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**STRENGTHENING COUNTRY PRESENCE TO DELIVER UNIVERSAL HEALTH
COVERAGE IN AFRICA**

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BACKGROUND

1. The adoption of the Sustainable Development Goals (SDGs) and the United Nations reform agenda have brought about additional roles and responsibilities for WHO, as the health agenda is now intertwined with other development goals. To achieve these goals, WHO has defined in its Thirteenth General Programme of Work (GPW 13), the triple billion targets for expanding universal health coverage (UHC), protecting people from emergencies, and promoting health and well-being for people across the world.

2. The WHO triple billion targets and health-related SDGs will only be achieved with a major breakthrough for universal health coverage. UHC targets have therefore been integrated into the national health strategies of most Member States of the WHO African Region.¹ The expected contribution of the WHO Secretariat to the implementation of these national strategies will be maximized by aligning the Secretariat's country presence to the needs of Member States. This, among others, is the aim of the Transformation Agenda launched in 2015 by the WHO Regional Director for Africa,² which seeks to engender a foresighted, proactive, responsive, results-driven, transparent, accountable, appropriately resourced and well-equipped organization.

3. As the health needs of Member States vary and are constantly evolving, WHO cannot adopt a one-size-fits-all approach in all countries. To identify the type and level of support required for the delivery of country priorities, WHO conducted a functional review (FR) of all its 47 country offices (WCOs) between August 2017 and October 2019. It included more than 800 interviews with anonymous sources, and over 300 consultations with various stakeholders, including ministers and senior staff of ministries of health, United Nations country teams, bilateral partners and civil society organizations. In some countries, representatives from the ministries of finance, national planning and agriculture were also interviewed.

4. The FR team identified key challenges to achieving UHC in the various countries, and stakeholders' expectation of the role WHO should play in addressing them. In consultation with stakeholders, including WHO country office staff, priority areas of focus for which WHO has a clear comparative advantage were agreed upon. Consequently, recommendations were made for resource reallocation to focus only on priority areas. The FR team also proposed the revision of each WCO structure to ensure that it has the appropriate skill mix and is aligned with the country's needs. In addition, the FR team recommended management practices that promote integration for optimal impact.

5. This paper presents the challenges identified during the FR and actions WHO is expected to take to support Member States to achieve UHC. It recommends approaches of the highest possible international standard that address the changing needs and expectations of populations.

ISSUES AND CHALLENGES

6. **Poor partner coordination:** Partner support in most Member States was described by different stakeholders as fragmented, vertical, and in many instances, duplicated and poorly aligned to national UHC priorities. This is a major source of inefficiencies and lack of effectiveness as most

¹ UHC in Africa: A framework for action P5, (<http://documents.worldbank.org/curated/en/735071472096342073/pdf/108008-v1-REVISED-PUBLIC-Main-report-TICAD-UHC-Framework-FINAL.pdf>), accessed on 27/2/2020.

² Transformation Agenda of the WHO Secretariat in the African Region.

Member States rely heavily on external funding, except for a few,³ where technical cooperation between the government and development partners is limited or where such partners are few. Efforts to ensure partner coordination are inconsistent and unsustainable, despite attempts at improving coordination of health investments and interventions between governments and partners in many Member States.⁴ For instance, the attempt by some health development partners to avoid duplication by coordinating their interventions through formal groupings⁵ does not necessarily guarantee alignment with national priorities.

7. Limited capacity for health sector governance at national and subnational levels: The capacity of the ministry of health to convene and coordinate partners around country priorities was found to be limited in most countries. This issue was particularly salient in Benin and Burkina Faso. As one of its consequences, multilateral agencies, including United Nations agencies, the Global Fund, Gavi, and civil society organizations are supporting vertical programmes that can hardly demonstrate their alignment with health sector strategic plans. Although these programmes may be well coordinated vertically, they are setting the stage for duplications and inefficient use of resources as seen with the donor-driven fragmentation of health information systems (HIS) among vertical programmes.

