Tracking Universal Health Coverage in the WHO African Region, 2022

World Health Organization
REGIONAL OFFICE FOR Africa

Tracking Universal Health Coverage in the WHO African Region, 2022

WORLD HEALTH ORGANIZATION
REGIONAL OFFICE FOR AFRICA
BRAZZAVILLE — 2022

Tracking Universal Health Coverage in the WHO African Region, 2022

ISBN: 978-929023475-3 (Print version)
978-929023476-0 (Web version)

Suggested citation. Tracking Universal Health Coverage in the WHO African Region, 2022. Brazzaville: WHO Regional Office for Africa; 2022. Licence: CC BY-NC-SA 3.0 IGO.

Cataloguing-in-Publication (CIP) data. CIP data are available at http://apps.who.int/iris.

Table of Contents

List of figures, tables and boxes

Foreword

In 2015, Member States of the United Nations adopted the 2030 Agenda for Sustainable Development and its accompanying Sustainable Development Goals (SDGs), with the third goal of the agenda focusing on health – good health and well-being – thereby identifying the attainment of universal health coverage (UHC) as its core target. In response to this development, the WHO Regional Office for Africa developed the Framework of actions for health systems strengthening towards UHC in the context of the SDGs in the African Region, as a harmonized guidance to countries in strengthening their health systems for the achievement of UHC. This framework was developed at the inaugural Regional forum on health systems strengthening in December 2016, in Windhoek, Namibia. It was subsequently adopted by the Sixty-seventh session of the Regional Committee for Africa in August 2017.

Across the Region, a range of technical actions, investments, monitoring approaches and innovations for health systems development are being adopted by countries. Similarly, at the regional level, the UHC flagship programme and a series of toolkits to support the implementation of the Framework have been put in place to support countries in these efforts. Platforms for policy dialogue have fostered cross-country learning and experience sharing. These have been through the Region's flagship forum on health systems strengthening for UHC and the Sustainable Development Goals.

This report comes at a time when countries are still picking up the pieces from the impact of COVID-19 on their health systems, with disruptions in the delivery of essential health services. The pandemic has exposed numerous vulnerabilities in the health systems of the Region, including disparities in service coverage between the rich and the poor, and gaps in social protection. It has also showed that health security and attainment of universal health coverage are inseparable aspirations and consequently, efforts to achieve these must go hand in hand, while building resilient populations.

Over the last two decades, substantial progress has been made in the Region in the UHC service coverage index (SCI). The report showcases the Region's commitment to aligning its development agenda with the attainment of the Sustainable Development Goals (SDGs) as well as the policy shifts needed for a people-centred approach to UHC. Additionally, it makes suggestions for strategic shifts towards the UHC agenda, providing the Region with the necessary strategic direction.

The commitment of all Member States to UHC and other SDG targets is highly critical. We hope that by sharing our regional story on progress towards the attainment of UHC, we can walk this path towards the 2030 Agenda together, leaving no one behind.

Dr Matshidiso Moeti
Regional Director
WHO Regional Office for Africa

Acknowledgments

Acknowledgements: The report was undertaken under the overall leadership of Dr Lindiwe Makubalo (Assistant Regional Director).

It is a collaborative effort by the different clusters within the WHO Regional Office. The information is consolidated from products and deliverables of the Life Course, communicable/noncommunicable, healthier populations and emergency preparedness clusters. We acknowledge the leadership and support of the cluster directors – Dr Kasonde Mwinga, Dr Benido Impouma, Dr Adelheid Onyango and Dr Abdou Salaam Gueye.

WHO AFRO wishes to thank the technical staff and consultants who reviewed and provided inputs into the development of this report and support during the country consultation process. These include (in alphabetical order):

– James Asamani
– Thierno Balde
– Benson Droti
– Hyppolite Kalambay Ntembwa
– Janette Karimi
– Solyana Ngusbrhan Kidane
– Hillary Kipruto
– Juliet Nabyonga
– Sam Omar
– Boniface Otieno Oyugi
– Aminata Binetou Wahebine Seydi

WHO AFRO would also like to thank the WHO headquarters team responsible for the UHC report, 2021 and all ministry of health and national statistical office focal points for reviewing figures and providing feedback during the country consultation process on SDG 3.8 indicators.

Technical coordination of the report development was led by Humphrey Karamagi, working with Regina Titi-Ofei and Thandekile Ntombikayise Moyo. Graphic design support was provided by Matthias Reichwald.

List of acronyms

UMA	Arab Maghreb Union
ASD	Agenda for Sustainable Development (ASD)
COMESA	Common Market for Eastern and Southern Africa
CEN-SAD	Community of Sahel- Saharan States
EAC	East African Community
ECCAS	Economic Community of Central African States
ECOWAS	Economic Community of West African States
SDGs	Sustainable Development Goals
SADC	Southern African Development Community
EAC	East African Community
NCD	Non communicable diseases
NTDs	Neglected tropical diseases
RECs	Regional economic communities
RMNCH	Reproductive, maternal, newborn, child and health.
WHO	World Health Organization
UHC	Universal health coverage
SCI	Service coverage index

Executive summary

The 47 Member States of the WHO African Region and their partners are committed to aligning their development agenda with the attainment of the Sustainable Development Goals (SDGs). The third goal, SDG 3, reflects the overall aspiration of good health and well-being for all, at all ages. Universal health coverage (UHC) represents the umbrella target for SDG 3, with a focus on ensuring "All people have access to the health care they need, when and where they need it, without facing financial hardships". Two indicators are used to monitor progress towards UHC: service coverage index (SCI) and financial risk protection.

Over the past two decades, substantial progress has been made in the Region in the UHC SCI. In 2019, the latest year for which data is available, the SCI ranged from 28 to 75 (out of 100) across all Member States. Of these, seven had high service coverage (index of 60 and above), 29 had a service coverage index value of between 40 and 59, and 12 had low coverage (index between 20 and 39). Although SCI values in some countries remain low, none of the countries had a value below 20. The highest values were recorded in the Southern and Northern African subregions (75 and 53 respectively). The most significant progress between 2000 and 2019 was observed in the Eastern African subregion (24 index points), followed by the Western and Southern African subregions (23 index points). There is a strong correlation between UHC SCI and gross national income per capita (current US$) in log scale (r=0.662), suggesting a close relationship between income level and the coverage of essential health services. Regarding the SCI subcomponents, the infectious disease subindex saw the most improvement between 2000 and 2019 (from 6 to 48), with a pronounced acceleration in 2005 due to the rapid scale-up of HIV, tuberculosis and malaria services. The RMNCH subindex also witnessed significant progress. The noncommunicable disease (NCD) component of the SCI was the slowest to progress.

Progress with FRP however has largely stagnated over the past 20 years. Across the countries of the region, the proportion of the population spending more than 10% of their income on health was reducing by more than 0.1% annually in 25 countries. Out- of-pocket expenditure increased by more than 90% in at least three countries. Only seven countries have their governments financing more than half of their health budgets.

In terms of combined service coverage and financial risk protection, a total of 15 countries are faring above the regional overage. Good performance is not income driven – with examples of upper-, middle- and low-income countries among the 15 good performers. Rwanda, Malawi and Mozambique are low-income countries among the 15 good performers, while Angola, Nigeria, Mauritania, Côte d'Ivoire, Cameroon and Comoros are middle-income countries with low performance in both service coverage and financial risk protection.

The functionality of the health systems is the strongest predictor of UHC service coverage in the Region. Investments targeted at improving system functionality will have the greatest impact on UHC in the Region.

Across the African Region, the COVID-19 pandemic continues to disrupt the delivery of essential health services. On average, countries in the Region reported greater disruptions across tracer service areas compared to other regions. It was also observed that high- and upper-middle-income countries reported fewer service disruptions than countries in other income groups. In the WHO African Region, findings from the third round of the Global pulse survey on continuity of essential health services during the COVID-19 pandemic: November–December 2021, demonstrated that substantial disruptions persisted after the first year of the pandemic. More than 90% of the 36 participating countries, territories and areas, reported one or more disruptions to essential health services, representing only a marginal improvement on the 2020 survey findings.

The report highlights three crucial lessons on moving forward with the UHC agenda in the Region. First is the need to invest in the resilience of health systems. This implies that communities must continue to use essential services even when a country is facing a threat event. Secondly, integrated service delivery remains a crucial need in the Region. The differentiated progress between infectious conditions and NCDs/RMNCAH shows how this gap will limit overall progress in countries. Lastly, there are many opportunities for countries within the Region to learn and share experiences, with each one taking a unique path to achieve UHC. The report highlights five areas of focus, to further the UHC agenda:

1) Accelerate efforts to improve financial risk protection

2) Explore practical means to decipher and target inequities driving the variations in outcomes among similar populations

3) Rethink and repivot health service delivery with a focus on essential service integration, community involvement, private sector engagement and enhancing resilience

4) Put in place a comprehensive monitoring of subnational system, functioning as an early warning system for UHC trends and distribution

5) Focus on post recovery and resilience in post-COVID-19 by investing in common goods that are fundamental in attaining UHC and health security simultaneously.

Chapter 1

Regional focus towards attainment of universal health coverage

1

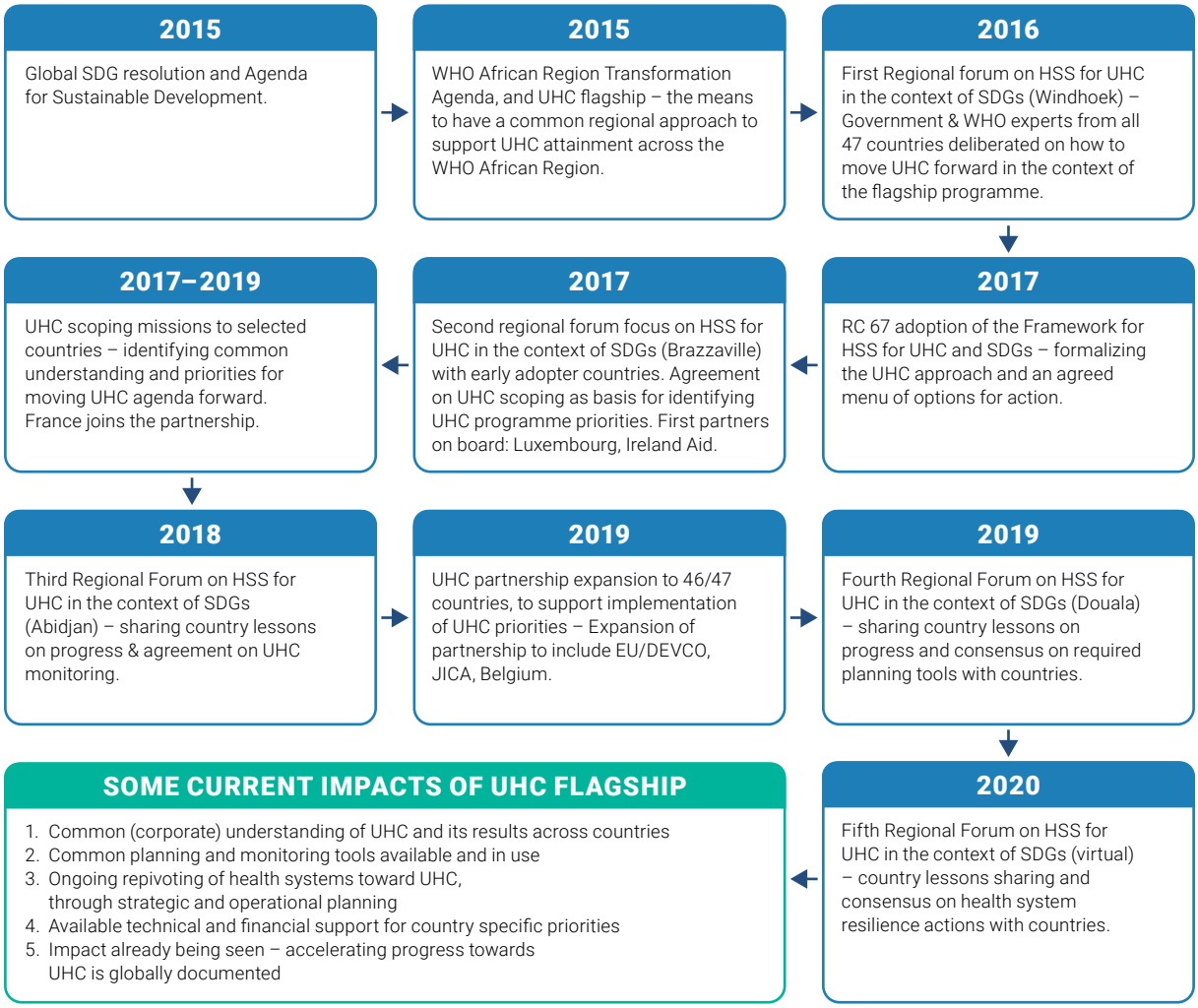
1.1 Policy orientations

The 47 Member States of the WHO African Region, together with their partners, are all committed to aligning their development agenda to the attainment of the Sustainable Development Goals (SDGs). The third goal, SDG 3, reflects the overall aspiration for health. The SDGs recognize that their attainment is only possible through realizing the targets, not only within SDG 3 itself, but also across all other health-related social, cultural, economic, commercial, environmental and political targets within the other SDGs.[1]

By having SDG target 3.8 (universal health coverage ensures that everyone has access to the health services they need, when and where they need it, without suffering financial hardship as a result) as the SDG 3 umbrella target, Member States can invest in their health systems in a cross-cutting manner, ensuring that the results from these investments benefit multiple services. There is currently not enough technical and political capital to move health systems closer to achieving UHC. During this Decade of Action, the countries of the WHO African Region definitely need a push to help them achieve UHC and other health-related SDG targets.

The commitment to attaining UHC targets in the WHO African Region is reflected at the highest levels of government in Member States. These have been guided by clear policy orientations on UHC and SDGs in the Region, which are illustrated in Figure 1.

FIGURE 1: *Key policy milestones in the journey towards universal health coverage in the WHO African Region*



1

Following the adoption of the SDGs, the WHO AFRO transformational agenda adopted a UHC flagship programme, to provide a common regional approach to facilitating movement towards UHC in the countries of the WHO African Region.[2] This UHC flagship programme in each country began with physical scoping missions to build a common interpretation of UHC within the unique country contexts and identify bottlenecks and actions on which they will focus to move their health services towards attainment of the UHC targets. Eighteen of the 47 Member States in the Region conducted UHC scoping missions and developed specific roadmaps that detailed their priorities for achieving UHC. These roadmaps were integrated into each country's health sector strategic plan, as they were the basis for health investment priorities.

In 2016, the Regional Office convened the First Regional Forum on Strengthening Health Systems for the Sustainable Development Goals and Universal Health Coverage, to develop shared guidelines for advancing the UHC agenda, as part of achieving the SDGs. The forum gathered Ministry of Health directors of policy and planning from all 47 Member States of the Region, together with WHO and its partners, who discussed ways to advance the UHC agenda.[3] Following this regional forum, a regional framework for health system strengthening for UHC and SDGs was formulated and consolidated and later adopted by the WHO Regional Committee for Africa in 2017 (RC67)[4]. The framework provided a menu of options to guide countries in making UHC operational.[5] Since then, some follow-up meetings on the implementation of the UHC flagship programme have been held annually in the Republic of the Congo in 2017, Côte d'Ivoire in 2018, Cameroon in 2019, and a virtual one in 2020 due to the COVID-19 pandemic, for directors of policy and planning. These meetings have facilitated the exchange of information on UHC implementation progress in countries, as well as the sharing of experiences in challenging areas. As a result of the UHC flagship programme in the Region, progress has been made in the following areas:

(i) A common (corporate) understanding and application of UHC across the countries of the Region[5,6]. The countries in the Region are now all moving towards the appropriate application of UHC, around its three thrusts: (1) increasing essential services coverage; (2) reaching unreached populations; and (3) financial risk protection. A corporate understanding of UHC prevents countries from focusing solely on one or two thrusts, such as financial risk protection, or specific programme areas such as UHC for immunization;

(ii) Ongoing repivoting of health systems development across the Region towards actions that will facilitate the attainment of UHC. There is increasing focus on organizing service delivery at the district level,[3] in addition to a better understanding and monitoring of the functionality of health systems;[4]

(iii) The Region has common tools to facilitate comprehensive planning and implementation support for monitoring progress towards UHC;[7,8,9]

(iv) Countries that have developed health policies and strategies during this period have clear UHC implementation priorities, with succinct country UHC result indicators and targets. In each country of the Region, these implementation priorities defined across the health system pillar areas are updated annually through the UHC roadmaps;

(v) As a result of having clear UHC implementation priorities, resource mobilization for health has been made easier. So far, the African, Caribbean and Pacific Group of States (ACP), Belgium, Canada, the European Union, France, Germany, the Republic of Ireland, Japan and the Grand Duchy of Luxembourg, have all provided direct support to countries in the Region, using this harmonized set of priorities;

(vi) WHO country capacity for policy dialogue has been immensely enhanced, with health policy advisors working in 36 of the 47 countries. They facilitate in-country dialogue to operationalize the UHC agenda;

(vii) The Region has an agreed results framework with specific strategic orientations and a menu of options for countries to consider when defining their UHC agenda[10]. This is further explained in the next section.

1.2 Strategic orientations

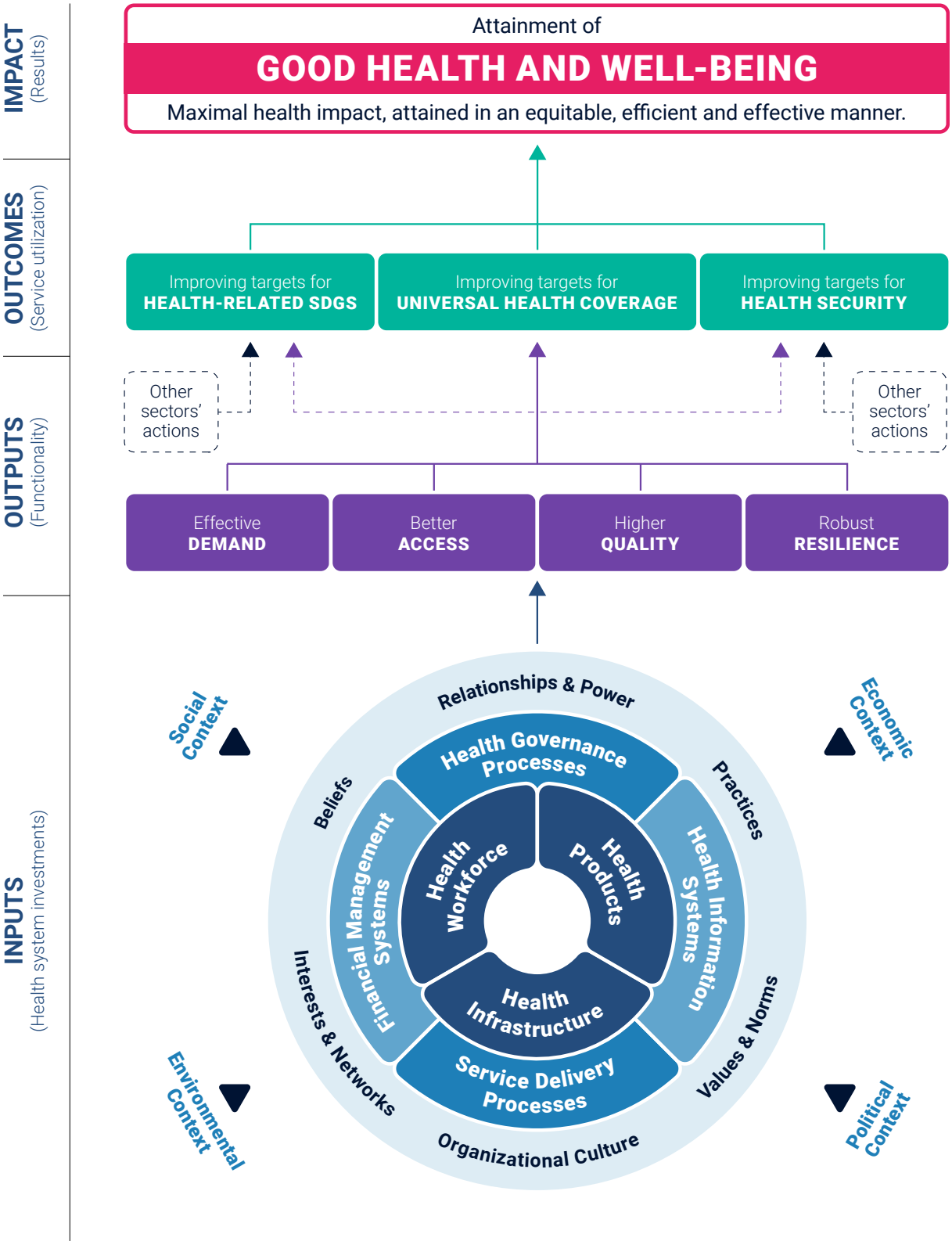
The Framework for health systems development towards UHC in the context of the SDGs – also known as the Framework of actions – is a novel way of advancing the health agenda.[5]

- It consolidates health systems and health services into one logical approach, emphasizing the interlinkages and influences that different health actions have on each other;
- It allows each country to define its own unique results and priorities, instead of having a set of top-down priorities and expected results;
- It avoids the verticalization of health system building blocks by providing countries with cross-cutting system performance measures that should improve if system investments are appropriately made;
- It provides a range of expected health and well-being outcomes, giving stakeholders a range of areas around which they should expect to see improvement from the investments made in a country;
- It is linked to SDG 3, and incorporates all the other targets needed for its attainment;
- Lastly, countries can track the performance of their health sectors, as it provides a monitoring and evaluation framework.

