of relevant social services alongside health.
- It is essential to ensure that individuals take responsibility for their own health.
- It is necessary to ensure that health reforms are affordable.
- There is need to adequately motivate and provide incentives for community health workers and health professionals.

4.3 Essential health services

The parallel session on essential health services was chaired by Dr S. V. Shongwe, Executive Secretary, East, Central and Southern African Health Community (ECSA). The session's supervisor was Dr Eriki, Western Region, Nigeria, and the facilitator was Dr Meena N. Cherian of the Department of Essential Health Technologies, Health Systems and Services, WHO Headquarters. Country reports were from Eritrea, Nigeria and Seychelles.

Dr Cherian gave a presentation entitled "Integrated management for emergency and essential surgical care: towards strengthening capacities at Primary Health Care facilities." She indicated that every year, half a million women die from pregnancy-related complications, approximately 5 million people die from injuries, and one million die in road traffic accidents. The rate of road traffic deaths in Africa is 50% higher than the global rate. The burden of diseases that require surgery has been estimated at 11% of the world's total disability-adjusted life years (DALYs). Equitable access to timely emergency, surgical and anaesthesia services at primary health-care facilities has both curative and preventive roles, and should be considered indispensable when addressing maternal and child mortality. These services now are mostly available at the tertiary level, limiting their access to only a few people. Delayed referrals make surgical procedures complicated, costly and life threatening. But this does not have to be the case: these could be managed by trained health personnel at the primary level.

Delayed treatment for fractures, burns, club foot, hernia and obstructed labour may result in loss of productivity, contributing to poverty. The primary level of care often has shortages of drugs, supplies, equipment, specialists and trained health personnel with the "skills mix" to manage emergency, surgical or anaesthesia procedures. For example, Kenya has eight physician anaesthesiologists, and Uganda has 13 trained surgeons and Tanzania has 80.

WHO has developed a comprehensive toolkit, the *WHO Integrated Management for Emergency and Essential Surgical Care (IMEESC)* www.who.int/surgery/imeesc, containing normative guidelines, policies and best practices for management of road crash injuries, burns, falls, violence, pregnancy-related complications, congenital anomalies, infections, and disasters, and for ensuring quality and safety (through needs assessment, monitoring and evaluation). This is available through WHO, ministries of health and local and international partners. WHO's Global Initiative for Emergency and Essential Surgical Care brings interested stakeholders together to collaborate in strengthening capacities at resource-constrained health facilities towards meeting MDGs 3, 4, 5 and 6.

Eritrea's experience

Dr Tewolde Ghebremeskel, head of the Eritrea's National Malaria Control Programme, Ministry of Health, gave a presentation entitled "Malaria control in Eritrea: a success story". He said that malaria was endemic in Eritrea, it was highly seasonal, focal and unstable, and about two thirds of the population was at risk. The most prevalent malaria parasite is *Plasmodium falciparum* followed by *Plasmodium vivax*. *Anopheles arabiensis* is the main vector.

Cognizant of the threat of malaria as a killer disease and as a deterrent to socioeconomic development, the Government of Eritrea endorsed the Roll Back Malaria Initiative in 1998 as the starting point to address the malaria problem. This was followed by the development of a five-year strategic plan (2000–2004) with the participation of all stakeholders. The main objective of the plan was to reduce malaria morbidity and mortality by 80% from 1999 levels. Comprehensive and integrated malaria prevention and control interventions were introduced.

The success of the malaria control programme in Eritrea is greatly attributed to the involvement of community health agents (CHAs), who regularly take refresher training before the beginning of the transmission season each year. The CHAs are well equipped to manage all suspected cases of uncomplicated malaria at the community level. The reasons for using CHAs were to bring the services closer to the population, strengthen the linkage with health facilities, sustain the programme and ensure community empowerment and ownership.

The second factor in the success of malaria control in Eritrea is the high level of political commitment, which was translated into tax exemption for all malaria control commodities and the free distribution of bed nets to vulnerable groups such as children under five, pregnant women and internally displaced populations.

Regular operational research is conducted on drug and insecticide efficacy to assist the Ministry of Health to make policy decisions. A technical working group of experts from the Ministry of Health and partners, focusing on antimalaria drug treatment, is charged with the responsibility of advising the government on malaria treatment issues. Thus, the emergence of malaria resistant to chloroquine resulted in policy change to use chloroquine plus sulfadoxine with pyrimethamine as an interim measure during 2002–2007. This was later replaced with artemisinin combination therapy plus amodiaquine in August 2007, as per current WHO treatment guidelines.

Other interventions frequently used by the Ministry of Health include promotion of effective use of the various channels of communications for promotion of positive behavioural change, regular and supportive supervision and implementation of the monitoring and evaluation framework and efficient coordination of all stakeholders.

Eritrea has succeeded in achieving the applicable Abuja targets and even superseded these. These include an 85% reduction in both overall malaria mortality and case fatality rates. Also, currently 79% of the population in malaria areas uses insecticide-treated bed nets.

As a result of these achievements, Eritrea is now moving towards the malaria pre-elimination phase while at the same time addressing the challenges of cross-border malaria transmission and low malaria immunity that has resulted from the drastic reduction in the transmission of malaria.

Nigeria's experience

His Royal Highness Dr Sahidu Yahaya, medical doctor turned traditional leader from Northern Nigeria, and Dr Ngozi Njebuome of Nigeria's Federal Ministry of Health, gave presentations on the role of community involvement in PHC in Nigeria.

PHC was introduced in Nigeria in 1986 and a PHC agency was created in 1998. Nigeria has a three-tier government structure, with PHC operating at the local government level (the level with limited financial and human resources). In Nigeria, community leadership is composed of traditional and religious leaders, politicians, bureaucrats and the wealthy. Traditional leaders are the most trusted.

Some of the issues raised following this presentation included the failure of the Polio Eradication Initiative in Northern Nigeria a few years ago due to inadequate communication between health-care providers and the traditional leadership and insufficient empowerment of traditional leaders to communicate with the communities on health issues.

In response to the question as to whether culture could negatively affect access to health services, it was noted that insufficient empowerment of traditional leaders did have a negative impact on access to health, especially in regard to communication about disease prevention and control and PHC approaches. Also, it was agreed that incentives for and supervision of community workers were vital for success of PHC.

Seychelles' experience

Dr Shobha Harjanis, Technical Adviser in the Seychelles Ministry of Health, gave a presentation entitled "Seychelles' experience in PHC: towards the achievement of the Millennium Development Goals".

The national health policy of Seychelles is based on the principle of health for all and by all. Primary health care is the key to attaining the goal of this policy. The government's strategy is to ensure that health-care services are accessible to all Seychellois and that access is based on need and not ability to pay. Health services are free at the point of use and are provided as close as feasibly possible to all those who require them. The constitution provides for free PHC. The top priorities are sustained development of PHC, development of human resources, quality assurance, and ensuring that health services respond appropriately to changing health needs. Health promotion emphasizes disease prevention, since most of the health problems are related to changing lifestyles. Noncommunicable diseases, notably cardiovascular disease, cancer, diabetes, substance abuse and senile dementia represent the greatest burden of disease in the Seychelles.

The target of MDG 4 is to reduce by two thirds the under-five mortality rate between 1990 and 2015. Seychelles achieved this goal by reducing the under-five mortality rate from 4.14 per 1000 in 2002 to 2.55 per 1000 in 2007.

MDG 5 has the target of reducing by three quarters the maternal mortality ratio (MMR) between 1990 and 2015. Seychelles met the target of MDG 5 by reducing this ratio from 67.52 per 100 000 live births in 2002 to zero by 2007.

MDG 6 aims to have halted and begun to reverse the spread of HIV/AIDS and the incidence of malaria and other major diseases by 2015. The battle is still going on to meet these targets. The trend of HIV/AIDS is yet to be halted and reversed, and a lot of effort is going in that direction.

Dr Harjanis said that it was safe to declare that PHC had worked in Seychelles. The evidence in terms of existing structure and health indicators testifies to that effect. Seychelles is now looking beyond the MDGs. As the Ministry of Health's Strategic Framework for 2005–2009 indicates, PHC is being explored as an approach to address the seemingly daunting challenge of reversing the trend of noncommunicable diseases. The country firmly believes that it will prevail over these through the PHC approach.

The issues raised in this session were concerned with how to deal with:

- Basic life disability-saving emergency and surgical interventions at the intermediate and peripheral levels;
- Reduced immunity resulting from the drastic reduction of malaria transmission, with distribution of artemisinin-based combination therapies at the community level, and insecticide and drug resistance;
- Noncommunicable diseases where they form the biggest disease burden;
- Empowerment of traditional leaders to communicate more effectively with the communities on disease prevention and control in provision of primary health care.

