

# Discussion Paper

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## International Conference on **Primary Health Care and Health Systems in Africa**

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*Towards the Achievement of the Health  
Millennium Development Goals*



AFRICAN DEVELOPMENT  
BANK GROUP



**International Conference on Primary Health Care  
and Health Systems in Africa: Towards the  
Achievement of the Health Millennium Development  
Goals**

**Discussion Paper**

## Contents

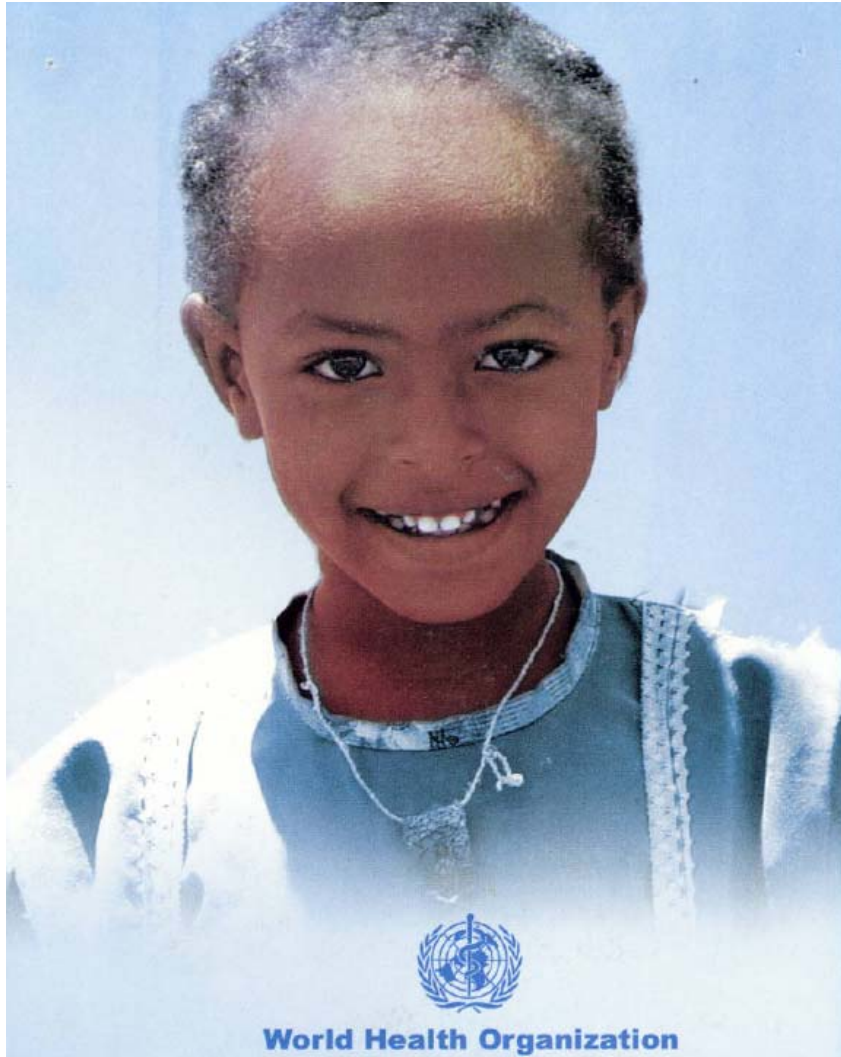
	Page
<b>Acronyms</b> .....	<b>v</b>
<b>Executive Summary</b> .....	<b>vii</b>
	<b>Paragraphs</b>
<b>Background</b> .....	<b>1–11</b>
Introduction.....	1–4
Primary Health Care .....	5–7
Health Systems .....	8–9
The Millennium Development Goals .....	10
Relation between PHC, health systems and the MDGs.....	11
<b>Performance of African Region Health Systems 30 years since Alma Ata</b> .....	<b>12–66</b>
Performance towards attainment of health systems objectives .....	13–21
Achievements based on the four functions of the health system.....	22–38
Weaknesses and challenges based on the four functions of the health system.....	39–58
Opportunities based on the four functions of the health system.....	59–66
<b>Rationale for revitalization of PHC</b> .....	<b>67–72</b>
<b>Interventions required to strengthen Health Systems using the PHC</b> <b>Strategy for Achieving the MDGs in the African Region</b> .....	<b>73–95</b>
Stewardship/Governance for Health .....	77–83
Health Financing .....	84–89
Creating Resources for Health .....	90–93
Organization of Service Delivery .....	94–95
<b>Roles and Responsibilities of Key Stakeholders</b> .....	<b>96–111</b>
Communities.....	97–99
Governments.....	100–105
WHO and other UN agencies .....	106–109
Partners .....	110–111
<b>Conclusions</b> .....	<b>112–115</b>
	<b>Page</b>
<b>References</b> .....	<b>35</b>

## Annexes

1. Table showing the Millennium Development Goals and the health related targets .....	36
2. Per capita government expenditure on health in 2001 and 2004.....	38
3. General government expenditure on health as % of total government expenditure in 2001 and 2004.....	39

## Acronyms

ACTs	Artemisinin-based Combination Therapy
AIDS	Acquired Immune Deficiency Syndrome
ART	Anti-retroviral Therapy
CHW	Community Health Worker
CMH	Commission on Macroeconomics and Health
DALEs	Disability Adjusted Life Expectancy
DALYs	Disability Adjusted Life Years
DHT	District Health Team
DHMT	District Health Management Team
DHS	Demographic and Health Survey
EmOC	Emergency Obstetric Care
FBOs	Faith-Based Organisations
GAVI	Global Alliance for Vaccines and Immunization
GFATM	Global Fund for AIDS, TB and Malaria
HFA	Health for All
HFSs	Health Financing Strategies
HIPC	Highly Indebted Poor Countries
HIV	Human Immune Deficiency Virus
HRH	Human Resources for Health
IMR	Infant Mortality Rate
ITNs	Insecticide Treated Nets
MDGs	Millennium Development Goals
MMR	Maternal Mortality Ratio
NGOs	Non-Governmental Organisations
NHSs	National Household Surveys
OIs	Opportunistic Infections
OOP	Out-of Pocket
ORS	Oral Rehydration Salts
PBA	Programme Based Approach
PDC	Parish Development Committee
PEPFAR	The US President's Emergency Plan For AIDS Relief
PHC	Primary Health Care
PMI	The US President's Malaria Initiative
PPA	Participatory Poverty Assessment
PPPH	Public Private Partnership for Health
PRSC	Poverty Reduction Support Credit
PRSPs	Poverty Reduction Strategy Papers
SWAps	Sector-Wide Approaches
TBAs	Traditional Birth Attendants
UNICEF	United Nations Children's Fund
VHC	Village Health Committee
VHT	Village Health Team
WHA	World Health Assembly
WHO	World Health Organization
WHO/AFRO	World Health Organization, Regional Office for Africa





## **Executive Summary**

1. The 30<sup>th</sup> World Health Assembly in 1977 agreed on the vision of *Health for All by the Year 2000* as a major social target of governments, international organizations and communities. The Alma Ata Conference in 1978 endorsed Primary Health Care (PHC) as the key strategy for implementation by all countries of the world in order to improve the health status of the people and lead to the achievement of Health for All by the Year 2000. The attainment of Health for All has remained elusive to date for many countries, especially in the African Region. There are renewed efforts both at the global and African Region level to put health back on the forefront of the development agenda. The Millennium Summit of the United Nations called for dramatic reduction in poverty and marked improvements in the health of the poor and agreed on the 8 Millennium Development Goals (MDGs), 3 of which are health MDGs) with targets to be achieved by the year 2015.

2. This Document is intended to serve as a discussion paper for the international conference on PHC and health systems in the African Region. Using the health systems framework, the document provides a synthesis of the experiences of implementing PHC over the last 30 years, including, achievements made, weaknesses and challenges met. Current opportunities are explored and proposals are made of interventions that would facilitate reform of health systems in Africa in line with the PHC ideals for the attainment of the Millennium Development Goals (MDGs).

3. The analysis of health systems in the African Region shows that over the last 30 years of implementing the PHC strategy there have been a number of achievements. Countries in the African Region have largely embraced their stewardship roles, including developing national policies and strategic plans that highlight universal access to essential services, intersectoral collaboration and community involvement in health. Increased availability of information for planning and decision-making has facilitated the stewardship role. A few countries have managed to substantially increase public funding for the delivery of health services.

4. In the countries of the region health workers are being trained across a range of cadres, and efforts are being made to ensure appropriate orientation and versatility of health personnel in the context of PHC. A few countries have managed to markedly increase the salaries of health workers to ensure recruitment and retention. Many countries have improved physical coverage of health facilities especially in previously underserved and rural areas. Essential medicines lists have been developed in many countries and increasing budgets earmarked for the provision of medicines. Many countries have used information on their burden of disease and the availability



of evidence-based cost-effective interventions to design an essential health services for universal delivery. Public Private Partnerships for Health (PPPH) have been developed taking into consideration areas of comparative advantage.

5. The above achievements have led to some improvements in health systems objectives over the last 3 decades. There have been improvements in health status as demonstrated by the decline of under-five mortality rates from 188 to 165 per 1000 live births between 1970 and 2005. Deaths of children from vaccine preventable illnesses have markedly declined and in a few countries the spread of HIV/AIDS has been reversed. However the trend of improvements in health status is unlikely to lead to attainment of most of the MDGs for the African Region. It is possible though for the African Region to achieve many if not all of the MDGs if specific actions are taken by the different stakeholders.

6. There have been many challenges in implementing PHC since Alma Ata. The lack of common understanding of the PHC strategy and the advocacy of different models by partners has been a major hindrance for its translation into appropriate policies and plans. A second challenge has been to implement the notion of multi-sectoral determination of health at various levels since the need for a multi-sectoral approach is easy to appreciate but its implementation is not. A major challenge for appropriate implementation of the PHC strategy has been the very low levels of health funding and especially public health funding in the African Region. Only 7 countries in the Region have a per capita Health Expenditure higher than US \$34 estimated by the Commission for Macroeconomics and Health (CMH) as minimum financing required covering essential interventions. The health financing architecture in most countries is not favourable for a PHC strategy to health service delivery, with minimal contributions from governments, high Out-of-Pocket (OOP) contributions, and vertically programmed donor projects. The structural adjustment programs reduced instead of increasing the fiscal space for sustained improvements in health systems.

7. The enjoyment of the right to health cannot be realized without addressing key determinants of health. Some of the key determinants of health are the access to clean drinking water and adequate sanitation facilities. Thirty years after the Alma Ata Declaration on Primary Health Care, Sub Saharan Africa when compared to industrialized countries in the world, has the highest levels of poverty, lowest percentage of population using improved drinking water sources and percentage of population using adequate sanitation facilities, particularly in the rural areas. Member States are implored to provide communities with the knowledge related to right use of water and make resources available for safe drinking water supply and good sanitation facilities.

