UHC in Africa: A Framework for Action

1. Executive Summary

Why Invest in UHC?

Investment in Africa's health systems is key to inclusive and sustainable growth.

Strong economic growth in recent years has helped reduce poverty to 43 percent of the population. Yet, as Africa's population expands—it is estimated to reach 2.5 billion by 2050—the region faces a critical challenge of creating the foundations for long-term inclusive growth. Many countries still contend with high levels of child and maternal mortality, malnutrition is far too common, and most health systems are not able to deal effectively with epidemics and the growing burden of chronic diseases, such as diabetes. These challenges call for renewed commitments and accelerated progress toward Universal Health Coverage (UHC)—the principle that everyone receives needed health services without financial hardship.

Investing in UHC pays off.

The primary reason for investing in UHC is a moral one: it is not acceptable that some members of society should face death, disability, ill health or impoverishment for reasons that could be addressed at limited cost. However, UHC is also a good investment. Prevention of malnutrition and ill health is likely to have enormous benefits in terms of longer and more productive lives, higher earnings, and averted health care costs. Effectively meeting demand for family planning will accelerate the fertility transition, which in turn will result in higher rates of economic growth and more rapid poverty reduction. And strong health and disease surveillance systems halt epidemics that take lives and disrupt economies. In 2015, the forgone economic growth due to Ebola amounts to more than a billion US$ in the three countries hit by the epidemic.

UHC in Africa: Progress and Challenges

Health expenditure in Africa have increased significantly, but domestically financed government spending has stalled.

Total health expenditure has grown rapidly over the last two decades, in particular in middle-income countries. But this increase has been driven mainly by out-of-pocket spending by households and development assistance, about half of which was earmarked spending for HIV/AIDS. In contrast, government spending on health as a share of total government spending has decreased in half of the countries in the region (figure 1). Only four countries met the Abuja target of 15 percent of general government spending in 2014. Limited commitment of domestic resources is often reflected in shortages of critical inputs such as human resources for health and pharmaceuticals.

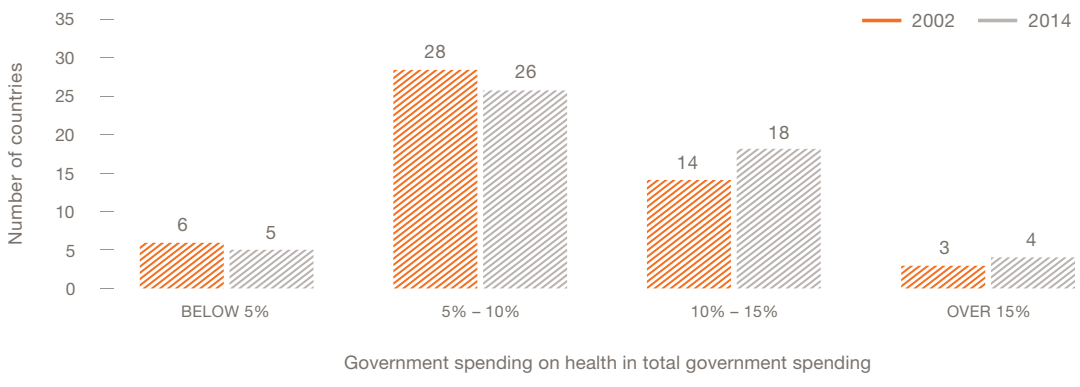
Coverage of key health services has increased but critical gaps remain.

Africa has seen rapid improvement in coverage of insecticide treated bed nets for children, which accounts for an important share of the decline in child mortality. Other indicators related to maternal and child health services, such as antenatal care and skilled birth attendance have also improved. Yet, wide disparities remain within countries, and coverage gaps remain large for many critical services. Access to HIV, TB, and malaria services also remains uneven and is lower than for other core indicators of UHC progress. Progress has also been slow in the case of improved water and sanitation, and the region is far from reaching the 2030 Sustainable Development Goal (SDG) basic essential health services objective of 80 percent population coverage.

Millions of Africans fall into poverty due to high out-of-pocket health payments.

Financial protection is generally low in Africa, requiring most patients to pay for health services from their own household income, so-called out-of-pocket (OOP) payments. Patients in low-income and lower-middle-income countries are less protected against high OOP than those in higher-middle-income countries. Out-of-pocket payments have increased in nearly all countries, and the regional average has increased from US$15 per capita in 1995, to US$38 in 2014. As a result, 11 million Africans are falling into poverty every year due to high out-of-pocket payments. Protecting people against the impoverishing effect of health payments is a cornerstone of UHC and will help prevent poverty in Africa.

GOVERNMENT SPENDING ON HEALTH IN TOTAL GOVERNMENT SPENDING *fig.1*



Accelerating Progress toward UHC: Opportunity, Directions and the Way Forward

Accelerating progress toward UHC in Africa is within reach but will require political leadership and a clear strategic vision.

Most African countries have integrated UHC as a goal in their national health strategies. Countries that achieve their UHC targets by 2030 will eliminate preventable maternal and child deaths, strengthen resilience to public health emergencies, reduce financial hardship linked to illness, and strengthen the foundations for long-term economic growth. Yet, progress in translating commitments to UHC into expanded domestic resources for health, effective development assistance, and ultimately, equitable and quality health services, and increased financial protection has been slow.

There is no one-size-fits-all approach to achieving UHC—strategies will depend on local circumstance and national dialogue.

Despite the great diversity of African countries, many are facing common challenges. This framework proposes a set of actions for countries and stakeholders involved in the UHC process. It is intended to stimulate action by demonstrating that progress toward UHC is not only possible, it is also essential.

UHC in Africa:
A Framework for Action

1 / FINANCING

More and Better Spending and Effective Financial Protection

- Improve efficiency of public and private health spending for better outcomes and resource expansion
- Increase government spending on health through budget re-allocation and increased domestic resource mobilization
- Use budget resources to reduce financial barriers to care and make services affordable to everyone
- Ensure that the poor, and people working in the informal sector benefit from pre-payment, and that providers get a fair deal
- Improve the effectiveness of development assistance for health through improved coordination and use of country systems

2 / SERVICES

People-Centered Services, Quality and Multisectoral Action

- Establish people-centered health services to improve quality of services and patient safety
- Prioritize investments in community and primary health care services within the framework of viable local governance systems
- Partner with civil society and non-state providers to expand access to key services and interventions
- Invest in pre-service education, particularly in underserved areas
- Engage in multisectoral action to address determinants of health

3 / EQUITY

Targeting the Poor and Marginalized and Leaving No One Behind

- Target vulnerable populations and design programs tailored to their needs
- Expand service delivery to marginalized groups and settings
- Scale-up pro-poor interventions such as demand-side incentives, including vouchers and conditional cash-transfers
- Ensure the rights and entitlements of women, children and minorities, particularly during vulnerable parts of the life course

4 / PREPAREDNESS

Strengthening Health Security

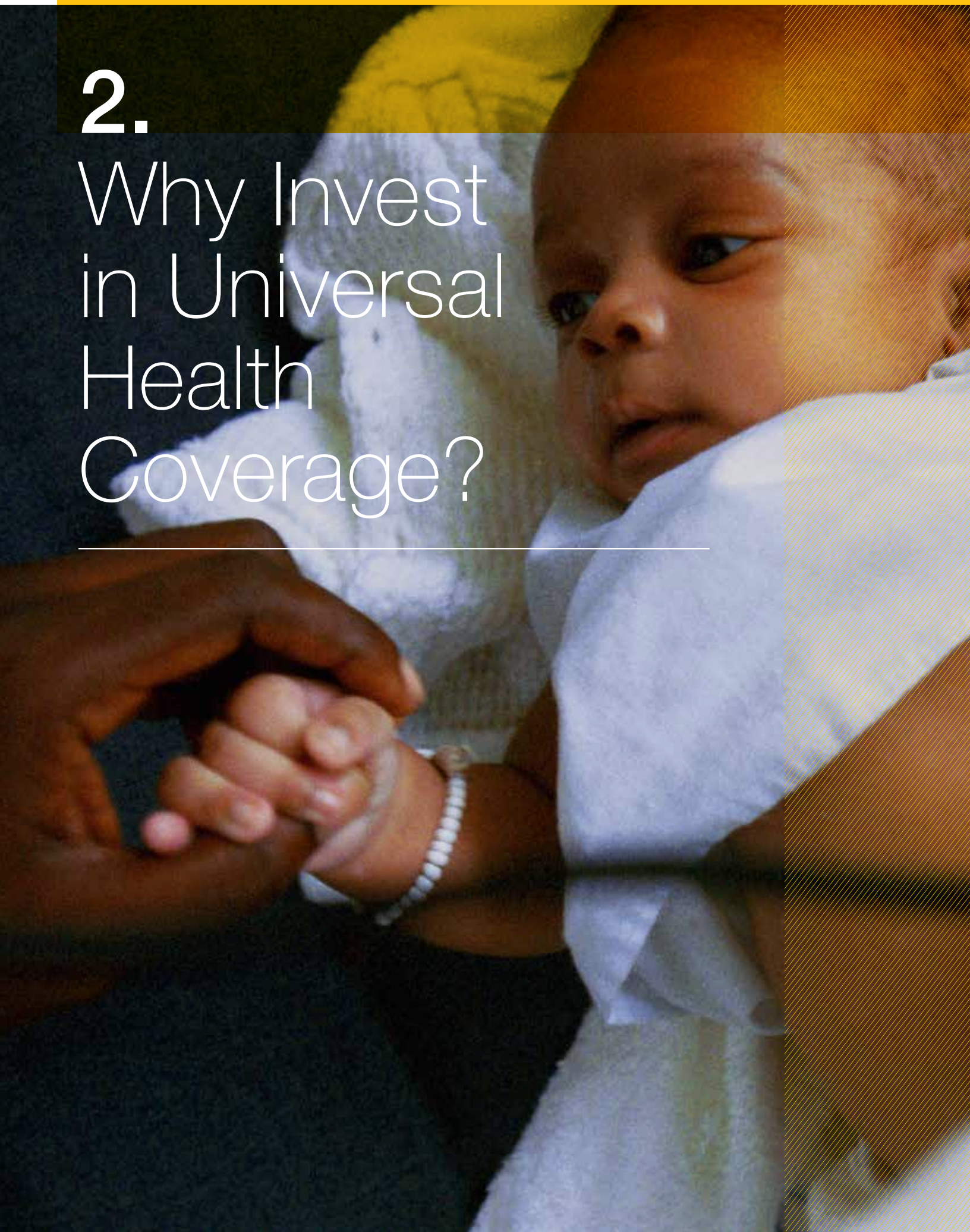
- Improve national preparedness plans including organizational structure of the government
- Promote adherence to the International Health Regulations (IHR)
- Utilize international framework for monitoring and evaluation of IHR
- Enhance relevant partners' and across countries' collaboration to prepare for and respond to public health emergencies

5 / GOVERNANCE

Political and Institutional Foundations for the UHC Agenda

- Establish platforms and processes to foster societal dialogue
- Enhance effective mechanisms for inter-sectoral dialogue and action
- Establish transparent monitoring and reporting on progress toward UHC
- Strengthen national institutions and organizations to lead implementation of reforms for UHC
- Ensure that all citizens have access to data and information on UHC, as part of societal dialogue and participatory processes


STUDENT



2. Why Invest in Universal Health Coverage?

During the past 15 years, many parts of Africa[1] have experienced rapid economic growth and impressive poverty reduction.

Between 2001 and 2014, gross domestic product (GDP) grew by five percent per year in real terms, compared to just over two percent during the 1980s and 1990s (International Monetary Fund 2016). Economic growth has contributed to poverty reduction in Sub-Saharan Africa (SSA) as the percentage of the population living below the international poverty line dropped from 57 percent in 1990, to 43 percent in 2015 (World Bank and International Monetary Fund 2016). Progress has been uneven, reflecting conflict and instability in parts of the continent. Yet, despite weakness in the global economy, strong domestic demand, improved macroeconomic management, and dynamic business environments are keeping the promise of an African renaissance alive.

Africa has also seen impressive gains in health outcomes.

Between 1990 and 2015, Sub-Saharan Africa and North Africa experienced child mortality reductions of 54 and 67 percent respectively (UNICEF 2015) (figures A1 and A2). During the same period, the maternal mortality ratio (MMR) fell by 45 percent in SSA, and 59 percent in NA. The number of AIDS-related deaths decreased significantly between 2010 and 2015 in SSA, the most affected region (from 1.13 to 0.8 million) (UNAIDS 2016b). This progress reflects substantial expansion of key maternal and child health interventions, as well as significant improvements in prevention efforts, and access to HIV/AIDS treatment across most African countries. Economic growth has been an important enabler of this progress, but many countries have made important health gains despite economic headwinds (figures A3 and A4).

Although there has been progress, many countries face large, unmet health needs, and pressures on health systems are expected to increase.