In response to these issues, the presenters indicated that WHO had developed a comprehensive, integrated package called IMEESC (*Integrated Management for Emergency and Essential Surgical Care*) for the PHC level. For malaria control, Eritrea had developed an "Integrated Malaria Programme" involving distribution of insecticide-treated bed nets, long-lasting insecticidal-treated nets and artemisinin-based combination therapies at the community level, and use of community health workers. In addition, policies have been developed for mental health and nutrition and a policy on tobacco use is being developed. Special clinics for managing diabetes are also being established. It was agreed that insufficient empowerment of traditional leaders had negative impact on access to health, especially in communicating about disease prevention and control and PHC approaches, and that incentives for and supervision of community workers were vital for the success of PHC.

The Chair of this session summarized the recommendations and the way forward for essential health services as follows:

- Partnership and collaboration are required at global and local levels for sustainability of essential health services.

- Involvement of local NGOs, academia, professional and civil society organizations, and directors of training programmes (for medical, paramedical and nursing staff and clinical officers) is essential to build capacity for provision of surgical care.
- The WHO IMEESC approach should be rolled out at all levels.
- Local needs should be addressed based on situation analysis of access to life-saving emergency and surgical care at the PHC level.
- Strategies for malaria elimination should be promoted, including integrated prevention and control activities such as insecticide-treated bed nets, long-lasting insecticidal-treated nets, indoor-residual spraying, and artemisinin-based combination therapies.
- The cross-border malaria problem should be addressed.
- Problems associated with the low immunity resulting from drastic reduction in malaria transmission should be addressed.
- Operational research should continue, especially on cost-effectiveness of different interventions and monitoring and evaluation of interventions.
- There is need to develop a comprehensive plan for noncommunicable diseases that integrates prevention and control of these diseases, mental health, substance abuse, and geriatric health with health care provision and promotion at the PHC level.
- Community participation in tackling noncommunicable diseases needs to be improved.
- All health cadres at the PHC level need to be trained to deal with noncommunicable diseases.
- There is need to recognize the important role of traditional leaders in PHC.
- Health workers need to be trained to empower traditional leaders with skills to communicate effectively with their communities.
- There is need to empower the communities to enable them participate actively in PHC delivery.

4.4 Quality of health services

The parallel session on quality of health services was chaired by Dr B.I. Issa, Chair of the Physician and Pharmacists Board of Comoros. Mr M.A. Mayouya of UNFPA was the facilitator. Country cases on efforts to improve the quality of health services were from Niger and Uganda.

Niger's experience

Mrs I.F. Tari Bako, Director of Health Care Organization in Niger's Ministry of Health, gave a presentation entitled "Summary of the experience in improving the quality of paediatric, nutritional, obstetric and essential newborn care in Niger".

Niger has one of the highest maternal and under-five mortality rates in the world, at 700 per 100 000 live births and 198 per 1000 live births, respectively, according to Niger's demographic and health survey and multiple indicator cluster survey (MICS)-3 of 2006.

To contribute to the attainment of the objectives of MDGs 4 and 5, the Quality Assurance Project implemented by the University Research Company/Centre for Human Services (URC/CHS) with financing from USAID and in collaboration with other partners such as WHO and UNICEF, supported the Ministry of Health to implement a collaborative partnership (Paediatric Hospital Improvement—PHI) to improve paediatric care. PHI covers 29 hospitals, while the improvement of obstetric and essential newborn care covers 33 maternity departments in the country.

The collaborative approach is based on mutual learning involving several teams organized in a network to improve service delivery. It also aims to develop good practices over a short period. The approach began with baseline assessments in the targeted centres. This revealed the needed improvements in the quality of care in these reference centres. After 12 months of implementation of the improvements in obstetric and essential newborn care, the following results were observed:

- The percentage of deliveries that had received the three essential active-management interventions for the third phase of delivery improved from 0% at baseline evaluation in April 2006 to 96.6% in June 2007.
- The rate of haemorrhage during delivery decreased from 2.5 to 0.6% for an average of 2500 deliveries per month in the 33 maternity departments.
- The proportion of health workers correctly employing essential newborn care techniques improved from 18 to 95.5%.
- The percentage of mothers involved in early breastfeeding improved from 23.7 to 96.4%.

After four years of implementation of the PHI initiative, the overall results in all the participating hospitals showed satisfactory levels of performance compared with the baseline situation. For example:

- The percentage of children triaged on arrival improved from 0% at the baseline evaluation done in August 2003 to 85% in June 2007, with an average of 75%, despite the periodic stock out of triage cards in some hospitals.
- The proportion of health workers applying standard case-management paediatric practices improved from 3% at the baseline evaluation to 82%.
- The proportion of health workers applying standard case management practices for malaria improved from 10 to 79%.
- The proportion of health workers applying standard case management practices for severe dehydration rose from 0 to 76%.

- The mortality rate for the first 24 hours of admission in the emergency room decreased from 25% to less than 5%.

To achieve these results, several best practices were implemented in the PHI hospitals:

- Improvement in organization of services;
- Management of emergencies before completing administrative formalities;
- Strengthening the availability and use of equipment such as oxygen concentrators, oxygen masks, glucometers, etc;
- Continuous capacity building on site, such as on how to insert the nasogastric tube and set up intravenous catheters;
- Regular monitoring of teams in the collaborative project.

The lessons learnt from the implementation of the PHI project and improvement of obstetric and essential newborn care include:

- Collaborative partnerships are a powerful way of improving service delivery even in countries with weak health systems and very limited resources such as Niger.
- Capacity-building strategies proved more effective and less expensive although more laborious and time consuming (for example training of trainers at the national level and at the sites, training of service providers at the sites, and post-training validation).

The difficulties and constraints encountered during PHI implementation included:

- Inadequate numbers and high turnover of health personnel;
- Periodic stock out of essential medicines and equipment;
- Lack of adequate equipment and materials;
- Inadequate motivation of health personnel.

As the way forward for future implementation of PHI in Niger, the following are recommended:

- Maintain and consolidate achievements;
- Expand coverage of the improvement in obstetrics and newborn care approach to peripheral levels;
- Finalize the review of the national programme;
- Ensure availability of oxytocine and its stock in the supply chain system;
- Introduce the improvement in obstetrics and newborn care approach in the basic training curricula for health providers.

Regular mentorship and commitment of site managers are essential conditions for success in improving the quality of paediatric, obstetrics and neonatal care.

Uganda's experience

Dr Ruth Nassanga, District Health Officer, Mpigi District, Uganda, gave a presentation entitled "Improving the quality of health service delivery at the community level through the VHT strategy, the experience of Mpigi District, Uganda."

Uganda's Ministry of Health has established the Village Health Team (VHT) structure as a strategy to reach every village household with quality health services provided in a coordinated manner with the participation of the beneficiary community and community organizations interested in health. The ministry's implementation guidelines ensure quality and uniformity in implementing the strategy countrywide. This strategy aims at bringing services nearer to the people, thereby reducing the gap in health service provision between the households and the service providers. It also aims at enhancing community involvement, mobilization and empowerment, hence promoting community ownership and acceptance of health programmes.

In Mpigi District, the strategy was initiated in 2004 with support from WHO. In total, 3017 village health team members were selected by the community and trained in the delivery of the integrated health-care package to households. Each village had 5–7 members with each responsible for 25–30 households.

Other than training the members, establishment of the VHT structure at the district level involved sensitization of the leadership at various levels, training of trainers and supervisors, identification of focal persons, development of a VHT register, linking VHT members to health facilities, orientation of all health workers based at the health facilities, facilitation of VHT and health facility coordination, provision of supplies and facilitation of logistics.

VHT members have been very active in community mobilization for the various programmes, such as health education, TB-DOTS, malaria, ORS, condom promotion and ITN distribution. They identify, notify and refer cases. As a result of their contribution, there have been positive outcomes in immunization, antenatal attendance, delivery of babies in medical institutions, and malaria and anaemia cases.

The challenges encountered relate to coordination, meeting the demands of the community, ensuring quality of care and sustaining service provision.

It is recommended that in order to improve implementation of the strategy, the functionality of the existing health facilities should be strengthened. Governments should coordinate the activities of the different partners to ensure service delivery at the community level through the VHT structure. There is need to match policy with resource allocation as well.

The participants raised the following issues in the discussion on the presentations:

- The presentations did not consider maternal and neonatal health or the reproductive health needs of adolescents and young people.
- Information on the mechanisms for ensuring quality assurance was lacking, particularly on issues related to criteria for selection of the village health workers, and their training and incentives.
- The focus on the client was not visibly demonstrated.
- The main challenge of the VHT initiative is how it is to be sustained it, particularly since it is based on volunteerism.
- It is not easy to determine the contribution of other initiatives to the outcomes of the strategy.