As shown in Figure 2, this framework is crucial as it clearly identifies the inputs, processes and outputs of a functional health system, which is expected to lead to desired outcomes and ultimately the attainment of good health and well-being for all. The functionality of the system is based on its output capacities in four areas: access to essential services; quality of care; demand for essential services; and resilience of the system. This allows for a better understanding in each country of how the investments made in the system lead to the intended health and related results. Given the four output areas, countries can prioritize areas where targeted improvement would lead to the greatest desired outcomes, without being prescriptive. For instance, if the country needs to improve the capacity relating to access to essential services, it can do this in multiple correct ways (increased staff strength, better use of existing infrastructure and more robust governance processes). The mix of investments made are determined by the country.

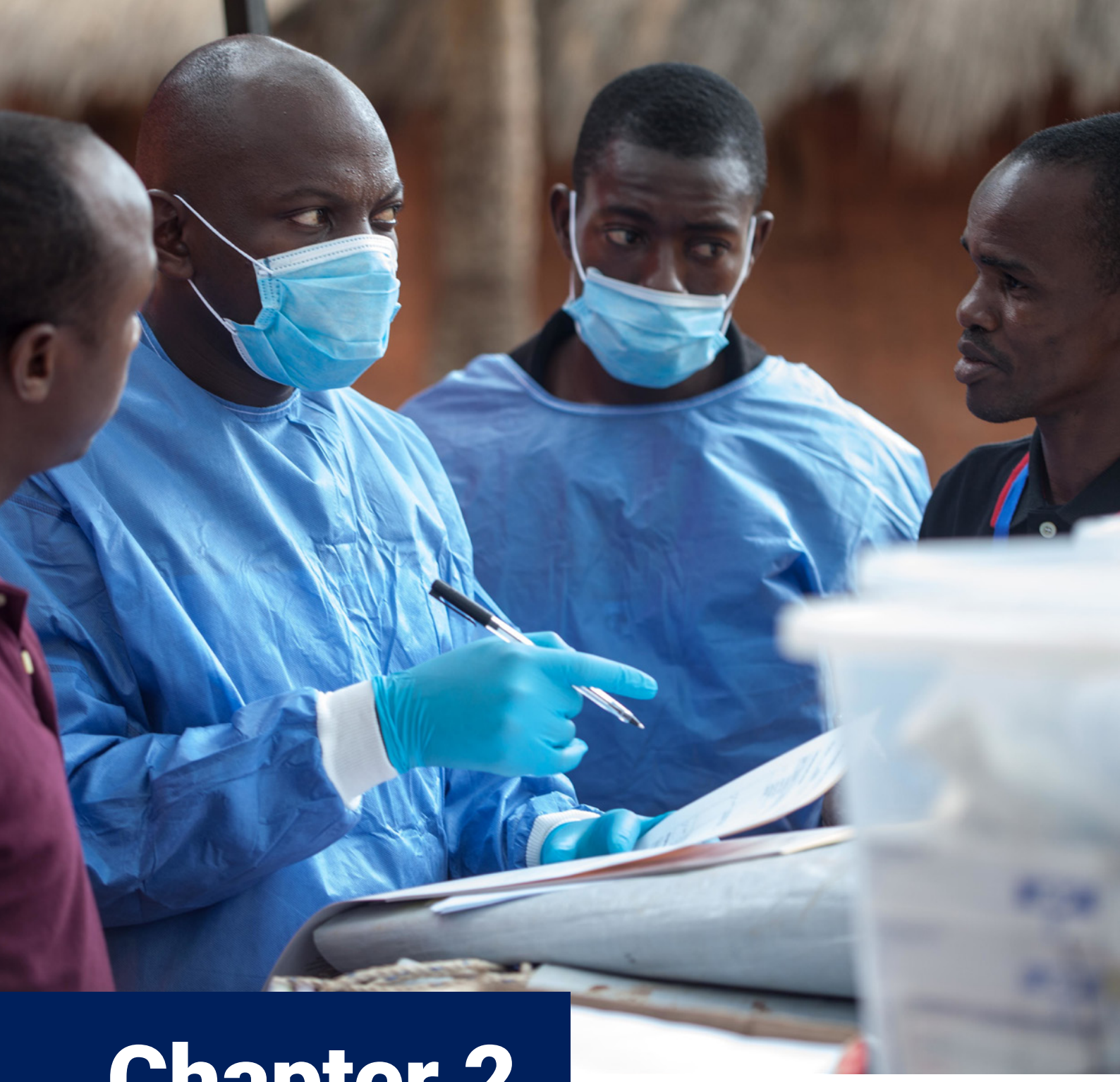
1

FIGURE 2: Framework for health systems development towards UHC in the context of SDGs



As a result of this, we can assess where countries stand regarding progress made towards UHC. The progress is relative to where they were in the past, and where other countries stand. These are presented in seven chapters:

- Chapter 1 focuses on regional priorities for the attainment of UHC;
- Chapter 2 looks at the trends and distribution of essential services availability and coverage in the Region. This is explored by geographical region, the income level, the UHC subcomponents, and also by assessing the health inequalities. This chapter also explores how well essential service availability and coverage relate to the system's functionality;
- Chapter 3 delves into the trends and distribution of financial risk protection in the Region, and explores how countries are performing relative to each other, and over time;
- Chapter 4, provides a detailed breakdown of the implications of the trends and the distribution of universal health coverage;
- Chapter 5, highlights the implications of the COVID-19 pandemic on UHC;
- Chapter 6 looks at key activities implemented across the health system pillar areas, based on UHC priorities identified by countries;
- Chapter 7 brings everything together with a lens of strategic shifts needed in the Region for the 2030 UHC agenda.



Chapter 2

Trends and distribution of essential health services utilization

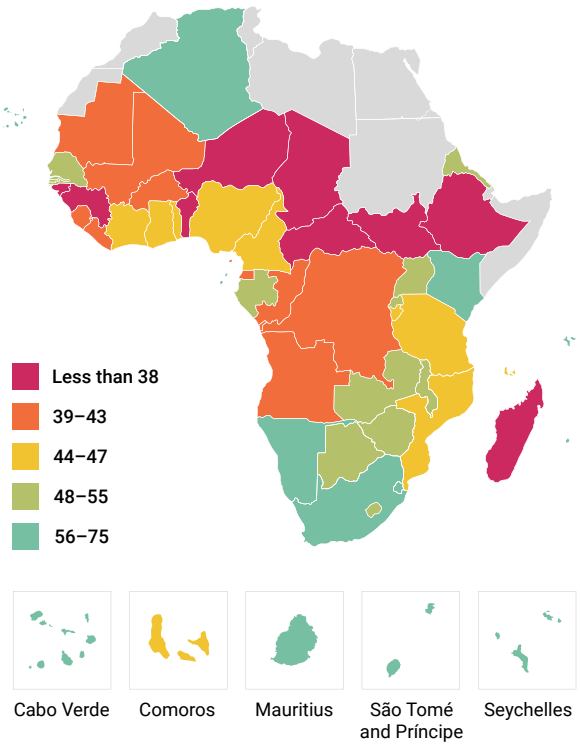
2

The goal of the service coverage dimension of UHC is that people in need of health promotion, preventive health care, curative health care, rehabilitative health care or palliative health care services receive them, and that the services received are of sufficient quality to achieve potential health gains. Resource constraints may limit countries in providing all health services, but they should be able to ensure coverage of essential health services. This chapter presents the 2019 results for the UHC service coverage index comprising 14 indicators, measuring coverage of essential health services with four indicator subsets. The UHC index is computed with standard indicators to enable comparison across countries. This chapter provides detailed analyses of country performance and trends of the UHC SCI, and per subset of service coverage indicators. It assesses the UHC SCI by the four subsets, subregion, and income level. It also evaluates inequality, summarizes limitations and discusses future developments in the current measure of service coverage.

2.1 Trends in the UHC Service Coverage Index

A UHC service coverage index is used as the overall measure, with countries having a value from 0 (no service coverage) to 1 (full-service coverage with all essential services). The UHC SCI is constructed from 14 indicators, extracted from various sources and organized around four components of service coverage: 1) Reproductive, maternal, newborn, and child health (RMNCH); 2) infectious diseases; 3) noncommunicable diseases (NCDs); and 4) service capacity and access. These are indicative of the service coverage across the Region. In 2019, the UHC SCI ranged from 28 to 75 across the 47 Member States Figure 3). Of these, seven had high service coverage (index of 60 and above), 29 had a service coverage index value of between 40 and 59, and 12 had low coverage (index between 20 and 39). No country had very low coverage (index below 20).

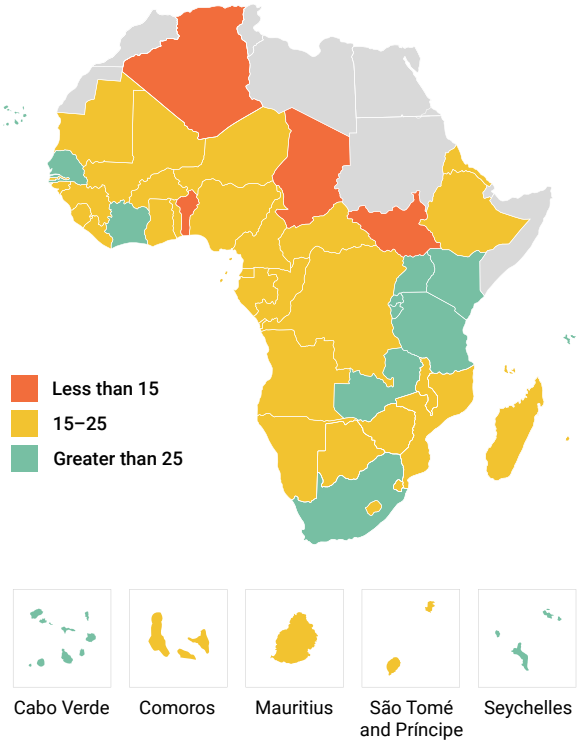
FIGURE 3: *UHC SCI by country, 2019*



Source: *World Health Organization, 2021.*

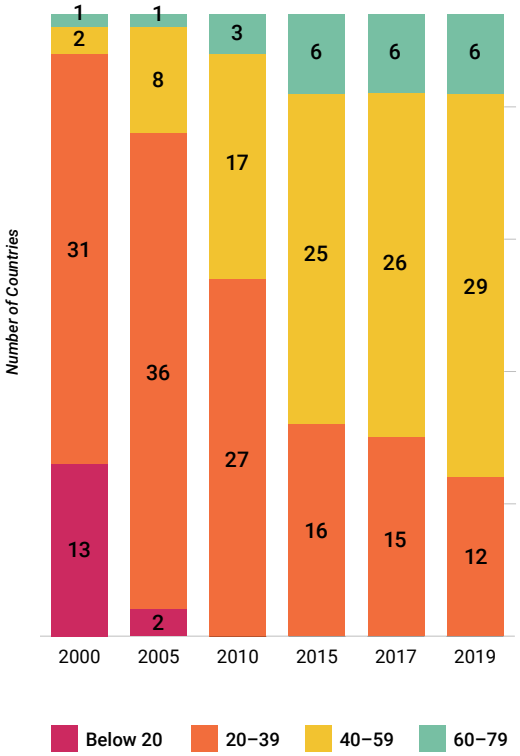
Over the past two decades, substantial progress has been made in the UHC SCI, across the WHO African Region (Figure 3). The regional population-weighted UHC SCI was 46 in 2019, up from 24 in 2000. Thirteen countries had a UHC SCI of under 20 in 2000, with only three countries with a UHC SCI above 40 then. By 2019 however, 35 of the countries had a UHC SCI above 40 and none was below 20. Six countries also performed better in 2019, with their UHC SCI index exceeding 60, compared to 1 in 2000 (Figure 4). All countries in the Region have shown an increase in the UHC SCI, with nine countries exceeding the 25% mark.

FIGURE 4: *Change in UHC SCI (in index point), 2000–2019*



Source: *World Health Organization, 2021.*

FIGURE 5: *Number of countries by UHC SCI group, 2000–2019*



Source: *World Health Organization, 2021.*

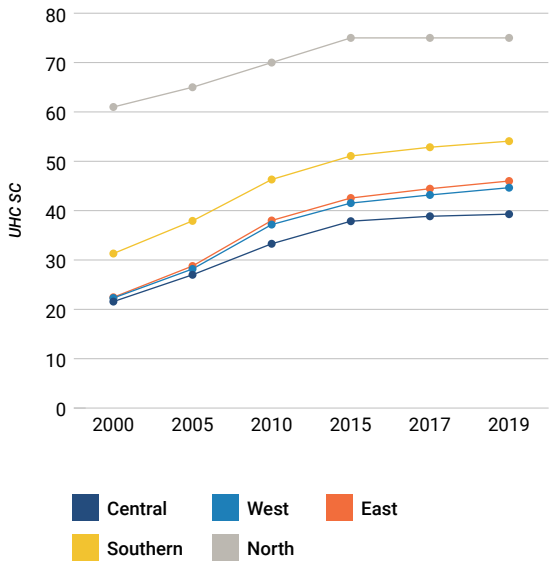
2.2 Disaggregation of UHC SCI trends

2.2.1 Geographical disaggregation

We looked at the trends with the SCI across the different regional economic communities (RECs) to explore any subregional trends and information. The highest values were in the Southern and Northern African subregions (75 and 53 respectively). However, the most significant progress between 2000 and 2019 was observed in the Eastern African subregion (24 index points), followed by the Western and Southern African subregions (23 index points). Across the RECs, the Southern African Development Community (SADC) and the Arab Maghreb Union (UMA) reported the highest service coverage index values in 2019, 55 and 52 respectively. However, the most significant progress between 2000 and 2019 was observed in the East African Community (EAC) and the Common Market for Eastern and Southern Africa (COMESA). Nonetheless, SCI trends during that period showed improvements, to varying degrees, across the subregion and their corresponding economic communities. This progress, though significant, remains falls short of meeting the SDG 3.8.1 global target of a minimum of 80% coverage of essential health services

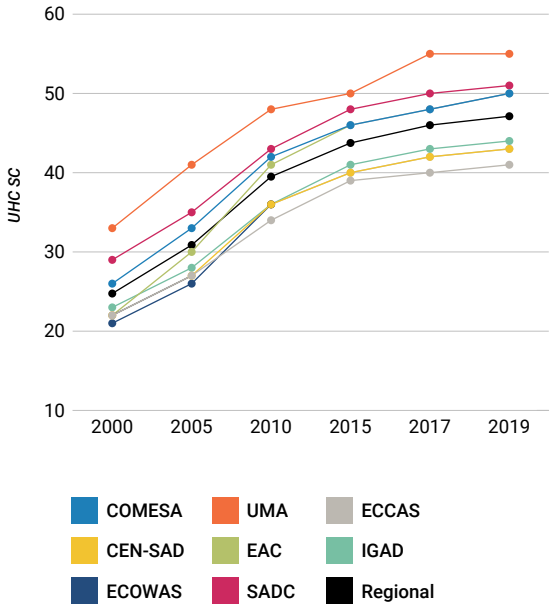
by 2030. Various factors contributed to the delayed achievement of this target, including the COVID-19 pandemic, which has disrupted essential health services, raising the need for stronger policy interventions to increase access and coverage of essential health services among various population groups in the African Region.

FIGURE 6: *Trend in UHC SCI by WHO Region, 2000–2019*



Source: *World Health Organization, 2021.*

FIGURE 7: *Trend in UHC SCI by regional economic community, 2000–2019*

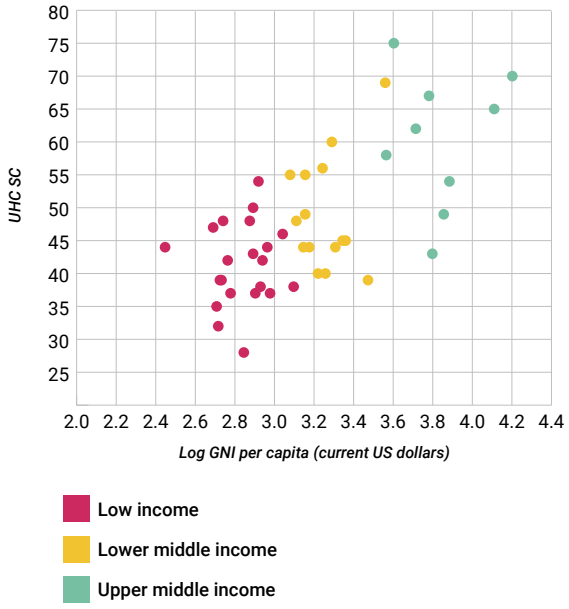


Source: *World Health Organization, 2021.*

2.2.2 Disaggregation by income level

We also looked at how the SCI trends varied in countries with different income levels. The strong correlation between the UHC SCI and the gross national income per capita (current US$) in log scale (r=0.662) suggests that there is a close relationship between income and the coverage of essential health services (Figure 8). Disaggregation of UHC SCI by World Bank income groups[11] shows the UHC SCI average scores for each income group, ranked in order of income level grouping (Figure 9). The average score observed in low-income countries (approximately 41) was almost 20 index points lower than the average score observed in high/upper middle-income countries (approximately 65). Improved index values were observed from 2000 across all income groups. Across the Region, absolute gain in service coverage was uniform for the various income groups. On average, from 2000 to 2019, progress across the Region, irrespective of income group, was between 20 and 25 index points.

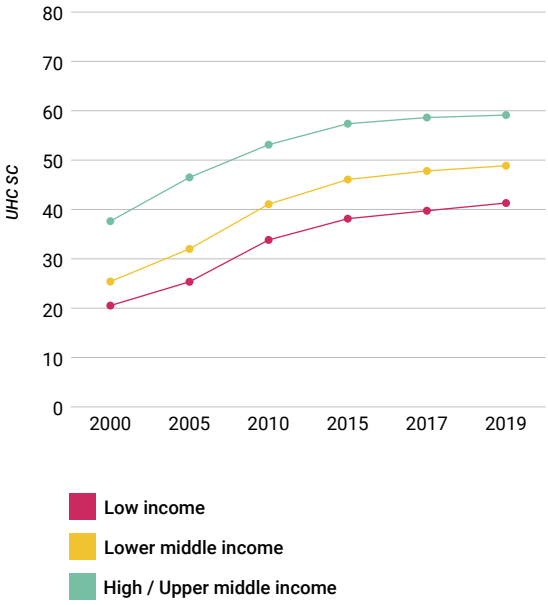
FIGURE 8: *Correlation between GNI per capita and UHC SCI, by World Bank income group, 2019*



GNI per capita is calculated using Atlas Method (current US$).

Source: *World Health Organization, 2021.*

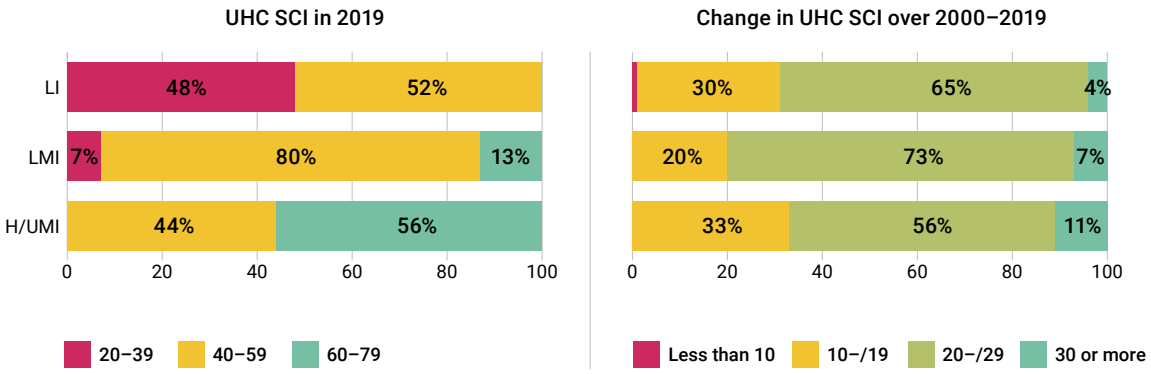
FIGURE 9: *Trend in UHC SCI by World Bank income group, 2000–2019*



Source: *World Health Organization, 2021.*

Furthermore, across the Region, the low-income group reported the lowest average score, while less than 20% of countries classified within this group (13%) reached an index value higher than 60 by 2019 (Figure 10). Similarly, although the high/upper middle-income group recorded the lowest absolute gain since 2000, approximately 60% of countries in this group recorded increases in their UHC SCI of more than 20 index points, suggesting that in the Region, progress continues to be made even in countries where income levels and socioeconomic conditions are already good.