In many African countries, reductions in child and maternal mortality fell short of the Millennium Development Goals (MDG) targets and achieving the SDG targets represents a daunting challenge (figure A5). Moreover, the prevalence of HIV/AIDS and malnutrition remains stubbornly high. Globally new HIV infections have stagnated at 2.5 million a year three quarters of which are in SSA. Furthermore health disparities along economic, social, geographic, gender, and ethnic lines remain unacceptably large (Heaton et al. 2016). There are also other important emerging agendas. The recent Ebola and yellow fever outbreaks in Africa highlighted the vulnerability of countries to public health emergencies. Chronic non-communicable diseases are growing at an alarming pace, and present a challenge in terms of both prevention and treatment. These challenges are emerging in a context of high fertility and population growth: current United Nations estimates suggest that Africa's population will expand from 1.2 billion in 2015, to 2.5 billion in 2050.

Progress toward Universal Health Coverage (UHC) is critical to promote equity, basic rights, and human security in health, but it will also bring significant economic gains.

Many countries in Africa have shown impressive leadership on the health agenda, underpinned by commitments under the MDGs and, more recently the SDGs. The commitment to UHC – the idea that everyone should receive the health services that they need without financial hardship – is based on the recognition of the intrinsic value of health and the right to health. Put more simply, it is not acceptable that some members of society should face death, disability, ill health or impoverishment for reasons that could be addressed at limited cost. However, UHC is also a good economic investment. Prevention of malnutrition and ill health is likely to have enormous benefits in terms of longer and more productive lives, higher earnings, and averted health care costs. Safeguarding against impoverishment due to medical spending will contribute to social stability which is prerequisite of sustained economic growth. Effectively meeting demand for family planning will accelerate the fertility transition, which in turn will result in higher rates of economic growth and more rapid poverty reduction. Stronger health systems that are able to prevent, detect, and respond effectively to pandemics or other public health emergencies can dramatically reduce the disruptions and economic costs of such events. And access to health services at affordable costs help reduce the financial hardship related to illness and contributes to social cohesion and poverty reduction. Finally, the health sector is increasingly contributing directly to economic growth and job creation. In short, UHC is not merely a social equalizer, but also a sound investment in human capital, health security, and a driver for employment creation in the health sector.

Increasingly, UHC is a political imperative as citizens in the region expect improved access to and quality of health services.

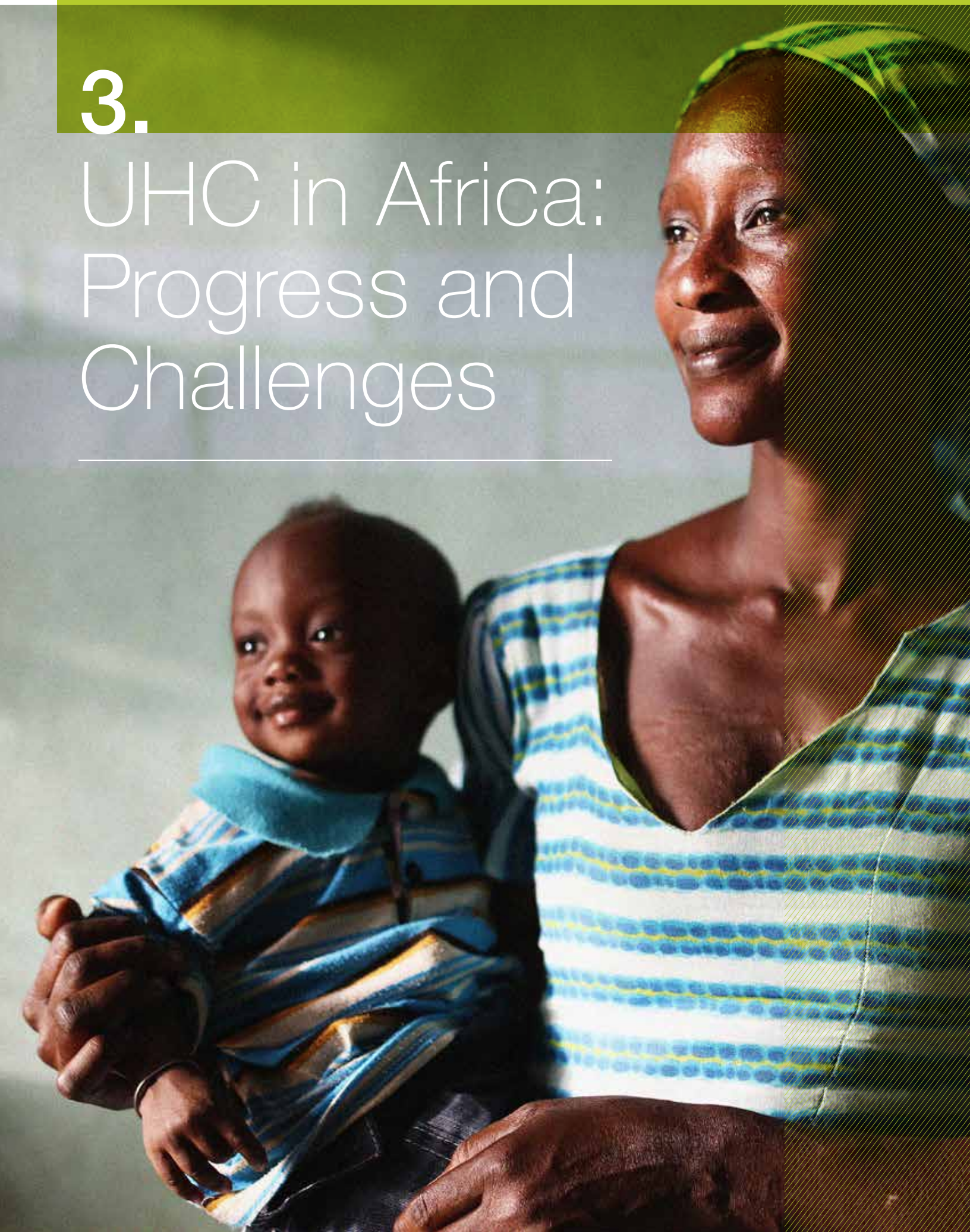
Given what is at stake, it is not surprising that health is a prominent political issue in countries across the world. Africa is not an exception. The most recent Afrobarometer opinion poll, which was conducted in 36 African countries, highlighted the importance assigned to health by the African population. Similar to opinion polls from other continents, the survey painted a picture of significant frustration and concern with health systems in the region. Respondents noted long wait times, high costs, a lack of respect from providers, and high levels of foregone care when they or family members experience illness or injury. Health is consistently identified as one of the top challenges that African countries face, and was rated as one of the top two priorities for more government spending in 27 out of 29 countries in the 2014/15 Afrobarometer survey.

This document provides a framework for action toward UHC in Africa.

It highlights progress in expanding coverage of key health services, protecting against the financial risk from health care payments and enhancing health security over the last couple of decades. Although there have been notable gains, enormous challenges remain. There is no blueprint for how these challenges should be addressed – countries will need to chart their own course based on country-led strategies or roadmaps that reflect the needs, aspirations, and constraints of the diverse set of countries in the region. Yet, African leaders have made shared commitments to UHC through the SDG process, as well as through regional bodies and declarations, and national policies and legislation.[2] Building on these commitments, this framework is intended to stimulate action by demonstrating that progress toward UHC is not only possible, it is also essential.

3.

UHC in Africa: Progress and Challenges



Progress toward UHC is measured by the coverage of key services or interventions and financial protection.

The UHC monitoring framework, developed by the World Health Organization (WHO) and the World Bank (WB), covers promotion, prevention, treatment, rehabilitation, and palliation services for maternal, neonatal and nutritional diseases. It also assesses protection against financial hardship caused by high OOP, using the incidence of catastrophic payments and of impoverishing expenditures (World Health Organization and World Bank Group 2014).[3] Indicators on health system capacity (e.g. infrastructure, human resources or pandemic preparedness) and the amount of financial resources dedicated to health are also critical in understanding progress toward UHC.

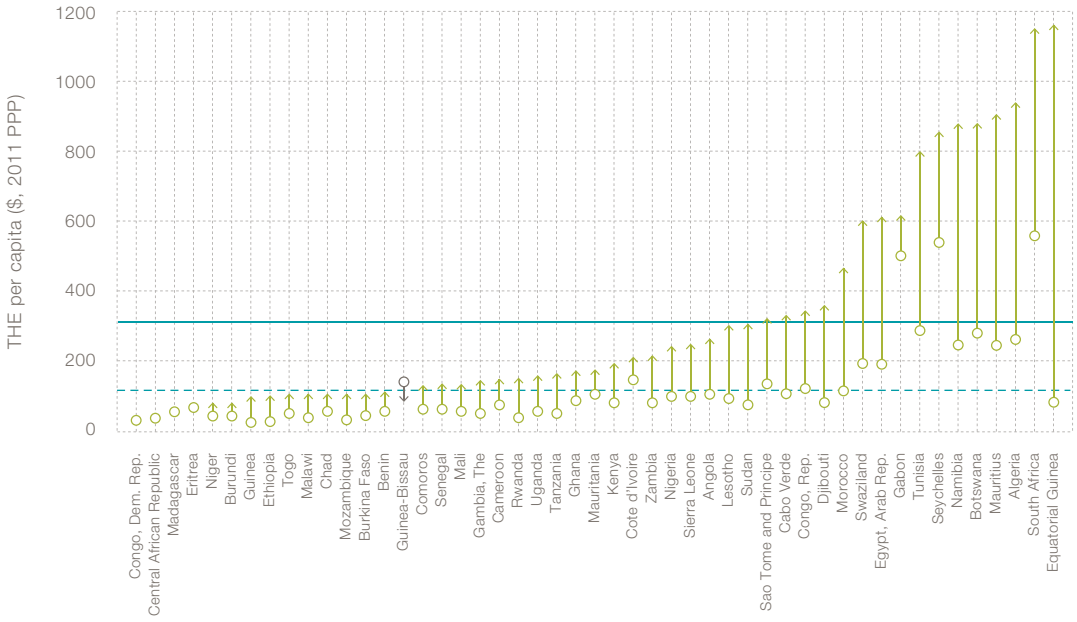
Health Expenditures Have Increased Despite Stagnant Government Financing

Between 1995 and 2014, total health expenditure (THE) per capita (at 2011 PPP factors) has increased on average from US$113 to US$306

Currently, total health expenditure in Africa is on par with that of low-income countries worldwide. However, regional averages hide substantial heterogeneity across the continent, and the degree of inequality in total health spending across countries has increased over time (figure 2). On average, THE has grown more rapidly than GDP—five percent per year over the last two decades, compared to two percent for GDP (figure A6). As a result, THE as a share of GDP has increased from five percent in 1995 to six percent in 2014 (figure A7), albeit with significant variation across countries.

LARGE VARIATION IN TOTAL HEALTH EXPENDITURE GROWTH AND LEVELS ACROSS COUNTRIES *fig. 2*

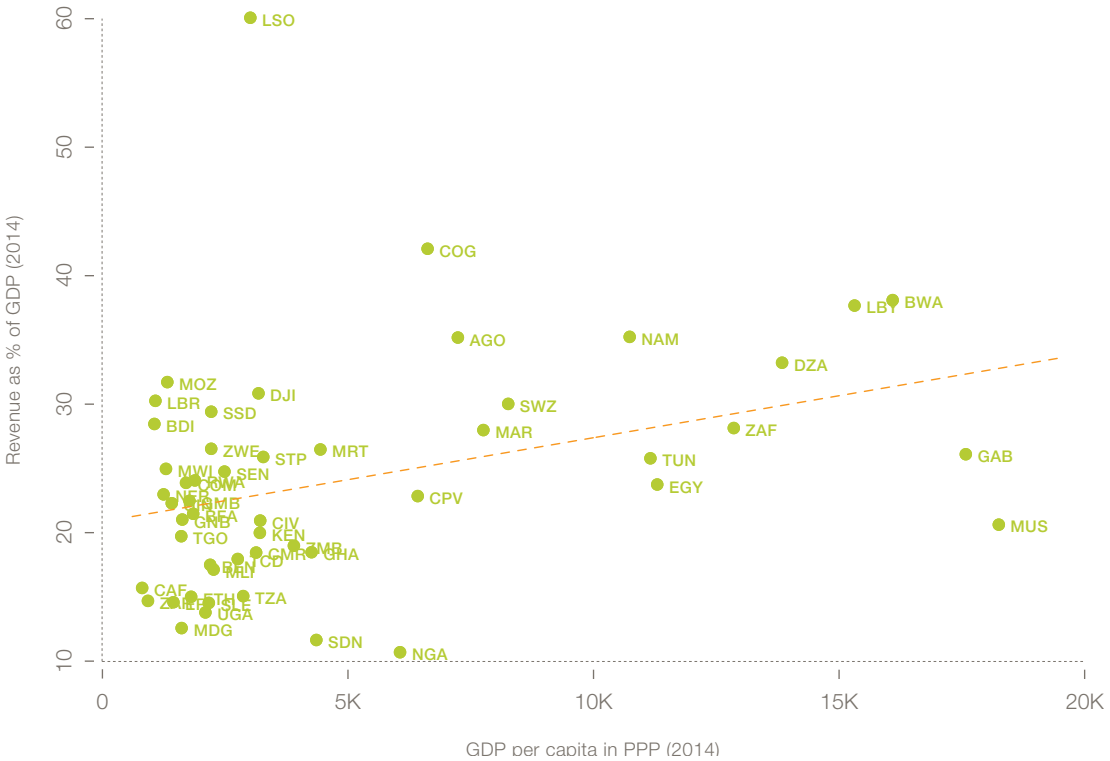
- Hollow (arrow) circles represent the average share of THE per capita in 1995 (2014).
- The dashed blue line represents the sample average of THE per capita in 1995 ($113.5).
- The solid blue line represents the sample average of THE per capita in 2014 ($306.1).