The Chair of this session summarized the recommendations and the way forward regarding quality of health services as follows:

- Successful interventions should also meet the reproductive health needs of adolescents and young people.
- Successful experiences from new initiatives should be documented, disseminated and scaled up nationally.
- Village and community health interventions should be linked to primary, secondary and tertiary levels of care to ensure case referral for severe conditions.
- There is need to improve community health management information systems (HMIS), particularly the registration of new births.
- New interventions should focus on the client and not on the process.
- Volunteerism has limited benefits, so payment of salaries to community-based agents should be considered.
- The collaborative approach to improving the quality of care should be regularly evaluated to determine its impact and generate evidence.

4.5 Public/private partnerships in health management

The session on public/private partnership in health management was chaired by Dr G.M. Grunitzky-Bekele of UNAIDS. Country presentations were drawn from Burkina Faso and the Democratic Republic of Congo.

Burkina Faso's experience

Dr S. Sanou, Director-General, Public Hospitals and Private Health Sector, Ministry of Health, Burkina Faso, made a presentation entitled "Public/private partnership: the Burkina Faso experience".

The approach of complementarity between a hospital and a private facility involves a contractual arrangement defined as a voluntary alliance of independent or autonomous partners committing themselves to reciprocal duties and obligations, each expecting some gains from the relationship through some conventional agreements. The exercise of complementarity was made possible through support mechanisms, legal and regulatory instruments, and supportive measures that the State and its partners put in place gradually.

Strengthening partnerships with subregional and international organizations, transfer of skills to territorial councils as part of implementing decentralization within alternate partnerships and strengthening effective partnerships with the community are the main challenges to be met in implementing the contracting policy that is being adopted.

Mutual mistrust of potential partners, adoption of competing positions, lack of incentives, and inadequate legal and fiscal frameworks hamper the continuity and accessibility of hospitals and public services and foment disregard for the wishes of patients.

The areas of complementarity that need to be promoted are mainly: care, equipment, logistics and infrastructure; human resources; and maintenance. The key factors that should be considered to ensure the success of this partnership are policy will of the actors; mutual recognition of the interests of stakeholders; balanced relations; and existence of legal and fiscal frameworks.

The viability of public partnerships calls for strengthening environmental regulation capacity and better piloting of the health sector. The integration of the public, private and traditional sectors strengthens the revitalization of Primary Health Care and enhances the performance of the health system.

Experience of the Democratic Republic of Congo

Dr L. Opetha, Director of Primary Health Care, Ministry of Health, Democratic Republic of the Congo, made a presentation on the DRC experience in the management of public/private partnership for health.

The concept of partnership covers several notions, including mode of collaboration between stakeholders in adhering to the responsibilities and obligations of each stakeholder in pursuing common objectives, formalization of relations by means of a services agreement or contract, and mode of financing and management of health services and facilities to increase the coverage of essential health services for the population.

The Democratic Republic of Congo established this public/private partnership given its geographical vastness and its limited resources to provide basic health care for the poor; the increasing need for universal access to satisfactory coverage of the population; the need to provide some relief for the rural populations who are victims of many endemic diseases and epidemics; and the fact that 63% of hospitals belong to the private sector.

The legal framework of this partnership is formalized by ordinances and legislative acts aimed at regulating the partnership; approval from the Ministry of Justice; ministerial orders on the necessary recognition; and framework conventions to cement the relations between the State and partners. The areas of the partnership include integration of health care facilities and Primary Health Care interventions into private health facilities. Transfer of the management of state enterprises to private profit-driven firms, partners' support to health facilities of the State, state support to private facilities integrated into the national health policy, and performance contract signed between the service provider and the partner.

Since the inception of this partnership, encouraging results have been achieved including the Mbanza-Ngungu Partnership Charter; the development of normative and management documents of the partnership; the establishment of 946 local NGOs and 52 international NGOs; the engagement of 1000 public health experts, 2000 doctors and 7000 nurses; and the establishment of 12 central stores for essential medicines procurement and distribution and one generic essential medicines procurement federation.

Notable among the strengths are the establishment of a functional inter-donor group, and signing of agreements with CIPLA which helped reduce the costs of antiretrovirals. Also notable are the commitment of partners, health sector reform based on partnership and establishment of services in charge of partnership management.

Many weaknesses persist, including information and communication gap at all levels; inadequacy of contracting skills at the intermediate and peripheral levels; weaknesses in the monitoring and evaluation of externally-funded projects; and non-mastery of financial flows and of the management of external aid.

As part of the lessons learnt, Dr L. Opetha stressed that public/private partnerships had contributed to increasing coverage of services for the populations. However, there was need for strong leadership to make the partnership more effective. Transparency, dialogue and consultation among stakeholders enhance the dynamism and effectiveness of partnerships.

Dr Opetha concluded by highlighting the way forward, focusing on updating of the national health development plan to keep partners in line with national priorities, national health policy, the organic framework, the framework-law, the Hospital Act and the Finance Act. Finally, he stressed the need to both operationalize the organs piloting the health sector strategy, specifically national steering committees and the provincial steering committees, as forums for dialogue and consultation among partners, and accelerate the training of intermediate and peripheral staff in contracting.

The session's Chair made the comment that public/private partnerships raise issues for countries that go beyond mere collaboration to such areas as training, acquisition of pharmaceutical products and equipment, hospital management, incorporating NGOs, and traditional medicines. This is often with the aim of reducing government funding and to release some specialized professionals like doctors from administrative duties so that they can have time for their professional duties.

The following were the issues and comments from the discussion on the presentations:

- An NGO representative from Nigeria provided personal experience on partnerships involving an NGO and the government in service delivery. He said that NGOs could also provide support in management and training.
- The presenter from the Democratic Republic of the Congo was requested to provide more details on the role of the public/private partnerships in ensuring maintenance of equipment when almost 63% of health services in the country are delivered by the private sector, and on how the government ensures quality control in health service delivery.
- The UNICEF representative reported that the UNICEF report, *State of the World's Children*, contained lessons that others could learn from on how PHC is to be integrated into health systems. She also mentioned that there were opportunities for involving the private sector in financing and bringing new technology such as bednets into the market and into the distribution system.
- A participant mentioned that a public/private partnership in Botswana had been very useful in scaling up antiretroviral therapy and beneficial to the health system by sharing of costs and services. This participant enquired from the presenters if there was a clear plan as to how participating agents contributed to the delivery of a service.
- The fact that the private sector is profit-driven calls for the need for incentives for its participation and determining whether it will be involved in non-core health issues such as water and sanitation, how this will be done and what the contribution will be. Also, it will be necessary to determine how to deal with the private sector's inclination to make profit.
- The Democratic Republic of Congo has two kinds of partnerships: integrated and non-integrated. The government deals with integrated partnerships. The non-integrated partnerships are difficult to manage. Most of the services are provided by church organizations, and it is difficult to monitor their quality since no government mechanisms exist for monitoring staff qualifications.
- The meeting was cautioned that although the private sector was important, time was needed to integrate it well into the health system.
- If more than 60% of health services are provided by the private sector, as is the case with the Democratic Republic of Congo, it is important to address questions about who funds the services, how monitoring and evaluation of service delivery is carried out, the difference in fee levels between the private sector and the public sector in such partnerships, and how the poor will pay fees.
- Issues concerning how donated drugs are to be handled in the partnerships need to be dealt with, since the private sector needs to make a profit, as well as how the drugs will reach the public in such cases.
- Well-formalized complementarities need to be established in the partnerships.

- It will be necessary to decide how the participants in the partnership will share service provision, technical know-how and financing responsibilities.

The Chair of this session summarized the recommendations and the way forward for public/private partnerships in health management as follows:

- The health sector is monopolizing PHC.
- Governments rely on partners, but they should rely on their own resources, particularly financial resources;
- Issues such as management of waste from health-care activities, how to engage the media and who will do research need to be addressed.
- Nonprofit, private health services such as those provided by faith-based organizations need be controlled.
- Government institutions should look for opportunities to learn and benefit from private sector management approaches.
- Issues such as the nonintegrated private sector approach brought up in the presentation from the Democratic Republic of Congo need to be dealt with.
- National health insurance is an important area that needs to be explored for improved health service delivery.

5. Health system resources

5.1 Overview of health system resources

This plenary session was chaired by Mrs A. Saade Souley, Minister of Community Development, Niger. Three presentations were made: “Human resource for Primary Health Care”, by Professor F. Omaswa, Executive Director of Global Health Workforce Alliance, “Is the concept of essential medicines still able to support the renewal of PHC?”, by Dr Hendrix Hogerzeil of WHO/HQ, and “Financing Primary Health Care”, by Dr C. Lemiere of the World Bank.