8. Unavailability of credible data for evidence-based decision-making: Credible data on overall health sector performance are difficult to obtain in most Member States, despite improved availability of programmatic information for certain programmes and the quality of routine data in the Region, with the introduction of the District Health Information System 2 (DHIS 2).⁶ There are many data collection and reporting tools which increase the burden of reporting on already overstretched health workers, and negatively affect the quality of data. On the other hand, the reporting of births and deaths is low, partly because of underperforming civil registration and vital statistics systems, and the delay in implementing or rolling out the International Classification of Diseases (which is a key data standard). Another challenge is the lack of interoperability between existing digital tools and DHIS2. Compounding these problems is the fact that health workers lack the requisite skills to properly diagnose and certify the cause of death. In addition, private health facilities and tertiary health institutions have been noted to significantly underreport health data. There is also suboptimal use of the available data especially at subnational level. Priority setting and resource allocation are therefore not often based on evidence.

9. Inefficient Health financing was a major challenge cited during the functional review consultations. A few countries like Algeria, Botswana, Equatorial Guinea, Mauritius, Namibia and Seychelles allocate adequate domestic resources to fund health, while others rely on external sources that are mostly earmarked, unreliable and duplicative. Out-of-pocket expenditure remains unacceptably high, above the level of catastrophic and impoverishing expenditure, and coverage of prepaid, risk pooling schemes remains low in many countries.

³ Algeria, Botswana, Cabo Verde, Equatorial Guinea, Mauritius and Sao Tome and Principe.

⁴ These include the signing of a compact based on International Health Partnership (IHP+) principles of one plan, one funding mechanism, and one accountability framework, in countries such as Chad, Mauritania and Zambia.

⁵ In some countries, WHO, UNICEF, UNFPA, UNAIDS, the World Bank and UN Women are working in partnership to advocate for reproductive, maternal and child health.

⁶ Gambia, Mauritius, Sao Tome and Principe and Seychelles are installing DHIS 2 now, while the following countries are not considering moving to DHIS 2 because they have another patient-level electronic system: Cabo Verde, Central African Republic, Comoros, Equatorial Guinea and Eswatini.

10. **Insufficient quality of technical assistance provided by WHO:** The results of the perception surveys conducted during the functional reviews brought out a number of issues. While Member States and some of the partners highly appreciated WHO support and their expectations were consistent with the mandate and core functions of the Organization, they nonetheless expressed concerns over the quality of some of WHO's work at country level. Examples include the development of multiple strategic plans that are not linked to the national health strategic plan, multiple guidelines without implementation strategies, biennial plans not properly aligned to national health plans and poor participation in the design and implementation of joint projects with other partners.

11. **Limited capacity to address health system weaknesses:** The ministry of health and partners in most Member States lack the capacity to develop targeted and context-specific strategies for improving human resources for health. Interventions to improve the working environment, retention of the health workforce and distribution between urban and rural areas are poorly designed or implemented, as particularly highlighted in Chad, Mauritania, and Niger. Another issue is the poor availability and irrational use of medicines, vaccines and health technologies, coupled with fragmented and ineffective supply chain management, including inadequate or substandard warehousing. Other areas with gaps are policy dialogue, including with private health providers and building relations with civil society organizations. Capacity building, community engagement, and quality of care are also areas with gaps, and they need to be supported. Major challenges were observed in the area of health service organization and management, including service delivery models and strengthening district health systems; these were highlighted as areas of support by WHO in many countries.

ACTIONS PROPOSED

12. **Differentiated approach to strengthening country offices:** To tailor its support to the Member States, WHO will use predefined criteria to group the Member States. This is based on the UHC service coverage index,⁷ ongoing or recent major emergencies, population size, and health system challenges. Strategies and guidance will be tailored to the country context, while intra and intercountry learning will be promoted. The following four country groupings are proposed: Member States requiring WHO's operational presence; Member States requiring WHO's full technical presence; Member States requiring WHO's moderate technical presence; and Member States requiring WHO's strategic presence.

- (a) **Member States requiring WHO's strategic presence:**⁸ The average UHC index is 60 for Member States in this group. WHO support will focus on building the health system for the future, to improve health security, quality of care, equity and financial access to health services.
- (b) **Member States requiring WHO's moderate technical presence:**⁹ The average UHC index is 46.9 for Member States in this group. They are considered to have stronger health systems. WHO will provide strategic support for the consolidation of gains towards achieving UHC and other health-related SDG targets. WHO will focus on evidence generation, monitoring of the health situation and trends, and development of innovative strategies for targeted interventions.