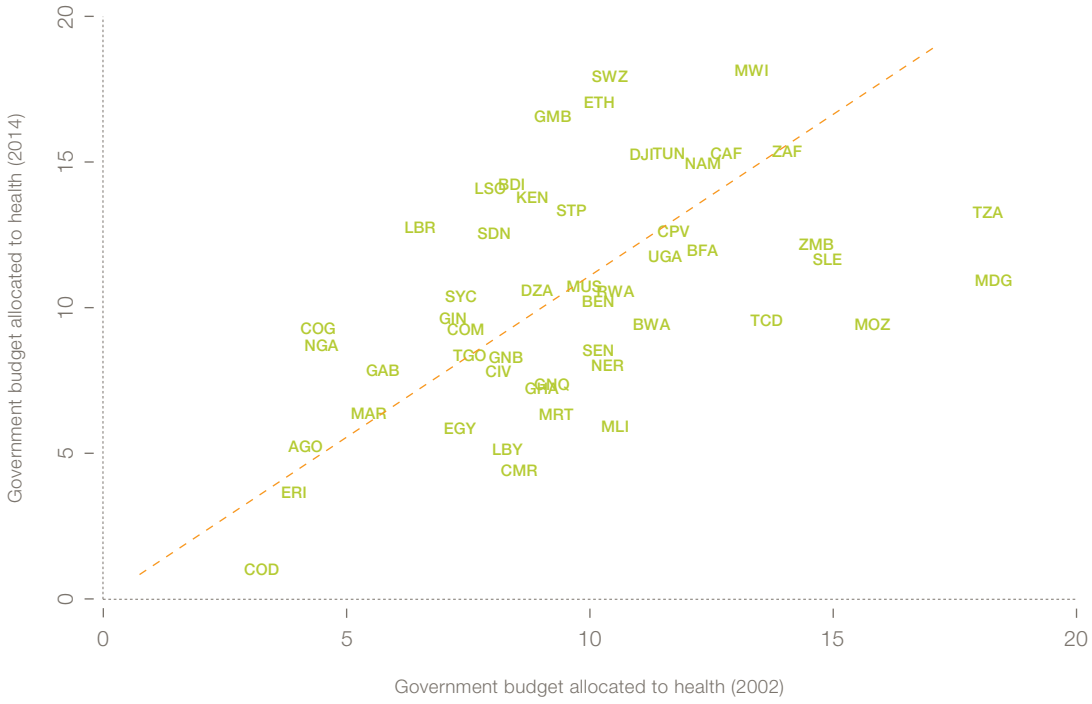
Government spending on health has grown slowly and is far from the aspirational goals of the Abuja Declaration.

In 2014, government revenue as a share of GDP, ranged from 10.5 percent (Nigeria) to 60.5 percent (Lesotho) in Africa. Relatively low levels of government revenues in many countries (figure 3) result in low government health spending. Most countries in the region committed to increase public health spending to at least 15 percent of the government's budget through the 2001 Abuja Declaration. However, between 2002 and 2014, the share of government spending allocated to health decreased in about half of African countries. Only four countries were above the Abuja target in 2014, even though some development assistance for health (DAH) is included in estimates of government spending[4] (figure 4). None of the five countries that achieved the 15 percent target in 2002 were able to maintain the target level of domestic health spending.

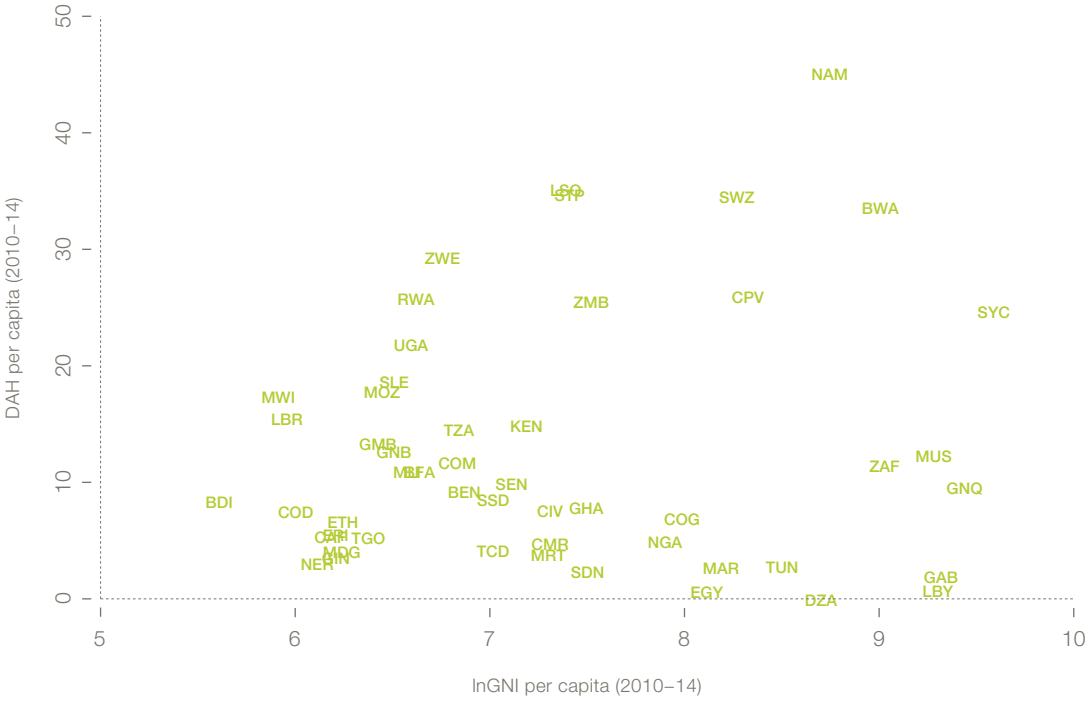
GOVERNMENT REVENUE IS LOW IN MANY COUNTRIES *fig. 3*



LIMITED PROGRESS TOWARD ABUJA TARGETS *fig. 4*



A WEAK RELATIONSHIP BETWEEN DAH AND INCOME *fig. 5*

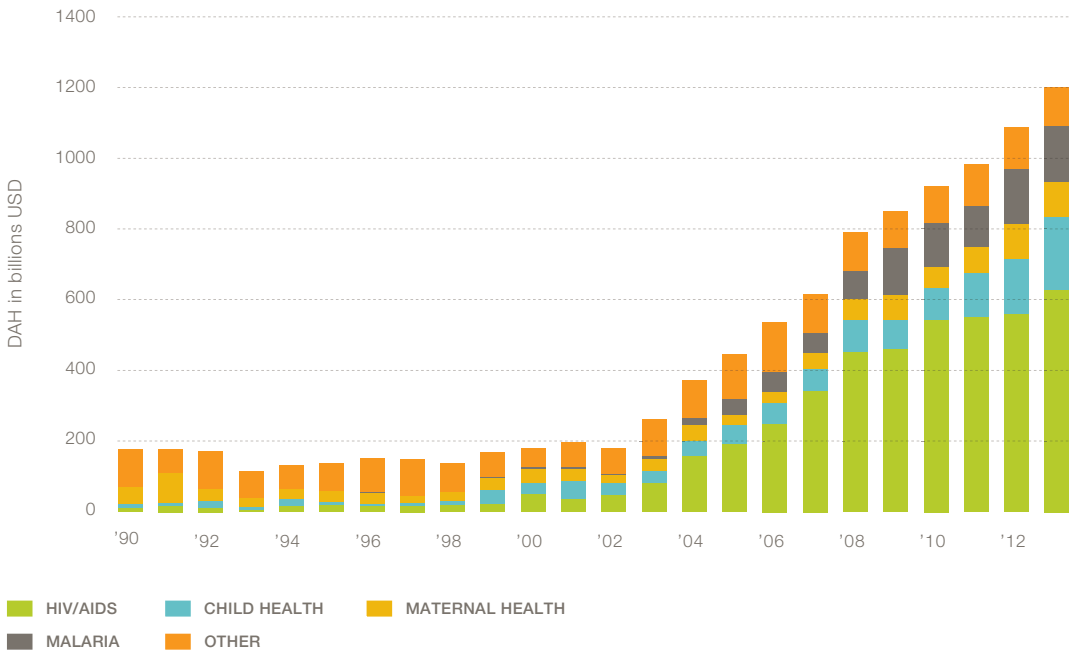


There has been significant growth in development assistance for health amidst growing concerns about sustainability, effectiveness and the displacement of domestic financing for health.

DAH in Africa grew rapidly in recent decades (figure 5). The growth in DAH to the region has been driven in large part by spending on HIV/AIDS and malaria. The share of DAH allocated to HIV/AIDS rose from seven percent of total DAH in 1990, to a peak of 54 percent in 2010. Similarly, DAH for malaria increased from one percent of THE in 1990, to 13 percent in 2010 (figure 6). However, at the same time as DAH has increased in Africa, domestic spending has stalled, particularly in low-income countries (LICs). As a result, the share of DAH in total health spending has increased from 20 percent in 2000, to 35 percent in 2014 in LICs [5] (figure 7), raising concerns that DAH may be substituting for domestic resources (i.e. fungibility) (Dieleman, Graves, and Hanlon 2013) as well as questions amongst development partners about the effectiveness and the long-term sustainability of DAH-funded priorities. Direct funding for health systems strengthening also has not increased during that period.

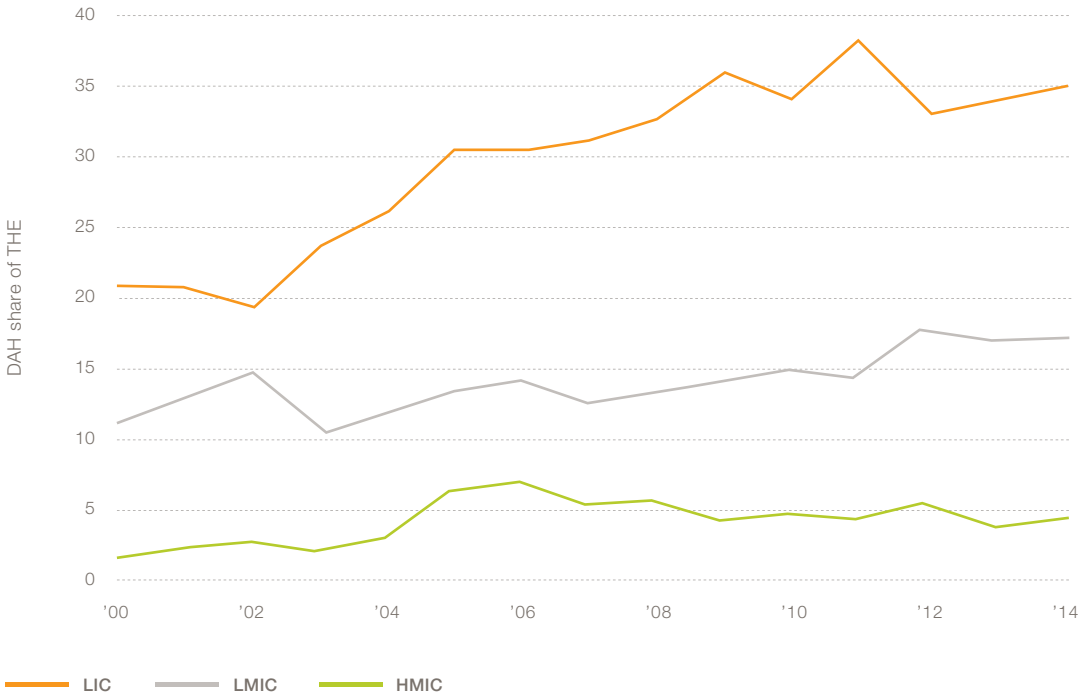
GROWTH IN DAH DRIVEN BY HIV/AIDS AND MALARIA *fig. 6*

» "Other" includes TB, other infectious diseases, SWAP and health system strengthening, NCDs, and other. In 2013, they respectively accounted for 2%, 1%, 6%, 1% and 8% of total DAH.