Human resources for Primary Health Care

In his presentation, Dr Omaswa welcomed the movement to renew the commitment to the Alma-Ata Declaration and Primary Health Care, underlining the central role the health workforce will play in this movement. Examining the health workforce crisis within the global and African contexts, he outlined the various levels of the “health systems pyramid”, linking these with their workforce needs and demonstrating their interconnectedness with other external factors. He reported on the elements of the Kampala Declaration and Agenda for Action, which had the slogan “Health workers for all and all for health workers”, and highlighted the critical factors for a successful health workforce programme and its Primary Health Care component. Finally, he proposed a number of key considerations for scaling up PHC in countries. The main highlights of the presentation were:

- Health workers are the cornerstone and drivers of health systems, but there is a global shortfall of health workers estimated at over 4 million, and Africa is the hardest hit by of this shortage. This is against a background of a long history of neglect, wrong policies, etc., and it touches more than just the health sector. The way forward will require working with institutions such as the Global Health Workforce Alliance, which was established to participate in addressing the crisis.
- The first Global Forum on Human Resources for Health held in Kampala 2–7 March 2008 produced a road map to guide the action in response to the health workforce crisis over the next decade. The key elements of the road map are: (i) building coherent national and global leadership for resolving the health workforce problem, (ii) ensuring capacity for an informed response base and evidence in joint learning, (iii) scaling up health worker education and training with the goal of attaining a need-based skills mix, (iv) retaining an effective, responsive and equitably distributed health workforce, (v) managing the pressure of the international health workforce market and its impact on migration, and (vi) securing additional and more productive investment in the health workforce.
- The critical success factors for scaling up health workforce education and training include political commitment and good governance, workforce planning and an enabling environment.
- Community health workers were identified as key to effective implementation of PHC. In this regard, development of a community health worker programme should be made a part of national policies and frameworks. The main pillars of this programme include multisectoral partnership, a health sector strategic plan, advocacy for health and health human resources, and leadership and management capacity.
- The African Response and Action should include political leadership, support of technical agencies, involvement of the civil society, technical frameworks and public goods, an African platform on human resources for health, and an African Union and NEPAD monitoring and reporting mechanism.

Essential medicines

Dr Hendrix Hogerzeil noted that there can be no PHC without essential medicines. He indicated that health services, including PHC, were delivered through three types of facilities: public, private not-for-profit, and private for-profit. The main points of his presentation were:

- Selection of essential medicines remains the cornerstone of PHC, and the *WHO Model List of Essential Medicines* is recommended. Although a functioning regulatory system is critical to ensure quality of essential medicines for PHC, some low income countries do not have such a system.
- Universal access to PHC depends on the real and perceived quality of care, including quality of prescribing, and availability, pricing and affordability of medicines.
- Large medical and economic losses are incurred through irrational use of essential medicines. Approaches to promote rational use are now much better supported by

scientific evidence than in 1978. Activities to promote rational use of medicines should be covered under procurement costs.

- Evidence shows that treatment is better and cheaper in the public than private sector. However, essential medicines are usually not available in the public sector.
- Essential medicines support social justice as a right and not as charity. Thus, emphasis on human rights strengthens the case for their universal access.
- Besides essential medicines, PHC depends on essential health technologies such as stethoscopes, simple diagnostic laboratories, blood pressure equipment and ECG machines, as well as essential referral facilities such as hospital laboratories, diagnostic imaging equipment, operation theatres and the intensive care unit.
- The concept of essential medicines is as relevant and valid in 2008 as it was at conception in 1977. Essential medicines have remained a universal brand associated with equity, social justice, common sense and good governance. The concept has evolved with time. It is now much more supported by scientific evidence and has entered into new arena covering prequalification, pricing, good governance and human rights. Most of these approaches can and should also be used to argue for support for essential health technologies within the overall support to health systems.

Financing Primary Health Care

Dr C. Lemiere of the World Bank gave a presentation on behalf of Agnes Soucat, Lead Health Economist for the African Region, with the following main points:

- Thirty years after the Alma-Ata Declaration most health spending in low-income countries is still private and from out-of-pocket sources. Government expenditures tend to concentrate at the upper level of care and benefit the better-off, and donor funding in low-income countries does not necessarily finance government priorities nor the greatest need as defined by morbidity and mortality indicators.
- PHC development is the key for improving health outcomes; however, Africa is still facing a daunting challenge in achieving the MDG targets. Cost-effectiveness is one criterion for prioritizing health expenditure, but financial protection and equity are also important. Ethiopia is an example of a country where major health problems such as infant and child mortality and maternal deaths could be solved with low-cost interventions.
- PHC should be funded by the government although various other approaches to funding are possible. Public funding of PHC can take several forms, and governments could also fund demand (instead of supply) through mandatory health insurance (as is done in Rwanda and Ghana). However, whatever mechanism is chosen for funding PHC, fiscal space will be a binding constraint.
- Revenue generation capacity is limited in low income countries and some countries face difficult external debt repayment problems. External aid is an important source of health spending in sub-Saharan Africa, and donor aid for health has increased significantly, most of it going to Africa for specific diseases and coming from bilateral

and multilateral sources such as the GAVI Alliance and the Global Fund to Fight AIDS, Tuberculosis and Malaria. However, donor commitments for health are volatile and unpredictable, and vertical aid distorts national priorities.

- Donor funding could be improved through country ownership, alignment, reduced earmarks, focusing on comparative advantage, pooled financing, improved data collection and increased coordination.
- Developing PHC is key for improving health outcomes in Africa, although efforts in other sectors are also needed. Donors need to be conscious of possible distortion when providing financing outside the basic package of services. They should focus on long-term and nonvolatile interventions.

During the discussion session, the participants raised a number of questions relating to:

- How to deal with counterfeit medicines;
- How to address the brain-drain problem and retain the health workforce in the countries, including by decentralization and the use of performance contracts;
- Whether the funding promised by President George Bush of the United States and Prime Minister Gordon Brown of the United Kingdom for human resources in health would cover salaries of the health workforce.

The presenters indicated that the issue of the counterfeit medicines can be addressed by strengthening national drug control laws and making trafficking of counterfeit medicines a crime. The workforce problem in African health systems should be considered in national development plans, and the countries should utilize multiple sources of funding, including national budgets to solve it. United States and United Kingdom should be seen as part of the multiple sources of funds.

Dr Omaswa emphasized that PHC could be implemented with existing resources and that countries should be committed and take action now.

Mrs A. Saade Souley, Minister of Community Development, Niger, and Chairperson of this session, summarized the recommendations and the way forward on public/private partnerships in health management as follows:

- The countries should develop human resource policies integrating health workers, including community health workers, within frameworks for and management systems based on the PHC concept.
- The countries should scale up the production of middle-level and community health workers to deliver essential health packages within PHC.
- The countries should develop sustainable motivation and retention strategies for health workers and work with other sectors, such as housing, transportation and communication.

- Public spending on health should be prioritized according to a country's morbidity and mortality levels and availability of funding.
- Donor finding management should be improved through country ownership, alignment and harmonization, reduced earmarking, pooled financing and improved data collection.
- The countries should establish national insurance schemes or community health funds within the appropriate legal frameworks, ensuring sustainability by providing reimbursement for revenues lost from waivers and exemptions.
- The countries need to develop national policies and define norms, standards and regulatory frameworks for health technologies, and train personnel to use the technologies.
- Member States should develop and implement policies and strategies for essential medicines, emphasizing procurement and use of generic medicines, training in rational drug use, quality assurance and re-organization and integration of traditional medicine into PHC.

The plenary session was followed by four parallel sessions dealing with human resources for health, essential medicines including traditional medicines, health technologies and health financing.

5.2 Human resources for health

This session was chaired by Professor David Sanders of the School of Public Health, University of Western Cape, South Africa. The presenter was Professor A.L. Adetokuboh, Adjunct Professor at Harvard University. Country reports were drawn from Ethiopia, Mali and South Africa.