FIGURE 10: *Percentage of countries by UHC SCI group in 2019 and change in UHC SCI (in index point) over 2000–2019, for each World Bank income group*



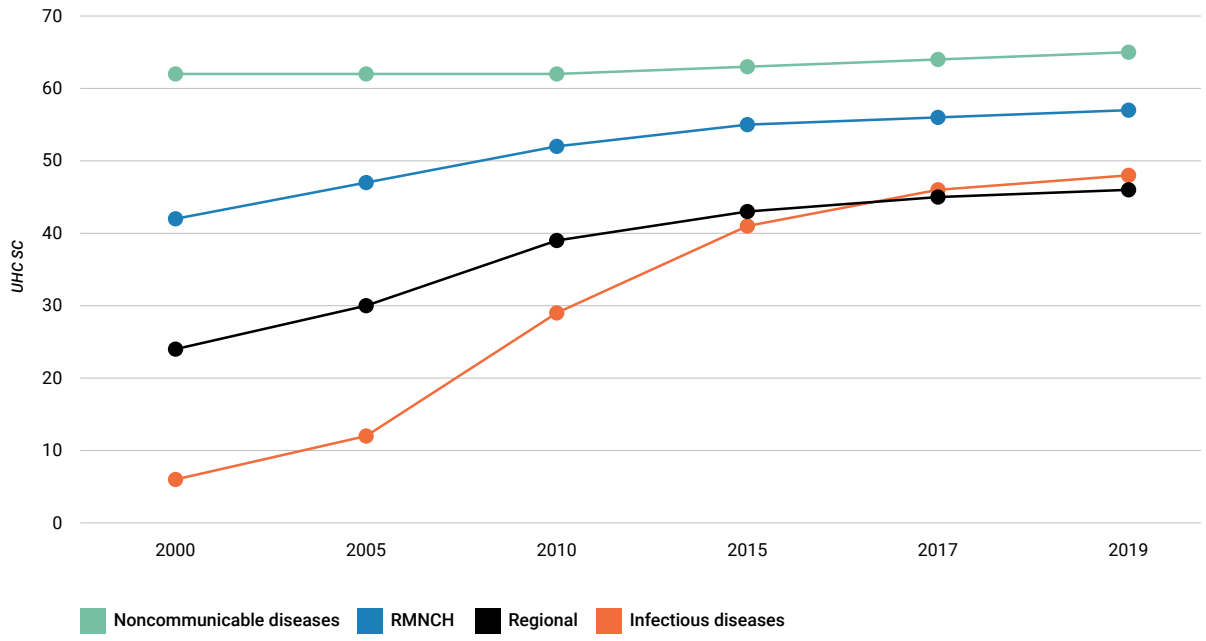
LI: Lower income, LMI: Lower middle income, H/UMI: High / Upper middle income.

Source: *World Health Organization, 2021.*

2.2.3 Disaggregation into UHC components

Regarding the four UHC SCI subcomponents, the infectious disease subindex improved the fastest between 2000 and 2019 (from 6 to 48) with a pronounced acceleration around 2005 due to the rapid scale-up of HIV, tuberculosis and malaria services (Figure 11). The RMNCH subindex also witnessed significant progress, increasing from 42 to 57 over the same period. The noncommunicable diseases component of the SCI remained the slowest to progress. This can be attributed to the ongoing epidemiological transition in the Region, where NCD services are becoming increasingly important, given the rise in chronic diseases, with the extent of NCD coverage more critical now than in the past.

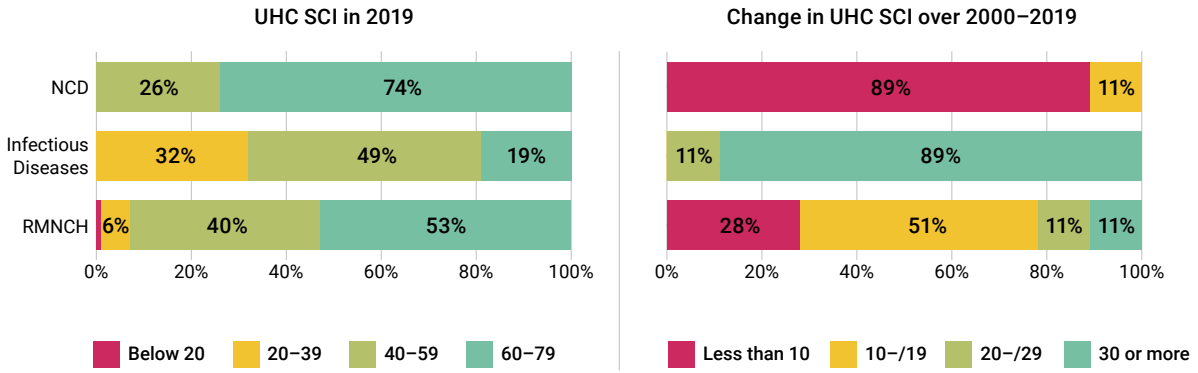
FIGURE 11: *Trend in UHC SCI by sub-component, 2000–2019*



Source: *World Health Organization, 2021.*

The NCDs subindex, which currently includes prevalence-based proxy indicators for the treatment of hypertension and diabetes and non-use of tobacco, ranged between 41 and 81, and were evenly distributed across income groups and subregions. Except for the infectious diseases subindex, which increased in most countries by more than 30 index points, not many countries saw any of their subindices increase by more than 10 index points.

FIGURE 12: *Percentage of countries by UHC SCI group in 2019 and change in UHC SCI (in index point) over 2000–2019, for each component*



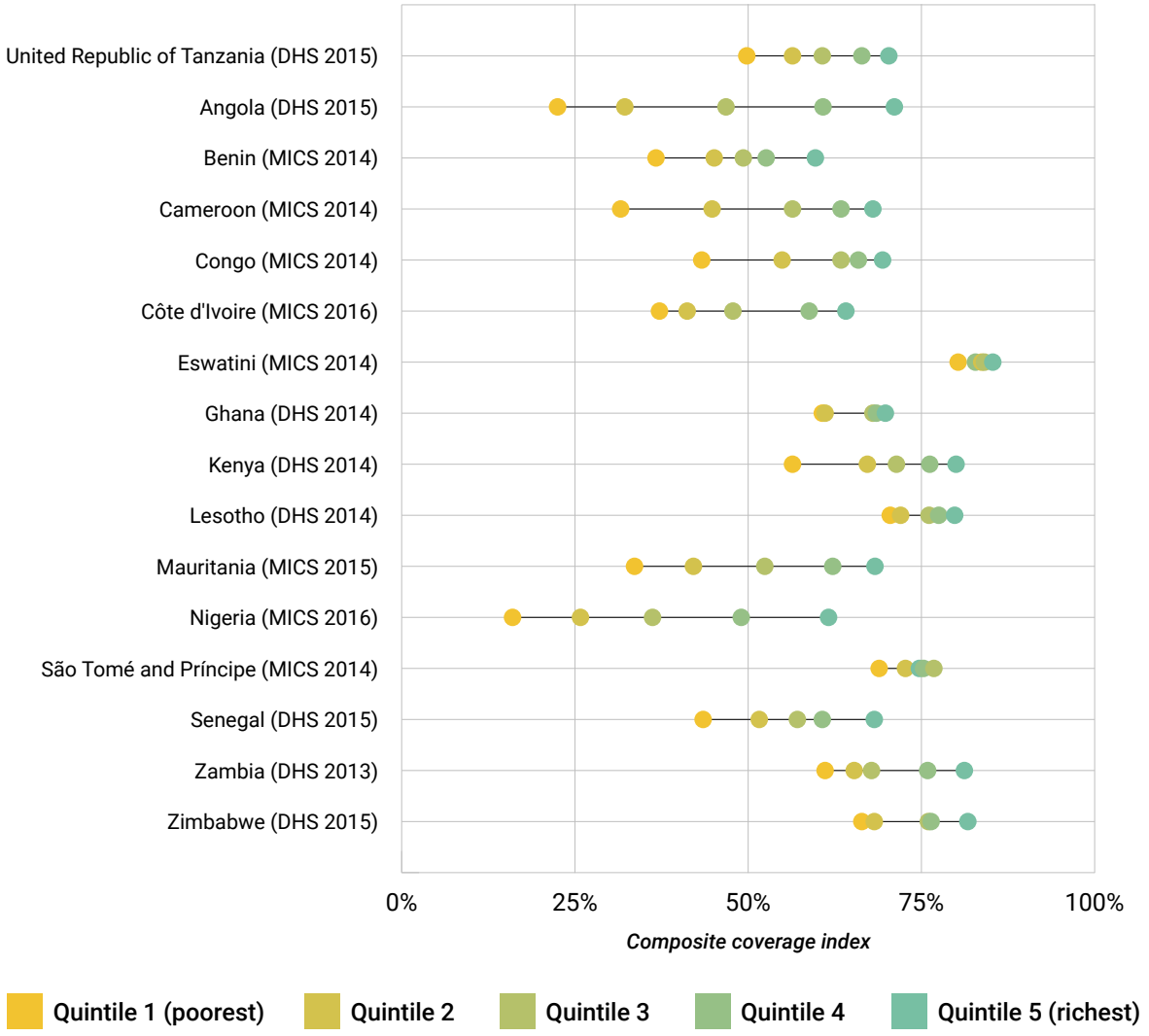
Source: *World Health Organization, 2021*

2.3 Inequalities in the coverage of essential health services

The purpose of UHC is to ensure that all people have accessible, affordable and quality health provision, regardless of their economic status, gender or other characteristics. However, inequalities in UHC do exist both between and within countries, meaning that certain population subgroups have less access to services and interventions, or have systematically worse health outcomes. A major challenge to measuring inequalities in the UHC SCI within countries is the lack of disaggregated data for many indicators. As a proxy measure, using a composite coverage index as an outcome measure of inequality, an assessment of the extent of inequalities within countries can be monitored. This composite coverage index is calculated as a weighted score reflecting coverage of eight RMNCH interventions along the continuum of care: demand for family planning satisfied (modern methods); antenatal care coverage (at least four visits); births attended by skilled health personnel; BCG immunization coverage among one-year-olds; measles immunization coverage among one-year-olds; DTP3 immunization coverage among one-year-olds; children aged less than five years with diarrhoea receiving oral rehydration therapy and continued feeding; and children aged less than five years with pneumonia symptoms taken to a health facility.

This indicator is based on aggregate estimates and spans a wider set of RMNCH interventions than those included in the RMNCH subindex of the UHC SCI. An assessment of this composite index across countries in the WHO African Region shows that coverage of essential health interventions varies substantially, both within and across countries. Within countries, coverage tends to be higher among more advantaged groups such as the richest, most educated, or those living in urban areas. For instance, data from 16 countries in the Region indicate a median coverage of 70% among the richest population quintile, compared with a median coverage of 46% among the poorest quintile (Figure 17), revealing a 24 percentage-point difference in coverage between the richest and poorest across these low-income countries. There are similar patterns for inequalities related to education level and place of residence.

FIGURE 13: *SCI by multiple dimensions of inequality: latest situation (2010–2019) for specific countries*



Note: Circles indicate median values across countries – one circle for each economic subgroup.

Source: *WHO Health Equity Monitor database, 2021.*

Data from the 16 countries in figure 13 show that economic-related inequality across many countries remains a crucial determinant of the level of service coverage. When the population is disaggregated across various equity stratifiers, it is evident that though service coverage might be high, it masks certain inequalities that persist.

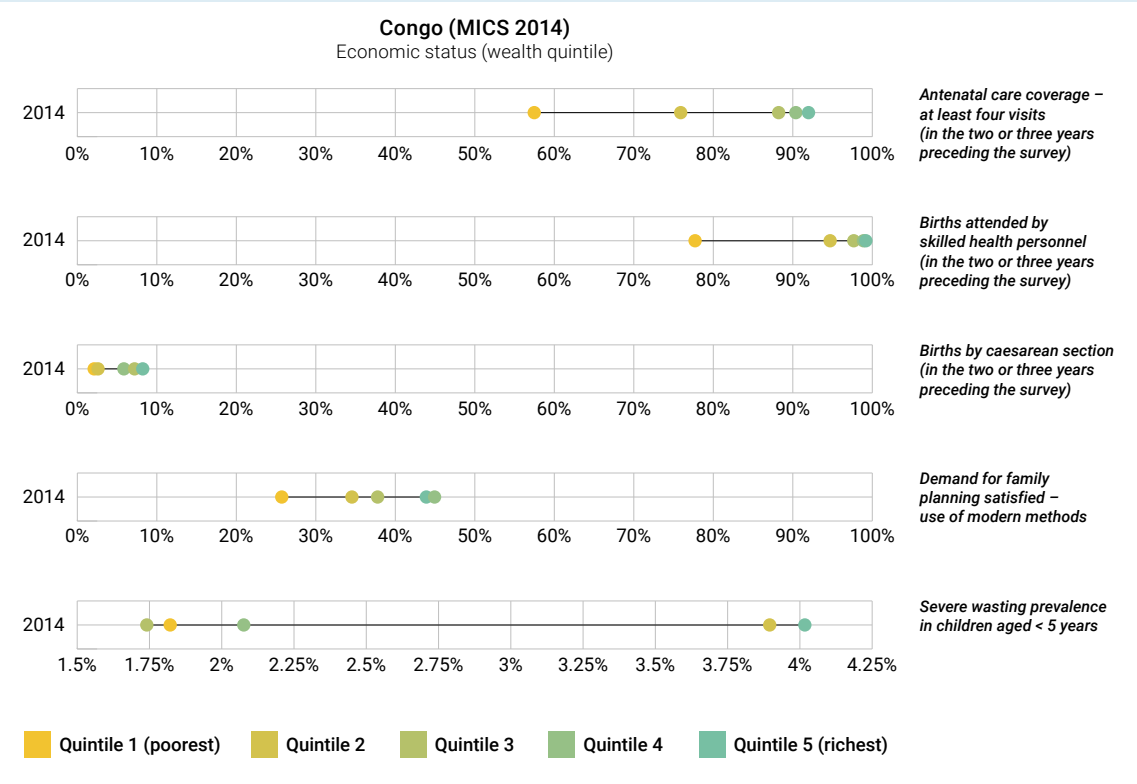
2

BOX 1: Understanding unmet needs and barriers in accessing RMNCH services in Congo

To ensure an equitable path to UHC, it is crucial to understand and address the full range of factors that act as potential demand-side and supply-side barriers. An analysis of demand-side factors related to access to RMNCH interventions in Congo was performed based on a household survey conducted in 2014. The analysis was performed for a range of essential health services. The results show that on average, the percentage of unmet needs was higher among individuals in the poorest income quintile than the richest quintile (Figure 25).

Of those who reported a health care need, socioeconomic barriers were shown to affect levels of access across the population. Overall, people in the poorest income quintile were those most likely to experience barriers. The urban-rural divide, education and sex were also shown to be critical factors.

FIGURE 14: *Inequalities in access to RMNCH services, among those reporting a need in Congo, by country and income quintile, 2014*

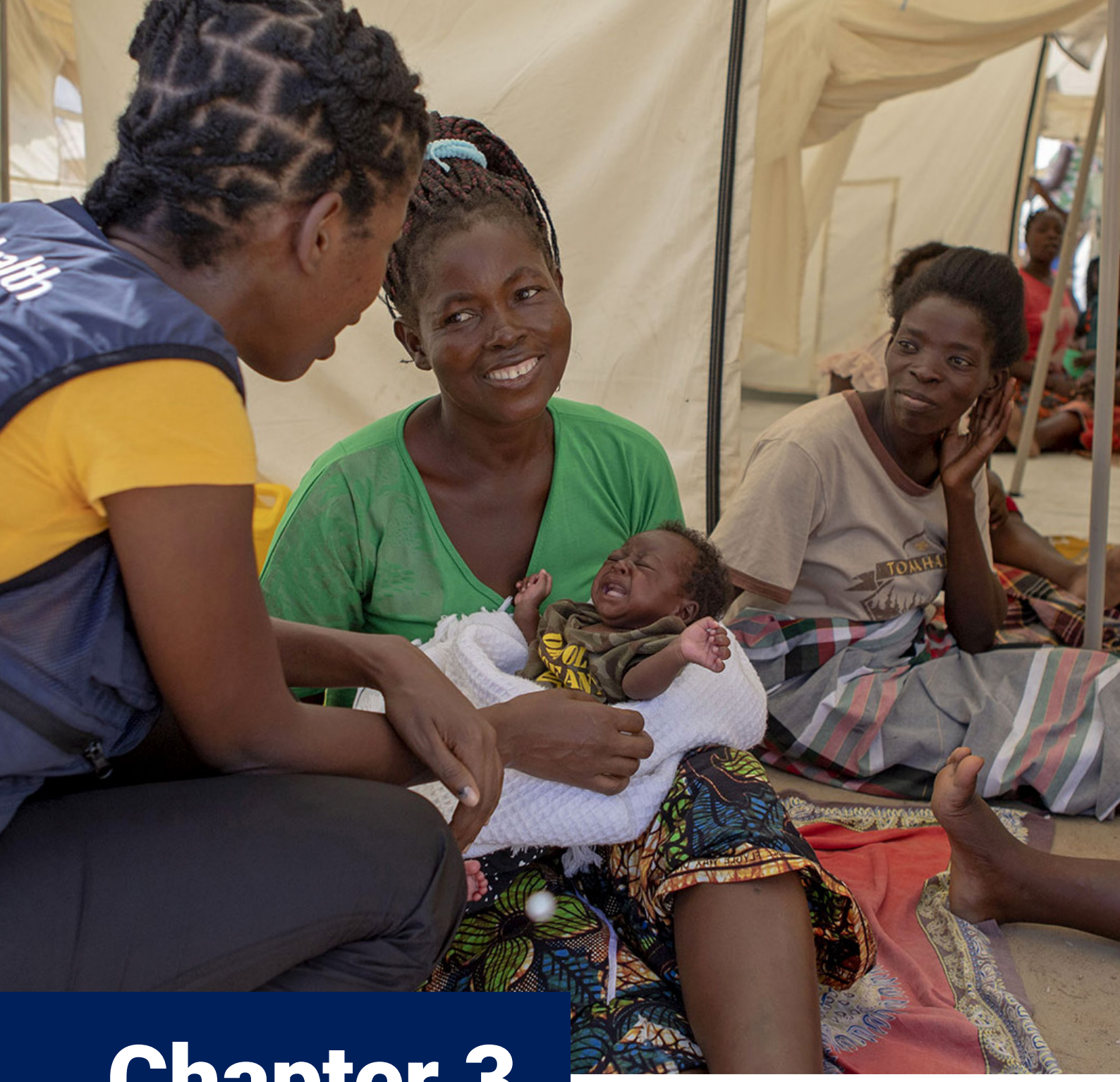


The Health Equity Assessment Toolkit (HEAT): software for exploring and comparing health inequalities in countries. Built-in database edition. Version 4.0. Geneva, World Health Organization, 2021.

The disaggregated data used in this version were drawn from the WHO Health Equity Monitor database (2021 update) which may have been revised or updated since that time. The most recent version of that database is available on the WHO website.

Source: *WHO Health Equity Monitor database, 2021.*

The results support the notion that advancing UHC requires integrated and multisectoral approaches aimed at reducing the barriers to accessing care, including factors that may disproportionately affect lower socioeconomic groups, such as high cost, insurance problems, lack of time, inadequate availability of resources, and low willingness to seek care. There is a need to advance information systems to include disaggregated data to improve analysis of health equity across and within countries.



Chapter 3

Trends and distribution of financial risk protection

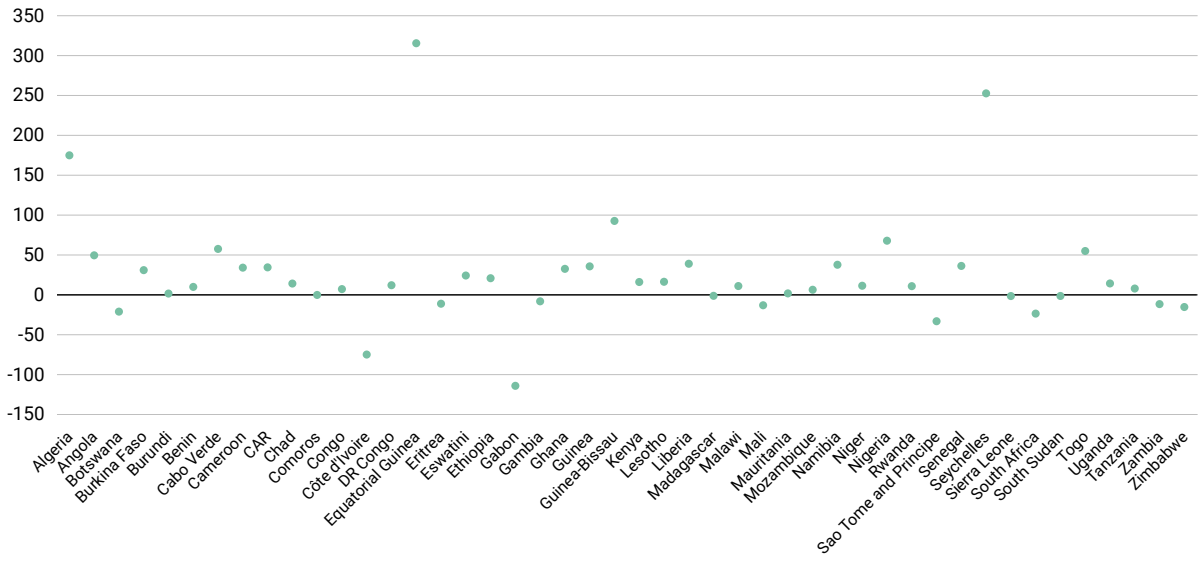
3

This chapter explores the financial risk protection at the regional and country levels over the period, with data available for the UHC indicators at both levels. It draws on a joint global thematic report on financial protection prepared by WHO and the World Bank and published in 2021.[12] Financial risk protection is achieved when OOP health spending is not catastrophic (household expenditures on health greater than 10% of total household expenditure or income, SDG 3.8.2). OOP health spending is defined as any spending that is: 1) incurred by a household when any member uses a health good or service to receive any type of care (preventive, curative, rehabilitative, long-term care); 2) provided by any type of provider; 3) for any type of disease, illness or health condition; and 4) in any type of setting (outpatient, inpatient, at home). It includes formal and informal expenses directly related to the cost of seeking care as mapped in division 06 of the UN Classification of Individual Consumption According to Purpose,[13] i.e., on medicines and medical products (06.1), outpatient care services, including dental care (06.2), inpatient care services, including inpatient dental care (06.3), diagnostic imaging services and medical laboratory services (06.4.1), and patient emergency transportation services and emergency rescue (06.4.2)[14]. It excludes prepayment (e.g., taxes, contributions or premiums) and reimbursement of the household by a third party such as the government, a health insurance fund or a private insurance company. It also excludes indirect expenses (e.g., nonemergency transportation cost) and the opportunity cost of seeking care (e.g., lost income).[13]

3.1 Out-of-pocket expenditure

The overall change in out-of-pocket expenditure (adjusted for purchasing power) between 2000 and 2019 are shown by country in Figure 15.