A RISING SHARE OF DAH IN TOTAL HEALTH EXPENDITURE *fig. 7*

- LIC = Low Income Countries
- LMIC = Lower Middle Income Countries
- HMIC = Higher Middle income countries
- LIC include: Benin, Burkina Faso, Burundi, Central African Republic, Chad, Comoros, DR Congo, Eritrea, Ethiopia, the Gambia, Guinea, Guinea-Bissau, Liberia, Madagascar, Malawi, Mali, Mozambique, Niger, Rwanda, Sierra Leone, Somalia, South Sudan, Tanzania, Togo, Uganda and Zimbabwe.



Service Delivery Capacity has Expanded, But Not Sufficiently to Meet Current and Future Needs

Health professionals are the most critical input in the delivery of health services.

The density of health workers is a good proxy for a country's capacity to deliver health services. The shortage of skilled health workers has been a consistent bottleneck to achieving UHC across the continent, and is particularly severe in SSA. SSA supports 24 percent of the global disease burden but only maintains 3 percent of the global health work force (World Health Organization 2006). The estimated shortage of doctors, nurses, and midwives in WHO AFRO countries below the SDG Index threshold (4.45 physicians, nurses and midwives per 1000 population) was about 2.7 million in 2013. When all categories of health workers are included, the shortfall is estimated at 4.2 million. This total shortfall is expected to increase to 6.1 million in 2030. Shortages of health workers at the country level are exacerbated by severe imbalances in the density of skilled health workers: it is estimated that over 90 percent of pharmacists and dentists practice in urban areas, other cadres have similar distributions (World Health Organization 2016a). Furthermore, accurate, updated, and nationally consistent information on health workforce is not always available, highlighting the need for strengthening essential countrywide information systems.

A diverse group of non-state health providers plays an active role in the UHC agenda.

About 40 percent of patients' out-of-pocket spending for health goes to non-state health service providers, including faith-based organizations, NGOs, not-for-profit institutions, and for-profit private providers. There is increasing experience of realizing synergies and efficiencies between state and non-state provision of healthcare. However, it has proven challenging for governments to provide the necessary stewardship to scale up and sustain such partnerships. There are also a growing number of examples across the continent of working with the private sector to influence markets in key commodities and medical equipment as well as in distribution and maintenance. Finally many countries have started to successfully contract out specific services such as transport and medical waste disposal to non-state sector.

Access to safe, affordable, and quality essential medicines and technologies remains a challenge.

Despite progress in some areas, access to medicines in Africa remains low. The availability of selected medicines was found as low as 21 percent in the public and 22 percent in the private sector in some African countries.[6] Common challenges include high prices, inadequate financing, weak pharmaceutical regulation, inadequate procurement and supply systems, limited access to information, and inappropriate use. In addition, the region has an increasing circulation of counterfeit or substandard medical products due to the weak performance of national regulatory authorities.[7] When medicines are not covered by health insurance or in public facilities, out-of-pocket payments can be significant and vulnerable populations are exposed to financial hardship and impoverishment.

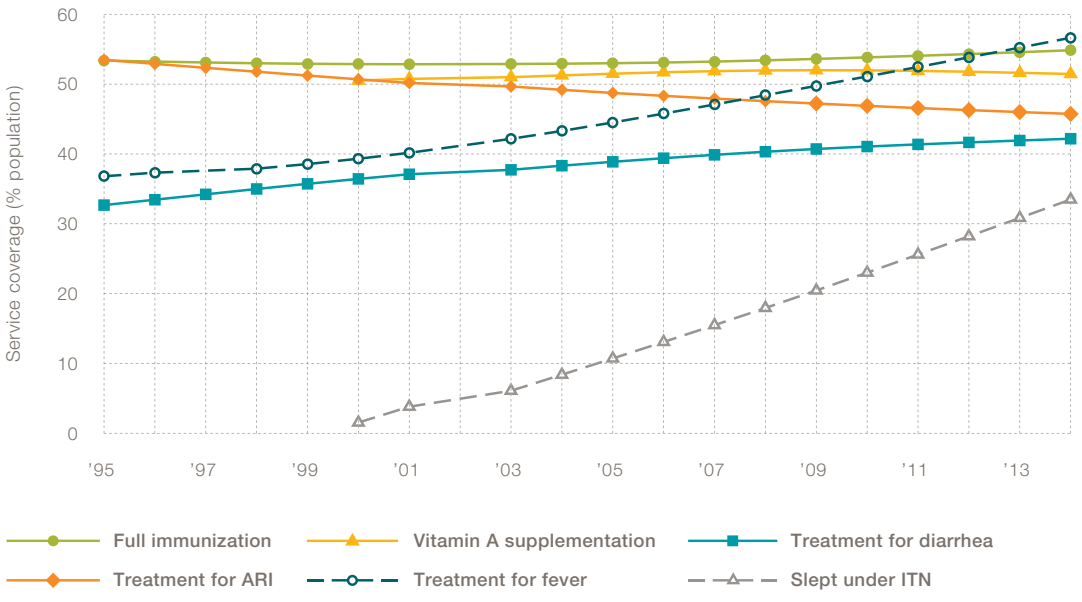
Coverage of Key Health Services and Interventions: Mixed Progress

There has been mixed progress on service coverage.

For some critical health services and interventions, there has been impressive progress in both coverage and equity over the last couple of decades (figure 8). Most of the service coverage tracers remain concentrated toward the better-off population, but the degree of inequality declined slightly. The most rapid improvement has been the change in coverage of insecticide treated bed nets for children, which increased on average by about 15 percent per year between 2006 and 2014. All of the maternal health-related indicators have also improved over the past 20 years (figure 9). Antenatal care visits (at least four) and skilled birth attendance have also both increased from about 40 percent in 1990, to around 60 percent in 2014. Wide disparities remain within countries especially for access to more complex interventions such as skilled birth attendants and treatment for severe illnesses. Even for more routine services such as immunizations, very few countries are achieving universal coverage.

MIXED PROGRESS IN CHILD SERVICE COVERAGE *fig. 8*

» Sample trends are based on Hodrick–Prescott filtering applied to yearly population weighted averages.

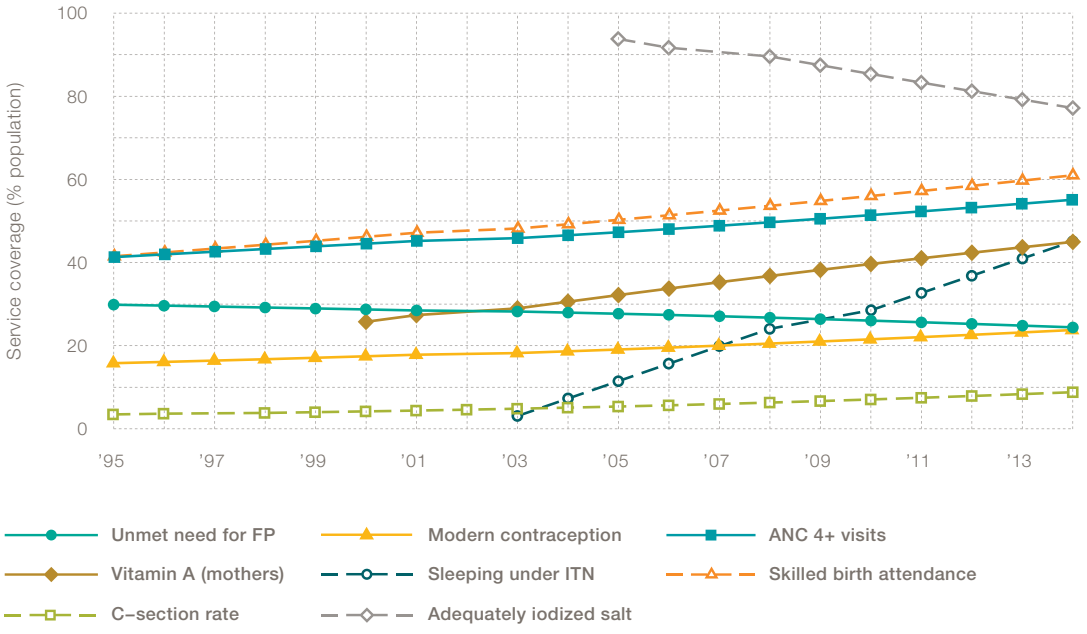


Gaps in access to essential HIV/AIDS, TB, and malaria services remain important barriers to achieving UHC in many countries.

SSince 2002, significant increases in coverage of critical health services for these diseases have occurred. Increases in coverage of prevention of mother to child transmission of HIV has resulted in a 60 percent reduction in new infections among children in Africa. By the end of 2015, programs supported by the Global Fund and other partners contributed to African countries providing 7.7 million patients with antiretroviral treatment, detecting and treating 4.2 million TB cases and purchasing more than 550 million insecticide treated bed nets. Improved access to AIDS treatment has resulted in a 36 percent decrease in AIDS related deaths since 2010 in Eastern and Southern Africa (ESA). However, access to HIV, TB, and malaria services remains uneven and lower than for other core indicators of UHC progress (figure A8). For example, in ESA, approximately 56 percent of People living with HIV have been diagnosed, and 54 percent of them are on treatment compared to 36 percent and 28 percent diagnosed and on treatment respectively in West Africa and 36 percent and 17 percent diagnosed and on treatment respectively in North Africa (UNAIDS 2016a).

MATERNAL HEALTH INDICATORS MOSTLY IMPROVING *fig. 9*

» Sample trends are based on Hodrick–Prescott filtering applied to yearly population weighted averages.



Access to improved water sources and sanitation has increased, although at a slow pace over the past two decades.

The trend in access to improved water sources has only slightly improved in Africa between 1991 and 2014 (by about 0.9 percent per year on averag). The trend in access to improved and unshared sanitation has increased at a faster pace around 2.5 percent annually (figure A9 and A10). Once again, positive trends for the continent as a whole hide important differences across economic groups, sub-regions and countries. Overall, the region is far from reaching the 2030 SDG basic essential health services objective of 80 percent population coverage.

Poor quality of health care undermines UHC in many countries.

Poor quality[8] of care costs lives and wastes scarce resources. Significant deficits in essential drugs and medical equipment availability, and in the knowledge and practices of frontline health workers are highlighted in recent Service Delivery Indicator (SDI) surveys (page 23). Achieving SDG mortality targets will not be possible unless quality gaps in a broader range of interventions are addressed.

Key Findings of the Service Delivery Indicators Initiative

Comparable data on quality of care in African countries are extremely limited. To help fill this information gap, a program of nationally representative Service Delivery Indicator (SDI) surveys have been implemented to measure three aspects of health services that can influence quality of care at the frontline: (i) health workers' absenteeism and case load; (ii) the availability of key infrastructures and inputs for health workers to do their work; and (iii) health workers' knowledge (as measured by clinical vignettes). As of June 2016, SDI surveys have been conducted in nine African countries and data is currently available for seven countries (table 1).

In the surveyed countries, the level of health workers' absenteeism is high, ranging from 20 percent (Senegal) to almost 50 percent (Uganda). For those who show up for work, their average caseload is often low, between five and seven patients per day in Uganda, Tanzania, Togo, and Nigeria. Heath workers' ability to deliver care is also handicapped by the lack of other inputs such as essential drugs and medical equipment. On average, in all the surveyed countries, except Senegal and Tanzania, only half or less essential drugs are available in a health facility. In Uganda and Nigeria, only a fifth of facilities meet the minimum requirements for medical equipment. In Nigeria, less than one in four health facilities simultaneously have water, sanitation, and electricity. Finally, the indicators reveal that health workers' basic clinical knowledge is inadequate in many countries. Given the well-known fact that health workers usually do much less than what they know (the "know-do" gap), the quality of care is most likely even lower than the unfavorable results reflected in the knowledge testing.

SELECTED INDICATORS FROM 7 SDI SURVEYS *table 1*

INDICATORS	Mozambique (2014)	Kenya (2013)	Senegal (2012)	Uganda (2013)	Tanzania (2014)	Togo (2014)	Nigeria (2014)
Absence from facility (% providers)	23.9	27.5	20	46.7	14.3	37.6	31.7
Caseload (per provider per day)	17.4	15.2	–	6.0	7.3	5.2	5.2
Availability of essential drugs (% drugs)	42.7	54.2	78	47.2	60.3	49.2	49.2
Availability of essential equipment (% facilities)	79.5	76.4	53	21.9	83.5	92.6	21.7
Infrastructure availability (% facilities)	34.0	46.8	39	63.5	50.0	39.2	23.8
Diagnostic accuracy for five tracer conditions (% clinical cases)	58.3	72.2	34	58.1	60.2	48.5	39.6
Adherence to clinical diagnostic guidelines for five tracer conditions (% clinical guidelines)	37.4	43.7	22	41.4	43.8	35.6	31.9
Adherence to clinical treatment guidelines for maternal and neonatal complications (% clinical guidelines)	29.9	44.6	–	19.3	30.4	26.0	19.8

SOURCE: www.sdindicators.org. SDI is a partnership between the World Bank, the African Development Bank, the African Economic Research Consortium and participating countries.