Human resources for Primary Health Care

Professor Adetokunbo's presentation was entitled "Human resources for Primary Health Care". The highlights were:

- There is alarm at the increasing shortage of doctors, nurses and other trained health personnel, a crisis that is undermining efforts to achieve ambitious health goals by developing countries. This is a global problem and unless substantial improvement occurs, many African countries will not achieve the targets of the health-related Millennium Development Goals. There is an urgent need to strengthen the health workforce in developing countries, especially in sub-Saharan Africa.
- Numerical analyses from recent studies have provided concrete evidence of the deepening crisis and useful material for advocacy and policy review. However, a somewhat narrow numerical approach has led to misleading conclusions and inappropriate recommendations, and cannot provide full understanding of the dimensions and determinants of the problem. Furthermore, the top-down approach from

a global viewpoint has led to prescriptions of arbitrary global targets. From such calculations, African governments have been advised to increase the number of health workers by 1 million by 2010—the so-called “1 by 10” target. In some African countries, the prescribed expansion of health staff could be counterproductive by further distorting the balance of investments in human resources in relation to other components of the health services.

- Developing effective and sustainable policies and strategies for human resources for health will require focusing on three goals: matching competence and deployment of health workers to needs, managing migration and achieving balanced investment.
- In the colonial days, the few available professionals devised many strategies for filling the human resource gap such as training health auxiliaries, medical assistants and other paramedical staff. Other creative approaches provided pragmatic solutions.
- There has been tension in professional training of doctors, nurses and other health care workers between those who wish to achieve what they regard as international standards and those who pursue the historical pragmatic pathway. An acceptable compromise could be to ensure that core training is of appropriate standard but specific content is suitably adjusted to meet local needs and circumstances. The starting point should be an objective analysis of the tasks that need to be performed, followed by training curricula that ensure relevant degree of competence.
- Some of the proposed solutions to the growing problem of migration of health workers from developing countries tend to overemphasize the pull factors without addressing the push factors. Little has been said about the “anchor” factors, those aspects of professional and social life that encourage health workers to stay in their home countries. It is a gross error to view the issue of migration in isolation or to rely solely on rules and regulations to bar migration. The migration of health workers is often not the cause but the result of problems within the health services.
- Rather than attempting to deal with human resources in isolation, it is better to review the policies and strategies for managing the health workforce in the context of the overall development of the health system. Because of the failure to adopt this broad comprehensive approach, often the human resource component tends to be unrelated to the other inputs within the health services. The aim should be to diagnose the dimensions and determinants of what has been described as the “sick system syndrome”, in which many essential components of health-care services do not function and are mismanaged. What is required is balanced investment in human resources, strengthening of the infrastructure, and optimization of logistic support and other essential components of the health services.

Ethiopia’s experience

Mr Wondwossen Temiess from Ethiopia gave a presentation on the Health Extension Programme (HEP) being implemented in Ethiopia. He indicated that HEP, which was started in 2002, was a package of basic and essential promotive, preventive and curative health services targeting households in a community and based on the principles of PHC, which are to improve family health status with the full participation of the beneficiaries.

The overall goal of HEP is to create a healthy society and reduce the rates of maternal and child mortality and morbidity. The specific objective is to improve access to and equity of essential health services at the village and household levels. HEP empowers individual households through giving them ownership of, and responsibility for, their health.

The programme has four implementation strategies: training and deployment of health extension workers, construction of health posts, provision of medicines and medical supplies and full community participation. The target is to train and deploy 30 000 health extension workers to achieve the objectives of the programme.

Since its establishment, HEP has seen the reduction in malaria cases and increases in antenatal care coverage and number of births attended by skilled personnel.

The challenges facing HEP are related to inadequacy of resources to effectively implement the maternal and child survival interventions to meet the MDG targets, critical shortages of appropriately skilled personnel for peripheral and middle-level health facilities to assist deliveries, and the need to strengthen higher level facilities to manage complicated cases.

Mali's experience

Dr Diakité Oumou Maïga of the Ministry of Health, Mali, made a presentation on the availability and retention of qualified health personnel in the rural areas of Mali.

The Ministry of Health of Mali has developed a strategy to address the scarcity of competent and motivated human resources in community health centres, a problem considered as the main constraint on the health system of Mali. The strategy is an integral part of human resource policy implementation involving:

- Signing of health delivery contracts between doctors, the communities and local councils;
- Decentralization of the national health sciences training institute and opening of private schools for training of health workers;
- Establishment of decentralized posts using HIPC funds (a facility for highly-indebted poor countries).

These actions helped provide rural areas with 1351 doctors and nurses and to increase the number of community health centres from two in 1960 to over 850 in 2007. Health workers retention actions involved:

- Medicalization of community health centres by the ministry of health;
- Authorization of the practice of minor surgery;
- Revision of the list of essential medicines for community health centres;
- Recruitment of doctors by community health associations and the mayor's office;

- Contractual arrangements with private medical practitioners;
- Integrated supervision.

The experience showed that countryside medical care, contractual arrangements and decentralization of health facilities are alternatives for accelerating the achievement of MDGs by 2015. However, the experience should be viewed from the standpoint of social non-profit service and should take account of the income levels of the population.

The ensuing discussions focused on the importance of having a highly-qualified staff especially doctors at the first level of the health system and the capacity of community health associations to conveniently pay the salaries of health workers of community health centres.

South Africa's experience

Professor M. Jacobs from South Africa gave a presentation on “Human resources for health equity: the South African perspective”. She said that everyone had the right to have access to health-care services, and, as such, the use of PHC-led human resource planning for health equity was desirable.

She indicated that the South African National Human Resource for Health Plan underscored the importance of having the right numbers of health workers with the right skills and in the right place, particularly in underserved areas.

She urged participants to promote South–South solidarity in the search for the solution to the crisis in human resource for health.

The issues raised during the session on human resources for health pertained to:

- Global human resource crisis in most countries of the African Region;
- Need for PHC-led human resource planning for health equity, reflecting the right numbers, the right skills and the right place for human resources deployment;
- Contribution of middle-level health workers in increasing coverage of antenatal care;
- Reduction in malaria cases as evidenced in Ethiopia;
- Effective use of community resources in retaining health workers and improving access to health care in the rural areas, as demonstrated by Mali's experience;
- Limitation of using workforce density as the main determinant of delivery of health care and health outcomes;
- Need to promote South–South solidarity and collaboration in addressing the human resources crisis in Africa.

Several recommendations were made with regard to the discussions and the issues raised:

- The countries should consider estimating the required number, skills and type of health workers based on their specific circumstances and not based on prescribed formulas.
- There is need to work together with professional associations in order to retain health workers in their countries.
- The countries are encouraged to put in place concrete measures for ensuring adequate human resource capacity for health development.
- The Mali experience of retaining health workers and improving access to health care using community resources should be documented and shared.
- There is need to promote training of middle-level health workers to effectively address the MDGs, as Ethiopia has done.
- The countries should promote South–South collaboration in addressing the human resource crisis.
- Best practices should be documented and shared widely.
- Estimation of health workers’ numbers and the required type of skills should be based on country-specific circumstances.
- Training of mid-level health workers should be promoted by the countries in order to achieve MDG targets.

5.3 Essential medicines

The parallel session on essential medicines was chaired by Professor H. Martins from Maputo, Mozambique. Country experience was reported from Algeria, Burkina Faso and Kenya.

Algeria’s experience

Professor M. B. Mansouri, Director-General of the national pharmaceutical products control laboratory, Ministry of Health, Algeria, made a presentation entitled “Regulation, quality and the issue of medicines: Algeria’s experience”.

The national health policy is based on the right to health as enshrined in the Constitution. The will to make this right a reality is affirmed in various governmental programmes approved by Parliament. Under the governmental programme of the current legislature (2004–2009), the goals in matters concerning medicines are to improve access to essential medicines; guarantee the quality of medicines; streamline expenditures by promoting generic medicines; and develop training in hospital management and industrial pharmacy.

Concerning the promotion of generic medicines, the government regularly shows a will as expressed recently by the amendment of Act 84/05 on Health Promotion and Protection by Presidential ordinance number 06/07 dated 15 July 2006 which states that incentives may be provided to promote generic medicine, and the Ministry of Health may, as necessary, set a

minimum threshold for import of generic medicines. The government has also revised the regulations governing the profit margins of generic medicines in the pricing of medicines.

Concerning quality assurance, the administrative body in charge of registration, distribution and production of medicines and certification of medical arrangements is the Directorate of Pharmacy under the Ministry of Health. The National Pharmaceutical Product Control Laboratory is the body in charge of the evaluation, quality control, safety and efficacy of pharmaceutical products subject to registration and the systematic control of batches of pharmaceutical products prior to their marketing, a system established to check against counterfeiting of medicines.

Parliament is finalizing the amendment of the Health Act in order to establish a national agency for pharmaceutical products. In this respect, the presentation focused on the organizational aspect of pharmaceutical product quality control and the issues concerning medicines.

Burkina Faso's experience

Professor Jean-Baptiste Nikiema, Director, Traditional Medicine Promotion, Ministry of Health, gave a presentation entitled "Experience and progress in institutionalization of traditional medicine in health systems: experience of Burkina Faso".