⁷ UHC service coverage index from WHO: <https://www.who.int/data/gho/indicator>. Accessed on 27 May 2020.

⁸ Algeria, Botswana, Cabo Verde, Comoros, Eswatini, Lesotho, Mauritius, Namibia, Sao Tome and Principe, and Seychelles.

⁹ Benin, Cameroon, Côte d'Ivoire, Eritrea, Equatorial Guinea, Gabon, Gambia, Ghana, Malawi, Mauritania, Rwanda, Senegal, South Africa and Togo.

WHO will also focus on building strategic partnerships and strengthening multisectoral actions.

- (c) **Member States requiring WHO's full technical presence:**¹⁰ The average UHC index is 41 for Member States in this group. They experience a high burden of communicable and noncommunicable diseases, and high maternal and child mortality. WHO's focus will be on providing technical assistance and building the capacity of the ministry of health to lead the sector at the national and district levels, and undertaking normative work to reduce morbidity and mortality.
- (d) **Member States requiring WHO's operational presence:**¹¹ The average UHC index is 36.9 for Member States in this group. They are currently contending with a public health emergency and/or a humanitarian crisis in addition to the current COVID-19 pandemic. WHO will provide technical assistance and operational support for the design and implementation of priority interventions towards achieving UHC and other health-related SDG targets, while ensuring service provision for the people affected by emergency and humanitarian crises. Partnerships and collaboration with civil society and the armed forces will be strengthened to enhance health service delivery in these countries.

13. **Enhancing cross-cutting functions:** WHO will strengthen country offices to build capacity for cross-cutting interventions in all Member States. These interventions include: prioritizing and implementing activities to strengthen partnerships for UHC and district health systems;¹² building resilient health systems; enforcing health security through the International Health Regulations; and ensuring the availability of credible health information and evidence to inform decision-making. Capacity strengthening will also prioritize analytical work to guide resource allocation and contribute to improved efficiency in the use of resources, including advice on sustainable health financing options and development of health investment cases. There will also be investment in capacity to engage key sectors to address health risks, strengthen management and support functions to consolidate the gains made in programme management, partnership coordination, communication, accountability and compliance. To this end, programme management and external relations officers, and dedicated staff will be appointed to manage compliance and risk issues in the largest WHO country offices, to improve donor relations.

14. **Improving value for money:** WHO will prioritize the allocation of flexible funds for its country office core functions. The effectiveness of the interventions will be improved by recruiting technical experts for key areas such as coordination, policy shaping, strategic health information, and intersectoral collaboration. To increase diversity and leverage international experience, the number of international staff in WHO country offices will be increased by 68%.

15. **Sustaining WHO Regional Office support:** The WHO Regional Office will provide quality and coordinated strategic support to Member States through its country offices. The Organization will promote integrated delivery strategies to minimize duplication of interventions¹³ and improve

¹⁰ Angola, Burkina Faso, Burundi, Chad, Congo, Guinea, Guinea-Bissau, Kenya, Liberia, Madagascar, Mozambique, Niger, Sierra Leone, United Republic of Tanzania, Uganda, Zambia and Zimbabwe.

¹¹ Central African Republic, Ethiopia, Democratic Republic of the Congo, Mali, Nigeria and South Sudan.

¹² As the performance of the subnational health teams is essential for primary health care revitalization, some Member States such as Angola, Benin, Botswana, Mozambique and Sierra Leone have requested WHO to support the building of robust district health teams as part of their ongoing decentralization efforts.

¹³ This includes the signing of a compact, as in Chad, Mauritania and Zambia.

alignment of these interventions with country priorities to maximize efficiencies and synergies with **other partners**.¹⁴

16. The Regional Committee noted the challenges and adopted the proposed actions.

¹⁴ Efforts are ongoing to provide a common approach to the preparation and implementation of programmes, joint annual sector planning and reviews, and funding of business plans in Benin, Burkina Faso, Eritrea, Madagascar, Mali and Rwanda.