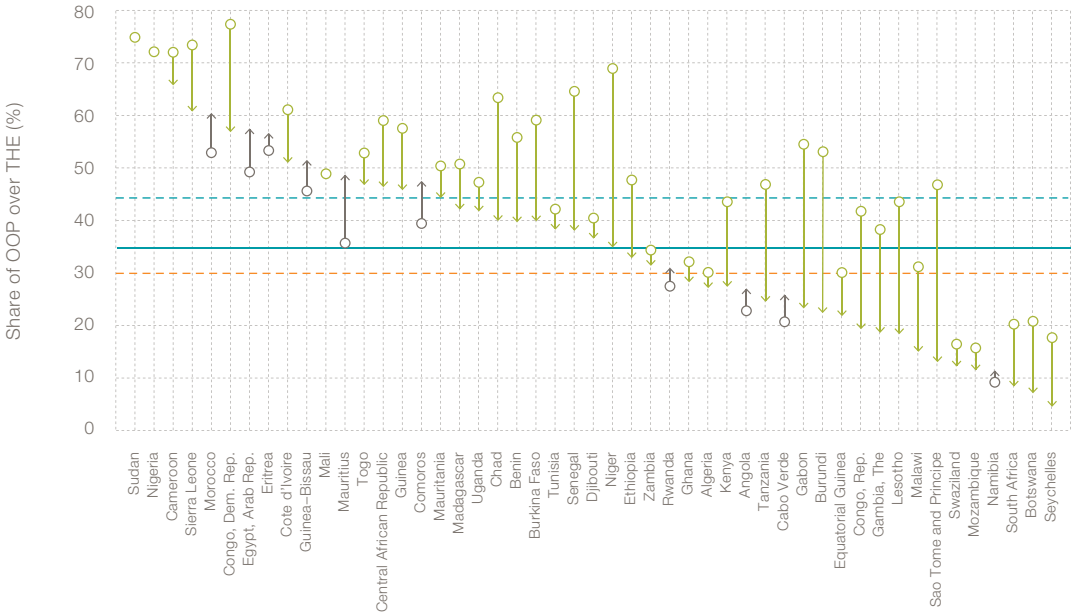
High and Rising Out-of-Pocket Spending is Contributing to Impoverishment

Out-of-pocket spending on healthcare by households remains high in Africa.

While the share of OOP over THE has decreased in most countries, the level of OOP has increased, and the need to strengthen domestic mechanisms for prepaid funding remains a priority for African health systems. In most countries in Africa, coverage through social health insurance and other forms of insurance is low. Government spending on health therefore represents the most important form of resource pooling for health services, and is a key means of promoting access and financial protection. However, due to low levels of government spending, a large share of the financial health burden falls on patients in the form of out-of-pocket payments for health services. In absolute terms, OOPs have increased in nearly every country in the region, from US$15 in 1995, to US$38 in 2014 (constant US$). Given that THE has increased at a more rapid rate over the same period, in most cases driven by increases in DAH, the share of OOPs in total health spending has declined, from 44 to 34 percent (figures 10 and 11).

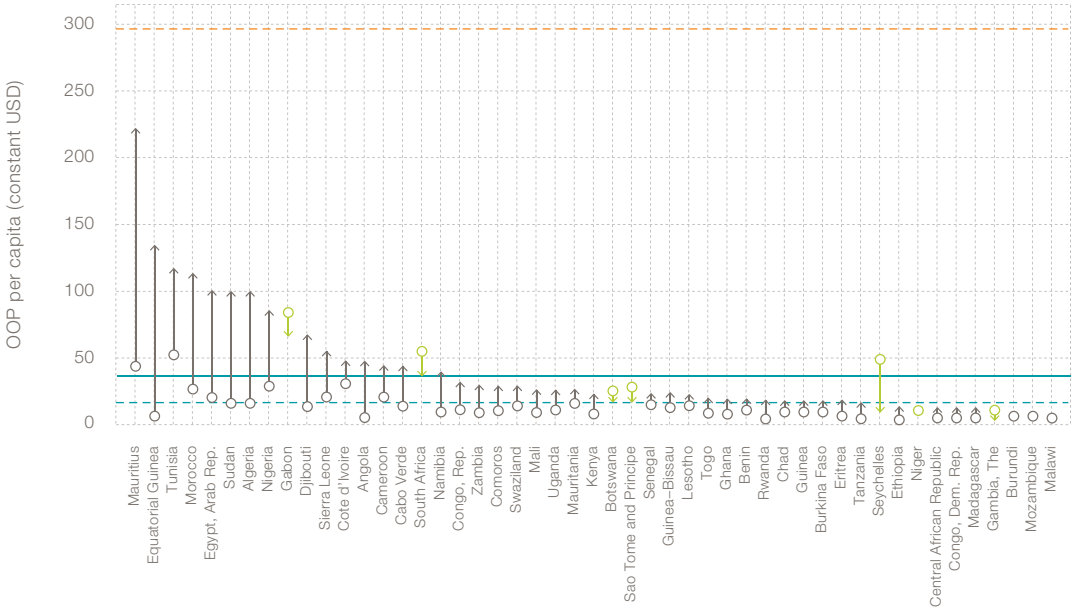
CHNAGES IN THE SHARE OF OOP OVER THE, 1995-2014 *fig. 10*

- Hollow circles represent the average share of OOP/THE in 1995 (2014)
- The dashed blue line represents the sample average of OOP/THE in 1995 (43.7%)
- The solid blue line represents the sample average of OOP/THE in 2014 (34.4%)
- The dash/dotted orange line represents the average of OOP/THE in 2014 for the rest of the world (29.5%)



OOP PER CAPITA (CONSTANT USD) 1994-2014 *fig. 11*

- Hollow circles represent the average OOP per capita in 1995 (2014)
- The dashed blue line represents the sample average OOP per capita in 1995 ($15.3).
- The solid blue line represents the sample average OOP per capita in 2014 ($38.1).
- The dash/dotted orange line represents the average OOP per capita in 2014 for the rest of the world ($297).

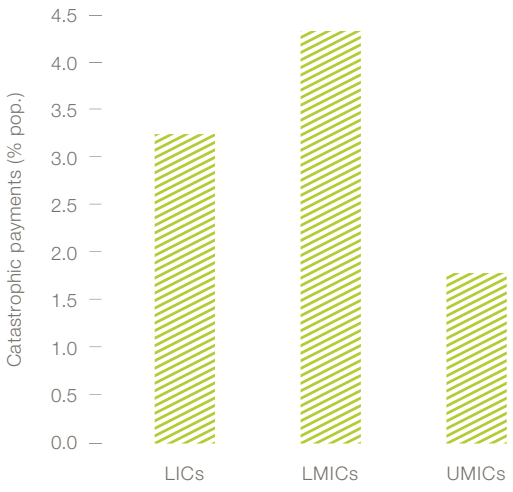


High and rising levels of OOPs represent a significant strain on households in Africa and are a major and growing cause of impoverishment.

Based on household surveys conducted across African countries during the past 25 years (1990–2014), millions of households reported catastrophic and impoverishing health spending, with households in LMICs and LICs being more vulnerable than those in HMICs. On average, 3.2 percent of the population (ranging from 0.8 to 5.4 percent across countries) – 35 million individuals – experienced catastrophic health payments in a given year (figure 12a). Similarly, almost 1.2 percent of the population – roughly 14.4 million people – in LICs and LMICs fell into poverty[9] because of health payments during the survey year (figure 12b).[10] The share of the population with catastrophic health payments (15 percent threshold) has increased from 1.2 to 5 percent over the last 25 years (figure A11), while available data suggest that the share of the population pushed into poverty as a result of health spending has also grown from 0.6 percent in 1990 to 1.5 percent in 2014 (figure A12).

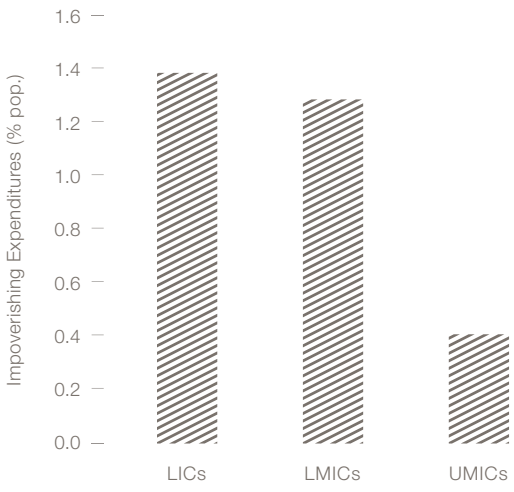
35 MILLION AFRICANS INCUR CATASTROPHIC EXPENDITURES EVERY YEAR *fig. 12a*

- Catastrophic payments are defined as out-of-pocket health payments in excess of a specified proportion of total consumption
- We consider here threshholds of 15% of total consumption



14.4 MILLION AFRICANS INCUR IMPOVERISHING EXPENDITURES EVERY YEAR *fig. 12b*

- The incidence of impoverishing expenditure measures the proportion of households pushed below the poverty line because of out-of-pocket payments for health.



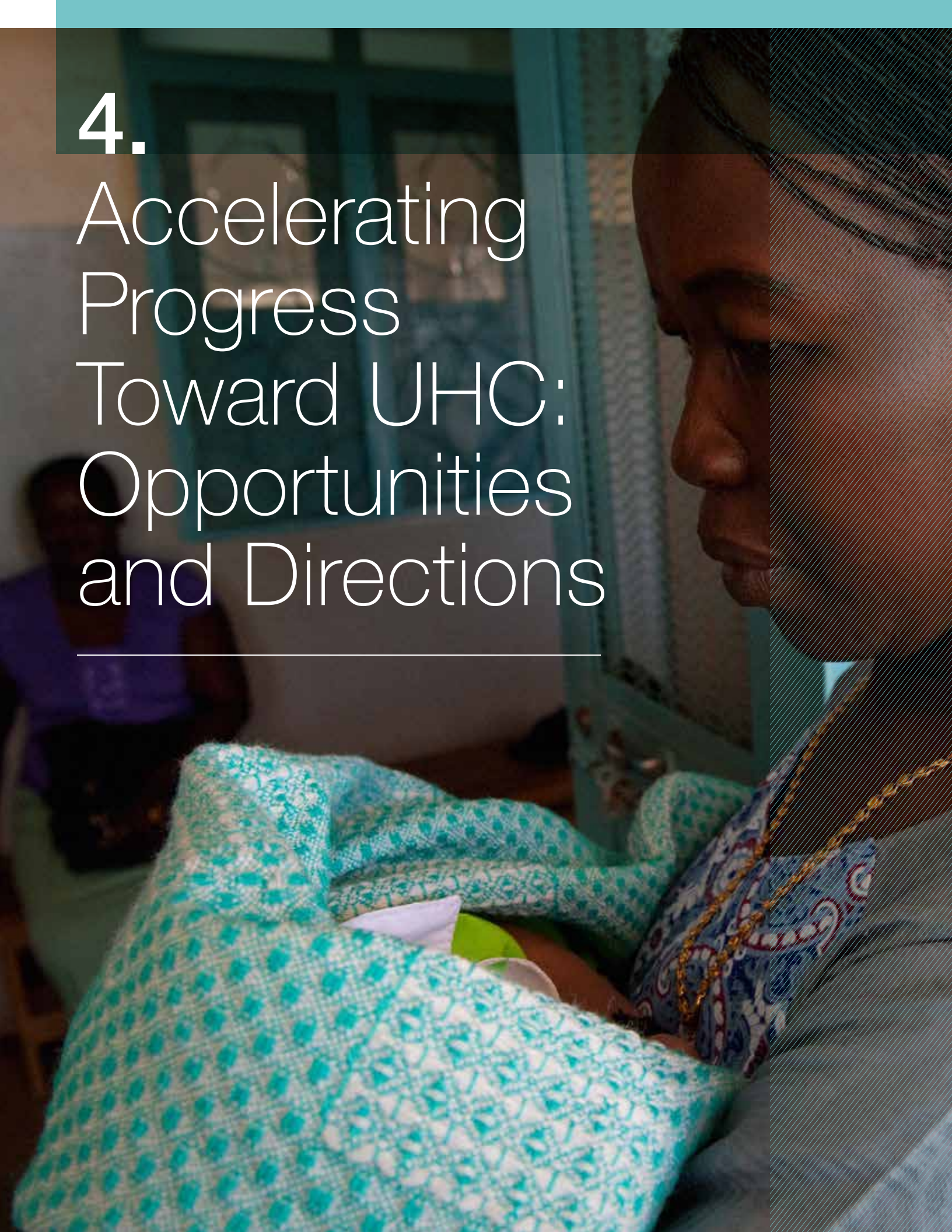
Shortcomings in Preparedness for Public Health Emergencies

The risk to human security of not having sufficient capacity to respond to pandemics has become paramount.