Traditional medicine in Burkina Faso is practised by 30 000 traditional health practitioners, with a ratio of 1 to every 500 habitants. Traditional practitioners are leaders in their communities, and, as true agents of community health, they use approximately 200 medicinal plants and generate about US\$ 20 million in annual sales.

Owing to the importance of traditional medicine—more than 70% of the population in rural environment depend on it—and to fulfil its obligation to the international community, Burkina Faso has adopted and met the necessary requirements for institutionalization and integration of traditional medicines into the national health system. These requirements comprise a law, a national policy and regulations on the practice and registration of traditional medicine. The traditional health practitioners also have adopted a code of ethics to control their profession.

The first results of the institutionalization process are emerging. Administration and coordination structures and consultation frameworks have been set up. Traditional health practitioners are now involved in reporting diseases whose declaration is obligatory. So far 11 local medicines have been registered, four of which have been placed on the national essential medicines list. To fund traditional medicine activities, the government has created a budget line of about US\$ 100 000 per year.

There is need to reinvigorate PHC by better defining the place of traditional medicine in the national health systems. To this effect, it would be desirable to take measures to document the traditional medicine situation, define the place of the traditional health practitioners, and develop local production capacity and the teaching of traditional medicine.

Kenya's experience

Dr T. Gakuruh, Health Planner, Ministry of Health, Kenya, gave a presentation entitled "Improving access to essential medicines: the experience of Kenya".

The key strategies for facilitating access to essential medicines include creation of enabling policy and legal framework for pharmaceuticals; provision of a basic package of essential medicines with special focus on the needs at levels I, II and III; review of financing options to increase affordability; improvement of procurement and supply systems; strengthening of drug regulation and quality control; addressing pharmaceutical human resource constraints; and developing or adapting appropriate monitoring and evaluation mechanisms.

The key achievements include functioning procurement and supply systems, improved availability of essential medicines in the public sector, definition and periodic review of the basic package, development of a strategy for community-level health services, improved financing for and affordability of essential medicines, increased government expenditure on medicines, provision of medicines free of charge for HIV, TB and malaria and for children below five years of age at public and mission facilities, tax breaks for medicines, and government subsidies for faith-based health facilities.

Monitoring of prices and availability of essential medicines entails quarterly evaluation by the Ministry of Health. Data are collected at facility level on availability and the price to the patient of a basket of selected essential medicines. There is regular feedback to policy-makers, consumers and health sector partners.

These efforts have resulted in increased availability of antimalarials and coverage of antiretrovirals. The main challenges include inadequate funding for procurement, warehousing, distribution and market regulation of essential medicines; presence of too many players in the pharmaceuticals market, creating coordination, alignment and regulation problems; inadequate levels and skills of human resources especially at the lower levels; low emphasis on rational use of medicines; and limited tools to measure access.

The lessons learnt include:

- The policies and strategies in place are bearing fruit.
- Ensuring affordability of essential medicines will require:
 - Special focus on enhanced procurement, exploration of pooling options, promoting use of generics, expanding health insurance coverage for medicines, and providing subsidies for critical, life-saving medicines such as insulin, inhalers and hypertension medicines;
 - Weeding out unauthorized sale of medicines by strengthening the systems for medicine regulation and enhancing laboratory capacity (this will require WHO prequalification);

- Promoting rational use of medicines by reinforcing monitoring and regulation systems and increasing pharmaceutical human resource capacity (especially for the lower levels of care);
- Exploring through research how traditional medicines are used and ensuring their safety and quality;
- Measuring progress on access to medicines by developing or adapting robust monitoring and evaluation tools.

The participants raised issues concerning:

- Access to essential medicines—specifically medicine regulation, the role of national regulatory authorities, registration, quality control and counterfeit medicines;
- Quality control and quality assurance, considering that most of countries lack a regulatory framework for local production, and there is lack of training in control of quality of traditional medicines;
- Traditional medicines in regard to the necessity of defining the role of traditional medicines in PHC; the lack of a relevant mechanism to deal with intellectual property rights, categorization of traditional medicines after research and development, or their registration; the challenges associated with secrecy surrounding data and information among traditional and formal institutions.

In their response, the presenters indicated that:

- Regulatory functions for medicines are handled by the Medicines Regulatory Authority, while the National Quality Control Laboratory is in charge of testing the quality of medicines.
- There is a need for a regulatory framework for local production of traditional medicines.
- The National Quality Control Laboratory of Algeria could train staff from other countries on quality testing of traditional medicines. Since the laboratory is a WHO collaborating centre, requests should come through WHO.
- There is need to document the role of traditional medicine in PHC. The vision for traditional medicines needs to be clearly defined, and should incorporate both scientific research strategy using WHO tools and goals to develop local expertise.
- WHO, in collaboration with partners such as the African Intellectual Property Organization (OAPI) and the African Regional Industrial Property Organization (ARIPO), is developing guidelines to protect African traditional medical knowledge.
- WHO has developed guidelines for registration of traditional medicines.
- The secrecy of traditional health practitioners is no longer an issue since information on the ailments the medicines are used for is now available, although not all countries use it.

5.4 Health technologies

The parallel session on health technologies was chaired by Dr M.A. Njelekela of Muhimbili University of Health and Allied Sciences. Dr M. Ekeke of the Department of Health Care Organization and Health Technology, Ministry of Health, Cameroon, and Dr K. Chetty of South Africa shared their countries' experiences.

Cameroon's experience

Dr Ekeke Monono, Department of Health Care Organization and Health Technology, Ministry of Health, Cameroon, made a presentation entitled "Appropriate health technologies".

Health technology may be defined as the application of knowledge and skills to the development of medicines, vaccines, health procedures and systems in order to solve a health problem and improve quality of life. Information systems including electronic archiving of health data and application of telemedicine are all part of the parameters of health technologies.

The WHO Regional Committee for Africa passed three resolutions on health technologies in 1994 and 1995. By Resolution AFR/RC49/R12, Member States adopted a regional strategy on health technologies in Windhoek in 1999. However, very few countries have implemented the recommendations contained in the strategy, which involves defining a national policy on health technologies.

Present-day medical practice is dependent on health technology which is changing very rapidly in all countries. Health technology should be appropriate, effective and affordable.

Cameroon has embarked on reforms to solve the problems identified in this area and has made management of equipment and infrastructure a priority in its national health policy. A study commissioned by the Ministry of Health identified the following problems: inappropriate choice(s) of technologies, lack of planning, misuse of equipment and lack of maintenance, inadequacy of financing and qualified personnel, poor governance, poor waste management and limited community involvement.

Analysis of this study and the outcomes of pilot projects led to the development of a national policy on health technology. The policy paper which is the fruit of a participatory process aims at: mastery of investment planning, streamlining of the cost of procuring health technologies, rational use of resources, efficient maintenance of equipment, safety of technologies, provision of trained personnel, rational and effective use of energy and other resources to protect the environment. This policy has 10 elements: an evaluation system, a planning and budgeting system, procurement, utilization and maintenance procedures, development of human resources, financing, public/private partnership, legislative and regulatory framework, information management system, and national and international cooperation.

Problems and questions pertained to the:

- Need for brainstorming on simple, appropriate and affordable technologies applicable in the African context;
- Level of implementation of Resolution AFR/RC49/12 on health technologies;
- Lack of information on new communication technologies and their limited use;
- Lack of maintenance culture and inadequate budget allocation;
- Influence of the promoters of various technologies, resulting more in the procurement of new equipment than in the maintenance of existing equipment;
- Choice of appropriate technologies matched to the needs of health-care facilities;
- Need to study the possibility of popularizing the use of solar energy which costs less in the long term and is always available in countries.

The following answers were suggested:

- Health technologies have not been considered by many as an essential component of primary health care. They deserve adequate consideration in the formulation of primary health care implementation strategies. There is need also to take account of technology needs as from the planning phase and to set up an appropriate procurement mechanism and contracts that include preventive and curative maintenance.
- Concerning Resolution AFR/RC49/12 of 1999, very few countries have implemented the Regional Committee recommendations. Actually, fewer than seven countries have formulated a national policy on health technologies.
- Solar energy is a good alternative in Africa because it is more cost-effective to use in the long term than electricity and generators.

South Africa's experience

E-health can be defined as combined utilization of electronic communication and information technology to generate, capture, transmit, store and retrieve digital data for clinical, educational and administrative purposes. The purpose of e-health is to contribute to the improvement the health status of the people of South Africa through optimal use of information and communication technologies (ICTs).

Telemedicine is the practice of medical care using audiovisual and data communication. This includes medical care delivery, diagnosis and treatment, as well as education and transfer of medical data.