8. Weak and fragmented Human Resources for Health (HRH) policy formulation and planning and limited fiscal space has made it difficult for many countries to scale up production, recruitment and the implementation of appropriate motivation and retention schemes for health workers so as to prevent both internal and international migration. This has led to inadequate numbers, inequitable distribution and poorly motivated health workers within the countries and increasing migration of health workers out of the African Region.

9. Inadequate distribution of health infrastructure in some countries coupled with limited functionality and poor maintenance due to inadequate resources for running costs are still proving to be major challenges in many countries. There is increased demand for essential medicines and health supplies due to the fast growing population in most countries of the region coupled with an increasing array of both communicable and non-communicable diseases, injuries and trauma. Health systems are overwhelmed even further when crises, strife and other catastrophic emergencies occur.

10. There are a number of opportunities today that can be exploited in the effort to revitalize PHC in the African Region. Human development including health remains high on the global agenda as shown by several international commitments including the UN Summit of 2000 and the Millennium Declaration. The Global Health Initiatives including Global Fund for AIDS, TB and Malaria (GFATM), Global Alliance for Vaccines and Immunization (GAVI), and bilateral initiatives like The US President Emergency Fund for AIDS Relief (PEPFAR) have substantially increased funds for health services delivery in the African Region though not adequate. The Paris Declaration on Aid Effectiveness Ownership, Harmonization, Alignment, Results and mutual Accountability and the development of Programme Based Approaches like the SWAp provide a conducive environment for appropriate funding of national health systems for universal access to a package of essential health services. The global movement of increasing awareness of people's rights is gaining ground in the African Region, and is expected to lead to improvements in accountability and governance. In addition there are strides to ensure that the playing ground is leveled in terms of international trade. The widespread advocacy towards reduction of the high cost of medicines and medical equipment has started yielding results especially in AIDS treatment.

11. The document proposes a number of interventions that would enable the African Region to attain the MDGs. At the stewardship level national sector policies and strategic plans should be explicit on the desired balance between health outcomes, system responsiveness and fairness in financing. This should be linked to appropriate allocation of funds from general tax revenue, and as raised from multilateral initiatives like debt relief for the Highly Indebted Poor Countries (HIPC) and Poverty Reduction Support Credit (PRSC) and bilateral partners. Marked efforts should be made to separate need from payment and especially target to reduce OOP.

12. Evidence-based HRH policies and plans should be developed and implemented. International migration of health workers should be explicitly addressed at a global level. Since not all health workers that are trained leave, ensure that appropriate incentives are provided to them to be retained while training is scaled up to boost the dwindled numbers.

13. Equitable distribution of health infrastructure including diagnostic equipment, appropriate transport and communication is vital, as is provision of adequate quantities of effective and good quality essential medicines including traditional medicine and health supplies. Grants should be provided to encourage reduction of fees charged and also improve on supervision and regulation to enforce adherence to acceptable standards of service. Decentralization of health service delivery should be encouraged, with more authority and resources to local authorities to enable them effectively contribute to the situation analysis, programme development and implementation, and monitoring of health interventions. PPPH should be scaled up with emphasis on efficiency, equity and accountability.

14. The different stakeholders have different but complementary roles and responsibilities to deliver the MDGs. National governments have the major responsibility for health systems stewardship including clarity on the health system objectives, and relating them with appropriate levels and modalities of funding and translating these into universal delivery of good quality essential services. The international community working through organizations like the United Nations and other mandated organizations and fora are responsible for providing global leadership and advocacy for human development and the mobilization and appropriate distribution of the necessary resources. Based on mandate and capacity, international organizations including the World Health Organization and especially the African Regional Office, should continue to build sustainable capacity of national governments to carry out their responsibilities in the health systems, with particular emphasis on monitoring performance against agreed goals and targets.

15. The document concludes that PHC remains as relevant and good a strategy as it was at Alma Ata 30 years ago. The challenges that have dogged PHC implementation are many but not insurmountable. The revitalization of PHC must appreciate the synergistic relationship between health systems and PHC, and recognize the utilization of the latter to reform health system as the best approach for producing sustainable and equitable improvement in the health of the people.





# Background

## *Introduction*

1. The Primary Health Care (PHC) movement began with a WHO Executive Board study in 1973 that identified widespread dissatisfaction of ordinary people with their health services, both in developed and developing countries. The study made a case for a complete revision of the way health services were viewed and organized<sup>1</sup>. A WHO/UNICEF study in 1974 entitled “Alternative approaches to meeting basic health needs in developing countries”, introduced and defined PHC for the first time as “a health approach, which integrates at the community level all the elements necessary to make an impact on the health status of the people. Such an approach should be an integral part of the health care system<sup>2</sup>”.
2. The World Health Assembly (WHA) in 1975 established the goal of Health for All (HFA) by the year 2000 and decided that an international conference on PHC should be convened. The 30<sup>th</sup> World Health Assembly in 1977 agreed on the vision of Health for All by the Year 2000 as a major social target of governments, international organizations and the community. The Alma Ata Conference in 1978 endorsed Primary Health Care as the key strategy for implementation by all countries of the world in order to improve the health status of the people and lead to the achievement of Health for All by the Year 2000. The attainment of Health for All has remained elusive to date for many countries, especially in the Africa Region. There are renewed efforts both at the global and Africa Region level to put health back on the forefront of the development agenda.
3. The twenty-two recommendations proposed at Alma Ata outlined changes that should be introduced in health systems to implement the PHC approach. For example recommendations one and four called on governments to incorporate PHC into national development plans, ensure that health plans take full account of national inputs from other sectors, and coordinate health activities of different sectors. Recommendation five on the content of primary health care outlined eight elements (programs), which should, at minimum, be included in PHC. Thus the PHC approach was a rational choice, emerging from a synthesis of ideas and experiences from various geographical regions. The PHC approach thus became a source of global inspiration for health improvement.

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<sup>1</sup> Organizational study on methods of promoting the development of basic health services, Resolution 26 WHA, 1973.

<sup>2</sup> Djukanovic V, Mach E., Eds. Alternate approaches to meeting basic health needs in developing countries: a joint UNICEF/WHO study. Geneva, WHO, 1975.

4. The purpose of this Discussion Paper is to provide the basis for discussions at the international conference on PHC and Health Systems, more specifically it aims to:

- Provide a synthesis of the achievements, weaknesses and opportunities that need to be considered by African Region’s political and technical leaders during PHC revitalization;
- Provide recommendations on specific interventions that are required to reform health systems in Africa using the PHC strategy, to enable attainment of the MDGs;
- Clarify the roles and responsibilities of different stakeholders in the revitalization of PHC in the African Region.

### *Primary Health Care*

5. Primary Health Care is founded on the concept that health is a fundamental human right and the attainment of the highest possible level of health is a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector. The Alma Ata Conference defined Primary Health Care as “essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and the country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination”.<sup>3</sup>

6. The five principles usually associated with the PHC strategy are:<sup>4</sup>

- **Universal accessibility and coverage in relation to need** – A continuing and organized supply of essential health services is available to all people with no unreasonable geographic or financial barriers.
- **Community and individual involvement and self reliance** – Individuals and communities have the right and responsibility to be active partners in making decisions about their health care and the health of their communities.

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<sup>3</sup> World Health Organization 1978: Declaration of Alma-Ata. International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September 1978.

<sup>4</sup> WHO: E. Tarimo, E.G. Webster, Primary Health Care Concepts and Challenges in a Changing World, Alma Ata Revisited. WHO Geneva.

- **Appropriate technology and cost effectiveness** – This includes methods of care, service delivery, procedures and equipment that are socially acceptable and affordable.
- **Intersectoral action for health** – Commitment from all sectors (government, community and health) is essential for meaningful action on health determinants.

7. The Alma Ata Declaration recognized eight core elements which are “education concerning prevailing health problems and the methods of preventing and controlling them, promotion of food supply and proper nutrition, adequate supply of safe water and basic sanitation, maternal and child health care, including family planning, immunization against major infectious diseases, prevention and control of locally endemic diseases, appropriate treatment of common diseases and injuries, and provision of essential drugs”<sup>3</sup>. Each element has two dimensions, the width of its content and the level of utilisation or coverage. It is important to note that these elements constituted the minimum of PHC services and that countries were at liberty to add as many elements as they could manage to provide through their health systems.

### *Health Systems*

8. The World Health Report 2000 defines a health system to include “all the activities whose primary purpose is to promote, restore or maintain health”<sup>5</sup>. The main objectives of the health systems are to improve people’s health; respond to people’s legitimate health expectations on the basis of need and not ability to pay; and ensure fair financial contribution for the users of health care. The main functions of a health system are: stewardship (referring to leadership, governance or oversight); health financing (including collecting, pooling and purchasing); generating/creating health resources (human and physical); and provision of health services<sup>i</sup>. These functions are in line with the WHO’s Framework for Action entitled “*Everybody’s Business: Strengthening health systems to improve health outcomes*” which highlights 6 building blocks including service delivery, information, medical products and commodities, health work force, financing and leadership and governance<sup>6</sup>.

9. Strengthening health systems is one of the seven priority areas of The Eleventh General Program of Work, Engaging for Health, Global Health Agenda, 2006-2016.<sup>7</sup> It also appears as a priority in the WHO Medium Term Strategic Plan, 2008-2013 and the Proposed Program Budget 2008-2009<sup>8</sup>. The Strategic Orientations for WHO Action in the African Region,

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<sup>5</sup> World Health Organization: The World Health Report 2000, *Health Systems: Improving Performance*, page 5.

<sup>6</sup> WHO 2007: The World Health Organization: *Everybody’s Business: Strengthening Health Systems to improve health outcomes*, WHO’s Framework for Action, Geneva, 2007

<sup>7</sup> WHO 2006: Engaging for Health, The 11<sup>th</sup> Programme of Work, Global Health Agenda, Geneva, 2006.

<sup>8</sup> WHO 2008: Medium Term Strategic Plan, 2008-2013 and Proposed Budget, 2008-2009, Geneva, 2008.



2005-2009 has even specified the priority of “supporting the planning and management of district health systems”<sup>9</sup>.

### ***The Millennium Development Goals***

10. The world’s political leaders at the Millennium Summit of the United Nations in September 2000 called for a significant reduction in poverty and marked improvements in the health of the poor. The Summit signed on to the 8 Millennium Development Goals (MDGs), as reflected in the annex, including the targets for the directly health-related goals to be achieved by year 2015. The fact that the targets are time bound is an indication that efforts have to be enhanced timely so that the observable trends of achievements are equal to or better than the expected trends based on the MDG targets country by country.

### ***Relation between PHC, Health Systems and the MDGs***

11. The MDGs represent specific measurable goals of the health outcomes that result from all health related activities. These health activities are carried out within the health system which consists of all activities whose primary aim is to promote, restore or maintain health. Through resolution AFR/RC56/R6, the Member States endorsed PHC as the strategy to be used in improving the efficiency and performance of the health systems to ensure universal access to essential health interventions in order to accelerate the progress towards the achievement of the health MDGs. PHC is the means through which health systems fulfill their role of improving the health outcomes and subsequently the health status of people. The revitalization of PHC through strengthened health systems will also assist in going beyond the MDGs given the need to also focus on non-communicable diseases as well as injuries and trauma.