As witnessed in the last few years, outbreaks of Ebola, Middle East Respiratory Syndrome (MERS), avian influenza and the Zika virus can devastate communities through loss of life and severe social and economic impacts. The recent Ebola outbreak in western Africa showed how an epidemic can proliferate rapidly in the absence of a strong health system that provides effective coverage of services not only for the better-off, but also for rural populations and marginalized groups. Recent outbreaks have also highlighted the importance of Essential Public Health Functions (EPHF) – the responsibility of the state to improve, promote, protect, and restore the health of the population through collective action – as the most cost-effective way to enhance population and individual health (World Health Organization 2016b). The ability to address social and environmental determinants of health also contributes to the prevention of public health emergencies.

Health system preparedness for public health emergencies is still in its infancy.

To date, Morocco is the only country on the continent that has conducted a EPHF assessment (Martin-Moreno et al. 2016), which suggests serious lack of attention to public health on the continent. Also, International Health Regulations (IHR) have a role in reducing the risk of emergencies and minimizing their potential damage, but recent assessments highlight important shortcomings in IHR core capacity in African countries.[11] For example, a recently completed Joint External Evaluation (JEE) in Ethiopia identified critical challenges in multi-sectoral engagement, integration of surveillance functions in human and animal health systems, and strengthening of laboratory capacity.



4. Accelerating Progress Toward UHC: Opportunities and Directions

The elimination of preventable maternal and child deaths, AIDS, TB, and other diseases in Africa is within reach.

Recent analysis by the Lancet Commission on Global Health showed that countries that achieve their UHC targets by 2035 will eliminate preventable maternal and child deaths – saving over 10 million women and children (Jamison et al. 2013). The commission also showed that many low- and middle-income countries already have the technology, experience and know-how to make UHC a realistic target for Africa. At the same time, recent events, like the Ebola virus outbreak, emphasize that the cost of failure is higher than ever. The lost economic output and direct costs for Guinea, Sierra Leone and Liberia amounted to US$1.6 billion in 2015 alone (World Bank 2014).

There is no one-size-fits-all approach to achieving UHC – strategies will depend on local circumstance and national dialogue.

Despite the great diversity of African countries, many are facing common challenges. This framework proposes a set of actions for stakeholders involved in the UHC process. It focuses on five areas:

1 / Financing
2 / Services
3 / Equity
4 / Preparedness
5 / Governance

1 Financing: More and Better Spending and Effective Financial Protection

KEY ACTIONS

- Improve efficiency of public and private health spending for better outcomes and resource expansion
- Increase government spending on health through budget re-allocation and increased domestic resource mobilization
- Use budget resources to reduce financial barriers to health care and make services affordable to everyone
- Ensure that the poor, and the informal sector benefit from pre-payment schemes, and that providers get a fair deal
- Improve the effectiveness of development assistance for health through improved coordination and use of country systems

Gains in the efficiency of public and private health spending will be critical to improve outcomes and expand resources over time.

Many health systems in Africa are characterized by significant inefficiencies.[12] In a context of tightening fiscal space, the health sector will have to increase and demonstrate efficiency and improved health outcomes to advocate for additional resources. Key approaches for improving technical and allocative efficiency are well established. They include allocating resources toward services and inputs that generate better results at lower cost, pooling of funds, increasing transparency and accountability, introducing strategic purchasing, and strengthening managerial capacities at both government and facility level. In some contexts, there may be opportunities to expand resources for health and other priorities by identifying inequitable budget items, such as fuel and food subsidies.

Sustained progress toward UHC will depend on improved domestic resource mobilization.

As populations in most countries continue to expand, demand for health services and health expenditures are expected to grow. Moreover, health systems will need to meet changing health needs, including chronic non-communicable diseases. The United Nations (UN) Conference on Financing for Development agenda established in Addis Ababa in July 2015 called for domestic resource mobilization as central to the SDG agenda (United Nations 2015). Countries agreed to an array of measures aimed at widening the revenue base, improving tax collection, and combatting tax evasion and illicit financial flows. Strengthening the tax administration will therefore be critical for financing UHC. Even modest improvements would be significant. If developing countries could increase their revenue collection by two to four percent of GDP, they would surpass the amount of development assistance currently received (World Health Organization 2014). In the post-2015 period, increased "health taxes", including tobacco taxation, could represent an additional domestic revenue stream to help finance the SDGs.

DAH will likely remain important in parts of the region through 2030, but needs to be re-positioned to better support countries' efforts toward UHC.

During the Addis conference on financing for development, countries reaffirmed their commitment to official development assistance and pledged to increase South-South cooperation. Most low-income countries in Africa will require sustained DAH to continue to accelerate progress toward UHC, but DAH must contribute to domestic resource mobilization rather than crowding it out (Evans and Pablos-Méndez 2016). The policy convergence around domestic financing also increases the importance for countries and partners to improve coordination of development assistance and expand the use of country systems (page 32). Overall, five shifts in health financing are needed : value for money, domestic revenue generation, innovation, integration and fragility (Lie, Soucat, and Basu 2015).

Effective Development Cooperation: Making it fit for purpose in the SDGs

As levels of DAH increased during the MDG era (2000-2015), concerns about the effectiveness of DAH due to fragmentation, lack of coordination, and use of parallel systems or approaches grew. Four consecutive High Level Forums on Aid Effectiveness to enhance the effectiveness of development cooperation took place in Rome (2003), Paris (2005), Accra (2008), and Busan (2011).

More specific to health, the International Health Partnership (IHP+) was established in 2007 to foster more effective development cooperation to achieve the MDGs through giving priority to national strategies and improving donor behaviours. IHP+ today has 66 partners which agreed to support comprehensive, country-led national health strategies in a well-coordinated way. Progress on these behaviours has however been mixed, suggesting that aid effectiveness is a process that requires persistence, sensitivity to context, and sustained effort (IHP+, 2015). IHP+ has started its transformation process to the International Health Partnership for UHC 2030, which will broaden its scope and membership. The Harmonization for Health in Africa (HHA) mechanism, which is coordinating the action of development partners in Africa, will also be reshaped as part of the UHC 2030 partnership to ensure better coordination of technical assistance and policy advice to countries as well as of health systems investments.

Corresponding with the IHP+ principles, and the new agenda on financing for development, there are concerted efforts to develop more fit-for-purpose DAH. For example, the Global Financing Facility for Every Women and Every Child (GFF) is a multi-stakeholder partnership that supports country-led efforts by aligning DAH with explicit strategies on domestic resource mobilization for high impact interventions. Development partners also increasingly support African countries' UHC plan in their respective areas of expertise. The Global Fund, for instance, is a key partner to achieve UHC targets related to HIV, TB and malaria services.

Expanding pre-payment for health care is critical for eliminating impoverishing health expenditures and achieve UHC.

High financial barriers for health services can have catastrophic consequences for households, either because they end up forgoing care they need, or because they become indebted or impoverished.

There are different approaches to organize pre-payment for health care, but no silver bullet.

Countries differ in how funds for health care are collected (e.g. general tax revenues, earmarked taxes, or mandatory of voluntary health insurance contributions), who manages the funding for health (e.g. Ministry of Health, local governments, a single public agency, or multiple health insurance funds), and how health services are paid for (e.g. budget allocations to government providers or payment to public and private providers for specific services). In many countries, different models for financing health care co-exist – for instance, government budgets to public facilities, social health insurance for formal sector workers, and voluntary health insurance for the informal sector or the better-off. There is no single best way to finance health care – each modality comes with its set of challenges, and contextual factors such as administrative capacity and the extent of formalization of the labor market are important factors.

As countries try to expand pre-payment, it is critical to ensure that the poor and the informal sector are included, and that providers get a fair deal.

One approach to reduce financial barriers is to abolish user fees. This approach has been tried in several countries, and it can have important benefits. In Malawi, user fee exemptions led to increased maternal health care utilization (Manthalu et al. 2016). In Zambia however, the elimination of user fees benefitted richer groups only (Lagarde, Barroy, and Palmer 2012). Simply eliminating fees will be a short-lived measure unless backed by government funding to replace forgone income and incentives from user fees (Mathauer, Mathivet, and Kutzin 2016). Financial barriers can also be reduced through insurance coverage. However, in order for insurance to be affordable for low-income groups, their enrollment will need to be subsidized. Several countries have already been doing this, notably Ghana, Kenya, Morocco, Rwanda, and Senegal. As a result, enrollment in pre-payment mechanisms has increased among low-income groups in these countries, and access to care improved - an important step toward UHC. In Ghana, the insured poor have greater access to health services, lower copayments, and better health outcomes than the non-insured poor (Nguyen, Rajkotia, and Wang 2011).

Financing models that promote equity and inclusiveness are likely to put pressures on the public purse.

Expanding coverage and financial protection will require country-tailored approaches using a combination of supply and demand side financing. However, experience from the region and globally suggest that the scope for broad-based and equitable coverage through traditional social health insurance or other contributory mechanisms for the informal sector is limited in most countries. In those contexts, public financing will be the main route to reduce reliance on out-of-pocket payments and expand coverage of services and interventions, either through financing for the provision of care, or significant subsidies for health insurance. Either way, expanding coverage of pre-payment across the population in a way that ensures that service providers have sufficient resources to provide quality services will need to be backed up by significant budgetary resources.

2 Services: People-Centered Services, Quality and Multisectoral Action

KEY ACTIONS

- Establish people-centered health services to improve quality of services and patient safety
- Prioritize investments in community and primary health care services within the framework of viable local governance systems
- Partner with civil society and non-state providers to expand access to key services and interventions
- Invest in pre-service education, particularly in underserved areas
- Engage in multisectoral action to address determinants of health

Citizens are at the center of UHC

With increasing interconnectivity, individuals are more aware of health issues than ever before. People-centered care[13] can produce better outcomes and reduce costs by improving the quality of the relationship between health providers, patient and family.

Countries can expand coverage and improve outcomes by strengthening community and primary care services

Services should be organized within the framework of viable local governance systems such as health districts or equivalent structures. Today, technological innovations in diagnostics and treatments allow community and primary care workers to provide nearly all of the essential interventions required to substantially reduce preventable deaths for women and children. Countries that have invested in establishing a solid community health platform have achieved substantial drops in mortality. These community health models rely on various mechanisms of community empowerment in health service delivery including community ownership, community management, and community monitoring (pages 35 and 36). Scaling up a community-based and primary care workforce will require some level of affirmative action, e.g. selecting students from underserved areas and creating training facilities in those areas. Networks of competent community and primary care providers are currently being created in many settings across Africa. Major investment is needed to scale up skilled community-based health workers including doctors, nurses, midwives, assistant nurses, and other frontline health service providers. Supporting functions such as supportive supervision, mentoring, continuous professional education and referrals need to be strengthened for the community-based health workers to perform better, together with provision of adequate incentives.

Scaling up of HRH: A Key Strategy to achieving Universal Health Coverage in Ethiopia

In 2005, the Government of Ethiopia produced a national health strategy entitled "Health Sector Development Programme III." This strategy identified health worker shortages and poor incentives as key bottlenecks to achieving MDGs 4, 5 and 6. Efforts to scale up health professionals in the cadres of health extension workers, midwives, doctors, health officers, and emergency obstetric surgeons, included:

1 / **A collaboration between the Ministry of Health and Ministry of Education to produce more than 30,000 health extension workers (HEW) in five years.**

2 / **Establishing Integrated Refresher Training for HEWs to create sustained delivery capacity of 16 health service packages.**

3 / **Transforming selected hospitals into medical and health science training colleges; increasing the number from five to 10.**

4 / **Improving human resource management and incentives.**

The government demonstrated its commitment by creating fiscal space for salaries and health worker incentives in the priority cadres. Development partners also rallied behind the national strategy by supporting the health infrastructure, medical equipment, drugs and supplies.

Almost five years after its initiation (in EFY 2002), Ethiopia has nearly 35,000 rural health extension workers staffing over 12,000 health posts in rural kebeles. An additional 3,400 urban health extension workers were deployed in urban centers. Ethiopia also expanded other cadres, including emergency surgery and obstetrics professionals and midwives.

Ethiopia's strategic investment in HRH has contributed to remarkable achievements in health outcomes. The Ethiopia Mini Demographic Health Survey (EMDHS) 2014 showed a steep increase in the contraceptive prevalence rate from 28.6 percent to 41.8 percent, and a decrease in total fertility rate from 4.8 to 4.1 children per woman.

The Community-Based Health Planning and Services: A key strategy toward UHC in Ghana

In Ghana, the Community-based Health Planning and Services (CHPS) strategy was adopted in 1999, based on the experiences of the Community Health and Family Planning Project launched in Navrongo in 1994. This national strategy aims to improve geographical access to basic health care by delivering essential PHC services at the community level, with planning and service delivery based on community initiative. Its primary focus is to serve communities in deprived areas and bring health services close to the community. CHPS involves mobilization of community leadership, systems for decision-making, and the placement of frontline health staff – known as Community Health Officers – with logistics support and a community volunteer system to support them. Key interventions at community level include reproductive and child health services, family planning, health promotion and control of communicable and non-communicable diseases. The district hospitals serve as referral centres for these community level service delivery points.