Telehealth is the management and support of national and international health by audio visual and data communications. This includes delivery of health care; access to repositories of knowledge, applications and literature; management of health-care institutions; education of the public; basic and continuous education; surveillance of diseases and services; management of health emergencies and hazards; and research.

The main objectives of the South African national telemedicine system are delivery of health-care services at a distance to South African rural communities, provision to rural communities of access to physicians and specialist expertise through telemedicine technology, health promotion and continuous professional development.

Telemedicine is applicable in primary health care, prenatal care, sonograms, skin diseases, cardiology, surgery, ophthalmology, mammography surveillance and radiology. In South Africa, telemedicine is currently used in radiology, pathology, ophthalmology, ultrasound antenatal screening and research and training at telemedicine centres.

Telemedicine sites now number 68 sites, and distance learning is generating huge benefits for health professionals in health education, clinical ward rounds and training. For example, in a recent study, 75.4% of referral cases were handled using telemedicine.

As part of the process, the department in charge of telehealth, in collaboration with Sentech, has established a closed Health Broadcast Channel that promotes health and educates patients and health workers in hospitals and clinics using satellite. In 2002, the project was piloted at 30 sites for six months. The channel is capable of reaching most rural communities. This important tool has expanded from the initial 30 to 110 sites. Establishment of 79 sites funded by John Snow was completed in December 2006. Currently, 300 sites are functioning.

The most critical component of telemedicine are the end-users, i.e. the health-care providers and the patients. This is true for any ICT health project. It is the people and not the technology that determine the operational success of this collaboration initiative.

The issues that arose from the presentation were as follows:

- Difficulties exist in getting specialists from reference hospitals to support peripheral health workers in the use of telemedicine as tool for improving performance in healthcare delivery.
- Use of the mobile phone should be explored to improve health delivery and the health information system;
- It might be difficult to expand telemedicine across a whole country, particularly in big countries like Nigeria, where facilities such as power supply are erratic or not available in rural areas.
- There are challenges in developing telemedicine in Africa, where power supply is inadequate and Internet connection hardly exists or connectivity is poor.
- Funding telemedicine using the national budget is difficult as is raising funds from donors for this sector, which is not considered a priority by many countries.
- There is need to explore the possibility of using telemedicine for basic education of medical doctors and other health professionals.

The following comments were made in response to the issues above:

- Many medical specialists are very busy and are reluctant to dedicate part of their time to support telehealth or telemedicine. There is a need to provide them with information on the benefits of this new technology and bring them on board. Telemedicine reduces the number of patients referred to secondary and tertiary levels and can save lives and time.
- It has been demonstrated in Cameroon, Uganda, Kenya and other countries that the mobile phone has improved data collection and the health information system. It reduces delay in receiving information from peripheral areas. Initial investment may be high but this method is cost-effective and efficient. Mobile phones have been used for follow-up in DOTS, evolution of outbreaks and to get information on maternal mortality rates.
- Funds can be raised from the community and mobile phone companies to support telehealth. Calls made in the framework of the projects generate incomes for mobile phone companies, and this is reason some such companies are willing to support the use of this technology.
- Telemedicine is currently mainly used for continuing, and not for basic, education. If this has to change, there will be need for standardization and accreditation supported by legislation.

The Chair of this session summarized the recommendations and the way forward for health technologies as follows:

- Health technology is an important component of primary health care but it should be appropriate, accessible and affordable.
- There is need to strengthen South–South collaboration to facilitate exchange of experience and learn from each other.
- It is important for countries to formulate, adopt and implement comprehensive national policies for health technology management as recommended during the Forty-ninth Session of the Regional Committee.

Use of solar energy should be promoted since this can be accessed everywhere on the continent provided the needed technology is available.

5.5 Health financing

The parallel session on health financing was chaired by Honourable Dr Saleh Meki, Minister of Health of Eritrea. Dr F. Njau of Tanzania and Dr O.C. Yapi of Cote d'Ivoire shared their countries' experiences in prepaid health financing.

Tanzania's experience

Dr Njau gave a presentation on “Community Health Fund implementation in Tanzania”, dealing on how the Government of Tanzania designed, pretested, piloted and scaled up the CHF scheme during the last 12 years. It touched on the context of the establishment of CHF and highlighted the huge resource gap in financing basic health care and the current under-funding of the sector against the background of increased demands for health services. The gap is also fueled by the HIV/AIDS epidemic, increased cost of inputs and many other factors. The health workforce also is in a crisis: skilled staff are not available in sufficient numbers and mixes, and their retention is difficult.

Dr Njau underscored the need for strong, tax-based financing with a mix of user fees and both voluntary and mandatory prepayment schemes. He pointed to the need for reducing donor dependency, fostering household participation in financing of health care through a prepaid arrangement, and putting community committees and health boards at the centre of decision-making. Participation of the community is critical for sustainability and ownership of the health programmes and for community empowerment. Dr Njau emphasized the importance of taking into account the local social, cultural and economic dimensions in decision-making.

Paying for services under CHF is by cash or in kind, and participation of cooperatives and similar groups is allowed. Dr Njau emphasized that the poor need to participate as equal partners in health development to enhance equity and empowerment. He said that the poor resented being treated as charity cases. Poverty should not be treated as a permanent phenomenon, and the poor need to be helped to exit from the poverty trap through human capital investment.

Cote d'Ivoire's experience

Mrs Clotilde Yapi Ohouochi, former Minister for Solidarity, Social Security and Disability and currently the President's special advisor for Universal Health Insurance made a presentation entitled “Health financing in Africa: Universal health insurance scheme in Côte d'Ivoire”.

A legislative Act in the Ivorian Constitution provides that: “The State shall provide equal access to health for all citizens”. Unfortunately, that has not been the case as evidenced by the following milestones in health financing in Côte d'Ivoire: free health care up to the 1980s; partial recovery of costs using the Bamako Initiative approach from 1987 onwards; and total cost recovery since 1994. Currently Côte d'Ivoire is operating a health insurance scheme covering only 6% of the population. Against this background, Government established a universal health insurance scheme intended to enhance the people's access to health care.

The scheme which is ongoing recommends collective management of disease risks, compulsory subscriptions by the population and a two-tier system, one for the agricultural sector and another for all others. The scheme covers nationals and foreigners living in Côte d'Ivoire. It is financed by the population with government contribution and covers the minimum package of activities: consultation, further tests, surgical operation, hospitalization, medicines and dental care. There are safeguards against abusive use of these services.

The universal health insurance scheme is managed by three institutions, namely the social fund for agriculture, the national health insurance fund in charge of technical matters, and a national universal health insurance fund in charge of financial matters.

Strong political will, the existence of a legal framework, a steering committee and an organic framework for social dialogue, participation of the population in the scheme and households' ability to pay are all factors contributing to successful implementation of the universal health insurance scheme in Côte d'Ivoire.

The participants raised the following issues:

- There is need to design appropriate methodology for incorporating community contribution into community health funds or insurance schemes.
- The choice of prepaid health financing schemes depends on the existence of a culture of solidarity.
- Given the prevalence of poverty in the Region, it would be unjust to use community health funds or insurance schemes to fund hospital services. Instead, hospital services should be fully financed by the government.
- The experience of Madagascar is that it is very difficult to cover a sizeable proportion of the population through community health funds or insurance schemes like that of Tanzania.
- A sizeable proportion of households in the Region may not afford to pay high health insurance contributions.
- The issue of the impact of the health insurance and community health funds schemes on utilization of health service needs to be considered.
- Health insurance schemes built around farmers' cooperative movements (e.g. in Cote d'Ivoire) that periodically generate revenue have a high chance of success mainly due to the existence of a culture of solidarity.

The following recommendations emerged from the discussion:

- When introducing health insurance, it is critically important to ensure that administrative costs are minimized.
- Before introducing health insurance it is necessary to ensure that quality health services are available.
- There should be legal frameworks to guide the setting up and implementation of health insurance schemes.
- Premiums should be based on evidence of unit costs of health services.
- In decentralized contexts, the role of the local government in health financing is crucial.
- The countries should strive to optimize the use of all the available health systems' resources.

- To ensure sustainability of health insurance or community health funds, it is important for governments to reimburse the schemes for revenues lost from issuance of waivers and exemptions from payment of premiums.
- Elimination of user fees for health services should be viewed as a poverty reduction strategy.

6. Experience from other WHO regions

Experience from three regions was shared: Dr P. Jongudomsuk, Director of the Health Systems Research Institute, Bangkok, Thailand, reported on the WHO Regional Office for the Western Pacific, Dr Saddique Sameen spoke on the WHO Eastern Mediterranean Region and Dr Juan Manuel, the WHO representative in Chile, spoke on behalf of the Pan American Health Organization/WHO Regional Office for the Americas. The session was chaired by Mr Per Engebäck, UNICEF Regional Director for Eastern and Southern Africa. The summary report was presented by Dr Patience Mensah of WHO African Regional Office.