### **Performance of African Region Health Systems 30 years since Alma Ata<sup>10</sup>**

12. It is clear that the goal of Alma Ata of Health For All (HFA) by 2000 has not been achieved. In spite of this there have been considerable efforts made by countries in the African Region with respect to the implementation of PHC. There have been some achievements, and analysis of the range of experiences provides information on the weaknesses and challenges and also the opportunities available today that can be exploited as we utilize the PHC strategy as a basis for reforming health systems for the attainment of Millennium Development Goals. The analysis was done using the health systems framework as provided by the World Health Report of 2000 which is composed of the following health

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<sup>9</sup> WHO AFRO Brazzaville: Strategic orientations for WHO Action in the African region, 2005-2009. Brazzaville, 2005.

<sup>10</sup> For specific country achievements , refer to WHO’s Draft Review of country experiences on Revitalising PHC in the African Region.

systems functions: stewardship/governance, financing, creation of resources, organization of service delivery; and the objectives of improved health, responsiveness to people's expectations, and fair financial contribution<sup>11</sup>.

### *Performance towards attainment of Health System Objectives*

13. The objectives of a health system have been indicated in the World Health Report of 2000 as: improved health, responsiveness to people's expectation, and fair financial contribution. Both the level and distribution of health status and responsiveness are important. The Alma Ata Conference Declaration of HFA by 2000 using the PHC strategy implicitly referred to these three objectives of the health system. The primary or defining goal of a health system is better health – this means making the health status of a population as good as possible over people's whole life cycle taking into account both premature mortality and disability. Life expectancy at birth, infant, and child mortality rates; maternal mortality ratios are often used to measure the health status of a population. When available estimates on the degree of disability in the population are used together with the mortality rates to provide disability adjusted life years (DALYs) and disability adjusted life expectancy (DALEs).

### *Improvement in Health Status*

14. There have been improvements in the last three decades in health status in the African Region, albeit slower than other parts of the world. Between the 1970s and 2005, life expectancy improved from an average of 40 to 49 years and under-five mortality rates declined from 188 to 165 per 1000 live births. Infant mortality rate declined from 116 in 1980 to 99 in 2005<sup>ii</sup>. There have been particular successes, for example, between 2000 and 2006 deaths from measles declined by 95%. The African Region though has the highest mortality rates or lowest DALEs in the world. This can be partly explained by the high double burden of communicable and non-communicable diseases. The diseases that contribute to this high double burden include among others malaria, HIV/AIDS, cardiovascular disease and mental health. In some countries there has been worsening of childhood mortality indicators.

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<sup>11</sup> WHO 2000: The World Health Report 2000: Health Systems: Improving Performance. Geneva, WHO

## *Fair Financial Contribution*

15. Equity in health care is understood to mean fair share of and opportunities in, distribution and access to health resources and services. An equitable health system emphasizes universal coverage – the whole population of an entity (e.g., a country) has access to the same range of quality services according to needs and preferences, regardless of income level, social status or residency. Such systems offer particular benefits to the poor by improving their access to health care, protecting them from financial impoverishment and ensuring that the rich pay a higher proportion of their income to support health care provision.

16. One of the most critical barriers to equity is in the manner health care is financed. Public financing systems based on ability to pay, preferably those that are tax based, promote universal coverage. They obviate the need for providing safety nets or procedures for verifying eligibility for such programs for the uninsured. They negate adverse selection. Public financing systems designed in this way promote equity and should be encouraged. At the same time all private financing including out of pocket payments and private insurance should be discouraged as these are inequitable and undermine social solidarity.

17. Over the last 20 years many African countries have sought to provide basic services using a mix of public (government and donor) and private sources of funds. However due to challenges already highlighted private sources have tended to provide the higher proportion of funding, and largely through out-of-pocket (OOP) expenditure. High OOP spending dissuades the very poor from utilizing health care services, which comprise a large proportion of the people in the African Region. It has been shown that the poor in the African region have much less coverage of preventive, promotive and curative services, and this is reflected in the much higher levels of mortality. A major reason for the lower service utilization is affordability<sup>iii</sup>. In the 80s and 90s many African countries introduced user fees in public facilities with mixed results – some additional funds were available for health services but quite often this was associated with limited access by the poor. In the recent past a number of countries have abolished user fees at some level and reported marked increases in utilization of health services by the population especially the poor<sup>12</sup>. Over the last decade a number of countries have developed alternative health financing mechanisms with a few countries in various stages of establishing Social Health Insurance Schemes.

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<sup>12</sup> World Health Organization 2006: The World Health Report 2006: Working together for Health, Geneva, World Health Organization.

18. User fees are a regressive form of health financing, placing a heavy financial burden especially on the poor. The removal of requirements for payment of such fees would facilitate improving equity. Fees removal however must be accompanied by action to mobilize more resources for health care in anticipation of the increased utilization of services after abolition of fees.

### *Responsiveness to People's Expectations*

19. Responsiveness is a measure of how the system responds to non-health aspects meeting the populations' expectations on how it should be treated by providers of health services. This involves respect for persons including dignity, confidentiality and autonomy; and client orientation including prompt attention, adequacy of the quality of amenities, access to social support networks and choice of provider. The appreciation of this objective of the health system is still limited, and the biggest challenge in the African Region is translating these into policy documents and measurement of performance. This was a challenge even for the WHO Report of 2000. This does not however deny the importance of this objective of the health system since it is important in itself and in line with the PHC principles; but it also has implications for the other objectives. An example in the African region is the very high Maternal Mortality Ratio which has been linked with the very low proportion of births in health facilities – the latter has been linked to lack of privacy and the poor attitudes of health workers especially midwives to the expectant mothers.

20. Advocacy for political orientation supportive of equity has to be undertaken not only by economists, public health experts and civil society organizations but by international development agencies as well. In this context it is worth noting that equity is receiving much international attention. The World Bank World Development Report for 2006 Equity and development highlights that the interaction between political, economic and sociocultural inequalities shapes the institutions and rules in all societies and that the way these institutions function affects people's opportunities and their ability to invest and prosper. WHO is putting equity high on its agenda and has set up a Commission on Social determinants of health. Within some countries, civil society organizations including NGOs and equity promoting networks can advocate for and put pressure on governments to adopt equity enhancing positions especially in terms of procedural justice. These efforts contribute to bringing consciousness and action in countries on equity.

21. Issues related to geographical access are important barriers to equity. As an example, some countries have as policy to have primary care facilities such as health centres serving about 6-10000 population and such that no one is more than 8km or two hours travel time to the nearest health facility. As health care infrastructure is developed, under served areas are

prioritized. It will also be necessary to ensure that such primary care facilities are run by qualified health workers, have medicines and other basic equipment required to enable them carry out their work. Special incentives have to be built into health worker payment systems in order to attract them to unpopular areas. A health care ethic, to get doctors to recognize their role in equity as an extension of medical ethics could also make a positive contribution to equity in health care.

### ***Achievements based on the four functions of the health system***

#### *Stewardship/Governance for health*

22. Over the 3 decades since Alma Ata many countries developed health policies and strategic plans based on PHC as the main strategy for achieving improvements in health and the universal provision of essential services as the core of these documents. A number of countries have developed legislative and regulatory frameworks governing the health sector and designated regulatory institutions e.g. Medical and Nurses Practice Councils. There have been improvements in availability of information for decision-making in the region with the institutionalization of health management information systems in most of the countries – a number of countries have good quality and comprehensive annual health sector reports; and some perform geographical or otherwise specific data analysis to support equitable policy formulation and prioritization. Regular Demographic and Health Surveys (DHSs) have been carried out at 5-year intervals in many of the countries providing much-needed information on health outcomes<sup>iv, v, vi</sup>.

23. Since the late 90s a number of countries have instituted Sector Wide Approaches to health development (SWAs) whose essence is a partnership of sector stakeholders including public and private actors and funding agencies under government leadership for the purpose of generating consensus on sector policy and strategies, and sharing implementation procedures like supervision, monitoring, accounting and purchasing<sup>vii</sup>. This has put some national governments more squarely in the steering role and made it possible to mobilize more resources in line with national policies and priorities including implementation of the PHC strategy.

24. Most national health policies and strategic plans demonstrate intersectoral collaboration for health as key for improving health status and human development. This is about establishing and utilizing synergistic relations with other sectors that have an impact on

health and broader development, with the health sector playing a leadership and coordination role. Community participation, a key ingredient of community development, is a process of involving the community by promoting dialogue with, and empowering communities to identify their own problems and participate in their resolution<sup>13</sup>.

25. A number of countries in the African Region have recognized the crucial role of community development and community involvement in human development and this is reflected in national documents including Poverty Reduction Strategy Papers (PRSPs) and sector policy documents. A few countries have built community involvement into the PRSPs through Participatory Poverty Appraisals (PPAs) whereby qualitative research is used to determine community perspectives on poverty and poverty reduction<sup>viii</sup>. Some countries are actively using their plans to efficiently mobilize, allocate and utilize resources in a harmonized manner.

### *Health Financing*

26. Some countries in the African Region have computed costs of implementing national health policies and strategic plans, and estimated resources available to their health systems for this purpose. Such endeavors have been supported at the regional level by the Abuja Declaration that recommends a budgetary provision of 15% for the health sector from the national budget (Annex 3). Some countries have substantially increased public funding for the health sector. They have managed to meet the more recent WHO Commission for Macroeconomics and Health Report recommendation of US \$ 34 per capita spending (Annex 2) which was estimated as the minimum requirement for providing essential health services to contribute to the achievement of the MDGs<sup>ix</sup>. Global Initiatives like the Global Fund for AIDS, Tuberculosis and Malaria (GFATM) and Global Alliance for Vaccines and Immunisation (GAVI) and funding from international organizations and donor countries have increased the level of funds available for health activities in many African countries in the recent past<sup>x</sup>.

27. Over the last decade, the development and funding of PRSPs, and the implementation of Programme-Based Approaches (PBAs) including Sector-wide Approaches (SWAp) in health, have enabled some governments to have access to flexible resources that have been earmarked for the provision of essential services to the population with emphasis on the poor. In several countries in Africa, funds have been targeted at extending and consolidating the primary health care infrastructure; providing salaries for an increased number of health workers and improving the availability of essential medicines and health supplies for the

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<sup>13</sup> WHO-AFRO 2003:Report on the Review of Primary Health Care in the African Region” WHO African Region Office, Brazzaville 2003.

wider delivery of an improved essential health services<sup>xi</sup>. Some countries have developed health sector public resources allocation formulae for sub-national levels taking into consideration the burden of disease, the level of human development and other factors. National Health Accounts have provided information on health expenditure by levels, sources, financing agents, and providers, in many countries in the Region<sup>14</sup>.