FIGURE 15: *Change in out-of-pocket expenditure per capita (Int $, 2000–2019)*

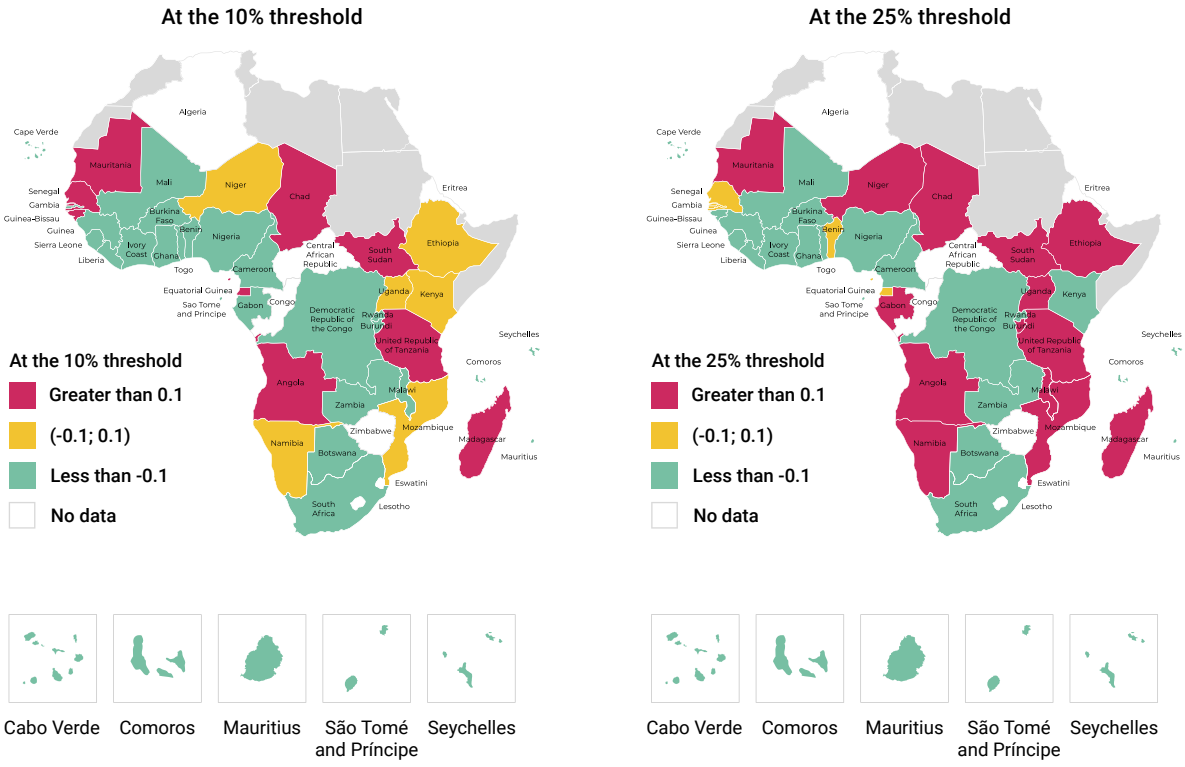


Source: *WHO Global Health Expenditure Database*

Over the past 20 years, out-of-pocket expenditure across most countries has increased. Some countries like Algeria, Equatorial Guinea, Guinea-Bissau, and Seychelles, have seen an increase in OOP per capita, PPP (international $) greater than 90, suggesting that efforts to improve financial risk protection in those countries have not seen much progress.

However, across the WHO African Region, many countries did manage to reduce the incidence of catastrophic health spending. Among the 47 countries, the proportion of the population spending more than 10% of their household budget on health OOP decreased on average by more than 0.1 percentage point per year in 25 countries. In six countries, the change ranged on average between -0.1 and +0.1 percentage points per year; in nine countries, it increased by more than 0.1 percentage points per year. In 66% of the countries where households are spending more than 10% of their household income on health out-of-pocket, the proportion spent is more than 25% of the household budgets. In 80% of the countries with reductions in the incidence of catastrophic health spending at the 10% threshold, it also decreased at the 25% threshold.

FIGURE 16: *Average percentage point change in the incidence of catastrophic health spending as tracked by SDG indicators 3.8.2*

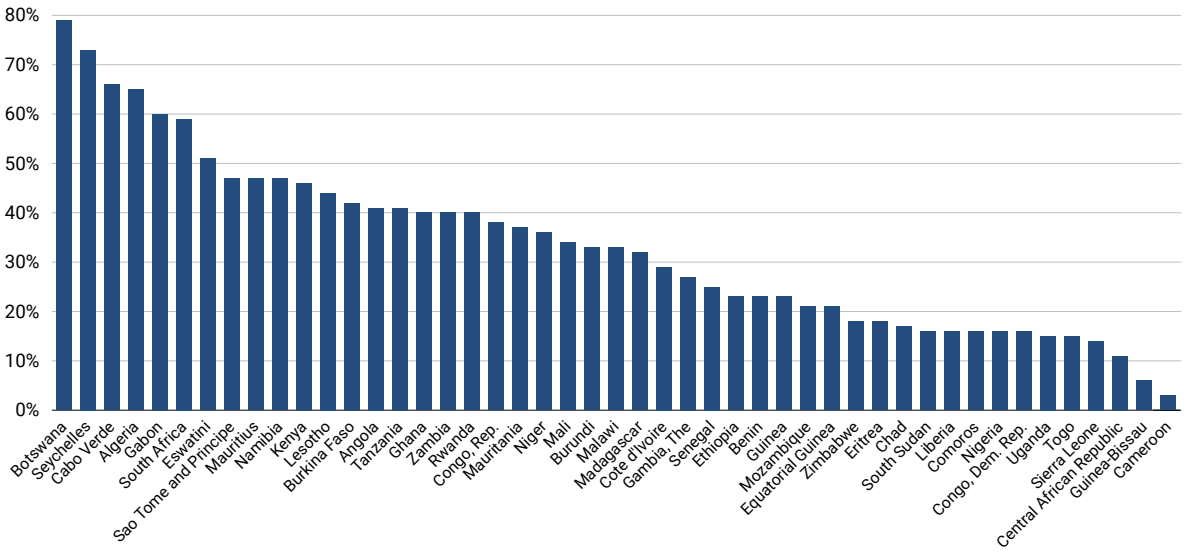


Source: *WHO, World Bank (2021). Global monitoring report on financial protection in health 2021. World Health Organization and International Bank for Reconstruction and Development / The World Bank; 2021.*

3.2 Public health financing

Looking at domestic government health expenditure as a percentage of the current health expenditure in the countries in the WHO African Region in 2019, most governments are funding less than 50% of the health budget. Only the governments of Algeria, Botswana, Cabo Verde, Eswatini, Gabon, Seychelles and South Africa fund more than 50% of the total health expenditure. The overall funding for health as a proportion of GDP and proportion of health funded by the government must increase to enable countries to reduce out-of-pocket spending and be able to steer their UHC agenda.

FIGURE 17: *Domestic general government health expenditure as a % of current health expenditure, 2019*



Source: *World Bank Data: https://data.worldbank.org/indicator/SH.XPD.GHED.CH.ZS*

There is still a wide scope for improvement in terms of reducing financial hardship in the care-seeking process and ensuring financial risk protection across all populations (SDG indicator 3.8.2). Protecting people against the impoverishing effect of health payments should be a focus for countries in the Region going forward, as we all work together towards the collective goals of 2030.

Chapter 4

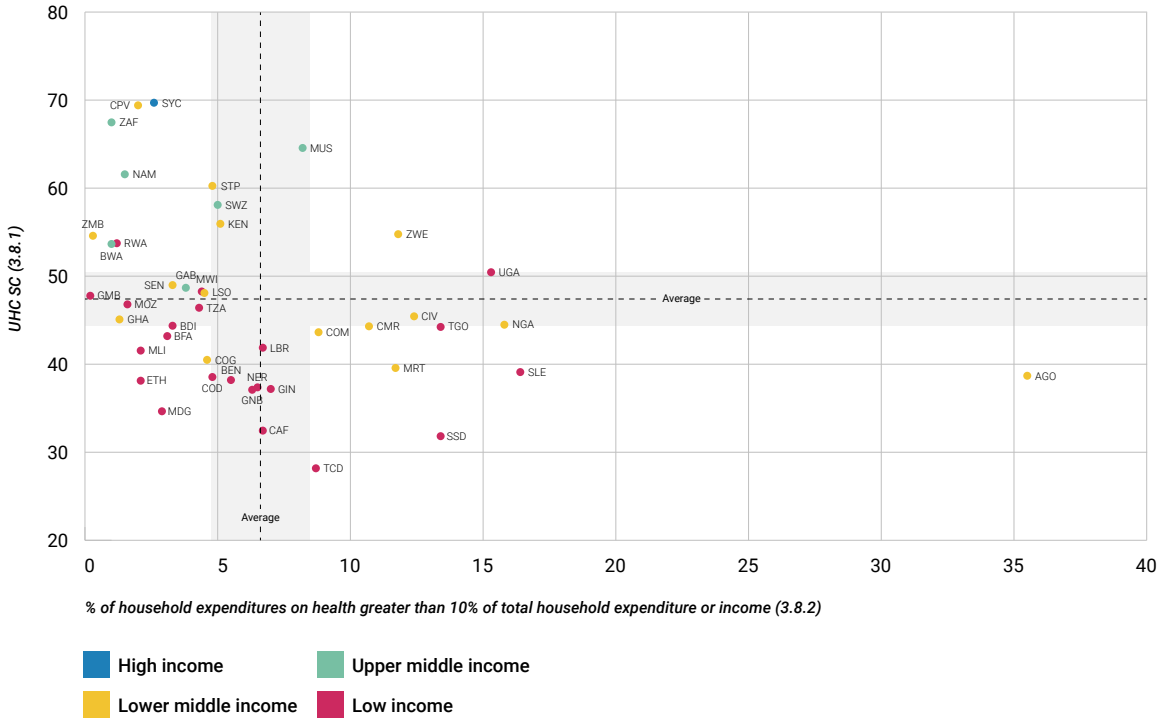
Implications of the trends and distribution of universal health coverage

4

4.1 Overall pattern with UHC progress in the Region

Although most Member States have integrated the attainment of UHC as a central goal of their national health strategies, progress in translating this commitment into equitable and quality services as well as increased financial protection remains varied. When we compare the two measures of the UHC status, the service coverage index, which represents the availability and coverage of services, with the proportion of households spending over 10% of their income on health care, which represents the financial risk protection dimension of UHC, we get a picture of UHC in the Region that is not solely reliant on a Member State's level of income.

FIGURE 18: *Relative state of UHC among Member States in the WHO African Region*



Source: *WHO World Health Statistics, 2022*

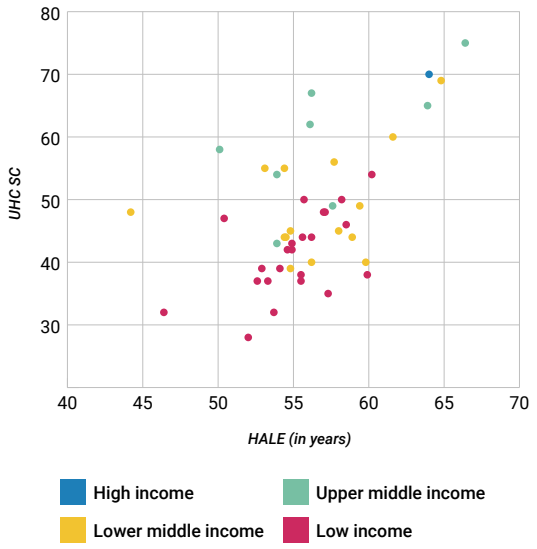
Exemplar countries are those in the upper-left quadrant – above average for both service coverage and financial risk protection. There are 15 countries in this quadrant, which include high/upper middle-, lower middle- and low-income countries. Rwanda, Malawi, and Mozambique are low-income countries having relatively high service coverage index and good financial risk protection as compared to their peers, and so are doing well vis-à-vis UHC. We also note some middle-income countries with very low financial risk protection and service coverage, such as Angola, Cameroon, Comoros, Côte d'Ivoire Mauritania and Nigeria.

4.2 Exploration of service coverage in the Region

Service coverage is an important outcome measure in the health sector, as shown in the overall regional Framework for action (see Figure 2). Together with health security and the progress made with health-related targets in other SDGs, it drives the overall attainment of health results in countries. When we compare healthy life expectancy and UHC service coverage, we note a positive correlation between the two measures (r=0.553), reflecting the impact that service coverage has on SDG 3 attainment.

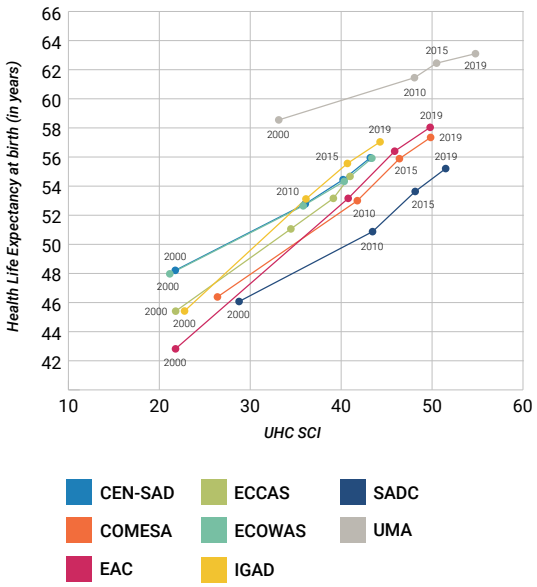
Healthy life expectancy in the Region increased from 47.1 years in 2000 to 56.1 years in 2019, while the service coverage index increased from 24 to 46 over the same period. Between 2000 and 2019, the WHO African Region had on average, an increase of 22 index points in service coverage, which contributed to a gain of nine years of life expectancy. High/upper middle-income countries tend to have much higher UHC SCI and life expectancy at birth than lower-income countries. A difference in life expectancy of approximately 10 years is evident when comparing countries in the top 10% of UHC SCI (median UHC SCI: 45, median healthy life expectancy at birth: 63.1 years) with those in the bottom 10% (median UHC SCI: 38, median life expectancy at birth: 52.5 years) for 2019. With regard to the subregional groupings, the East African Community (EAC) and Intergovernmental Authority on Development (IGAD) subregions have experienced the most marked improvements in service coverage and healthy life expectancy (highest increase in the slope of the graph, Figure 20), while the Southern African Development Community (SADC) and Arab Maghreb Union (AMU) have had the least improvements. The UHC service coverage is having a higher impact on healthy life expectancy in the IGAD/EAC subregions, compared to the SADC/AMU subregions.

FIGURE 19: *Relationship between UHC SCI and healthy life expectancy at birth, by World Bank income group, 2019*



Source: *World Health Organization, 2021 and World Bank Group, 2021.*

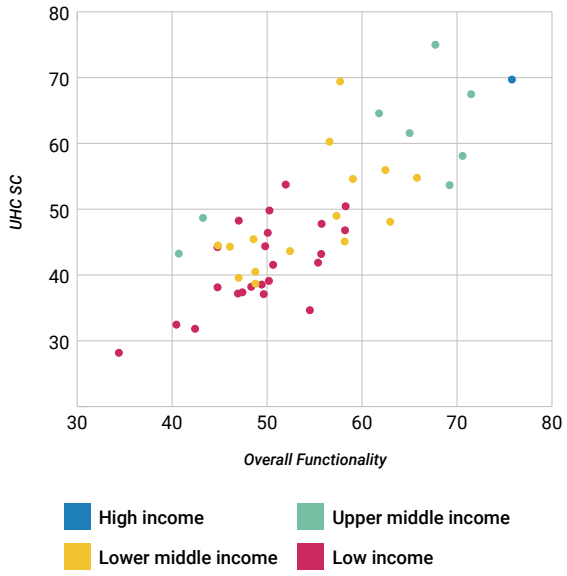
FIGURE 20: *Trend in UHC SCI and life expectancy at birth, by regional economic community, 2000–2019*



Source: *World Health Organization, 2021.*

On the other hand, looking at the contribution to UHC service coverage, the functionality of the health system is significant. In the WHO African Region, this recognition of the importance of functionality led to the report at the Seventieth Regional Committee for Africa on monitoring health functionality in the Region (AFR/ RC70/13). Functional health systems facilitate movement towards universal health coverage and other health-related service coverage outcomes. In the Region, a health system is considered functional when it can exhibit the capacity to (1) ensure access to a (2) quality range of essential services that (3) communities demand, (4) even when facing shock events. These four attributes are the basis for a measure of functionality of the systems in the Region, allowing them to achieve UHC.[15] We illustrate the relationship between the functionality of the health systems and the UHC service coverage (minus the service capacity and access component, which has functionality components in it) below.

FIGURE 21: *Relationship between SDG 3.8.1 UHC SCI, 2019 and the health system functionality index*



Source: *World Health Organization 2021.*

The results suggest a high level of association between the UHC service coverage index and health system functionality (r=0.767). The capability of functional health systems is therefore a strong predictor of the progress towards UHC service coverage in the Region. In the preceding chapter, we highlighted several interventions implemented by countries to enhance the functionality of their systems. It is important to enhance support to these system strengthening initiatives. Countries need to consider interventions across the entire health system, and not focus on only a few, as they tend to be interconnected and complementary. Specific interventions must be determined in each country and should be prioritized based on the improvements desired for the functionality of the system.

4.3 Exploration of financial risk protection in the Region

Overall, the African Region has managed to expand service coverage without any major increases in catastrophic health spending over the past seven years. In some countries, there have been converging trends observed between SDG 3.8 indicators, with UHC SCI (3.8.1) improving, service coverage increasing, and catastrophic health spending (3.8.2) also improving. This data is for 2010 to 2017 (the years for which data was available for countries in the WHO African Region). The data shows that while service coverage increased from a population-weighted average of 40 in 2010 to 44 in 2017, the share of the regional population spending more than 10% of their household budget on health out-of-pocket remained relatively unchanged (with a slight decline of 0.5 percentage points from 7.76% in 2012 to 7.26% in 2017).

TABLE 1: *Progress in UHC SCI and incidence rates of catastrophic health spending (10% threshold), 2012–2017*

	UHC service coverage index (SDG 3.8.1)	**Catastrophic health spending** (SDG 3.8.2, 10% threshold)
2012	40	7.76
2015	43	8.02
2017	44	7.26

Source: *SDG 3.8.1, WHO global database, 2021 update. SDG 3.8.2, WHO & World Bank global financial protection database, 2021 update*

In populations where seeking health care is impoverishing or near impoverishing, the opportunity cost is often too high, and this leads to the disparities observed in health care outcomes of the rich and the poor. In the African Region, where the $1.90 poverty headcount ratio a day is 40.4% of the population, definitions of catastrophic expenditure at 10% of household consumption may leave out large pockets of the population for whom out-of-pocket health spending represent spending on regrettable necessities. Although this is incurred to compensate loss in welfare triggered by illness, injury or adverse health events, it poses a risk to livelihood if it displaces spending on other basic needs. In line with this, it is important to consider financial hardship from the perspective of catastrophic out-of-pocket spending, and also indicators of impoverishment, in alignment with SDG target 1.1 (elimination of extreme poverty). We use the poverty line of extreme poverty (PPP $1.90 a day) to reflect the concern with ending poverty "everywhere" at the core of SDG 1, as well as a relative poverty line defined as 60% of median per capita consumption or income, which is country-specific. Table 2 shows that across the Region, the population with impoverishing health spending at the PPP $1.90 a day line of extreme poverty has decreased over the years, by 17.2 percentage points, with similar decline also observed among the population with impoverishing health spending at the relative poverty line of 60% of median per capita consumption or income, despite the 5-percentage point increase between 2015 and 2017. As more data becomes available, it will be critical to continue to monitor these indicators post-COVID-19 as countries recover from the unprecedented effects of the pandemic.