The number of functional CHPS zones has steadily increased and has generated positive results. In 2016, the new national CHPS policy was launched to “attain the goal of reaching every community with a basic package of essential health services toward attaining UHC and bridging the access inequity gap by 2030.”

Innovative partnerships with the non-state sector can potentially be scaled up to accelerate UHC.

The private sector in Africa is very diverse, including for-profit organizations, not-for-profit, and faith-based providers ranging from individual drug merchants to large corporations. As a recent Lancet series summarized, government policies play a crucial role to support widespread availability of financially accessible and competent providers, whether public or private, and hence ensure that services reach the population as a whole (McPake and Hanson 2016). There are multiple examples of innovative partnerships across the continent, ranging from social health franchises in East Africa, to contracting of specific services in North Africa and social marketing of health commodities in West Africa. However moving from promising initiatives to scaled up and cost effective programs has proven challenging. Ensuring good quality services and products in the non-state sector will require investing in health governance, including stronger regulatory framework, accreditation systems, and enforcement capacity.

Quality and patient safety is integral to UHC.

Approaches such as performance-based financing, clinical audits, quality improvement processes and accreditation have shown that quality can be improved in a relatively short time, even in highly constrained settings and without major additional investments in other health inputs. Achieving and sustaining such gains requires additional policies that address some of the systems constraints. These include common definition and monitoring of quality of care, strengthening professional associations and regulatory bodies, increasing the voice of users, and more inclusive governance and accountability systems for health facilities.

Access to affordable medicines and health products is critical for the provision of quality health services.

Investments to enable countries' strengthen their pharmaceutical systems are key for improving access to quality assured medical products. Support is needed to develop and implement evidence-based pharmaceutical policies, strategies, and plans; to create a mechanism for policy dialog to involve stakeholders in the pharmaceutical sector, establish the cooperative regulation of medical products across the region, build capacity in management and use of health products. Some innovations are currently being tested: for example, the Global Fund developed an algorithm for more efficient use of technology, offering explicit and specific combinations of 10 innovative detection technologies.

Improvements in health services should be complemented by multi-sectoral action to address determinants of health.

Environmental and social factors influence individual and community health. Expanding access to clean water and sanitation is paramount if further progress in health status is to be achieved. Addressing these health challenges requires the collaboration of different sectors to increase knowledge, establish strong partnerships, and drive innovation in addressing cross-cutting issues. The development of an Essential Public Health Functions framework for the African region would be a first and essential step.

3 Equity: Targeting the Poor and Marginalized and Leaving No One Behind

KEY ACTIONS

- Target vulnerable populations and design programs tailored to their needs
- Expand service delivery to marginalized groups and settings
- Scale-up pro-poor interventions such as demand-side incentives, including vouchers and conditional cash-transfers
- Ensure the rights and entitlements of women, children and minorities, particularly during vulnerable parts of the life course

Appropriate targeting and design of interventions can help address the need of vulnerable population groups.

Certain population groups such as displaced people, deep rural and peri-urban populations, and adolescent girls are consistently underserved. Expansion of primary health care services needs to be targeted to the most under-served geographic areas, and the design and implementation of programs tailored to meet the needs of specific vulnerable groups. This includes ensuring the availability and acceptability of key services for women, in particular during vulnerable parts of the life course, such as adolescence. Policy commitments, strong information systems, and fine-grained data and analysis will be critical components to meet the needs of population groups.

Technology and operating models, and organizational insights can be particularly important for reaching marginalized groups.

A mix of innovations in the way health services are delivered will be required to build a 21st century health care system in Africa. From e-learning nursing programs to the use of new diagnostic tools, countries across Africa are using new approaches to improve their health systems. More than 400 hospitals in Africa, mainly public, are now applying continuous quality improvement (CQI or kaizen) as an innovative means of realizing quality and efficient health service delivery. More than twenty countries in Africa have experimented with performance-based payment to incentivize greater productivity and quality of health services. Other strategies that have been tested include public and community information about life saving behavior (e.g. hand washing and nutritional practices), expansion of outreach services including mobile clinics and home visits, and the development of community-based services. Increased technology usage through mobile phones, social media, and traditional media, provide policy makers with a much wider set of channels to communicate effective behavioral interventions, especially for the poor (page 39).

Conditional cash transfers (CCT) and other financial incentives for uptake of health services are increasingly common in Africa and can help expand access and outcomes for the poor.

In Malawi, the introduction of a cash incentive doubled the number of individuals attending a Voluntary Counselling and Testing (VCT) center (Thornton 2008). In Uganda and Kenya, vouchers also led to promising results in the utilization of reproductive health services and health outcomes (Bellows, Bellows, and Warren 2011, Warren et al. 2011). Mobile payments can be used to target cash transfers and e-vouchers to the poor.

Innovations to Expand Coverage of Key Health Services and Interventions

Performance-based financing (PBF)

Over the past 10 years, more than 20 African countries have attempted to better link funding with health services results. The performance-based financing movement has triggered innovation throughout Africa (Meessen et al. 2011) and has led to a significant increase in utilization and quality of services in some contexts. PBF works best when supported by broader system change, including providers' autonomy, decentralization, civil service and budget reform. Quality and transparency of data and information is paramount.

Integrated service delivery

A Countdown to 2015 country case study documented the integration of service delivery in Niger to successfully reduce child mortality rates by half (Amouzou, Habi, and Bensaïd 2012). This goal was achieved through the expansion of primary health care services, provision of free health care for women and children, and scale up of nutrition interventions. The effort was supported by concomitant multi-sectoral investments such as food security and water and sanitation.

Conditional cash transfers

In Malawi, lack of education and economic dependence are important risk factors for HIV infection in women. Results from a cluster randomized trial revealed that a cash transfer program reduced HIV and HSV-2 infections in adolescent schoolgirls (Baird et al.).

Mobile health

In Uganda, U-Report is empowering young people through access to a free SMS service that also allows participants to receive information and respond to polls. The polling tools are an excellent way to collect data on vulnerable populations. For instance, one of the polls addressed the effectiveness of Uganda's child protection services in meeting the needs of child abuse victims (Cummins and Huddleston 2013, WDI 2016). In Kenya, SMS is used to improve the timeliness of reporting and information sharing in disease surveillance.

Partnership with the private sector

To improve service delivery of lifesavings drugs in rural Tanzania, the Global Fund, Coca-Cola, and the Bill and Melinda Gates Foundation initiated a project in 2009 that aimed to leverage Coca-Cola's distribution channels to address challenges within the supply chain of the Medical Stores Department (MSD). It enabled the MSD to expand its distribution network to service over 5,000 clinics (from an initial 500 delivery points) and reduce stock replenishment lead times by up to two-thirds (The Global Fund).

4 Preparedness: Strengthening Health Security

KEY ACTIONS

- Improve national preparedness plans including organizational structure of the government
- Promote adherence to the International Health Regulations (IHR)
- Utilize international framework for monitoring and evaluation of IHR
- Enhance relevant partners' and across countries' collaboration to prepare for and respond to public health emergencies

Investing in critical core public health functions is important in preventing and managing future pandemics.

To date, two-thirds of countries worldwide, most of them in Africa, are not compliant with International Health Regulations and have not met their core capacities. Pandemic preparedness requires adequate institutional arrangements combined with actionable plans, strong multi-sectoral action, and resource mobilization. Enhancing collaboration among countries, relevant partners, and global initiatives including the programs by WHO and World Bank is crucial for building capacity in emergency preparedness, response, and recovery. Regional collaboration is needed to increase heath systems resilience beyond national borders, including strategic investment in highly specialized laboratories and surveillance networks to benefit the entire African continent.

Financing is a critical element of the health security and preparedness agenda.

The recent Ebola and yellow fever outbreaks highlighted the core responsibility of African governments to invest in financing public goods such as preparedness and response to epidemics. Currently, the WHO, with the support of the World Bank and other partners, is reorganizing its emergency programs to provide faster and more effective assistance to countries in cases of pandemic.

5 Governance: Political and Institutional Foundations for the UHC Agenda

KEY ACTIONS

- Establish platforms and processes to foster societal dialogue
- Enhance effective mechanisms for inter-sectoral dialogue and action
- Establish systematic monitoring and reporting on progress toward UHC
- Ensure that all citizens have access to data and information on UHC, as part of societal dialogue and participatory processes
- Strengthen national institutions and organizations to lead implementation of reforms for UHC

Ensuring universal access and guaranteeing the right to health requires citizens to voice their choices in terms of public policy and priority setting.

Universal Health Coverage is the outcome of a country-level social contract. Coalitions and coordination mechanisms are necessary to foster societal dialogue; ensure robust political commitments to UHC; and translate such commitments into funding, actions, multi-sectoral coordination and results. The National Conference on Health in Tunisia provides an instructive example of societal dialogue (top of page 42). Experience shows that this exercise must be as inclusive as possible involving grassroots community organizations, professional organizations, private sector providers, and academic institutions.

Development and implementation of UHC strategies depend on effective mechanisms for inter-sectoral dialogue and action.

Africa has made significant progress in this area since the joint Tunis Declaration of Ministers of Finance and Health (page 43). The activities of the joint Value for Money (VfM) program will have to be sustained and expanded, particularly with the Africa Union and regional economic communities.

National capacity to generate and use high-quality data for measuring progress toward UHC is critical for accountability.

Across Africa, there has been a data revolution in the health sector, and there are opportunities to build on this progress, expand operational research and learning, and increase accountability toward UHC. Through the Health Data Collaborative (HDC), countries, and other stakeholders, are capitalizing on such opportunities (bottom of page 42). While tracking of indicators is important, indicators can only describe change, not explain it. It is essential to build and institutionalize national capacities for applied policy research and evaluation, and to use findings in decision-making. As part of this process, countries are encouraged to formally adopt a core set of indicators to monitor UHC progress and incorporate them in national monitoring and evaluation systems. It is also important to ensure that all citizens have access to data and information on UHC, as part of societal dialogue and participatory processes. Moreover, systematic UHC monitoring also needs to be complemented by strong capacity in Ministries of Health in the areas of planning, finance and metrics.

Societal Dialogue in Tunisia: Population Participation in Health Policy-making

Tunisia made headlines when citizens engaged in civil resistance, leading to the "Arab Spring." The transition government of Tunisia decided that an in-depth population consultation was crucial to capture people's views, needs, and daily challenges. In 2012, a program called "societal dialogue" was launched, with technical support from the WHO. The population consultation in Tunisia was done with the simultaneous goals to capture population opinion, and provide people a new platform to express themselves.

The first-ever 'Citizens' Estate General of Health' ("Etats Généraux de la Santé") was organized in the 24 Tunisian administrative regions. Citizens and civil society organizations shared key health sector challenges, and their values, attitudes, and views on how to improve health services. Approximately 100 people, selected by lottery from each of the administrative regions, formed a "Citizens' jury" ("Jury Citoyens") and were tasked with answering specific questions around these themes:

- Health system financing
- Neighbourhood health services
- Promoting healthy lifestyle choices
- Revitalizing and rebuilding confidence in the health sector

The population consultation events were captured in a "White Book", the first, comprehensive health sector diagnostic. It has served as a basis for the next five-year National Health Plan, which is being discussed and finalized.

SOURCE: WHO-EC-Luxembourg partnership

Launch of the Kenya Health Data Collaborative (HDC)

The HDC is a joint effort by countries, development partners, civil society, and academia to strengthen national health information systems, improve the quality of health data, and track progress toward UHC and the other health-related SDGs. In 2016-17, Collaborative partners will respond to five to eight country requests for engagement and joint action, through provision of technical support and better alignment of financial support with national plans.

As one of the HDC's pathfinder countries, Kenya launched its own HDC at the country level on May 18 in Nairobi. Kenya's Ministry of Health has developed a roadmap for its Collaborative, which articulates priority areas around strengthening its health information system. These include data analytics, quality of care, civil registration and vital statistics, a new national health data observatory, and informatics. The roadmap also outlines the roles and responsibilities from government, global and regional partners, civil society, public health institutions and other stakeholders.

The Value for Money (VfM) in Health Programme: A Call to do More with Less

In July 2012, the African Development Bank (AfDB) hosted the Tunis Conference on Value for Money, Sustainability and Accountability in the Health Sector. The conference brought together 62 African Ministers of Finance and Health, together with heads of institutions, and CSOs for a high-level dialogue. The conference culminated in the Tunis Declaration on Value for Money, Sustainability and Accountability in the Health Sector, which is a call for collaboration between the two ministries, development partners, parliamentarians, and civil society to deliver equitable, efficient, and sustainable health services in Africa while ensuring accountability at all levels of the health system.

To respond to the multifaceted and complex needs of countries to improve VfM in health sectors, and translate the Tunis Declaration into action, AfDB partnered with the WHO, the World Bank, and UN organizations (UNICEF, UNFPA and UNIFEM) with the support of NORAD and GAVI Alliance and set up a trust fund, of about US$6 million over five years, for VfM Program implementation.