Dr Jongudomsuk talked about a meeting to review three decades of PHC implementation in Cambodia, Canada, Ethiopia, Rwanda and Thailand. He noted that in the changing global context, what remains to be solved on the agenda to have a functioning PHC system relates to financial and human resources and other health system constraints. In this regard, strong political commitment and evidence-based policy were needed. He declared that there was a need to promote and support country ownership of health planning and implementation through establishment of partnerships of all stakeholders.

Dr Sameen Siddiqi spoke on “Health systems based on Primary Health Care” in the Eastern Mediterranean Region of WHO. He covered some community-based initiatives (the Basic Development Need approach) being implemented in four countries and elaborated on challenges in strengthening the countries’ health systems. These challenges include strengthening district health systems and making decentralization effective; handling public/private partnerships; working with health systems disrupted by conflicts in Afghanistan, Iraq, Pakistan, Somalia and Sudan; and applying the PHC strategy through country-appropriate approaches given the economic and social diversity of the countries in the subregion. He suggested that the way forward was to develop and institutionalize the tools for improving performance of health services, including instruments for assessing and monitoring basic development needs at the community level.

Dr Juan Manuel gave highlights on “The renewal of Primary Health Care in the Americas”. He enumerated the challenges for national health development as being related to poor management, economic adjustment to globalization, social exclusion, incomplete decentralization and human resources problems, including personnel reduction in the public sector. He said that what was needed was strengthening public health sector infrastructure, extending of social protection in health and developing the health workforce and the operative capacity of services. He traced the steps for renewed commitment to the fulfilment of PHC goals starting from the decision by the Regional Committee in 2003 to the endorsement of the Montevideo Declaration in 2006. Finally, he classified PHC renewal activities under five main activities: defining competences of PHC staff, developing integrated health services, building up

evidence on best practices for PHC, evaluating system performance and linking essential public health functions with PHC.

Several issues were raised concerning the presentations:

- Intersectoral collaboration has been a cross-cutting issue in presentations at the Conference. It is a very difficult issue to address particularly in the current globalized context. The example of the prevailing food crisis, which is linked to the control of the food chain by multinationals, was cited. The profits of the multinationals have increased as has the countries' expenditure on imports. The impact of trade on intersectoral collaboration for health needs to be addressed. There is need for the health sector to work with other sectors to adopt policies that address issues that impact negatively on health.
- It is necessary to consider the importance of community health workers and ensure the recognition of their role as part and parcel of the health system.
- There is a need to make the community an integral part of the health information system by linking community-based information mechanisms with the formal information system.
- The role of the national health accounts is important as they show the different sources of financing for health care and provide information for the development of policies for improving access to services by the population.
- Contracting of services to the private sector has generated positive outcomes in expanding health care, but there are funding and sustainability uncertainties.
- Health is not a matter for the health sector only: there is need to de-monopolize health and open up the sector to other major sectors to achieve health objectives.
- While PHC is thought not to cost much, there is evidence to the contrary. There is need to empower communities to generate resources in order to take charge of their health needs. Recognizing that without health there is no development, it was proposed that health systems be build based on local resources to ensure sustainability.
- Intersectoral collaboration is important in improving access to services. In creating demand for health services, we need to ensure the availability of adequate response at all levels of the health system. This requires linkages between the community and the health sector to ensure a continuum of care, including supervision of the referral system.

The presenters responded to the issues raised with the following comments:

- The question of motivating community health workers who work as volunteers should be addressed with caution so that the value of volunteerism is not undermined. Community health workers are part and parcel of the health system and there is need to invest in them; however, there are pros and cons of paying them.

- Contracting out services to the private sector has helped in improving access to services. However, the equity and efficiency of the services, which are usually more expensive, are questionable. To deal with issues relating to the quality of the services, it is necessary to integrate indicators of quality of care in the monitoring frameworks.
- The challenge in contracting out services to the private sector is the lack of skills in contracting procedures such as tendering and bidding. For contracting to be effective, these skills should be learned by both the health sector and NGOs.
- To ensure the use of available information, community-based information systems should be strengthened and linked with the formal information system.
- In provision of primary health care, there is no “one-size-fits-all” approach: countries should build the services according to their needs.

The following recommendations were made:

- Health provision should be promoted as a development issue and a concern for all the sectors to ensure a multisectoral approach.
- Governments to revitalize primary health care based on country needs to ensure ownership.
- Governments should initiate collaboration with international partners, the civil society and the communities to revitalize primary health care and strengthen health systems.
- Community services should be promoted as an integral component of the health system, for example by including incorporating community information systems in the management of health information.
- Health information systems should be strengthened, including community-based information systems, to ensure availability of evidence for advocacy, policy dialogue and policy development in favour of health.
- Suitable mechanisms should be put in place to guarantee sustainability of health financing, including mutualities and insurance schemes.

7. Plenary deliberations on the Draft Declaration

The plenary session on the Draft Declaration was chaired by Honourable B.A. Yoda, State Minister of Health, Burkina Faso. The Draft Declaration was presented by Dr Veronica De Clerk of Namibia.

The participants made some general comments about the draft declaration, and these were integrated into the Declaration.

The adoption and signing of the Ouagadougou Declaration on Primary Health Care and Health Systems was presided over by Honourable B.A. Yoda.

8. Closing ceremony

After the introduction of the programme for the closing ceremony, the ministers of health and heads of delegation signed the Ouagadougou Declaration on Primary Health Care and Health Systems in Africa: Achieving better Health for Africa in the new Millennium. The Declaration was then read out to the participants by Dr L. Imboua, IST Coordinator, Central Africa.

A vote of thanks to the Government and the people of Burkina Faso was read out by Dr J. Vieira Dias Van Dunen, Vice Minister of Health of Angola.

Closing remarks on behalf of the co-sponsoring agencies, were from Ms E. Guluma, UNICEF Regional Director for West and Central Africa. She thanked the Government and the people of Burkina Faso for their hospitality. She alluded to the Alma-Ata Declaration of September 1978 and the significant progress that has been made since its inception. She, however, reminded the delegates that more needed to be done, especially in sub-Saharan Africa, where indications show stagnation in some indicators. She called on Africa and its partners to seize the current momentum around health and the MDGs and put PHC at the centre of multisectoral efforts to achieve tangible results for children, women and families.

On behalf of the cosponsors, she assured the countries of unfailing support for implementation of the Declaration through the Harmonization for Health in Africa framework. She assured the countries of continued lobbying and advocacy for more and better aligned development assistance based on countries' result-based plans and commitment, but asked Africa to take the lead on MDGs, PHC and other development agendas.

The WHO Regional Director for Africa, Dr Luis G. Sambo, thanked the president and people of Burkina Faso, the co-sponsors, members of the Scientific Committee and the Expert Group, staff of WHO and other agencies, all national staff involved in the organization of the Conference, and all participants for having contributed to the success of the Conference. He alluded to the enthusiasm by all stakeholders for this Conference, which exceeded expectations both in numbers and contributions made.

He assured Member States of WHO support to implement the Declaration, working together with partners and African regional and subregional institutions. He committed WHO to developing a framework for implementing the Declaration and creating the African Health Observatory to monitor trends and share best practices. He assured Member States of the partners' commitment to working together to strengthen national capacity for the implementation of the Declaration. Recalling the way that the UN agencies and partners worked together for the success of this Conference, he hoped that this approach would continue to be translated at the country level in the same coordinated manner to support countries to achieve MDGs.

He reminded the delegates of the upcoming ministerial meetings to be held this year in Algeria, Cameroon, Gabon and Mali.

His Excellency B.A. Yoda, Minister of State for Health, Burkina Faso, delivered the closing remarks on behalf of the Prime Minister of Burkina Faso. He noted that the expectations

of His Excellency the President made at the opening ceremony had been realized in the Ouagadougou Declaration. He confirmed his country's commitment to implementation of the PHC strategy for health development. He noted that there was a diversity of experience from the Conference and from the rest of Africa that would continue to be shared through the African Health Observatory.

He welcomed the Ouagadougou Declaration as a turning point for PHC revitalization and assured the delegates that Burkina Faso would live up to the expectations. He asked all countries to adopt relevant policies, allocate appropriate resources, use innovative initiatives and commit themselves to achieving the MDGs through PHC and strengthened health systems.

On behalf of His Excellency President Blaise Compaore, His Excellency B.A. Yoda declared the Conference closed.