### *Creating Resources for Health*

28. Some countries have developed HRH policies and strategic plans, and some of these plans have been costed. A few countries have put in place structures to bring together the various stakeholders in HRH Development and Management to generate consensus, agree on priorities and essential requirements including the public and private sector and the various concerned ministries and professional councils and training schools. Health workers with basic training in a range of competencies have been recognized as being most versatile: thus the training of medical assistants/clinical officers; comprehensive nurses (enrolled and registered level), diagnostic technicians – lab technicians is preferred over higher qualified but more specialized technologists and medical doctors. The Faith based organization (FBOs) which run many general hospitals and health centres across the continent have developed a number of these innovative approaches which have been adopted by national governments<sup>xii</sup>.

29. Efforts have been made to reorient and equip health personnel in the context of PHC for the delivery of good quality health services. The district managers and members of the district health teams, who are charged with the responsibility of sub-national health system stewards, have received training in health services planning and management in almost all countries. Nursing/Midwifery Schools, Medical Schools and Schools of Public Health have adapted by introducing more field-based modules for the students at the various levels. Under-graduate and post-graduate medical training in Community Medicine and problem-based learning approaches aim to provide health workers with appropriate skills for primary and secondary level service provision and management. In addition many countries have trained and utilized community health workers (CHWs) and village health teams (VHTs) to promote the delivery of basic, preventive and promotive services to the majority of the people<sup>xiii</sup>. The community health workers have enabled some countries to expand the coverage of services to the general population and thus ensuring that the essential health services are within reach of the poor.

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<sup>14</sup> World Health Organization 2007: World Health Statistics 2007. Geneva WHO

30. Health workers once trained need to be recruited and retained in the health sector, in the public and private sub-sectors. Public funds are used to pay some/all health workers in FBO health facilities in some countries. Funds have been mobilized from the Health Sector Basket with support from the development partners to fund increased training and salaries of health workers. Some countries in the region have implemented plans to retain and motivate health workers where contractual arrangements are used to oblige personnel to stay in their positions for an agreed length of time; other countries have substantially increased the salaries of public sector health workers<sup>xiv</sup>.

31. At independence most of the African countries inherited a health infrastructure composed largely of urban-based hospitals whereas the majority of the population lives in the rural areas. In the last three decades efforts have been made by many countries to build facilities for provision of basic health services spread out in the rural areas. This has led to improved geographical access to basic health services for larger numbers of people especially in rural areas.

32. Essential medicines including traditional medicine and health supplies are a key health system input, and were recognized as very important by the Alma Ata Conference and indicated as one of the elements of PHC<sup>2</sup>. This recognition provided the right environment for marked efforts across the African Region with substantial support from international organizations especially WHO. Essential medicines lists have been developed in many countries and increasing budgets earmarked for the provision of this input. An increasing number of countries have developed national policies, strategic plans, legal frameworks and codes of ethics for traditional medicine. There have been marked efforts to build human and logistical capacity for regular supply of good quality and effective medicines and supplies to the users of the health systems.

#### *Organization of Health Service Delivery*

33. Many countries have used information on burden of disease and the availability of evidence-based cost-effective interventions to provide universal access to health services. The design of such essential services provides for a set of minimum health activities to be undertaken at the various levels of care<sup>15</sup>. Many of the countries in the African Region have implemented decentralization. This may have been carried out as a generic reform as part of

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<sup>15</sup> WHO 2000: The World Health Report 2000: Health Systems: Improving Performance. Geneva, WHO



broader civil service reform or specific to the health sector. Decentralization in the health sector has contributed to the growth of more responsive and equitably distributed health facilities. The lower levels of care – often referred to as health centres -and the general hospitals are usually the responsibility of the local governments, the districts.

34. In many countries the higher levels of care – regional and national level hospitals have varying levels of autonomy. Health services managers have been trained at the various levels to ensure appropriate planning and monitoring of services in their areas of mandate. In some countries, annually, there is a National Health Assembly, styled on the World Health Assembly, which discusses the previous year's sector performance, district variations; and policy priorities and resource allocation for the next year. Participants include political administrative and technical representatives of all districts, and representatives of all key stakeholders.

35. The providers in the African Region are a combination of the public and private sector. In a number of countries pragmatic decisions have been made to form partnerships with private providers of health services including Non-governmental Organisations (NGOs) in many cases Faith-Based Organizations (FBOs) and other private providers of health services and goods. This has been documented in a variety of forms and has led to wider effective coverage of basic services, with in some cases application of public subsidies to exploit the comparative advantages of the providers – e.g. flexibility and responsiveness to population needs; and presence of service delivery points in remote and otherwise under-served areas.

36. In the health sector several models of community participation have been tried across the continent and include: the utilization of Community Health Workers (CHWs) to provide a range of preventive and promotive services like distribution of Oral Rehydration Salts (ORS) to children with diarrhea; distribution of contraceptives and first-line antimalarials; registration of births and deaths; mobilization of the community for services like immunization and other services in the community<sup>xv</sup>. In some countries these have been consolidated into Village Health Teams (VHTs) so that individual CHWs can work with others in the same village as a team and ensure comprehensive coverage of services and continuity. Generic Parish Development Committees that have responsibilities in the health sector is another model that has been utilized<sup>xvi</sup>.

37. Another form of participation/involvement by the community in the health system has been the inclusion of community members on health facility management committees/boards and area health committees. In countries with advanced forms of decentralization local governments at district and lower levels have councils, development and sectoral committees comprising of community representatives, these committees usually have mandates to discuss

development and sectoral issues and can allocate resources across and within sectors. A specialized form of community participation is the traditional healers; and the Traditional Birth Attendants (TBAs) who assist women in child birth in most African countries. Some few countries have developed laws and guidelines for the management of this form of community involvement.

38 In all the 16 countries of the African Region where Onchocerciasis is endemic, the Community Directed Intervention (CDI) strategy that has been implemented through the community drug distributors (CDDs) has been shown to drastically increase the treatment coverage for Onchocerciasis. As of mid 2007 46 million people were treated by a network of more than 400 000 trained CDDs. This network provides a very good opportunity for integrating health interventions at community level (WHO Progress Report, 2007).

### ***Weaknesses and challenges based on the four functions of the health system***

#### *Stewardship/Governance for Health*

39. A major weakness noted is the lack of common interpretation of the PHC concept by the various players which is a hindrance to its translation into appropriate policy strategies and activities. PHC has been taken by various individuals and organizations to mean different things including: PHC as providing primary care with limited resources or cheap poor quality first level health care. However the Alma Ata Declaration is more in line with the understanding of PHC as health care, comprehensive and integrated health care for everyone and by everyone, care that is multi-sectoral and multidisciplinary; health promoting and health promotive<sup>16</sup>. This though has its challenges; it does not seem possible for countries with major resource constraints to plan to provide universal access to a package of services for the whole population. This has reduced declarations of PHC as the main strategy for achieving improved health in national policies and the stated intent to provide universal access to essential services to political promises that have no correlation with available resources, capacities, needs and expectations of populations. Development partners who promote vertical programming contributed to this challenge!

40. Health is a social phenomenon whose determinants cannot be neatly separated from other social and economic determinants – as such many decisions which affect people's health e.g. on education, food security, political and economic development are influenced at state and not sectoral level. Appreciation of this by government and other actors both within the health sector and beyond is often poor. The potential of inter-sectoral collaboration on health has not been adequately utilized due to: inadequate clarity of roles and responsibilities;

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<sup>16</sup> Tejada de Rivero Davia A 2003: Alma-Ata Revisited. Perspectives in Health Magazine Vol 8, No. 2, 2003.

verticalisation of public health services; underestimation by health care authorities of the potential of other sectors in addressing health problems; and low levels of funding<sup>xvii</sup>. A similar challenge of complexity and poor understanding of concepts occurs with community development and community involvement for health. This often leads to community involvement only being given lip service or marginalized to token involvement and translates to poor ownership by government institutions and communities, and lack of tools and methodologies for evaluation of community involvement<sup>xviii</sup>. As well there is a marked weakness of health consciousness/awareness among people, a challenge that Africa must overcome quickly.

41. There are challenges of regulation, governance, accountability in many developing countries and this is the case in many African countries as well. There are issues of capacity and resources to develop appropriate regulatory frameworks and where these are present to ensure compliance. Another challenge is for governments and partners to demonstrate efficient accountability for the whole spectrum of resource management, that is, resource mobilization, allocation and utilization.

### *Health Financing*

42. Only a few countries have comprehensive health financing policies and strategies detailing the cost of implementing the strategic plans and the sources and mechanisms for financing<sup>17</sup>. In addition, very few countries budget for those aspects of PHC that relate to the health of the population as a whole.

43. A major challenge in the region is the fact that national health systems are suffering from absolute inadequacy of financial resources to deliver good quality essential health services- a problem of long-standing under-investment<sup>xix</sup>. On average more than 50% of health expenditure is from the private sources, the bulk of which is out-of pocket expenditure (OOP) which is highly regressive and often drives households deeper into poverty.

44. A high proportion of funding to the health sector in many developing countries is still provided by Development Partners in the form of Global Initiatives and Projects some of which target particular disease programmes. GFATM, GAVI, and the US President's Emergency Plan for AIDS Relief (PEPFAR), are some of the major ones. Often the set up of these funds does not make them readily available for the provision of integrated essential health services; rather they provide specific inputs e.g. Anti-retroviral therapy (ART);

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<sup>17</sup> WHO/AFRO (2006). *Health Financing: a strategy for the WHO African Region*. Document AFR/RC56/10. Brazzaville: WHO/AFRO.

Artemisinin-based Combination Treatment for malaria (ACTs) and Insecticide Treated Nets (ITNs). The management of these funds does not always take into consideration the health system costs (e.g. human resources; health infrastructure including diagnostic capacity and logistics; integrated support supervision and monitoring) and the vertical arrangements usually utilized in the implementation of these projects is a major source of inefficiency and inequity, with challenges for sustainability of outputs and outcomes once the project stops<sup>18</sup>.

45. In many countries, budgetary allocations to the health sector are not only minimal but also inequitable and inefficient – with higher proportion of funds to urban-based hospitals attended by only a small proportion of the community. There have also been challenges of governance and accountability of public funds, especially related use of inappropriate procurement procedures. The WHO Regional Committee for Africa adopted resolution AFR/RC37/R6 at its thirty-seventh session in September 1987 with a view to revitalizing district health systems through the establishment of community co-management and co financing mechanisms centered on essential medicines.

46. Almost 100% of the private health spending on health (which is 50% of total health spending) in the Region is from household out-of-pocket spending.<sup>19</sup> Those resources are not pooled to spread the risk of health care costs between the healthy and the sick, the rich and the poor, and the elderly and the young. As a result, a significant majority of the people in the African Region are exposed to catastrophic and potentially impoverishing out-of-pocket health care expenditures. Therefore, there is need for countries to develop prepaid health financing systems.<sup>20</sup>

47. Over the last twenty years the number of people living on less than US\$1 a day in the Sub-Saharan Africa has increased<sup>21</sup>. Without significant gains in poverty reduction, food security, education, women's empowerment and living conditions, most countries will not attain the health related goals. Evidence shows that the poor are not only more prone to illnesses but are unable to cope with diseases. Evidence also shows that the richest 20% of the population receive over twice as much financial benefit from government health service expenditures as the poorest 20%. Wealthier population groups have a higher probability of obtaining health care when they need it. Though they use less of their total expenditure on health care than the poor, they are more likely to be seen by a doctor and receive medicines when they are ill.