TABLE 2: *SDG-related indicators of impoverishing health spending, in % of the global population*

	2000	2005	2010	2015	2017
Population with impoverishing health spending at the PPP$1.90 a day line of extreme poverty	58.4	51.9	47.5	42	41.2
Population with Impoverishing health spending at the relative poverty line of 60% of median per capita consumption or income	52%	30%	26%	26%	31%*

Source: *WHO, World Bank (2021). Global monitoring report on financial protection in health 2021. World Health Organization and IBRD*

**with the exclusion of Zimbabwe where impoverishing health spending at relative poverty line of 60% of median per capita consumption was 394%.*

Catastrophic health spending as defined by the 2030 Agenda for Sustainable Development describes people who spend more than 10% of their household budget on health, regardless of their poverty status. Indicators of impoverishing health spending complement catastrophic health spending and point to the financial hardship experienced by the near-poor and the poor, including those spending any amount on health OOP. Jointly, both types of indicators are needed to capture financial hardship among the whole population, using global metrics. For an accurate picture of the number of households and persons who benefit from service coverage without incurring financial hardship, data on service coverage components, household out-of-pocket health spending and total consumption and spending on necessities must be collected within the same survey or for similar population groups. It is important to gather joint data on financial hardship and service coverage, as well as have a better understanding of the joint distribution of these components. Data on forgone care, and barriers to access and utilization are also needed to unpack and understand trends in service coverage and financial hardship, especially in the context of COVID-19.

Furthermore, the way services are financed plays a role in the equitable access to these essential services needed by the population. Income inequality sets in when services are financed from household income (insurance premiums, or OOP payments). While government taxes account for a sizable portion of health care funding in many African countries, direct out-of-pocket payments continue to account for a sizable portion as well. When a country's health system relies on OOP in financing itself, it means that patients must pay for health services from their own pockets when a disease episode or health event occurs even though such an occurrence may take place at any time without warning. When this happens, patients and their families rely on their disposable savings and assets, contributions from friends and waivers from the health facilities. Oftentimes, this predisposes them to poverty.

Countries in the Region must therefore deliberately create a strong link between fiscal policy and health policy. To do so, taxation must be the most sustainable source of financing health, and African governments must boost their efforts towards improving taxation. Considering the importance of financial stewardship, focus should be placed on improving the state-citizen relationship through increased transparency and accountability, to foster legitimacy and improve tax morale and voluntary tax compliance. Improving transparency includes participatory tax policy-making, the publication of tax revenue collected, and the ways in which taxes are utilized. Improving accountability means creating a linkage between taxation and the provision of public goods and services, particularly health services, and this should be communicated to the public through different means to reach all segments of society. For instance, this could mean introducing a pro-poor health financing policy that focuses on financial protection, not only for those on the verge of poverty, but also for those who are already below the poverty line in both rural and urban areas, or increasing health care investment through social health insurance and/or tax-based government funding.

Chapter 5

Implications of the COVID-19 pandemic on universal health coverage

5

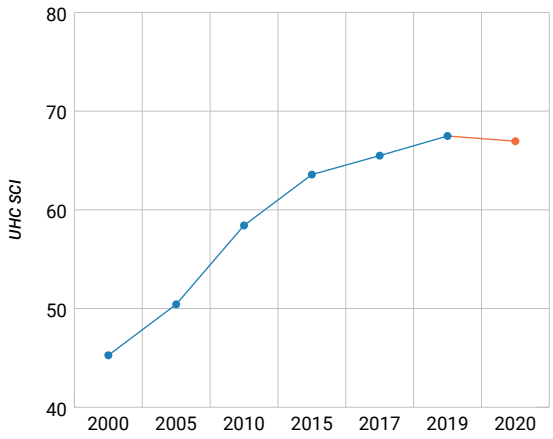
Across the African Region, the COVID-19 pandemic disrupted the delivery of essential health services. Health systems continue to grapple with the delivery of routine services amid a surge in cases and a need for a more robust emergency response to the pandemic. Since 2020, over 8.5 million confirmed cases of COVID-19, including over 170 000 deaths have been reported to WHO for the African Region.[16] Furthermore, the pandemic has exposed numerous vulnerabilities in the health systems of countries, including disparities in service coverage between the rich and the poor, and gaps in social protection. It has showed that health security and attainment of universal health coverage are inseparable ambitions, and efforts to achieve them must go hand in hand, while building resilient populations.

This chapter discusses the extent and magnitude of disruptions to essential health services in the context of the COVID-19 pandemic.

5.1 Disruptions to essential health services due to COVID-19

Preliminary estimates for the UHC service coverage index for 2020 is available for only nine out of the 14 UHC SCI subindicators, precluding a comprehensive assessment of the impact of COVID-19 on the coverage of essential health services. Nevertheless, preliminary analyses suggest that UHC SCI decreased slightly in 2020 compared to 2019. While it might be possible that this preliminary 2020 UHC SCI value is an overestimation, it suggests that the progress made across the Region in improving health service coverage may be under threat.

FIGURE 22: *UHC Service coverage Index, 2000–2019 and 2020 preliminary estimate*



Source: *https://www.who.int/publications/i/item/9789240040618*

5.2 Findings from the third round of the pulse survey on continuity of essential health services during the COVID-19 pandemic

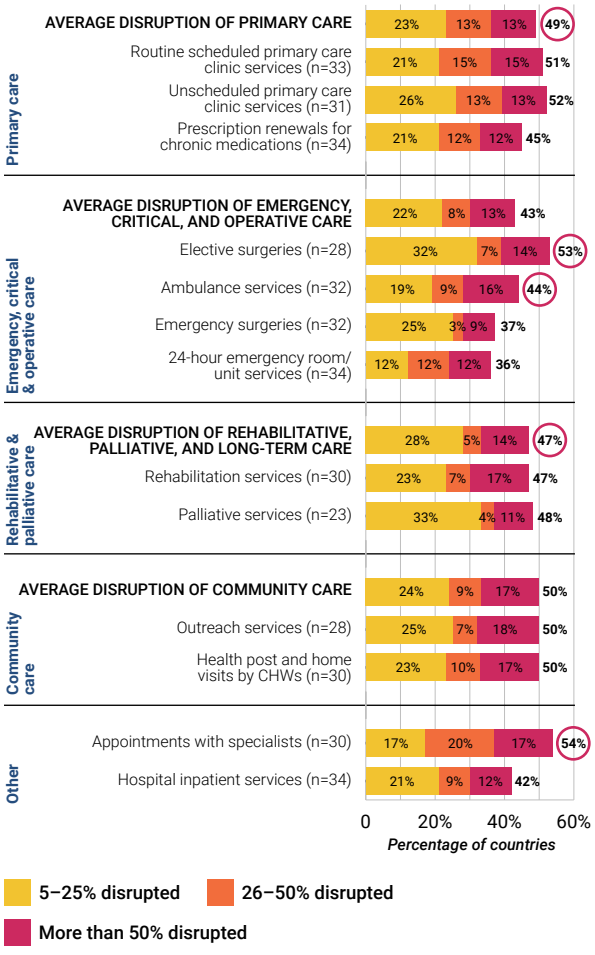
To better understand the extent of disruptions to essential health services caused by COVID-19 globally, WHO has been tracking the rapidly evolving situation. In 2020, WHO published results from the first national pulse survey[17] on the continuity of essential health services during the COVID-19 pandemic and from specific pulse surveys on noncommunicable disease resources and services, mental, neurological and substance use services, and immunization. Those surveys were followed, in early 2021, by the second round of the national pulse survey on the continuity of essential health services. In late 2021, by the third round of the national pulse survey, which sought to highlight the extent to which countries are on the path of recovery and restoration of essential health services, while also shining light on the continuously

prevailing gaps where interventions to restore service provision are most needed. On average, countries in the WHO African Region reported greater disruptions across tracer service areas compared to other regions. It was also observed that high and upper-middle income countries reported fewer service disruptions than countries in other income groups.

In the WHO African Region, findings from the third round of the pulse survey demonstrated that despite early evidence of service recovery, countries continued to face disruptions to essential health services, with many reporting one or more such disruptions during the preceding six months from the date of survey submission (June to November 2021). This was similar to what was reported in the first quarter 2021 (round 1 of the pulse survey) and the third quarter 2021 (round 2 of the pulse survey), raising issues of potential concern, considering the wave of the COVID-19 Delta and Omicron variants. The findings from the third round showed that no service delivery platform is exempt from adverse impacts, and many people are missing out on essential first-contact care, with primary care and community care among the most affected service delivery settings.

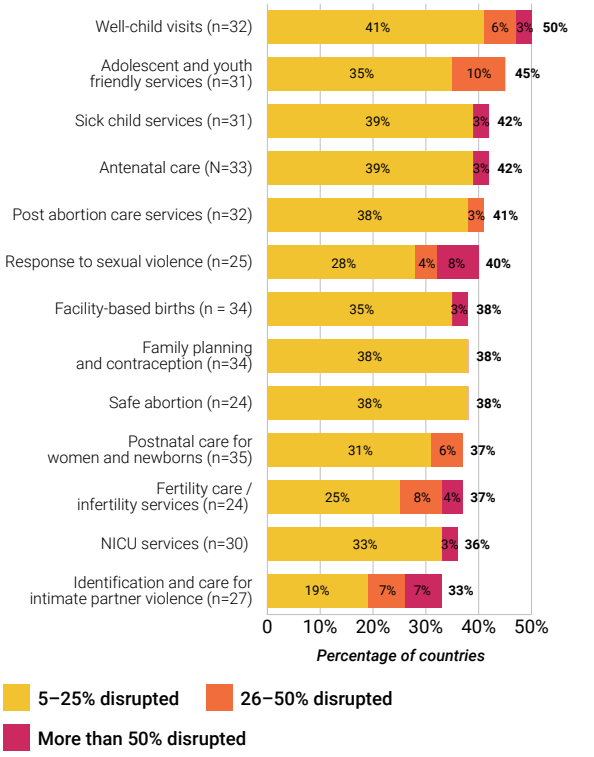
Furthermore, the third round of the pulse survey also showed that overall, improvements have been observed across all tracer services (Figure 27). This may be attributed to the concerted efforts at the country level to resume progress in various service coverage targets that may have been derailed, including efforts to modify service delivery and intensified efforts to respond to challenges, bottlenecks and barriers in national health systems revealed by the pandemic. Conversely, some tracer services reported increased disruptions between the second and third rounds of the survey. Immunization, neglected tropical diseases (NTDs) and nutrition services reported higher disruptions than 2020 levels, despite widespread rollout of COVID-19 vaccines in the Region. Overall, counteractive measures have been widely implemented to restore service delivery and enable recovery from the disruptions (Figure 29).

FIGURE 23: *Percentage of countries reporting disruptions by service delivery setting, Nov–Dec 2021 (n=38)*



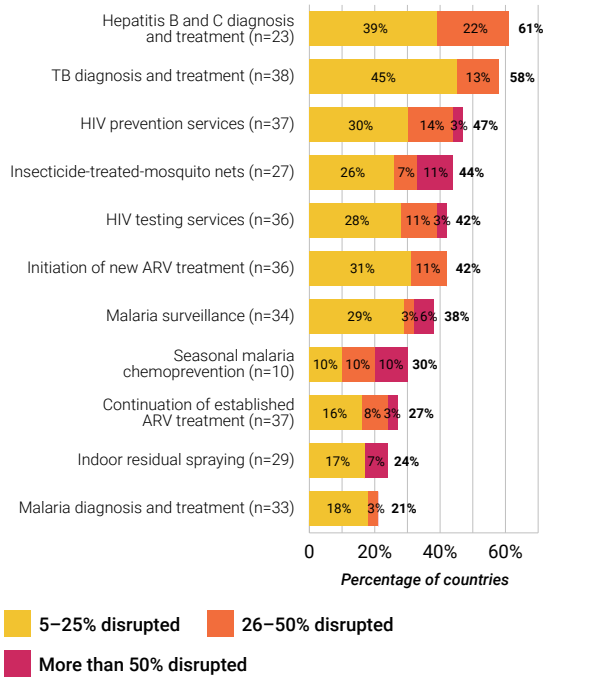
Source: *World Health Organization, 2021.*

FIGURE 24: *Percentage of countries reporting disruptions in RMNCAH, Nov–Dec 2021 (n=36)*



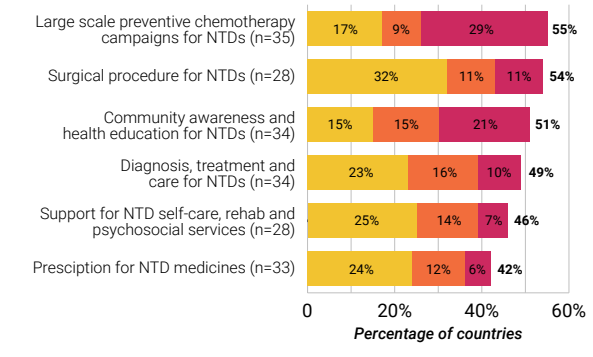
Source: *World Health Organization, 2021.*

FIGURE 25: *Percentage of countries reporting disruptions in communicable disease services Nov–Dec 2021 (n=36)*



Source: *World Health Organization, 2021.*

FIGURE 26: *Percentage of countries reporting disruptions in NTD services, Nov–Dec 2021 (n=39)*



Source: *World Health Organization, 2021.*

FIGURE 27: *Comparison of disruptions by tracer services in countries that responded to all three survey rounds: Q3 2020 (Round 1), Q1 2021 (Round 2) and Q4 2021 (Round 3)*

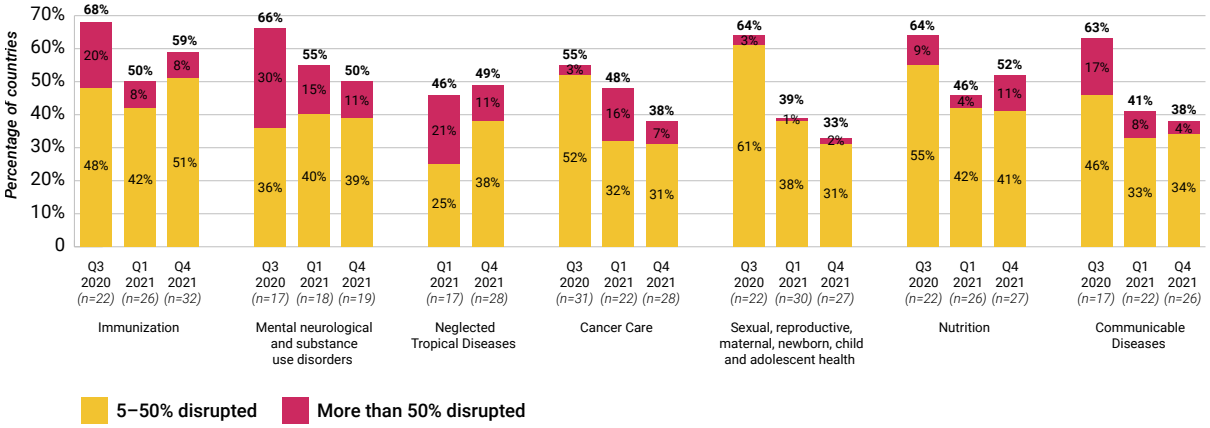
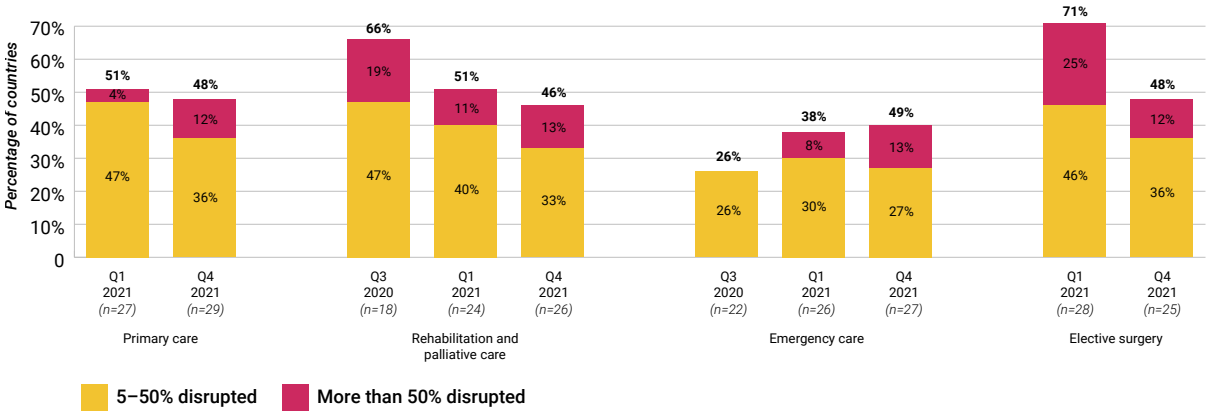
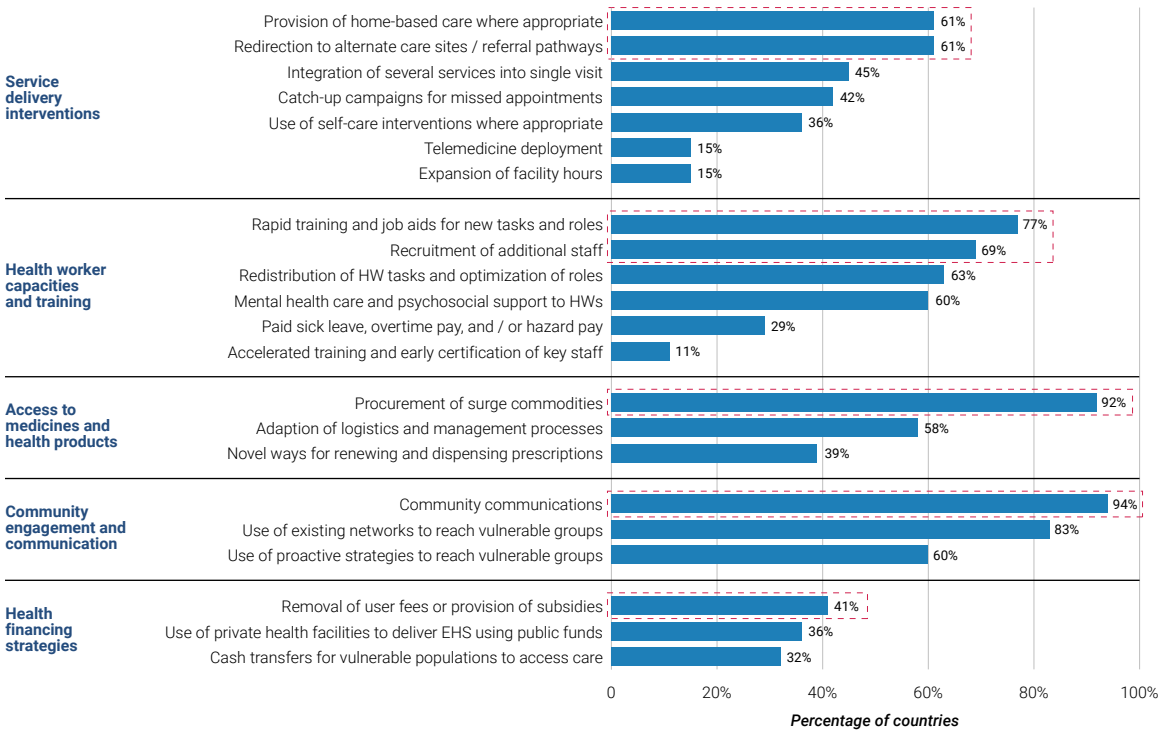


FIGURE 28: *Comparison of disruptions by service delivery settings in countries that responded to all three survey rounds: Q3 2020 (Round 1), Q1 2021 (Round 2) and Q4 2021 (Round 3)*



Source: *World Health Organization, 2021.*

FIGURE 29: *Country measures taken to counteract COVID-19-related disruptions of health services Nov–Dec 2021*



Source: *Third round of the national pulse survey on continuity of essential health services during the COVID-19 pandemic. WHO2021*

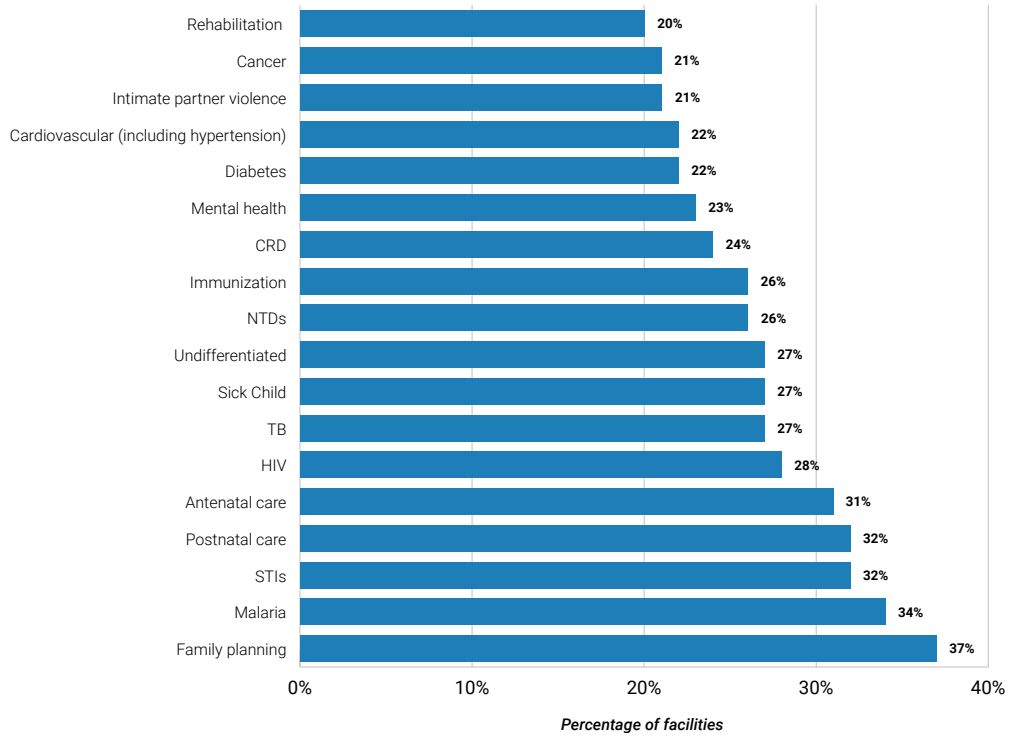
5

BOX 2: **Real-time tracking and monitoring of essential services and health system bottlenecks during the COVID-19 pandemic** *Experience from six countries**

The COVID-19 pandemic has challenged public health systems and health services, revealing that even robust health systems can be rapidly overwhelmed and compromised by an outbreak. Countries are confronting a multitude of questions that must be addressed to prepare for and respond directly to the COVID-19 pandemic, while simultaneously maintaining the delivery of other health services. Key decisions and actions to mitigate the risk of potential health system collapse must be informed by accurate and real-time data. In response to this challenge, countries in the WHO African Region are deploying a suite of innovative facility and community assessment tools, as well as approaches to detect and monitor health system bottlenecks and health facility capacity and readiness gaps throughout the course of the pandemic.

In the African Region, six countries* have deployed the frontline readiness assessment, spanning a total of 282 hospitals and 1255 primary care facilities. The findings in countries consistently show that service volumes for some outpatient services have changed, with RMNCH and communicable disease services reporting decreases in the largest proportion of facilities.

FIGURE 30: *% of primary care facilities reporting decreases in outpatient service utilization in 3-month period prior to assessment (n=1255 facilities in 7 countries)*



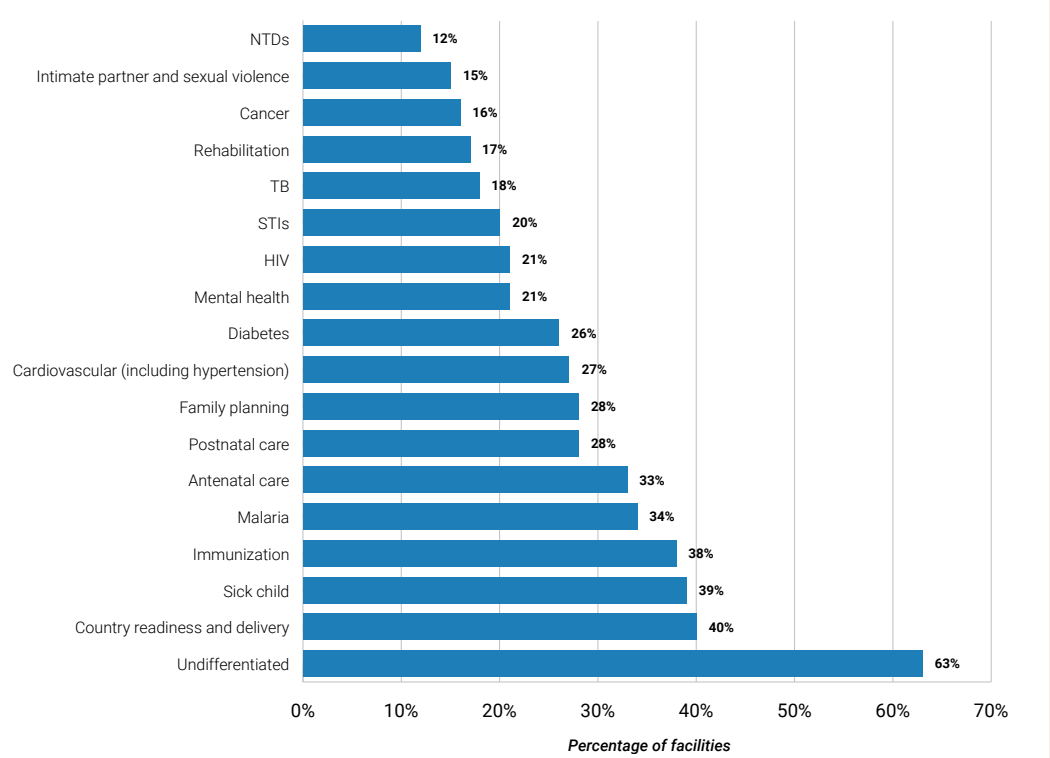
Source: *World Health Organization, 2021.*

Conversely, services, such as in primary care, have also experienced disruptions due to increased demand for services, for undifferentiated symptoms (e.g., headache, pain, fever), with reporting countries noting increases in about two thirds of facilities.

* Cameroon, Ghana, Kenya, Mali, Namibia and Zambia

5

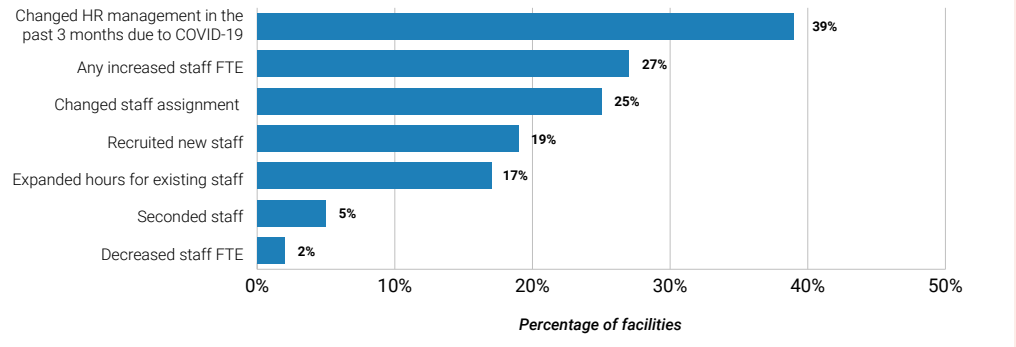
FIGURE 31: *% of primary care facilities reporting increases in outpatient service utilization in 3-month period prior to assessment (n=1255 facilities in 7 countries)*



Source: *World Health Organization, 2021.*

Even minor disruptions can have a significant negative impact on health outcomes, especially in settings where UHC attainment remains threatened. Catch-up strategies to sustain various investments in the system and ensure continued availability and access of high-quality services and addressing the main barriers to care will be critical to mitigate the immediate and long-term consequences of the ongoing pandemic. Data from the six countries conducting these assessments reveal that catch-up strategies, particularly related to HR management, have been implemented.

FIGURE 32: *% of primary care facilities implementing changes in HR management (n=1255 facilities in 7 countries)*



Source: *World Health Organization, 2021.*

Chapter 6

Key activities implemented across the health system pillar areas to facilitate UHC attainment

Member States across the WHO African Region carried out a wide range of activities which facilitated movement towards UHC, based on priority-setting exercises. In this section, we highlight some of the activities that countries managed to implement in 2021, driving their overall health systems development and UHC progress.

6.1 Health workforce

Health workforce activities comprise workforce accounts, HRH strategy development, staffing needs assessments, and pretraining and in-service training. Activities implemented in these areas are highlighted below.

6.1.1 Health labour market analysis and the national health workforce accounts

Countries were at different stages of implementing their health labour market analysis (HLMA) to understand the health workforce context, demand and supply factors, so as to inform their HRH policy. **Mali** organized working meetings for the preparation of the HLMA study. **Ethiopia** conducted HLMA in nine regions and two city administrations. **Lesotho** finalized health labour market analysis and used the findings to develop recruitment and deployment guidelines. **Zimbabwe** carried out an HLMA study, focusing on specialist doctors, nurses, pharmacists and laboratory scientists to guide projection of specialist needs for training.

The national health workforce accounts (NHWA) are used as part of the health labour market analysis framework. It is a system to improve the availability, quality and use of data on the health workforce to inform measurement of country HRH performance using standard indicators. Seventeen countries carried out activities to establish the national health workforce accounts. Eritrea conducted advocacy meetings for the NHWA. **United Republic of Tanzania**, **Mozambique** and **Cameroon**, **Central African Republic**, **Senegal**, **Lesotho**, **Uganda**, and **DRC** trained officials to lead development and institutionalisation of the NHWA. **Senegal** and **Ethiopia** established national NHWA technical working groups (TWGs) to oversee their respective NHWAs. **Burundi** identified HRH data sources and validated the data collection tools for NHWA. **Kenya** conducted NHWA and reported on 12 indicators. **Malawi** finalized its NHWA and uploaded the data on the NHWA platform. **Cameroon** finalized their NHWA report. **Zambia** conducted NHWA 2017–2019 and used the findings to inform development of the NHSSP 2022–2024. **Mauritania** and **Burkina Faso** finalized their NHWAs. **Eswatini** is piloting the utilization of the Integrated Human Resources Information System (iHRIS) to quantify nursing cadres, while **Ethiopia** established an iHRIS TWG, developed and tested the iHRIS requirements, and conducted an (iHRIS) training of trainers. **Nigeria** established the National Health Workforce Observatory, which hosts the National Health Workforce Registry (NHWR) and made plans to collect data to update the registry.

6.1.2 Human resources for health strategy review and development

Mozambique finalized the mid-term review of its National plan for human resource 2016–2024 and disseminated the HRH annual statistical report. **Niger** finalized the evaluation of the 2011–2020 health human resources development plan (DRHS). **Ethiopia** conducted a mid-term review of the HRH strategy, 2016–2020. **Togo** recruited a consultant to support evaluation of the Human resource development plan 2016–2020 and completed and validated a best practices report on the retention of health human resources, particularly those in maternity wards in disadvantaged areas. **Uganda** developed the HRH strategic plan and its implementation plan.

Eritrea finalized planning discussions for review of the HRH strategic plan. **Lesotho** revised and updated its HRH strategic plan. The **United Republic of Tanzania** developed its Human Resource Strategic Plan as part of the Health Sector Strategic Plan. **South Africa** developed the costed HRH strategic plan 2020/21 to 2024/25, the National Strategic Direction for Nursing and Midwifery Education and Practice, and disseminated the Roadmap for Strengthening Nursing and Midwifery 2020/21–2025/25. **Mauritania** and **Senegal** finalized and validated their human resource development plans. **Eritrea** also completed a health care worker job analysis assessment for the revision of the job descriptions of health care workers. **Burkina Faso** conducted an evaluation of the 2013–2020 plan and was in the process of developing the new HRH strategic plan. **Gambia** revised its Human Resource for Health Policy and developed the Health Workforce Strategic Plan (2022–2026). **Zimbabwe** revived its Human Resource for Health Task Force and its subcommittees. **Cabo Verde** carried out an evaluation of the Strategic plan for the development of human resources for health 2015–2020 and devised its new Human Resource Strategic Plan 2022–2026.

6.1.3 Staffing needs assessment

Kenya, **Mauritania** and **Togo** trained stakeholders in the use of the Workload Indicators of Staffing Need (WISN) methodology and tools. **Ethiopia** conducted the WISN study on seven professional categories, which were finalized to inform staffing and financial requirements. **Kenya** was also in the process of developing a multidimensional productivity index (MPI). **Benin** completed the workload assessment in the zonal hospitals, which will form the basis for scaling up HRH needs assessment according to workload. **Seychelles** planned for its WISN study to be conducted in 2022 to inform health workforce recruitment and deployment planning. **Liberia** conducted a ToT on WISN and further trained expert working groups and data collectors. The **Zimbabwe** Health Services Board developed a specialists' need-based plan based on a gap analysis and training needs assessment to inform the development of national training needs. The study findings are now guiding the projection of specialist needs for training.

Mali, **Guinea** and **Senegal** conducted surveys on the impact of COVID-19 on human resources for health. **Kenya**, using AFRO tools, estimated HRH needs for COVID-19 response and the maintenance of essential services. **Angola** finalized the country study on mapping of HRH interventions during COVID-19. **Zambia** recruited COVID-19 surge capacity human resources (48 medical doctors, 135 nurses and 14 biomedical technologists), while **Seychelles** increased surge capacity to support data management by recruiting one additional data manager. **Congo** strengthened the country's capacity in public health skills through the recruitment, supervision and redeployment of 24 public health junior officers in 12 departmental services and 12 health districts.

6.1.4 Pre-service training

Comoros received support to set up the School of Medicine Faculty at the Comoros University. **Rwanda** developed standards for teaching institutions, including clinical placement manuals. **Sierra Leone** developed a post-college draft strategic plan for health specialists and their draft scheme of service. **South Sudan** completed the review and update of its National medical education training curriculum. The **United Republic of Tanzania's** pre-service curriculum and in-service training package in adolescent health were developed and adapted.

6.1.5 In-service training

Health care workers benefited from various training instances and opportunities. **Ghana** trained 55 senior members in the health sector on leadership and management. **Mauritius** conducted ToT sessions for 32 laboratory professionals in WHO's laboratory quality management system and developed a cascade training plan targeting the training of 400 laboratory personnel across the country. Additionally, 58 infection, prevention and control (IPC) trainers were trained, followed by cascade training reaching 1845 health care workers. Twenty-one Ministry of Health officers were trained on haemovigilance to support the establishment of a national haemovigilance system. In **Mali**, 442 community health workers were trained in community-based surveillance and 319 SACO members in community mobilization strategies. Three hundred and thirty-two health providers were trained on protocol for the prevention and management of NCDs (diabetes and hypertension) at the peripheral level. A master trainers' training was undertaken in **South Africa** to build the capacity of community health workers in priority NCDs and their interaction with COVID-19. In **Tanzania**, 500 health workers were mentored and supervised in screening and triage, essential emergency and critical care, and IPC measures.

6.2 Health infrastructure

Health infrastructure activities focused on strengthening physical infrastructure, equipment and ICT infrastructure in countries. The progress made is highlighted below.

6.2.1 Physical infrastructure

Ethiopia developed a draft national health infrastructure roadmap. **Mauritius** drafted the statement of requirements for a modern warehouse of international standard for essential medicine, medical and laboratory consumables, nonmedical products and medical equipment. The statement was approved and sent to the Ministry of Finance, Economic Planning and Development for further implementation. **Senegal** finalized and validated the physical inventory conducted by the health system strengthening platform, pending the distribution of the report. The Equipment and infrastructure policy and strategic plan were developed and validated in the **Central African Republic**. **Madagascar** introduced data on the infrastructures and materials into the District Health Information Software 2 (DHIS2). **Mali** renovated the National reference laboratory and the National public health institute, equipping them with laboratory equipment and reagents worth US$ 110 000. **Congo** has begun rehabilitation work for a maternity ward in the Ouesso

health district. **Liberia** updated its health infrastructure guide and reviewed the draft accreditation guide for hospitals.

6.2.2 Equipment

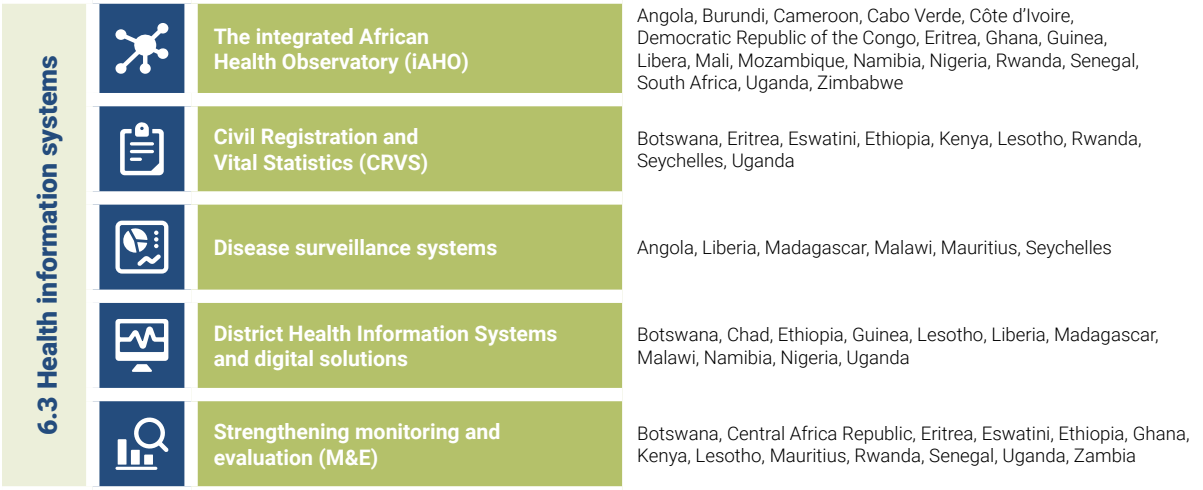
The **United Republic of Tanzania** completed the definition of standard equipment for establishing newborn care units in primary health care (PHC) services; while **Sierra Leone** developed a standard equipment list and launched a prioritized assistive technology list. The **Central African Republic** developed a policy and strategic plan for equipment and infrastructure maintenance. **Eritrea** procured selected laboratory equipment for subnational level health facilities. **Zambia** procured and distributed 4000 oxygen cylinders to COVID-19 case management centres. In **Burundi**, two national antimicrobial resistance (AMR) surveillance systems were purchased (two densitometers for national AMR monitoring centres). **Congo** equipped its 24 integrated health centres with diagnostic equipment and provided health care services, including for noncommunicable chronic diseases.

6.2.3 Information and communication technology (ICT)

Eritrea developed its national health infrastructure roadmap and procured IT equipment (printers and desktops) for 58 subzobas, and also equipped the national health observatory office with IT equipment. **Zimbabwe** received support to purchase ICT equipment for the innovation hub in health informatics and data analytics, monitoring and evaluation, and the health information systems department in the Ministry of Health and Child Care.

6.3 Health information systems

Health information systems strengthening activities were focused on support to the regional and national health observatories, vital statistics systems strengthening, disease surveillance activities, routine information systems improvements, digital health solutions, and the elaboration of health information plans and reports.



6.3.1 The integrated African Health Observatory (iAHO)

Countries across the African Region were provided support to set up or strengthen the use of their national health observatories (NHOs), including validating and updating data and information products (analytical and knowledge resources) to feed into the Integrated African Health Observatory. Countries received targeted support from AFRO, depending on their NHO development status – establishment, appropriation or institutionalization. **Burundi**, **Cabo Verde**, **Cameroon**, **Côte d'Ivoire**, **Guinea**, **Mali**, **Liberia**, **Namibia**, **Nigeria**, **Rwanda**, **South Africa** and **Zimbabwe** received technical and/or financial support to establish

their national health observatories. **Côte d'Ivoire**, **Namibia**, **Nigeria**, **Rwanda** and **Senegal** provided staff training in the use of NHO platforms. **Burundi** updated its national observatory database and organized a national advocacy workshop for the official establishment of the observatory and developed regulations on its operation. **Mali** and **Côte d'Ivoire** developed a national roadmap for the establishment of their respective NHOs. **Ghana** re-established its national health observatory, while **Mozambique** trained 14 professionals from the NHO in the use of the iAHO, with three officers from the WHO Regional Office for Africa providing technical assistance.

Forty-one countries worked with AFRO to complete an annual data verification and validation exercise, reviewing data and other published evidence on their national health observatories, as embedded within the iAHO. The purpose was to strengthen the quality of the data and identify areas for improvement. The NHO data from the remaining six countries was reviewed by the Regional Office team.

Output development progressed for a dedicated regional knowledge platform within the iAHO called the African Health Observatory Platform on Health Systems and Policies (AHOP). This is the result of a partnership between AFRO, the London School of Economics and Political Science, the European Observatory on Health Systems and Policies, and the Bill & Melinda Gates Foundation. AHOP promotes evidence-informed policy-making in the Region. Its network of national centres based in **Ethiopia**, **Kenya**, **Nigeria**, **Rwanda**, and **Senegal** focuses on the collation, synthesis and packaging of evidence in the form of different products, as well as dialogue on pressing health systems and services issues.

The iAHO also played a key role in knowledge generation and dissemination during the pandemic, including the creation of the COVID-19 information hub for the African Region, which houses crucial data and evidence for the consumption of various stakeholders.

6.3.2 Civil Registration and Vital Statistics (CRVS)

Botswana uploaded an electronic tool for medical certification of cause of death (MCCOD) into DHIS2. **Kenya** received support in the development, implementation and health facility user training on a DHIS2-based MCCOD application for coding and reporting the cause of death using the International Classification of Diseases (ICD-11). **Seychelles** built the capacity of staff to institutionalize MCCOD coding using ICD-11. In **Uganda**, health workers were trained and supervised in MCCOD and ICD-11. The country developed an ICD-11 coding tool that was integrated into the DHIS. **Lesotho** received support in capacity-building and training of national-level experts from the Ministry of Health and Bureau of Statistics in the application of the MCCOD, and morbidity and mortality coding using the ICD-11. **Ethiopia's** national classification of diseases was revised in line with ICD-11.