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<sup>18</sup> Republic of Uganda 2000: Uganda Participatory Poverty Assessment Report: Learning from the Poor. Ministry of Finance Planning and Economic Development 2000, Kampala.

<sup>19</sup> Kirigia JM, Preker A, Carrin G, Mwikisa C, Diarra-Nama AJ: An overview of health financing patterns and the way forward in the WHO African Region. *East African Medical Journal* 2006, 83(8): S1-S28.

<sup>20</sup> WHO/AFRO (2006). *Health Financing: a strategy for the WHO African Region*. Document AFR/RC56/10. Brazzaville: WHO/AFRO.

<sup>21</sup> World Bank: *World Development Indicators Report 2005*, World Bank, Washington DC, 2005.

48. Given the low per capita incomes and the high poverty levels, the challenge is to ensure that investments in health do benefit the poor. Progress towards achieving the MDGs through a pattern that benefits primarily the better off while largely bypassing the poor should be avoided<sup>22</sup>.

### *Creating Resources for Health*

49. The Health Workforce Crisis in the African Region has been recognized. While it is estimated that 2.5 professional health workers are needed per 1,000 population to achieve the Millennium Development Goals. The challenge for the African Region is that in order to reach this threshold, there is need to increase professional health workers by 140%.<sup>23</sup> Weak and fragmented policy formulation and planning for HRH, low investment coupled with limited fiscal space has made it difficult to scale up production, recruitment and the implementation of appropriate motivation and retention schemes in many countries<sup>23</sup>. A key negative effect of such situations is unemployment of already trained health workers in Africa while there are still not enough of them to deliver health care in countries. Health personnel account for 50-75% of the recurrent health budgets of their countries in salaries alone, which in real terms is still very low in actual salaries. However it is often the least strategically planned and managed resource in the health sector. This is partly due to the multiplicity of stakeholders making crucial decisions on HRH, without an appropriate consensus building framework.

50. Migration of health workers from African countries to the developed world has reached very high levels with recorded rates of migration as high as 60% in some countries. A study done by WHO-AFRO showed that 26 to 68% of health workers interviewed intend to migrate to other countries. The main factors indicated for migration were poor salaries, poor working conditions, lack of opportunities for professional development, unclear career paths, conflicts and wars. Health workers are not only scarce but also inequitably distributed. For example in one of the Member States, the ratio of health personnel/population in its capital compared to the rest of the country is about 5:1 for most cadres while in another Member State, 60% of all doctors, 50% of all midwives and 30% of all nurses in the country are found in the capital city<sup>11</sup>. The training and education of health workers in some of the countries remains elitist and hospital focused. Cadres are therefore primarily not appropriately equipped to deal with promotive and preventive care in line with PHC. Many health workers still do not possess the appropriate skills or conceptual awareness of the PHC strategy.

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<sup>22</sup> World Bank 2006: Pablo Gottret and George Schieber, *Health Financing Revisited*, 2006, World Bank Washington DC 2006.

<sup>23</sup> World Health Organization. *The World Health Report 2006, Working together for health*. Pages 11 & 12.

51. The inadequacy and inequitable distribution of health infrastructure across many countries is still a challenge. However even where this infrastructure has been put in place there are challenges of functionality and maintenance due to a combination of inadequate resources for running costs and the technical and management capacity of the health workers. There is marked inefficiencies with hardly used equipment being replaced due to lack of routine maintenance.

52. The fast growing populations in most countries of the region, coupled with an increasing array of both communicable and non-communicable diseases have led to an increased demand for essential medicines and health supplies. Advancements in technology and increased drug-resistance have contributed to the higher costs involved in providing essential medicines and health supplies. Limited data on safety, efficacy and quality of traditional medicines and subsequent inadequate protection of African traditional medical knowledge and access to biological resources are the major challenges in traditional medicine.

#### *Organization of Health Service Delivery*

53. The performance of decentralized health services has been mixed. In a number of cases the right balance between autonomy, accountability and financial and technical support has not been achieved. The national level often lacks the capacity – financial/ technical – numbers, instrument, skills; for effective supervision of local governments. The incentives often in place in the public sector do not yield appropriate accountability.

54. There are challenges in the selection of community members to participate in committees and activities – ranging from who is doing the selection (process may be politicized) to the capacities and competencies of the individuals selected (literacy may be a requirement in a community with low literacy levels)<sup>xx</sup>. There are high rates of drop-outs from CHWs and VHTs, and many non-functional community management structures. For example in one Member State, only 10% were found to be operational<sup>24</sup>. This is due to a number of reasons including poor support structures (weak managerial capacities at the various levels; high rates of illiteracy in the communities) and lack of funding.

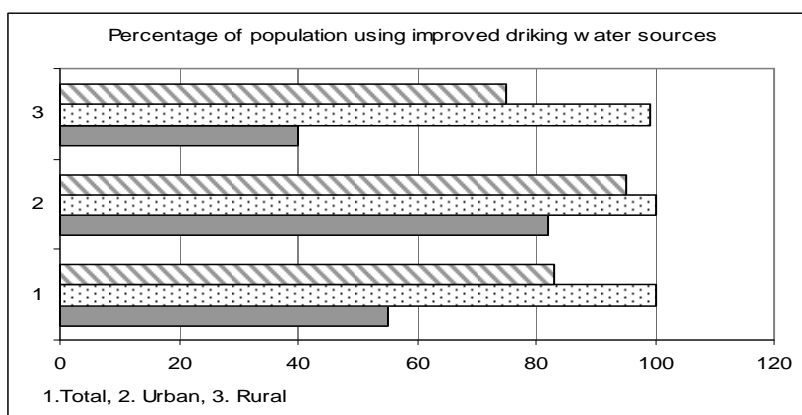
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<sup>24</sup> World Bank 2005: Improving Health, Nutrition, and Population Outcomes in sub-Saharan Africa: the role of the World Bank. IBRD/World Bank Washington DC, 2005

The Community Involvement Concept presupposes high levels of voluntarism, which has been noted not to be sustainable - without incentives the drop-out rates among CHWs and management committee members is very high. The role of the traditional health practitioners, who are providing a lot of services to the communities, is not well integrated into many national health systems.

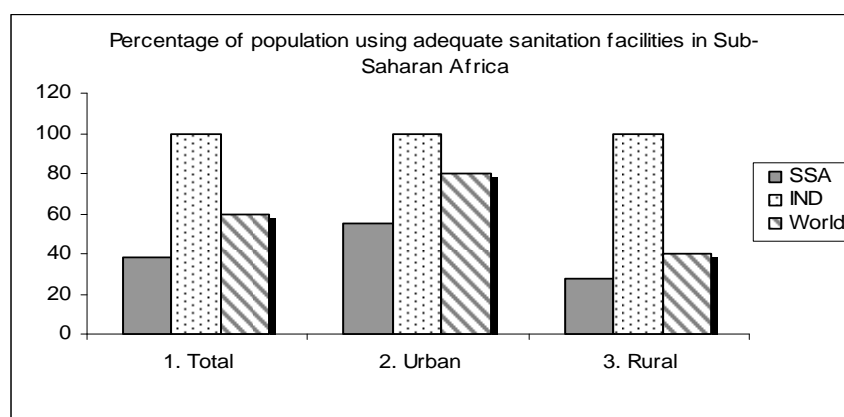
55. The enjoyment of the right to health cannot be realized without addressing key determinants of health. Some of the key determinants of health are the access to clean drinking water and adequate sanitation facilities. Thirty years after the Alma Declaration on Primary Health Care, Sub Saharan Africa when compared to industrialized countries in the world, had in 2004 the lowest percentage of population using improved drinking water sources and percentage of population using adequate sanitation facilities, particularly in the rural areas<sup>25</sup>. The situation may not be very different in 2008. Member States are implored to provide households and communities with the knowledge related to right use of water and make resources available for safe drinking water supply and good sanitation facilities. This will contribute to the realization of the right to health. Appropriate installation of water supply and sanitation facilities in improved housing structures will also improve access.

**Figure 1:** Percentage of population using improved drinking water sources in Sub-Saharan Africa Versus the industrialized countries and the world (2004)



<sup>25</sup> UNICEF: The State of the World's Children, 2008

**Figure 2:** Percentage of population using adequate sanitation facilities: Sub-Saharan Africa versus the industrialized countries and the world (2004)



56. Inadequate sanitation and access to clean water are linked to the poor performance of multi-sectoral and multidisciplinary programmes of the ministries of health and those in charge of infrastructure. As well the general situation of hygiene in African towns and villages is indicative of the absence of strong and progressive policies in this field. This implies the need to advocate for capacity building in the field of hygiene through the establishment of multisectoral programmes involving the ministries of health, local government as well as those responsible for water and sanitation.

57. The current environmental problems such as climate change, pollution and loss of biodiversity also have negative effects on health. Their progression is a major concern for the entire African Region. This requires a broadening of the Primary Health Care to promote sustainable environments for better human development.

58. Emergencies and disasters especially in the African region strike communities without warning. The resilience is usually nil. Large portions of the population are displaced in a chaotic and disorganized manner. The displaced end up as recipients of “Humanitarian Aid” in a passive manner, without their involvement. They usually have no power to determine what, when and where the humanitarian support should go to. The challenge is to operationalize the Emergency Preparedness and Response (EPR) objective of protecting assets and livelihoods during an emergency/disaster to ensure the continued functionality of the assets such as health facilities (hospitals, health centres, warehouses, and labs), especially during the acute phase of an emergency so as to contribute to saving lives.



## *Opportunities based on the four functions of the health system*

### *Stewardship/Governance for Health*

59. Health is once again on the global agenda, as seen most conspicuously with the MDGs. This has in turn created awareness of the importance of health among national leaders in the region as shown by the declarations of political support for the HFA objectives and the MDGs. This provides potential for increased prioritization of health at national and sub-national levels, in terms of advocacy and resource allocation. National leadership and stewardship has been given a big boost by the Paris Declaration on Aid Effectiveness, Ownership, Harmonisation, Alignment Results and Mutual Accountability<sup>xxi</sup>. Increased awareness by people of their rights across the globe, and more slowly but steadily in Africa, is leading to more calls for improvements in governance and accountability at all levels. All these are opportunities that can be utilized by health sector leaders and managers at various levels in the revitalization and implementing the PHC strategy.

### *Health Financing*

60. The Commission for Macroeconomics and Health Report has provided an updated and realistic estimate of the funding (US\$34 per person of government spending) requirements for the universal delivery of essential services in line with the MDGs, which can be adapted to the different circumstances of prevailing in the countries of the African Region<sup>26</sup>. The previous figure of US \$ 12 per capita from the World Development Report of 1993 was a gross underestimate and out of date<sup>xxii</sup>.