Kenya reviewed its CRVS business process mapping and identified areas of improvement. This has informed the development of a national CRVS electronic system. Rapid mortality surveillance (RMS) was implemented in six counties to assess all-cause mortality patterns during the COVID-19 pandemic, quantify excess mortality due to COVID-19 and inform decision-makers about the full magnitude of the health consequences of the COVID-19 pandemic in **Kenya**. Support included the design of the reporting system, data quality review and monitoring visits. The findings were disseminated during a national CRVS stakeholders' forum. **Ethiopia** finalized and disseminated the costed CRVS strategic plan. **Eritrea's** CRVS roadmap was developed. **Eswatini** started CRVS strategy development. **Rwanda** scaled up the use of its CRVS system.

6.3.3 Disease surveillance systems

Malawi completed the roll-out of the One Health Surveillance Platform (OHSP) to 20 districts through training for weekly and monthly Integrated Disease Surveillance and Response (IDSR) reporting, interoperable with DHIS2. Mentorship support on troubleshooting and data entry monitoring was enhanced, resulting in improved IDSR reporting using OHSP. **Malawi** has invested in further capacity-building of the IDSR focal persons, supply of reliable internet and gadget mapping. **Madagascar** conducted the supervision of health professionals on IDSR and DHIS2, while **Angola** implemented a DHIS2 case-based surveillance information system for vaccine-preventable diseases. **Liberia** revised its IDSR technical guidelines and printed them for all public and private health facilities in the country. The curricula of 26 health training institutions, including that of three universities, were reviewed. IDSR modules were incorporated and 67 lecturers were trained. **Seychelles** procured digital technology to support the COVID-19 response, including for surveillance and data management.

6.3.4 District Health Information Systems and digital solutions

Technical and financial support was provided for the optimization of **Botswana's** DHIS2 platform. **Lesotho** updated key elements of the national web-based data systems for the health sector (DHIS2) and strengthened staff capacity to use DHIS2. **Chad** trained its technical team on DHIS2; the district core team in 50 health districts were also trained in the use of DHIS2 and have started utilizing it. **Madagascar** carried out the supervision of health professionals on IDSR and DHIS2 use and validated the procedure manual for the management of the DHIS2 data. **Ethiopia** conducted integrated supportive supervision for DHIS2 data reporting. **Malawi** conducted health facility-based annual data quality reviews in 135 out of 140 health facilities, with a focus on the data quality aspects of completeness, timeliness and validity, as well as addressing computation errors with transfer of data from paper to the electronic DHIS2 system. Elements of data interpretation, display and use were also emphasized.

Several countries took steps to strengthen the use of digital health information platforms. The e-Health Strategy in **Namibia** was finalized and launched. The WHO digital health platform was adopted and the billing and dependent modules were piloted. **Malawi** launched and disseminated a digital health strategy among stakeholders. **Uganda** developed a health information and digital health strategy. **Guinea** validated the strategic plan for the development of digital health in the country for the period 2021–2025. **Nigeria** developed its first National Digital Health Policy 2021, National Digital Health Strategy 2021–2025 and the National Digital Health Operational Plan 2022. In **Liberia**, NCD indicators were developed for inclusion in the DHIS2 platform. The DHIS2 server was upgraded and 63 data officers from 15 counties underwent training in DHIS2 use and data analysis.

6.3.5 Strengthening monitoring and evaluation (M&E)

The Ministry of Health **Lesotho**, in coordination with all the district health offices and other stakeholders, developed and validated a harmonized health system performance monitoring and review guideline. **Ethiopia** finalized and disseminated the National monitoring and evaluation plan for the Health sector transformation plan (HSTP) II and the CRVS strategic plan. **Eritrea** developed its research agenda priority document. **Eswatini** finalized the health information system (HIS) strategy, while **Ghana** developed the draft HIS policy.

Countries worked to strengthen routine health sector monitoring and reporting and conduct surveys for evaluation. **Botswana** conducted data analysis and report-writing for the Annual Health Sector Performance Report 2020. **Zambia** held a joint annual review meeting and published its Annual Health Statistical Bulletin 2020. **Senegal** conducted routine data review of routine health services (vaccination, malaria, HIV, TB, etc.) as part of the "Continuity of services" pillar during the COVID-19 period. **Uganda** automated

monthly reporting for continuity of essential health service performance and supported routine analysis of programme indicators.

WHO provided technical support to the **Kenya** National Bureau of Statistics (KNBS) to harmonize and finalize the data collection tools and manuals for the 2022 Demographic and Health Survey. **Zambia** conducted a harmonized health facility assessment (HHFA) in more than 3275 health facilities. Additionally, a COVID-19 recovery needs assessment was performed with WHO support. The **Central African Republic** completed its Health Resources and Services Availability Monitoring System (HeRAMS) survey, and the report is being finalized. The research protocol for the service availability and readiness assessment

(SARA) survey was drawn up and validated. WHO supported **Rwanda** to plan for the 2022 census and the STEPS survey, and to develop the Integrated Management of Childhood Illnesses (IMCI) Survey concept note, costed methodology, and tools. Meanwhile, **Mauritius** implemented the national drug survey and released the accompanying report.

6.4 Health governance

The activities pertaining to health governance were focused on UHC policy dialogue support, development of policies/strategies, leadership and management capacities, and support to coordination mechanisms.

6.4.1 Policy dialogue for universal health coverage

The **Kenya** UHC policy was finalized, edited and launched by the President. **Namibia's** national policy dialogue on UHC was initiated and a roadmap to finalize the universal health coverage policy framework developed. **Mozambique** celebrated 2021 UHC day by undertaking a national conference with the participation of the Permanent Secretary of the Ministry of Health. **Madagascar** participated in working meetings on UHC advocacy for revitalizing the national health system strengthening committee, and developed the national strategy for health financing for UHC. **Gambia** organized a South-to-South learning process led by the Minister to support UHC policy dialogues.

6.4.2 Development of national policy and strategy documents

Various countries reviewed and updated their national health policies and strategic plans. **Eritrea** completed its National health policy and Health sector strategic development plan 2022–2026 (HSSDP III). The **Ethiopia** health policy was revised but is awaiting approval by the Council of Ministers. The **Mali** Strategic plan 2015–2019 was reviewed and the new strategic plan 2020–2024 was developed. The **Mali** National strategic plan for essential care in the community (PS SEC) 2021–2025 was finalized and validated. The **Rwanda** Health Sector Policy 2015 was reviewed and the new health policy draft is available for validation. The **Rwanda** Joint Annual Health Sector Review was conducted, and policy directions have been identified. **South Sudan** conducted the Joint Annual Health Sector Review, including a national policy

dialogue to generate consensus on strategic directions. **Zambia** developed the National Health Strategic Plan 2022–2026 and conducted six policy review meetings in 2021. WHO provided high-level policy advice and guidance to the **Zambia** MOH through a serving permanent member of the health sector troika coordination platform. **Sierra Leone** developed and launched the National health and sanitation policy.

6.4.3 Strengthening leadership and management skills

In **Lesotho**, 24 senior management members of the Ministry of Health have been recruited for training in leadership and management competencies to drive the ministry's health sector reform goals (UHC, SDGs) and effectively address the rapidly changing pandemic context, to strengthen the efforts and capacity of Government, civil society and the private sector to deliver quality HIV and TB prevention and treatment care and support services. **Angola** conducted capacity-building on the SDG model for national counterparts (UN Collaborative initiative). **Malawi** built the capacities of district health management teams (DHMTs) through training on leadership, governance and integration of quality of health care in 13 of 14 districts. **South Sudan** conducted a leadership and governance conference that oriented senior national and state-level MOH leadership on key governance structures, principles and skills. In **Ghana**, senior MOH and MOH agency leaders participated in the Leadership for Health Transformation Programme[18] to build leadership and governance skills. **Gambia** finalized its National Health Policy 2021–2030 with support having been provided to train the policy writing team, organize policy dialogue sessions and validate the policy. The **Seychelles** National Health Strategic Plan 2022–2026 was developed and is awaiting validation. **Liberia** reviewed the current National Health Policy and Strategy and drafted the next one for 2022–2026. **Congo** disseminated legislation reinforcing the reorganization and functioning of the DHMTs, hospital and health centre management teams in accordance with the law on transfer of the management of primary health care to local authorities. A rapid follow-up evaluation of the takeover of PHC management by the people and local authorities was carried out. **Congo** also conducted the mid-term review of the National health development plan 2018–2022 and began drafting the new National development plan 2022–2026. **Zimbabwe** launched its National Health Strategy 2020–2025, which was then aligned to the Health sector monitoring and evaluation plan and policy.

6.4.4 Partnership coordination

South Africa conducted multiple bilateral and multilateral health system strengthening partner engagements and policy dialogues to achieve UHC in the context of COVID-19. WHO coordinated UN and development partners' support for the COVID-19 vaccine roll-out. **Botswana** held its first Health Partners' Forum after five years. Partners recommitted to support the health sector and galvanized stakeholders towards strengthening the continuity of essential health services during the COVID-19 pandemic. **Mozambique** endorsed and operationalized the new structure for the health sector coordination and dialogue platform. **Tanzania** held a joint annual planning, monitoring and evaluation and reporting meeting at the district, regional and national levels to strengthen partnership coordination and accountability. More than 40 partner bilateral, multilateral, civil society and nongovernmental organizations and the private sector convened in monthly and biweekly interpillar heads and emergency preparedness and response (EPR) meetings. In **Zambia**, the WHO country office facilitated the coordination of health cooperating partners. **Mali** developed the consultation framework for the strengthening of PHC between partners and the Ministry of Health. **Kenya** operationalized the health sector partnership framework by holding intergovernmental health forums, thematic technical committees, and interagency coordinating committees within the health sector. **Gambia** established a health partners group for partner coordination. **Benin** worked on its cooperation strategy and advocated for the mobilization of local and funding partners to strengthen the health system. **Zimbabwe** finalized its health sector coordination framework and held quarterly sector coordination meetings. **Liberia** conducted an assessment of its health sector coordination, including a situation analysis, and held consultative meetings and discussions on strengthening and improving health sector coordination.

WHO provided technical and financial support to coordinate incident management teams (IMTs), comprising partners and stakeholders, in all the countries of the WHO African Region throughout the pandemic response. Additionally, WHO supported the establishment of emergency operations centres in 2020 and continued strengthening support across the COVID-19 response pillars. The Organization has also played a key role in vaccine mobilization and planning.

6.5 Health products, vaccines and supplies

The activities pertaining to health products were focused on strategic guidance, updating of essential medicines lists, antimicrobial resistance, regulation and pharmacovigilance, medical products of human origin, and quality assurance of health products.

6.5.1 Strategic guidance for health products

Botswana approved and finalized the National pharmaceutical traceability vision and strategy, while **Cameroon** developed a strategic plan to strengthen the supply chain of pharmaceuticals and other health products. **Eritrea** formulated the institutional development plan for the National Medicines and Food Administration (NMFA) and updated the standard operating procedures (SOPs), tools and working documents for the NMFA. The country also completed a review and provided recommendations for the accreditation process of the Drug quality control laboratory (DQCL). **Eswatini** finalized and shared its review of the essential medicines list (EML), as well as standard treatment guidelines, while **Kenya** began the process of developing draft national clinical guidelines.

Ghana finalized the National medicine pricing strategy, which is awaiting launch. Additionally, the National supply chain master plan was reviewed and disseminated, and the National Health Technology Assessment (HTA) strategy was finalized, printed and launched. In **Lesotho**, the Ministry of Health, in collaboration with relevant national and international partners, reviewed and updated the National medicines policy and strategic plan 2022–2026, which was validated by national stakeholders and developed, printed and disseminated guidelines for licensing and monitoring pharmacovigilance.

Mauritius' National pharmaceutical policy was developed in 2021 and disseminated in 2022, and the strategic plan for the pharmaceutical sector was printed and disseminated. The country also began the process of developing a new medicine and health care bill that aims to enumerate essential medicines.

The **United Republic of Tanzania** developed a national medicine policy to cater for the mainland, while **Zanzibar** printed their own medicine policy. **Comoros** updated, validated and adopted the National pharmaceutical policy 2021–2030 at the National draft revision retreat and National validation and adoption workshop. Additionally, **Mauritania** developed a National pharmaceutical policy. **Nigeria** finalized and launched the National Drug Policy, the Strategic Plan for the National Institute for Pharmaceutical Research and Development (NIPRD) and the **Nigeria** vaccine policy. **Uganda** printed and disseminated the updated National Pharmaceutical Sector Strategic Plan.

6.5.2 Essential medicines lists

Comoros printed 380 copies of the list of essential medicines 2020 and briefed some 115 people (prescribers and dispensers) at three workshops on its use. **Chad** commenced the revision of the national list of medicines, while **Rwanda** supported the self-benchmarking of the **Rwanda** Food and Drugs Authority (FDA) and the development of the FDA strategic plan, the standard treatment guidelines, and the essential medicines list. In **Sierra Leone**, the standard treatment guidelines, treatment cards and essential medicines list were finalized and validated. **Mozambique** was provided with technical assistance to draft the national essential medicines list, which was submitted to the Ministry of Health for approval. The **United Republic of Tanzania** launched the standard treatment guidelines within the mainland. **Zambia** also revised and published the NEML, the emergency use listing of medicines and allied substances (EUL-MAS) guide, and an abridged registration procedures guideline for emergency medicines and allied substances were developed. **Madagascar** updated its list of essential drugs and prepared for the purchase of essential drugs for the SDG fund project health centres. **Seychelles** strengthened its central medical stores by finalizing the guiding documents and SOPs. **Gambia** finalized its essential medicines policy and strategy.

6.5.3 Antimicrobial resistance (AMR)

In **Sierra Leone**, 76 hospital staff from 12 hospitals had their capacities built in antimicrobial stewardship (AMS) and pharmacovigilance. In **South Africa**, an AMR consumption survey report was developed as part of the AMR national action plan report. The **United Republic of Tanzania** developed antimicrobial stewardship guidelines for health facilities, reported AMR surveillance data to the Global Antimicrobial Surveillance System (GLASS), and submitted information on antimicrobial use (AMU) in facilities in 15 regions to GLASS-AMU.

Zambia conducted an antimicrobial point prevalence survey, received support for the development of a national AMR monitoring guide, conducted AMR 2020 data collection, and supported seven sentinel laboratories by providing reagents for culture and antibiotic susceptibility testing. **Burundi** began the development of an AMR surveillance system, which included development of the national microbiological diagnostic protocol, the technical manual of medical bacteriology, and a list of priority pathogens to be monitored in the AMR surveillance system. Trainers underwent training in the implementation and monitoring of bacteriology testing techniques. **Guinea** developed guidelines for the proper use of antibiotics. **Mali** launched an external quality assurance programme to ensure data quality on antimicrobial resistance, consumption, and use (AMR/AMC/AMU). Masters-level training in AMR began to build capacity in the field.

6.5.4 Regulation and pharmacovigilance

Rwanda supported the inspection of the pharmaceutical and non-pharmaceutical products. In **South Africa**, the **South African** Health Products Regulation Authority (SAHPRA) conducted and concluded benchmarking using the WHO global benchmarking tool (GBT). **Mozambique** commenced capacity-building for transitioning the National directorate of pharmacy of **Mozambique** (DNF) to the National medicines regulatory authority (ANARME) (training and equipment), resulting in the official establishment of the authority at the end of 2020. Additionally, WHO provided technical assistance for the recruitment of the two executive administrators in 2021.

The **Tanzania** Medicines and Medical Devices Authority (TMDA) provided capacity-building to 26 medicine evaluators in the areas of assessment of clinical safety and efficacy of medicine information. Additionally, 50 TMDA drug inspectors acquired new skills on prevention, detection, and timely response to incidents of substandard and falsified medicines. **Guinea** developed a law on biosafety and produced tools for monitoring of adverse effects following immunization. **Chad** revised its national pharmacovigilance manual and notification tools and reviewed the **Chad** drug authority documents. Support was provided for the revision of the legislation on the establishment of the **Chad** pharmaceutical purchasing centre (CPA), which would oversee the provincial purchasing pharmacies (PPA).

Burundi trained 709 care providers in pharmacovigilance, while **Sierra Leone** established four more drug and therapeutics committees, bringing the total to 12, within public hospitals across the country. **Liberia** began the planning process for the revision of the NEML. **Congo** provided 24 health areas with essential medicines and emergency care commodities. **Cabo Verde** updated its NEML with an agreement signed to enable the implementation of joint medicine purchasing across the small Islands.

6.5.5 Medical products of human origin

Mozambique had the opportunity, for the first time, to capacitate 10 professionals from the National medicines regulatory authority (ANARME) and the National blood service, using the global benchmarking tool, and performed a self-assessment covering all the core functions related to blood products (including whole blood, blood components and plasma-derived medicinal products). **Guinea** organized awareness and blood collection sessions, producing communication material in the five local languages, to create awareness of blood donation and donation sites. In **Mauritania**, blood transfusion guidelines were developed but are awaiting validation. **Togo** set up the haemovigilance system, including the development of regulations, and assessed the availability of labile blood products during the COVID-19 pandemic. The country also developed a guide to prescribe the proper use of labile blood products. In **Botswana**, the blood bank strategic plan for 2020/2021–2024/2025 was prepared, printed, and disseminated and included in the HSSP II. Additionally, support was provided for capacity-building for blood management, data collection and maintenance of the quality management system of the National Blood Transfusion Services, and the certification by the African Society for Blood Transfusion. A WHO country mission took place in **Seychelles** to assess its implementation of the Small Island Developing States (SIDS) pooled procurement agreement. The SIDS agreement aims to leverage the pooled procurement programme to reduce costs and improve access to quality medicine.

6.5.6 Quality assurance of health products

In **Malawi**, a quality assessment was conducted from July to September 2021 for essential medicines and supplies status at health facilities. Focus was placed on 100 health facilities in 10 districts to address stock-outs. Guinea trained 30 biologists in the quality assurance of medical biology laboratories.

Mauritania began upgrading its National drug quality control laboratories (LNCQM) for its prequalification. WHO planned a support mission for the audit of the LNCQM to ensure better compliance with the requirements for the WHO medicines prequalification and ISO/IEC 17025: 2017 accreditation. **Togo** carried out laboratory quality control of specific health drugs to improve health outcomes for mothers and children. In the **United Republic of Tanzania**, 30 **Zanzibar** Central Medical Stores staff underwent orientation to institute a quality management system, with SOPs developed to ensure a good quality management system for **Zanzibar's** medical stores supply system.

6.6 Service delivery systems

All countries in the African Region put measures in place to ensure the continuity of essential health services even in the face of the COVID-19 pandemic. The African Region countries updated policies and guidelines for the prevention and management of various conditions and also developed guidelines for the continuity of essential health services. IPC measures for health care workers were prioritized across all countries to lower the risk of COVID-19 infection.

6.6.1 Policy and strategy development

South Africa's National Strategic Plan for the Prevention and Control of Noncommunicable Diseases was under development, with launch and dissemination across the provinces planned for 2022. **Mali** developed its NCD prevention and management protocol at the community level and trained 332 health providers at the community level in seven health districts. **Senegal** reviewed its noncommunicable disease strategic plan for 2017–2020. **Cabo Verde** finalized the pilot structures and supervision instruments for the essential package of WHO noncommunicable disease interventions for NCDs in primary health care (WHO-PEN implementation). **Seychelles** introduced the **Seychelles** package of essential noncommunicable diseases interventions (SEY-PEN) in two health facilities. The **Central African Republic** developed national guidelines on self-care, delegation of tasks, safe abortions and post-abortion care, maternal and perinatal death monitoring and response (MPDSR), and a national maternal death audit guide. Health care workers were trained in various guidelines: MPDSR and IPC measures, hormonal contraception and HIV, diagnosis and treatment of cervical cancer and delegation of tasks and self-care. **Mauritius** MOH developed a joint HIV testing services national policy. **South Sudan** completed the review, update and validation of the new package of essential noncommunicable guidelines and developed tools for primary and secondary care. Additionally, the review, update and validation of the COVID-19 case management guidelines was completed. Training of trainers was conducted in the revised guidelines, for 25 people. An interactive virtual training facility was established at the national level (College of Physicians and Surgeons at Juba Teaching Hospital) for the continuous training of health care workers. **Cabo Verde** adopted the new WHO partograph. Additionally, the country developed and validated the policy and standards for sexual and reproductive health (SRH) services and implemented the plan to improve maternal, neonatal, and infant care. **Seychelles** finalized the adolescent and sexual health report and built the capacity of health care workers on strategic assessment based on the WHO-sponsored strategic approach. **Benin** developed the national guidelines for the creation of the network of Emergency obstetric and newborn care (EmONC) maternity units. The country also updated and disseminated sexual and reproductive health and research (SRHR) guidelines, protocols, algorithms and training materials, including on comprehensive safe abortion care. The updated SRHR guidelines were integrated into the curricula in health worker training schools.

6.6.2 Service delivery mechanisms and quality

Countries reviewed service delivery mechanisms for alignment with the attainment of UHC. **Lesotho** revised, updated and costed its essential health service package in accordance with UHC and health security

objectives, while **Cameroon** assessed its health district functionality to enable updating of activity packages for primary health care. **Mozambique** finalized its National community health strategy, developed the community-based health workers (CHW) training manual, and conducted ToTs for 35 CHWs in the community health package. **Nigeria** strengthened primary health care centres to screen and treat NCDs, including cervical cancer, using the WHO package of essential NCDs, and to provide integrated care for older people (ICOPE). **Uganda** finalized the Community Health Extension Workers Strategy, and further developed training materials for the CHWs curriculum.