61. The Global Initiatives like GFATM, GAVI and Development Partner Programmes like PEPFAR and the Presidential Malaria Initiative (PMI) given the big budgets they command are a good opportunity for increasing funding for health activities. The PRSPs and their focus on poverty reduction and human suffering, with poor health as a major focus, provide another opportunity for increasing funding for the sector. This is particularly pertinent, since in addition to the World Bank and debt relief funding, many more Development Partners have moved to funding government budgets in line with the Paris Declaration and in many cases use the PRSP as an entry point. This provides for a sizeable amount of funds that can be applied for the universal delivery of a basic package of good quality services. Such an arrangement provides a good framework for national and sectoral stewardship furnished with appropriate resources. Governance and accountability issues are also better managed given the requirements for transparency by the different partners.

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<sup>26</sup> Commission on Macroeconomics and Health 2001: Macro-economics and Health: Investing in Health for Economic Development. WHO Geneva

62. There is a growing consensus that the health-related MDGs cannot be achieved and sustained without adequate investment in the systems that underpin health service delivery. This consensus has been expressed most recently by the launch of a number of initiatives such as the International Health Partnership, the Catalytic Initiative to Save a Million Lives, Providing for Health, Innovative Results Based Financing, the Secretary-General's MDGs Africa Initiative. All these initiatives, with broadly similar objectives of better coordination of development assistance and increased predictable and long-term investment in health to accelerate the achievement of the health MDGs, provide very good opportunities.

63. The Harmonization for Health in Africa mechanism, which aims to support the development of evidence-based outcome oriented health development policies, strategies and plans towards achieving the MDGs is yet another opportunity for countries to have long term resource mobilization plans.

#### *Creating Resources for Health*

64. The global community has recognized the HRH crisis in the African Region, and it is hoped that this will provide much needed advocacy and resources to face the challenge. Discussions that are currently taking place around substantial funding for HRH from the Global Initiatives and PEPFAR are encouraging, provided that appropriate linkages with national governments stewardship in the context of national HRH costed plans that include regular payment of salaries to ensure concurrence and sustainability of initiatives. Migration of qualified health workers from developing to developed countries is being frankly discussed; this opportunity can be exploited to develop long-term strategies rather than ad hoc solutions to a complex problem.

#### *Organization of Health Service Delivery*

65. The global movement of increasing awareness of people's rights is gaining ground in the African Region. This is supported by the improving literacy rates especially for women.

66. A number of opportunities exist for organizing health services. These include: strengthening support for community and home-based care; the creation of district and sub-district level teams of health workers who provide services for a designated catchment population; support for PHC services from hospitals (specialist services based at hospitals travel into the district to provide services to reduce the burden on patients traveling to hospitals, including the use of telemedicine for distance learning and care); support for early

childhood development centers from district health services; and greater participation of district level health personnel in planning services for the district as a whole (including participating in the drafting of district wide development plans).

## **Rationale for revitalization of PHC**

67. Member States endorsed the revitalization of PHC after recalling the relevant importance of the 1978 Alma Ata Declaration on primary health care and keeping in mind the 1998 Health-for-all policy for the twentieth century. They were concerned by the slow pace of progress being made by the majority of the countries in the Region towards the Millennium Development Goals. They noted that national health systems have deteriorated due to a number of challenges including structural adjustment programmes, manmade disasters, HIV/AIDs and poor community involvement. They recognized that universal access to essential health interventions requires efficient, well functioning district health systems.

68. There is renewed recent effort and interest across the globe and in Africa in the recent years to address challenges in human development especially the inequities and the marked differences in levels of population health. Improving the health status of the people across the world has already been seen both as a human right and as a precursor to development and sustainable global health and peace. This international awareness need to be grasped by countries in the African Region and stakeholders in the health sector for improving population health and human development.

69. The burden of disease in the Africa Region, besides causing much pain and suffering, stands as a stark barrier to economic growth and therefore must be addressed centrally using a comprehensive development strategy. There are proven and cost effective health care interventions to address the burden of disease thereby contributing to the achievement of the MDGs and economic growth. In the past these interventions have at best been delivered in a piece meal fashion with very limited coverage and impact. The health systems within which to deliver such cost effective health care interventions are weak and fragile and therefore unable to equitably, effectively and efficiently deliver existing interventions to the populations.

70. PHC with the principles of universal accessibility and coverage in relation to need, community and individual involvement and self-reliance, intersectoral action for health and appropriate technology, provides the appropriate strategy for health systems reform in the Africa Region. PHC offers the opportunity to radically reform the health systems and make

them more efficient, equitable, accessible and responsive to the needs of the populations. The PHC-based health systems thus created offer the potential of delivering the required cost effective interventions and the possibility of achieving the MDGs.

71. The PHC strategy will be utilized to address the issue of gross inequality in the health status of the people, that is, progress towards achievement of the MDGs, particularly between the developed world and countries in the African Region as well as within the countries themselves. It involves, in addition to the health sector, all related sectors and aspects of national and community development. These include in particular agriculture, animal husbandry, food, water, sanitation, industry, education, housing, public works, communication and other sectors. It demands coordinated efforts of all those sectors to ensure simultaneous enjoyment of equitably provided services by all the citizens in the countries.

72. The PHC strategy ensures accountability for both the means (resource volume, allocation and utilization) and the results achieved through efficient use of the available resources. In short, PHC has all the attributes to ensure improved performance of the health systems and achieve universal access to essential health interventions so as to increase the pace of the progress towards the Health Millennium Development Goals attainment.

### **Interventions required to strengthen Health Systems using the PHC Strategy for Achieving the MDGs in the African Region**

73. It is critical that as we revitalize PHC we recognize the importance of the key principles of the PHC strategy. These are: accessibility; public participation; health promotion; appropriate technology; and intersectoral collaboration. These principles must influence our actions. As well, the social determinants of health which lie outside of the responsibility of the ministry of health, must be given due consideration. These issues are currently under discussion by the Commission for the Social Determinants of Health which is investigating the 'causes of the causes' to ensure that when health services are being planned and delivered upstream factors that impact on health are taken into consideration.

74. **Critical issues that should shape interventions:** Countries – both developed and developing - that have improved the health status of their populations have implemented comprehensive social policies across a range of areas. Countries in the African Region can learn from such developing countries that have achieved good health outcomes which appear in broad terms to have the following characteristics in common: (a) development of a social security network for all vulnerable groups in society based on the principle of solidarity; (b)

use of general revenues to fund social programmes, including health services; (c) investing in human development, including education for women and the girl child in particular; (d) empowering women in particular and communities in general to participate in society and in the health system; (e) strengthening the public health sector through proper planning, management and investing resources in the sector; (f) designing health systems that provide comprehensive care; and (g).strengthening monitoring and evaluation and greater investment in health research.

75. In order to achieve the above it is necessary to strengthen institutional management capacity especially in ministries of health. Mechanisms to strengthen learning from good practices from other regions should also be considered.

76. This section provides a set of interventions based on the PHC strategy in the context of the health system framework that if implemented can enable the African Region to achieve the health MDGs and make it possible to achieve the rest of the MDGs.

### ***Stewardship/Governance for Health***

77. A key undertaking on the function of stewardship involves equity and universal agreement of the interpretation of PHC. This document recommends that such interpretation should revolve around: comprehensive and integrated health care that is for everyone and by everyone; care that is multisectoral and multidisciplinary; health promoting and preventive; participatory and decentralized; as opposed to low cost (and low quality) curative treatment that is aimed at the poorest and most marginalized segments of the population; provided through parallel programmes, without direct, active and effective participation of the population. This is a very important aspect of revitalizing PHC, as this will lead to more appropriate translation into policies and activities.

78. It is crucial to consolidate the gains made in the last three decades in getting governments to prioritize and indicate universal access to good quality essential services as a right for their populations. Countries' sector policies and strategic plans should be explicit on the desired balance between health outcomes, system responsiveness and fairness in financing. This reduces room for ad hoc decisions and piecemeal reforms especially in choosing appropriate models of health financing given resources required to ensure universal access to good quality services. Specifically efforts should be made to secure the legislative and funding base of such policies, and the processes to enable collective claims on these rights by marginalized and vulnerable groups.

79. Mechanisms have to be put in place to ensure that governments move beyond the statements and rhetoric of universal access to basic services and establish clear health equity goals to guide implementation and enable appropriate evaluation. This need not be very sophisticated to begin with but rather stakeholders can learn through doing by monitoring and evaluating the experiences in general and specific health resources allocation; service delivery; utilization of services and health outcomes. Such information can be derived from health systems administration data; and surveys like National Household Surveys (NHSs), DHSs, PPAs and Client Satisfaction surveys. It is important to look beyond national figures for outcome, output and input indicators and consider geographic, socio-economic, age, gender and other variations in performance. The capacity at national, district, health facility and community levels for establishing information systems that support action on health inequity should be adequately addressed. There is also the issue of absorption of new financial resources – especially when these are allocated to the development of manpower, which always requires long lead times.

80. Policies and regulatory frameworks to govern inter-sectoral collaboration and partnerships, including mechanisms for strengthening public-private-partnerships e.g. public-private-partnerships divisions/desks and inter-sectoral councils/committees at national and district levels should be developed. PRSPs (at national and sub-national levels) are good tools that can be used to address comprehensively the social determinants of health and facilitate the provision of basic social infrastructure (such as schools, water, sanitation, roads, transportation).

81. The creation of an enabling environment for community development through the provision of an institutional framework including laws, national policies and strategic plans, and identifying and supporting specific institutions to provide leadership and advocacy for community development is essential. Efforts should be made to ensure synergies, coordination and harmonization of the efforts of multiple partners working with communities from different sectors and organizations. At the level of the health sector it is important that community involvement in health is recognized as an integral component of the national health system and essential services, and appropriate stature, visibility, capacity and tools be provided to units that are in charge of community health in the ministries of health and training institutions.

82. Appropriate capacity should be developed for effective health sector regulation, including setting up of autonomous regulatory institutions where they do not exist and providing them with appropriate funding and human resources in addition to sufficient space

to carry out their duties. Issues of governance and accountability need to be given due consideration – this is important because the population served is entitled to this consideration, but also because this has implications for the buy-in of other stakeholders including funding partners.

83. Governments must rapidly overcome the lack of health consciousness/awareness among our peoples, a challenge which has so far gone largely unnoticed. Governments are therefore called upon to review and strengthen their plans to revitalize PHC, in consultation with communities and to implement these plans as a matter of urgency.