Numerous interventions were carried out in different countries to improve the quality of care of health services offered. **Zambia** developed a service quality assessment tool and quality improvement pocket guide to reinforce IPC in 52 COVID-19 case management centres. **Ethiopia** finalized and disseminated its national quality and safety strategy. **Liberia** reviewed the 2011–2021 Essential package of health services (EPHS) and developed the 2021–2025 EPHS. **Liberia** also developed its community health programme policy and strategy using WHO guidelines. In **Gambia**, policy dialogue and technical meetings were held to revitalize the delivery of primary health services with advocacy for phasing out of user-fee driven revenue retention at PHC facilities. Benin developed the community health policy and an implementation guide, which were distributed to all the country's departments and to departmental development actors. With support from WHO, **Benin** was able to carry out supervisory visits to PHC facilities, covering over 50 remote health facilities and linked community health workers. **Burkina Faso**, developed and validated the person-centred integrated essential health services packages by level of care to achieve UHC. In **Congo**, health workers in 93 health centres of the 12 health districts were trained in the minimum package of primary care and services with new modules focused on skills. Health teams in 48 health areas have benefited from eight supervision missions. Furthermore, the health facilities selected to provide care for the universal health insurance scheme were accredited. **Seychelles** developed, adapted and printed various tools to support health system strengthening, including the guidelines for continuity of essential health services.

Namibia finalized its National Quality Management Policy and National Quality Management Strategic Plan to provide quality health services. **Rwanda** initiated planning of the assessment of quality of care and continuity of essential Health services in the context of COVID-19 and hired a firm to conduct it. Continuous support has been provided to **South Africa** to develop the National Health Insurance (NHI) war room[19] quality improvement workstream and develop a comprehensive monitoring and evaluation framework to monitor progress in the implementation of the National Health Quality Improvement Plan (NHQIP). **Rwanda** integrated the maternal, newborn and child health (MNCH) standards into accreditation standards. **Burundi** carried out training in the quality reference framework and conducted post-training follow-up in two health provinces. **Nigeria** carried out several processes in the development of the Comprehensive health sector national quality policy and strategy implementation plan, including the development of a protocol to assess the quality of care in the country. Additionally, the national integrated supportive supervision tools were revised.

6.6.3 Infection prevention and control (IPC)

Botswana developed several IPC guidelines, including for the management of COVID-19 among health care workers, monitoring and evaluation framework with follow-up health care worker training, and supportive supervision for IPC, using the WHO scorecard. About 36 trainers underwent training using WHO-adapted curriculum. These in turn conducted training for about 8000 of the district's health care workers. **Eswatini** and **Mauritius** finalized their IPC guidelines. **South Africa** developed the National Infection Prevention and Control Strategic Framework and its Practical Manual, with follow-up training of over 550 IPC focal points across all nine provinces. **South Sudan** procured and distributed basic IPC materials to health facilities for the practical illustration of IPC practices for health workers.

6.7 Health financing systems

Activities relating to health financing systems were focused on health financing policies and strategies, and completion of the national health accounts.

Benin, Burundi, Ethiopia, Gambia, Kenya, Liberia, Madagascar, Malawi, Mali, Mauritania, Mozambique, Nigeria, Rwanda, Senegal, Sierra Leone, South Africa, United Republic of Tanzania, Uganda, Zambia

Botswana, Burundi, Cameroon, Central African Republic, Comoros, Democratic Republic of the Congo, Ethiopia, Gabon, Guinea, Kenya, Lesotho, Madagascar, Malawi, Mali, Mauritius, Mozambique, Niger, Nigeria, Sierra Leone, Togo, Uganda, Zambia

6.7.1 Policy and strategy development

Kenya conducted policy dialogue on effective public finance management to improve strategic purchasing at the subnational level. The Health Financing Strategy was finalized and launched by the President of the Republic to guide financing of UHC. The health facility financial management guidelines was also developed in a participatory manner. The **Mozambique** National health strategic plan was costed using the OneHealth Tool. The **South Africa** National Health Insurance Work Streams underscored the importance of strategic purchasing mechanisms.

Benin validated the evaluation report of the health insurance component of the Insurance for building human capital development (ARCH) pilot phase. Dialogue is ongoing to consider relevant recommendations, revise the health care package and develop a country strategy paper for scaling up the initiative. **Gambia's** National Health Insurance Scheme Bill was passed into law (NHIS Act) in November 2021, with follow-up development of the Act's regulations. **Liberia** conducted one public dialogue on health financing with a focus on pooling and strategic purchasing for UHC and drafted the National Health and Social Welfare Financing Policy and Plan.

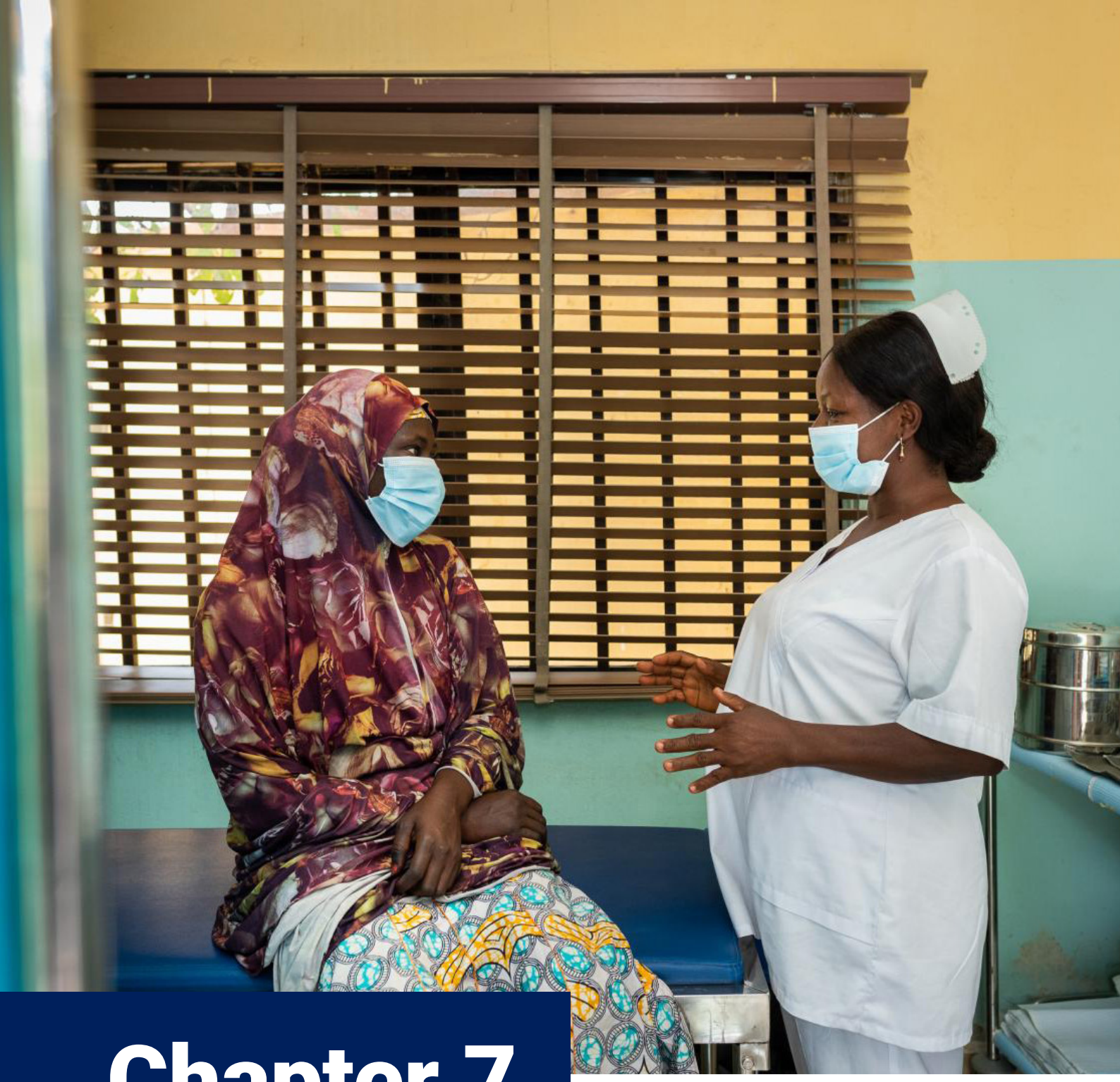
Malawi developed its costed health financing strategy, while **Sierra Leone** officially launched theirs. **Madagascar** validated its national strategy for health financing for UHC. **Mauritania** commenced work on developing a draft funding strategy document. **Burundi** conducted a situation analysis to inform development of its national health financing strategy, while **Zambia** developed the National Medium-Term Expenditure Framework (MTEF) of the Health Sector Plan 2022–2024. **Senegal** developed the monitoring and evaluation plan for the National finance strategy roadmap, which was validated by the technical committee. The **Rwanda** Community Based Health Insurance (CBHI) implementation and sustainability plan 2021–2030 was developed and validated. In **Tanzania**, 20 officials of the Ministry of Health and the Ministry of Finance underwent orientation in public finance management. **Mali** received support to make progress in its UHC health financing policy, while also relaunching the universal health coverage monitoring committee. **Nigeria** conducted costing for the health benefit package for Imo State and began implementation of a mobile technology health insurance programme. **Uganda** conducted an assessment on the transition to programme-based budgeting reforms and finalized the accompanying report. The country also conducted cross-programmatic efficiency analysis of five programmes, including HIV/AIDS, TB, malaria, immunization and RMNCH.

6.7.2 National health accounts (NHAs)

The national health accounts is a process for the systematic, comprehensive and consistent monitoring of resource flows into a country's health system. They are designed to facilitate the successful implementation of health system goals by its stewards. Stewards of the health system have been entrusted with providing an optimal package of goods and services to maintain and enhance the health of individuals and populations, be responsive to their genuine expectations and protect them from an unfair financial burden. For any given year, NHAs trace all the resources that move through the health system over time and across countries.

In 2021, most countries were in various states of carrying out their national health accounts, with activities ranging from formation of NHA TWGs, training of stakeholders in the NHA development process, data collection, analysis, and reporting. Countries that conducted activities towards the NHA report include **Burundi**, **Botswana**, **Central African Republic**, **Cameroon**, **Comoros**, **Ethiopia**, **Democratic Republic of the Congo**, **Lesotho**, **Guinea**, **Gabon**, **Kenya**, **Madagascar**, **Malawi**, **Mali**, **Mauritius**, **Mozambique**, **Niger**, **Nigeria**, **Sierra Leone**, **Togo**, **Uganda** and **Zambia**.

More specifically, **Burundi**, **Botswana**, **Central African Republic**, **Comoros**, **Kenya**, and **Uganda** had final national health accounts reports in place in 2021.



Chapter 7

Strategic shifts towards the 2030 UHC agenda

7

The WHO African Region, like other regions, has faced challenges in its steps towards achieving UHC, as discussed in this report. However, the COVID-19 pandemic has shown that despite the issues that have challenged the Region's health systems in the past, many have proven to be resilient in the face of the pandemic and have weathered the attendant disruptions to service delivery. However, there more remains to be done, as countries work towards the 2030 agenda of realizing universal health coverage.

7.1 Policy shifts towards people-centred care for UHC

A people-centred health system is central to the UHC agenda. Integrated and multi-sectoral approaches aimed at addressing this policy shift are critical. This requires designing a health system that includes appropriate and equitably distributed health infrastructure, based on the needs of the population. It must also have a comprehensive approach to addressing high out-of-pocket payments and catastrophic health expenditures. This could be with the introduction of sound financing mechanisms, according to need, rather than ability to pay (covering the most vulnerable first), ensuring geographical access for those in remote areas.

Furthermore, a people-centred health system must address the human resource challenges centred on shortages and inequitable distribution of qualified health care workers, while also addressing the high cost of medicines by looking at skills transfer and local manufacturing, and finally, leveraging technology to ensure the appropriate organization of health services and real-time data generation for prompt actions and decisions by management.

7.2 Strengthening the functionality of sub-national health systems as a critical step for UHC

Improving access to essential health services is a prerequisite for health service utilization. Given the pivotal role played by districts or subnational units in universal health coverage and the comprehensive primary health care approach, in coordinating service delivery, the health workforce and financial resources to provide quality health care, it is vital to shift our focus to delivering services through robust subnational health systems. Botswana, Cameroon, Chad, Malawi, Mali and United Republic of Tanzania have already made this shift. The Region must scale up the focus on district systems as the vehicle through which essential health services can be made widely available to all people, leaving no one behind.

7.3 Scaling up data-driven and empirical evidence on progress towards UHC

WHO has been pushing for regular health systems monitoring, appraisals and assessments that aim to provide countries with empirical evidence on where to invest in improving health system functionality and performance towards UHC. The WHO Regional Office for Africa has developed tools to help countries in the Region to systematically explore the functionality of their subnational health units, recognizing that operational subnational health systems are key to advancing the UHC agenda in countries. Without such action, there is likely to be a gap in knowledge regarding the level of functionality of subnational health units, which can limit effective, evidence-informed policy responses now and into the future. The output from the assessment is expected to comprise specific areas on which a subnational unit or country would need to focus, in order to accelerate the achievement of health outcomes.

7.4 Focusing on recovery and resilience in a post-COVID-19 world

The COVID-19 pandemic disrupted the delivery of essential health services in all countries. Countries must therefore invest in common goods that are fundamental to promoting health and well-being, and protecting populations from future pandemics. Mitigation recovery actions, such as service delivery interventions, health worker training, access to medicines and health products, community engagement and communication, and health financing strategies should be prioritized by governments. Catch-up strategies to sustain investments in health systems and ensure continued access to high-quality services, as well as addressing barriers to care, should also be given their due significance.

Health systems should be built to be resilient and responsive to shocks. This must include measures to improve the system's inherent abilities to anticipate, absorb, adapt, and transform when faced with unknown threats, which may be of a health-related, environmental, political/security, and/or economic nature. Resilience interventions should also focus on preparing for specific and well-known health threats.

To respond to future pandemics efficiently and effectively, governments must increase investments and deploy strategies for clear communication on policy changes such as task-shifting of the health workforce, comprehensive risk communication, no-fee delivery of essential services, enhanced measures for the protection of human rights and prevention of gender-based violence, which entails committing all available resources to meeting the minimum core obligations under the right to health. These functions are integral to the commitments that all Member States made in the *International Health Regulations, as well as the United Nations Political Declaration on universal health coverage in 2019*.[20]

Chapter 8

Conclusion

8

Universal health coverage is founded on equity and has the potential to be a powerful social equalizer if countries move quickly to full population coverage in a balanced manner. It has proven to be an economic growth catalyst that benefits individuals, families, communities, businesses and economies. Economic and social progress is an outcome and a driver of good health.

Despite increases in overall service coverage at the national level, inequities persist at the subnational level, with disparities in coverage among several key and vulnerable populations across various socioeconomic groups in the African Region. It is only by reaching these marginalized groups that overall country health outcomes can be improved and UHC achieved.

Financial risk protection continues to be the rate-limiting step for several countries in the Region as they work towards UHC attainment. Even before COVID-19 struck, the world was off-track to reducing financial hardship because trends in catastrophic health spending were going in the wrong direction, with the number of people incurring financial hardship remaining unacceptably high. Most countries continue to report high out-of-pocket spending for health, despite the slight reductions in catastrophic health expenditure that have been observed over time. Government spending on health as a proportion of total health expenditure is relatively low in African countries, with most governments funding less than half of the total health expenditure. Efforts to move countries closer to the targets set for domestic health financing in the Addis Ababa Declaration and the Abuja targets will be key indicators of improved government prioritization of health in the overall national development agenda.

The Region will focus on five key areas for emphasis:

1. Accelerate efforts to improve financial risk protection
2. Explore practical means to decipher and target inequities driving the variations in outcomes among similar populations
3. Rethink and repivot health service delivery with a focus on essential service integration, community involvement, private sector engagement and enhanced resilience
4. Put in place a comprehensive monitoring of the function of the subnational system, as an early warning system for UHC trends and distribution
5. Focus on post-COVID-19 recovery and resilience by investing in common goods that are fundamental in attaining UHC and health security simultaneously.

In working towards the UHC agenda, the weight of leadership and governance cannot be overemphasized. Countries are encouraged to consider in-depth context issues and make sustainable and timely adaptations to global guidance and strategies for maintaining essential health services to deliver the desired outcomes.

With less than 10 years left on our global call to achieve UHC and the Sustainable Development Goals, Member States and their people have a key role to play in pushing forward interventions and efforts, leaving no one behind.

References

1 Transforming our world: the 2030 Agenda for Sustainable Development | Department of Economic and Social Affairs [Internet]. Bit.ly. 2022 [cited 15 July 2022]. Available from: https://bit.ly/3J3rFu6

2 WHO support for Universal Health Coverage in Africa [Internet]. Apps.who.int. 2022 [cited 15 July 2022]. Available from: https://apps.who.int/iris/bitstream/handle/10665/272276/HSS-FlagshipsPg-eng.pdf?sequence=1&isAllowed=y

3 Statement on the First Regional Forum for Strengthening Health Systems for UHC and SDGs [Internet]. WHO | Regional Office for Africa. 2016 [cited 15 July 2022]. Available from: https://www.afro.who.int/publications/statement-first-regional-forum-strengthening-health-systems-uhc-and-sdgs

4 RC67 - FRAMEWORK FOR HEALTH SYSTEMS DEVELOPMENT TOWARDS UNIVERSAL HEALTH COVERAGE IN THE CONTEXT OF THE SUSTAINABLE DEVELOPMENT GOALS IN THE AFRICAN REGION [Internet]. Afro.who.int. 2017 [cited 15 July 2022]. Available from: https://www.afro.who.int/sites/default/files/2018-01/AFR-RC67-10%20Framework%20for%20health%20systems%20development-Rev%2023.09.17.pdf

5 Leave no one behind: Strengthening health systems for UHC and the SDGs in Africa [Internet]. WHO | Regional Office for Africa. 2017 [cited 15 July 2022]. Available from: https://www.afro.who.int/publications/leave-no-one-behind-strengthening-health-systems-uhc-and-sdgs-africa

6 WHO Africa's Third Forum on health systems strengthening for UHC and the SDGs [Internet]. IHP. 2018 [cited 15 July 2022]. Available from: https://www.internationalhealthpolicies.org/blogs/who-africas-third-forum-on-health-systems-strengthening-for-uhc-and-the-sdgs/

7 Tumusiime P, Karamagi H, Titi-Ofei R, Amri M, Seydi A, Kipruto H et al. Building health system resilience in the context of primary health care revitalization for attainment of UHC: proceedings from the Fifth Health Sector Directors' Policy and Planning Meeting for the WHO African Region. BMC Proceedings. 2020;14(S19).

8 RC69/8 Framework For Provision Of Essential Health Services Through Strengthened District/Local Health Systems To Support UHC In The Context Of The SDGs [Internet]. Afro.who.int. 2022 [cited 15 July 2022]. Available from: https://www.afro.who.int/sites/default/files/2019-08/AFR-RC69-8%20Framework%20for%20provision%20of%20essential%20health%20services.pdf

9 Karamagi H, Tumusiime P, Titi-Ofei R, Droti B, Kipruto H, Nabyonga-Orem J et al. Towards universal health coverage in the WHO African Region: assessing health system functionality, incorporating lessons from COVID-19. BMJ Global Health. 2021;6(3):e004618.

10 State of health in the WHO African Region [Internet]. WHO | Regional Office for Africa. 2018 [cited 15 July 2022]. Available from: https://www.afro.who.int/publications/state-health-who-african-region

11 World Bank Country and Lending Groups – World Bank Data Help Desk [Internet]. Datahelpdesk.worldbank.org. 2022 [cited 15 July 2022]. Available from: https://datahelpdesk.worldbank.org/knowledgebase/articles/906519

12 Global monitoring report on financial protection in health 2021. Geneva: World Health Organization and International Bank for Reconstruction and Development / The World Bank; 2021.Licence: CC BY-NC-SA 3.0 IGO

13 World Health Organization and World Bank. Global Monitoring Report on Financial Protection in Health 2021. World Bank, 2021. https://doi.org/10.1596/36723

14 United Nations Department of Economic and Social Affairs Statistics Division Meeting of the Expert Group on International Statistical Classifications New York, 6-8 September 2017 ESA/STAT/AC.340/5b ac340-5b.PDF (un.org)

15 Karamagi HC, Tumusiime P, Titi-Ofei R, et al. Towards universal health coverage in the WHO African Region: assessing health system functionality, incorporating lessons from COVID-19. BMJ Global Health 2021;6:e004618.

16 WHO African Region EPR.HIR https://aho.afro.who.int/outbreaks-and-emergencies-who-africa/af

17 WHO Global pulse survey on continuity of essential health services during the COVID-19 pandemic report, available at https://www.who.int/teams/integrated-health-services

18 Ghana: WHO Launches Leadership for Health Transformation Programme to Provide High-Level Strategic Leadership to Senior Managers of Ghana's Health Sector [Internet]. allAfrica.com. 2021 [cited 15 July 2022]. Available from: https://allafrica.com/stories/202109010179.html

19 South Africa President sets up NHI war room [Internet]. Bizcommunity. 2022 [cited 15 July 2022]. Available from: https://www.bizcommunity.com/Article/196/824/187168.html

20 WHO, International Health Regulations (2005) Third Edition, 1 January 2016, available at https://www.who.int/publications-detail-redirect/9789241580496


World Health
Organization
REGIONAL OFFICE FOR Africa