### ***Health Financing***

84. Health financing has major implications for the health MDGs and broader development in the African Region. It is essential that countries develop comprehensive Health Financing Strategies (HFSs) including computation of the cost of implementing the National Health Policies and Strategic Plans and provision of the essential services, and the financing sources and mechanisms that will be employed to fund them. These HFSs should clearly indicate the steps being taken to move towards universal financial risk protection against costs of illness. It is crucial to have good information for decision-making, and therefore National Health Accounts should be institutionalized in all countries of the African Region to facilitate financial planning, monitoring and evaluation. In addition efforts should be made to document beneficiaries of public spending, through different scientifically proven approaches like the benefit-incidence analyses. This is very important for national and sub-national resource allocation decisions.

85. Governments should allocate more funds from general tax revenue and Highly Indebted Poor Countries (HIPC) and Poverty Reduction Support Credit (PRSC) initiatives where they apply, to the health sector and aim at achieving a health sector share of budget of 15% as per Abuja Declaration. The funds made available need to be allocated efficiently and utilized accountably especially in procurement goods and services.

86. In addition budgets approved through appropriate government processes should be made available and fully executed. Donors should scale up their support to African countries and especially the health sector in line with international agreements and commitments like the PHC, MDGs, the G8 Summit at Gleneagles and the 2005 World Summit. Donor programmes should be closely aligned and harmonized with government priorities, policies, institutions and management arrangements in line with the Paris Declaration.

87. Emphasis should be on public funding for universal provision of essential services that have been agreed by key sector stakeholders, and that are known to target the most common causes of morbidity and mortality. Resource wastage can be reduced by allocating resources on the basis of assessed need for health services; improving input procurement, distribution systems and prescribing practices; perfecting financial management systems; and strengthening the planning, costing, budgeting, monitoring and evaluation capacities at all levels of the health system – all of which require additional capacity. Particular focus should be on providing adequate funds for the District Health System to provide and monitor the delivery of the essential services to their populations. Public funding across the country should take into consideration population health needs, available infrastructure and other funding sources. It is specifically recommended that resource allocation formulae developed in some countries should be shared and adapted to different country contexts.

88. Efforts should continue to develop prepaid funding mechanisms that maintain the principle of separating need for health services from payment of the cost of services. These may include: development of national or social health insurance, innovative ways of increasing tax-based financing for health care (e.g. introduction of ear marked taxes on tobacco and alcohol). Where fee-for-service or user fee schemes still exist efforts should be made to strengthen safety nets to protect the poor by: making communities aware of exemption policies; issuance of exemption cards to the poor long before the need for health care arises; strengthening administrative capacity for monitoring, supervising, interpreting and applying exemptions; and compensating health facilities for revenue lost through granting of exemptions.<sup>27</sup>

89. Governments as well as partners should ensure that funding for PHC is increased in line with country plans to revitalize PHC.

### ***Creating Resources for Health***

90. All countries should have evidence-based HRH policy documents and plans, indicating the cost and available financial resources in the medium to long term. The process of developing these documents should be very consultative to encourage buy-in by key stakeholders. Innovative and non-traditional sources for HRH funding may have to be sought including from Global Health Initiatives and Donor Projects for medium term support with

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<sup>27</sup> WHO/AFRO (2006). *Health Financing: a strategy for the WHO African Region*. Document AFR/RC56/10. Brazzaville: WHO/AFRO.



consultations ensuring that in the long term space will be provided in the national budget. Institutions responsible for planning and production of HRH should be strengthened and supported to ensure that health workers of appropriate numbers and skills will be made available in the medium term.

91. Health workers training should be reoriented, with particular emphasis on the productions of multi-skilled professionals with competencies for providing a range of basic services particularly in primary and secondary level health facilities. Generic integrated in-service modules should be available to update health workers skills with minimal disruption of service delivery – rather than several independent and uncoordinated trainings by various disease programme and donor-funded projects. A policy for task shifting needs to be institutionalized by creating a legal framework that legitimizes it. There is need to provide the necessary incentives for the training institutions to train cadres that arise from the process of identifying the tasks that can be shifted. At community level, task shifting is useful in creating and training a multipurpose health worker carder that is recognized by the professional regulatory bodies.

92. The migration of health workers to developed countries needs to be addressed at both the national and international levels. At the international level, countries should agree on a code of good practice in international recruitment based on moral and ethical considerations and the recognition of the need to compensate investments made in training by the source countries. National governments should strengthen national HRH plans with a focus on strengthening PHC which: provide clear and flexible career development paths for all levels of health care providers; provide appropriate health worker salaries; and invest in attractive work-place environment including staff accommodation and improved availability of equipment, supplies and medicines. Affirmative actions should be implemented in favour of marginalized parts of countries to enable internal redistribution of health workers. Focused HRH resources allocation and innovative means of attracting and retaining health workers in these areas – binding contractual arrangements for health workers trained on public budgets; targeted incentive packages – both cash and non-cash e.g. opportunities for post-basic training and promotions can be implemented in a variety of mixes given circumstances.

93. Equitable distribution based on long term forecast of health infrastructure including diagnostic equipment, appropriate transport and communication is key. Capacity for appropriate running and maintenance of available infrastructure is crucial for efficient utilization of such resources. Provision of adequate quantities of effective and good quality essential medicines and health supplies cannot be overemphasized. It is important to streamline the various funding and logistical setups for essential medicines and supplies including ACTs, ART, treatment for opportunistic infection (OIs), vaccines and family

planning supplies into a common framework to enable improvements in transparency, efficiency, equity and allow for building strong and sustainable institutions for the management of essential medicines and supplies in the region.

### ***Organization of Health Service Delivery***

94. The health services provided have to be technically appropriate, of good quality and acceptable to the communities that are to use them, for both equity and efficiency objectives to be achieved. It is therefore essential to invest in first level services with appropriate referral linkages to the secondary level. A minimum of health infrastructure, human resources, medicines and health supplies plus appropriate technologies and transport systems in a variety of combinations for the various levels of care is required. Appropriate human resources (nursing, medical, diagnostic) should be available, in addition to adequate amounts of publicly provided essential medicines and health supplies. Public Private Partnership for Health with public subsidies to the private sector should be encouraged to facilitate increased geographical access whilst maintaining good quality including responsiveness to clients' non medical expectations, financial access and minimizing stigmatization.

95. Decentralization of health service delivery should be encouraged, with more power and capacity given to local authorities to enable them effectively contribute to the situation analysis, programmes development and implementation and monitoring and evaluation of health interventions. The District Health System should continue to be strengthened in its role as the focal point for the wider community and inter sectoral action needed to address the social determinants of inequity in health and broader development. There is need to continuously build the capacity of district, health facility and community levels for appropriate implementation and management of health services including Community Involvement. This should take place through incorporating Community Involvement into basic training curriculum and into generic in-service courses; and through providing appropriate technical back-up through on-the-job training, mentoring and support supervision; and provision of appropriate tools including pharmaceuticals and other supplies required for their duties. Communities should be supported to appreciate their roles especially in regard to the oversight function over resources for health.

## **Roles and Responsibilities of Key Stakeholders**

96. The previous section indicated the main interventions that need to be carried out to ensure appropriate health systems given the PHC strategy, for the achievement of the MDGs. For further emphasis and clarity, this section considers some of these interventions and highlights the roles and responsibilities of the various stakeholders in health – at the international, regional, national and district and community levels.

### ***Communities***

97. Communities need to mobilize themselves to ensure that individuals and households promote and protect their health. As well communities should participate in providing oversight over health services that they use. This can take the form of involvement in community/village health committees as well as clinic committees and hospital boards.

98. Communities should take ownership of health services to ensure that the best possible care is provided. This implies that communities need to ensure that they work with government and other health service providers to protect health infrastructure, equipment, medicines and other medical supplies from abuse and destruction.

99. Intersectoral action is best achieved at community level. Communities must therefore use all mechanisms available to ensure maximum intersectoral action. Communities need to participate in the progressive monitoring of the attainment of the MDGs. This requires communities to understand the health and other MDGs and relate them to the occurrence of events such as deaths or illnesses in their communities. These should have clear benchmarks per year that can be monitored on a monthly basis using simple data collection and analysis tools at community level.

### ***Governments***

100. National governments have the major responsibility for stewardship, with clear requirement for the development, where they do not exist, and regular updates of a comprehensive national health policy and strategic plan based on the PHC strategy and aimed at achieving the MDGs, that is integrated into an overall national development strategy; and takes into consideration realistic allocation from multiple funding sources. This is the responsibility of the ministry of health, including ensuring buy-in at the highest political level to facilitate allocation of adequate resources and ensure broader ownership and sustainability.

101. National governments, specifically the ministries of finance, should work towards providing adequate resources for health, including fulfilling the Abuja commitment of allocating at least 15% of national budgets or US\$ 34 per capita (whichever is higher) to the health sector, and prioritizing other sectors critical for acceleration of progress towards the health MDGs in line with the African Heads of State commitments.

102. Ministries of health have the responsibility to develop Health Financing Strategies indicating resource requirements for universal provision of essential health services of good quality; possible sources of funds; and implications of inappropriate funding for health (level, modalities) on attainment of MDGs. The HFSSs should provide for a framework for regular evaluation.

103. Governments need to create frameworks for joint monitoring of the progress towards the MDGs attainment. Ministries of health, agriculture, water development, education, environmental affairs, works, local government, economic planning and development and finance need to jointly assess the progress towards MDGs attainment district by district and within each district constituency by constituency.

104. Governments should create more fiscal space through tax measures and administration and reallocating resources from lower priority expenditures to more desirable ones to enable use of increased funding for health. Use of debt to create fiscal space should take into account the impact on the economy and the country's ability to service the debt<sup>28</sup>.

105. Governments are encouraged to operationalise equity by gathering information and undertaking research to build evidence for policy and decision-making regarding inequity. It is known that mortality is highest among the poorest households and lowest among the richest households exhibiting a social gradient between these two extremes. Similar trends are shown with level of education, gender, rurality or place of residence and ethnicity. Abolition of user fees demonstrates movement towards ensuring equity.

### ***WHO and other UN agencies***

106. The international community under the stewardship of international organizations especially the United Nations should continue to provide overall leadership and advocacy for human development including improvements in health for all the people of the world and especially the heavily challenged African Region. Goals that have been set like the MDGs

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<sup>28</sup> The World Bank: Pablo Gottret and George Schieber, *Health Financing Revisited*, 2006. Washington DC

and their targets should be kept in sight during the already planned statutory meetings of the UN and other international organization to ensure targets are met, and if not to ensure that the necessary adjustments are made in line with the Paris Declaration.

107. WHO and other agencies, working with bilateral partners and other multilateral organizations should support a common and updated understanding of a PHC-based health system (with models for service delivery based on the best evidence), and the possibilities this offers the countries in the region for the attainment of the MDGs. The Partners should facilitate the countries' efforts to achieve these goals by enabling the sharing of experiences and best practices; developing and disseminating regional policy and strategy documents like Agenda 2020; and facilitate advocacy meetings with political and technical leaders for consensus building and goal-setting and provision of increased funds.

108. WHO in collaboration with development partners at country level has the responsibility for provision of technical support to countries for stewardship including for:

- Developing appropriate policies and plans;
- Setting up Monitoring and Evaluation frameworks for health systems performance, including tracking of the MDGs.

109. WHO in collaboration with other UN agencies, International Financial Institutions, and development partners should provide harmonized country demand driven technical support to translate the international consensus into country led and country based actions; to facilitate: (i) evidence- and country-based planning, costing and budgeting for health outcomes, (ii) alignment to country processes and harmonization, and (iii) systems bottleneck analysis and support to overcome them; and to maintain the momentum to achieve the health related MDGs.

### ***Partners***

110. Development Partners should ensure that commitments made at various international forums, including the Millennium Summit on the MDGs, the Third United Nations Conference on the Least Developed Countries and the Paris Declaration on Aid Effectiveness, Ownership, Harmonization, Alignment, Results and Mutual Accountability are implemented to substantially increase the level, predictability, flexibility and effectiveness of aid for health activities to facilitate the achievement of the MDGs.

111. All stakeholders: international community, various arms of government; private providers; civil society and representatives of the community should play their roles to ensure greater equity and efficiency in the use of available resources for health.

## **Conclusions**

112. The goal set by the 30<sup>th</sup> World Health Assembly of 1977s of Health for All by the year 2000 was a worthy and ambitious one for the end of the second millennium. The social and political circumstances that led to the goal of HFA by 2000 still exist, and are even more pronounced today. Extreme poverty and poor health still exist today, despite major technological and economic advancements and globalization. The number of people living below acceptable economic and human development standards continues to grow; with gaping inequities and social injustice leading to large segments of the population without basic health services. The appreciation of these circumstances at the dawn of the third millennium led to the renewal of international awareness and the articulation of the MDGs at the Millennium Summit in 2000. The inclusion of three directly health-related MDGs out of the eight, clearly illustrates the importance decision-makers put on health.

113. The Alma Ata Declaration of 1978 endorsed Primary Health Care as the key strategy for the achievement of HFA by 2000. This was based on the appreciation of the principles and ideals of PHC namely: social justice, equity, human rights, universal access to services and community involvement. This document has documented the experiences of PHC implementation over the last 30 years using the WHO 2000 Report health systems framework for the analysis. The HFA by 2000 goal was not achieved. However the analysis shows that the some improvements were registered at the level of health status, fair financing and responsiveness. The analysis shows that the potential for PHC to improve the functioning of health systems has not been fully utilized and that there are opportunities today which can be used for further improvements in health system goals.

114. For a better chance of realization of the MDG vision there is need to articulate the strategic and specific plans to achieve the set goals. National governments need to appreciate that MDGs will not happen as a matter of course: dramatic improvements in quality and coverage of health services are required to have significant influence on the MDGs<sup>21</sup>. Regular evaluations have to be planned and implemented to ensure the right choices have been made. The international community has to be prepared to provide the additional resources required in the African region; and bilateral and multilateral organizations have to support national governments for effective leadership and service delivery. The judicious combination of the

MDG vision coupled with the PHC Strategy and the realism of health systems can get us there.

115. This document concludes that PHC remains as relevant and good strategy today, as it was at Alma Ata 30 years ago. The challenges that have dogged PHC implementation are many but not insurmountable. The revitalization of PHC must appreciate the working of health systems, and the application of the PHC principles to reform health systems as the best approach for producing sustained and equitable improvement in the health of populations in the African Region. The ideals and principles of PHC can be built into the pragmatism of the health system to create a PHC-based health system as the tool for attainment of the MDGs.

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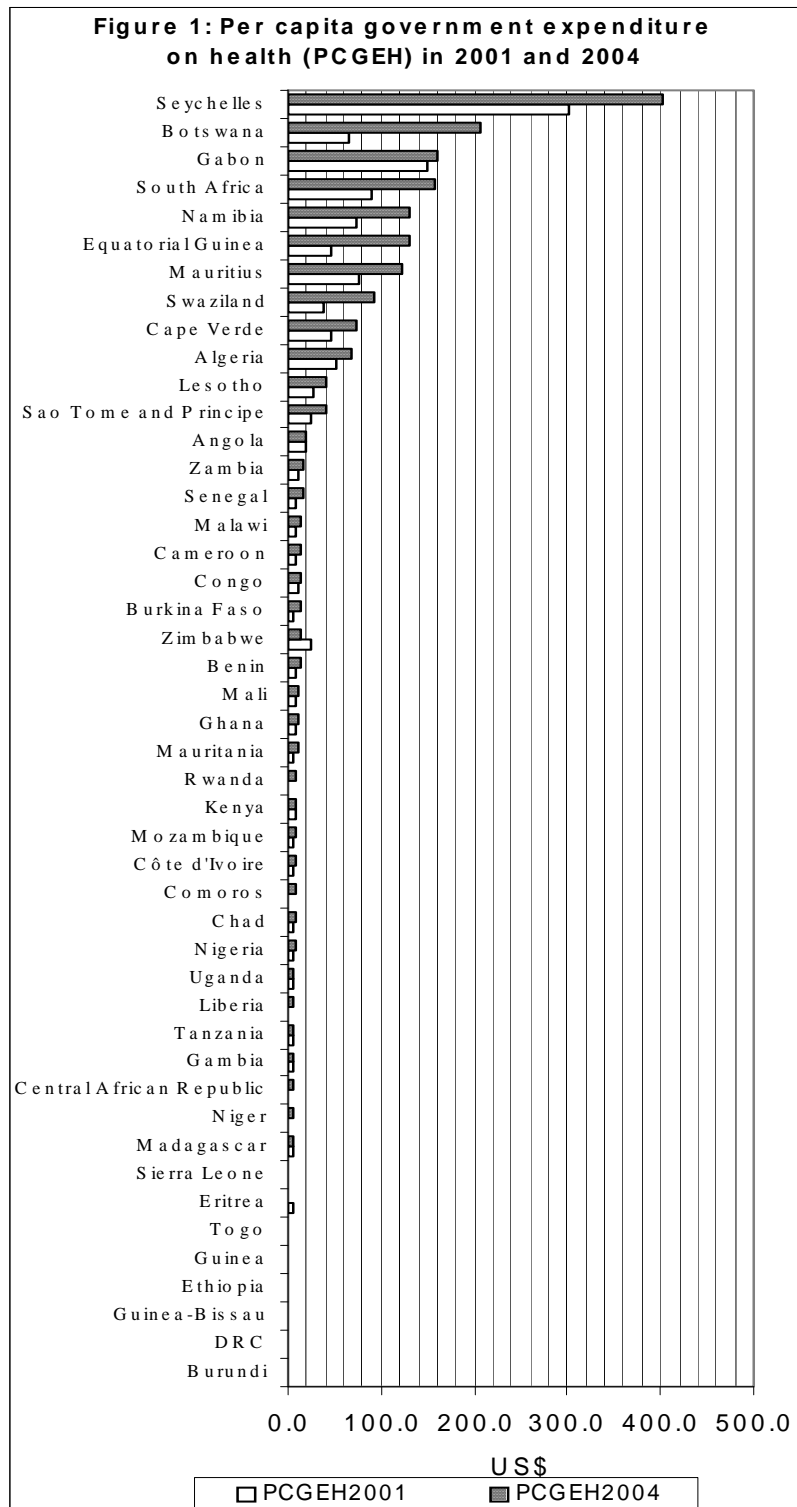
**Annex 1: Table showing the Millennium Development Goals and the health related targets**

<b>Health in the Millennium Development Goals</b>			
<b>Millennium Development Goals, target and indicators related to health</b>			
<b>Health Targets</b>		<b>Health Indicators</b>	
<b>GOAL 1:</b>	<b>ERADICATE EXTREME POVERTY AND HUNGER</b>		
Target 1	Halve, between 1990 and 2015, the proportion of people whose income is less than one dollar a day	4.	Prevalence of underweight children under five years of age
Target 2	halve, between 1990 and 2015, the proportion of people who suffer from hunger	5.	Proportion of population below minimum level of dietary energy consumption
<b>GOAL 2:</b>	<b>ACHIEVE UNIVERSAL PRIMARY EDUCATION</b>		
Target 3	Ensure that, by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling		
<b>GOAL 3:</b>	<b>PROMOTE GENDER EQUALITY AND EMPOWER WOMEN</b>		
Target 4	Eliminate gender disparity in primary and secondary education, preferably by 2005, and at all levels of education no later than 2015		
<b>GOAL 4:</b>	<b>REDUCE CHILD MORTALITY</b>		
Target 5	Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate	13.	Under-five mortality rate
		14.	Infant mortality rate
		15.	Proportion of one -year-old children immunized against measles
<b>GOAL 5:</b>	<b>IMPROVE MATERNAL HEALTH</b>		
Target 6	Reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio	16.	Maternal mortality ratio
		17.	Proportion of births attended by skilled health personnel
<b>GOAL 6:</b>	<b>COMBAT HIV/AIDS, MALARIA AND OTHER DISEASES</b>		
Target 7	Have halted by 2015 and begun to reverse the spread of HIV/AIDS	18.	HIV prevalence among pregnant women aged 15-24 years
		19.	Condom use rate of the contraceptive prevalence rate
		20.	Ratio of school attendance of orphans to school attendance of non-orphans aged 10-14 years
Target 8	Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases	21.	Prevalence and death rates associated with malaria
		22.	Proportion of population in malaria-risk areas using effective malaria prevention and treatment measures
		23.	Prevalence and death rates associated with tuberculosis
		24.	Proportion of tuberculosis cases detected and cured under DOTS (Directly Observed Treatment Short-course)

**Annex 1: continued.....**

<b>GOAL 7:</b>	<b>ENSURE ENVIRONMENTAL SUSTAINABILITY</b>		
Target 9	Integrate the principles of sustainable development into country policies and programmes and reverse the loss of environmental resources	29.	Proportion of population using solid fuels
Target 10	Halve by 2015 the proportion of people without sustainable access to safe drinking-water and sanitation	30.	Proportion of population with sustainable access to an improved water source, urban and rural
Target 11	By 2020 to have achieved a significant improvement in the lives of at least 100 million slum dwellers	31.	Proportion of population with access to improved sanitation, urban and rural
<b>GOALS:</b>	<b>DEVELOP A GLOBAL PARTNERSHIP FOR DEVELOPMENT</b>		
Target 12	Develop further an open, rule-based, predictable, non discriminatory trading and financial system		
Target 13	Address the special needs of the least developed countries		
Target 14	Address the special needs of landlocked countries and small island developing states		
Target 15	Deal comprehensively with the debt problems of developing countries through national and international measures in order to make debt sustainable in the long term		
Target 16	In cooperation with developing countries, develop and implement strategies for decent and productive work for youth		
Target 17	In cooperation with pharmaceutical companies, provide access to affordable essential drugs in developing countries	46.	Proportion of population with access to affordable essential drugs on a sustainable basis
Target 18	In cooperation with the private sector, make available the benefits of new technologies, especially information and communications		

## Annex 2: Per capita government expenditure on health in 2001 and 2004



**Annex 3: General government expenditure on health as % of total government expenditure in 2001 & 2004**