Targeting those who make the most difference with the right tools: The VfM Program targets key stakeholders that play pivotal roles in improving VfM in health. The program supports regional economic communities, such as the EAC, SADEC and ECOWAS in increasing the capacity of their budget officers in health planning, budgeting, and purchasing. The program supports both training and technical assistance and works in close partnership with African technical networks such as CABRI (Africa Network of Budget Officers), AHEA (African Health Economics Association), and civil society groups such as the Africa 15% campaign. Some of the accomplishments include:

A / The Ministerial Forum on VfM Program: Designed for serving ministers of finance in collaboration with Harvard University

B / Capacity building for parliamentarians. Parliamentarians are key decision makers regarding social sector financing and also have a key role in the design of legislation that impacts social sectors.

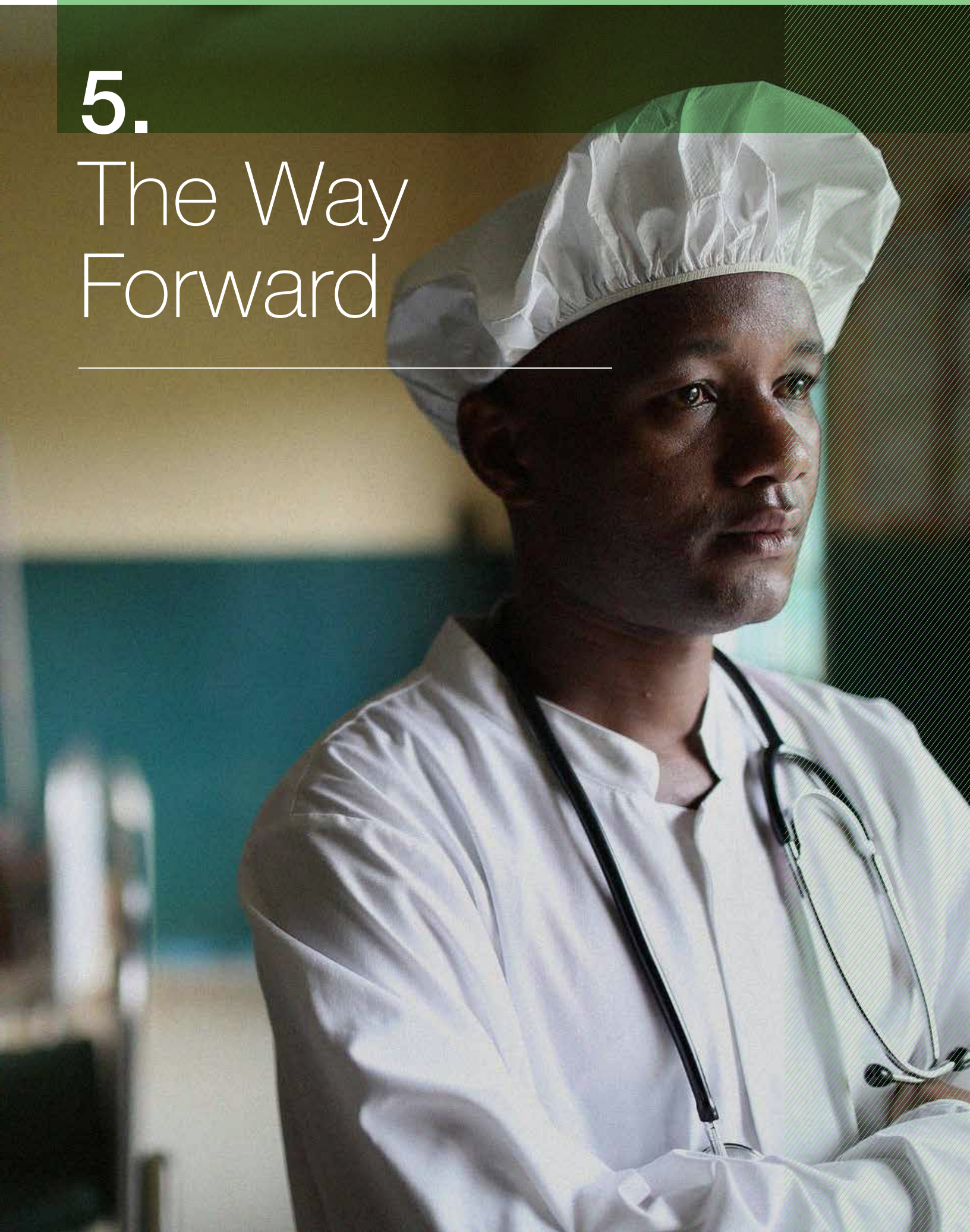
C / Capacity building for senior officials and civil society organizations: One of the strategies for improving value for money is building the capacity of senior officials from the concerned ministries and institutions.

D / Generating evidence for policy formulation at the country level. The program supported Tanzania in generating evidence on fiscal space and exploring innovative financing strategies toward UHC.

E / Exploring the potential links between domestic public health expenditure and foreign direct investment.

SOURCE: AfDB-WB-WHO

5.
The Way Forward



Moving Toward UHC

Africa has experienced unprecedented economic growth, poverty reduction, and improvement in health outcomes, but progress has been uneven.

Economic and population growth combined with an evolving disease burden will continue to increase demand for health services and put pressure on health systems. To respond to these challenges, countries will need to invest in their health systems. This calls for renewed commitments and accelerated progress toward UHC across Africa.

African governments and development partners have made significant commitments to UHC.

Financing for health has increased, however, this increase was mainly driven by development assistance. Service delivery capacity has expanded but human resources for health remain insufficient. Recent epidemics revealed that many health systems are not prepared to manage such outbreaks. Coverage of maternal and child health services and other key interventions have expanded and become more equitable, but most countries did not achieve the health-related MDGs. OOP spending on health care is high and represents a significant strain on households, contributing to impoverishment.

Accelerating progress toward UHC in Africa is within reach but will require political leadership and a clear strategic vision.

Most African countries have integrated UHC as a goal in their national health strategies. Yet, progress in translating these commitments into expanded domestic resources for health, effective development assistance, and ultimately, equitable and quality health services, has been slow. Countries that achieve their UHC targets by 2030 could eliminate preventable maternal and child deaths, strengthen resilience to public health emergencies, reduce financial hardship linked to illness, and strengthen the foundations for long-term economic growth.

This framework (page 47) proposes a set of actions for stakeholders involved in the UHC process.

UHC will require the strengthening of existing institutions such as National Health Insurance Agency, National Purchasing agencies, National Center for Disease Control and Prevention, Health Policy Unit of Ministry of Health, professional associations, licensing and accreditation bodies, tort mechanisms and training and research institutions. Institutions involved in training and research are particularly important as high quality health workers and know-how are critical inputs for UHC. The establishment of new legal and regulatory institutions and mechanisms for citizen participation and progress monitoring may also be necessary in some countries. Development partner support will be critical to help countries in the region push the UHC agenda forward.

UHC in Africa:
A Framework for Action

1 / FINANCING

More and Better Spending and Effective Financial Protection

- Improve efficiency of public and private health spending for better outcomes and resource expansion
- Increase government spending on health through budget re-allocation and increased domestic resource mobilization
- Use budget resources to reduce financial barriers to care and make services affordable to everyone
- Ensure that the poor, and people working in the informal sector benefit from pre-payment, and that providers get a fair deal
- Improve the effectiveness of development assistance for health through improved coordination and use of country systems

2 / SERVICES

People-Centered Services, Quality and Multisectoral Action

- Establish people-centered health services to improve quality of services and patient safety
- Prioritize investments in community and primary health care services within the framework of viable local governance systems
- Partner with civil society and non-state providers to expand access to key services and interventions
- Invest in pre-service education, particularly in underserved areas
- Engage in multisectoral action to address determinants of health

3 / EQUITY

Targeting the Poor and Marginalized and Leaving No One Behind

- Target vulnerable populations and design programs tailored to their needs
- Expand service delivery to marginalized groups and settings
- Scale-up pro-poor interventions such as demand-side incentives, including vouchers and conditional cash-transfers
- Ensure the rights and entitlements of women, children and minorities, particularly during vulnerable parts of the life course

4 / PREPAREDNESS

Strengthening Health Security

- Improve national preparedness plans including organizational structure of the government
- Promote adherence to the International Health Regulations (IHR)
- Utilize international framework for monitoring and evaluation of IHR
- Enhance relevant partners' and across countries' collaboration to prepare for and respond to public health emergencies

5 / GOVERNANCE

Political and Institutional Foundations for the UHC Agenda

- Establish platforms and processes to foster societal dialogue
- Enhance effective mechanisms for inter-sectoral dialogue and action
- Establish transparent monitoring and reporting on progress toward UHC
- Ensure that all citizens have access to data and information on UHC, as part of societal dialogue and participatory processes
- Strengthen national institutions and organizations to lead implementation of reforms for UHC

Notes

1. This paper aims to cover the entire African continent. Africa refers to the continent as a whole while SSA or NA are used with reference to Sub-Saharan Africa or North Africa countries respectively.

2. At the global level, the UHC movement can be traced back to the 1978 Alma Ata Declaration, which advocated for the strengthening of primary health care. More recently, UHC has been the focus of several UN resolutions to which all African countries are signatories, including the 2012 UN General Assembly resolution on 'The Future We Want", the 2012 UN resolution on UHC and the 2015 UN General Assembly resolution 70/1 on "Transforming Our World: the 2030 Agenda for Sustainable Development" (World Health Organization 2005, 2009, 2011, 2016b). Moreover, numerous regional initiatives have promoted UHC in Africa: the 2001 Abuja Declaration on HIV/AIDS, Tuberculosis and other related infectious diseases, the 2009 Ouagadougou Declaration on Primary Care and Health Systems in Africa, the 2012 Tunis Declaration on Value for Money, Sustainability and Accountability in the Health Sector, the 2014 Luanda Commitment on UHC in Africa, and the Africa Health Strategy 2016-2030. Complementing global and regional commitments, nearly all countries in the region have made explicit country-level commitments to UHC through their constitutions or health-specific legislation or strategies.

3. The incidence of catastrophic expenditure is a headcount indicator calculated as the proportion of households in the population for which health expenditures are equal to or greater than a threshold expressed in terms of total consumption expenditure. In this paper, we consider here two thresholds: 15% and 25% of total consumption expenditure. The second key indicator relates to impoverishing health expenditures, or the proportion of households pushed below the poverty line because of OOP payments. We use the absolute international poverty line of $1.90 per person per day in 2011 PPP factors, as well as the $3.10 poverty line. Furthermore, in order to assess the extent to which those households already below the poverty line and incurring OOP payments for health contribute to increasing poverty, we also look at the effect of OOP on the poverty gap. Finally, since OOP only informs about financial protection insofar as households actually are able to afford to pay for health services, we also use available information on health care use and non-use to assess the extent to which households might actually forgo care because of financial or geographical barriers.

4. These estimates have to be treated with some caution as NHA estimates of government spending in many cases include expenditures financed by DAH. General government expenditure on health presented in the NHA database is "*the sum of health outlays paid for in cash or supplied in kind by government entities, such as the Ministry of Health, other ministries, parastatal organizations or social security agencies (without double counting government transfers to social security and extrabudgetary funds). It includes all expenditure made by these entities, regardless of the source, so includes any donor funding passing through them. It includes transfer payments to households to offset medical care costs and extrabudgetary funds to finance health services and goods. It includes current and capital expenditure*" (WHO 2015).The numbers cited here are hence not estimates of domestically financed government spending on health.

5. This average is driven by the high level of aid dependence of 9 countries where DAH exceeds 40% of THE (Burundi, CAR, Ethiopia, Gambia, Liberia, Malawi, Mozambique, Rwanda, South Sudan)

6. http://www.aho.afro.who.int/en/atlas/health-system/4.9-medical-products-vaccines-infrastructures-and-equipment

7. http://www.who.int/medicines/regulation/ssffc/surveillance/en/

8. A commonly used definition of quality of health care is as "the degree to which health care services for individuals and populations increase the likelihood of desired outcomes and are consistent with current professional knowledge" (Lorh, 1990, Institute of Medicine 2001, WHO 2006).

9. Defined as $1.90 a day.

10. Longitudinal data would be needed to examine the poverty impact of health payments and households' income smoothing over time.

11. The strategic Partnership Portal provides country level data on the JEE: for instance for Tanzania see: https://extranet.who.int/donorportal/jeeta/tanzanias-jee-assessment-scoring; for Ethiopia see: https://extranet.who.int/donorportal/jeeta/ethiopias-jee-assessment-scoring#; for Mozambique see: https://extranet.who.int/donorportal/jeeta/mozambique.

12. Between 20 and 40 percent of total health spending is wasted, with inefficiencies related to human resource management, inappropriate use of medicines, medical errors and suboptimal quality, and corruption and fraud being the main sources (World Health Organization 2010).

13. People-centred care is an approach to care that consciously adopts individuals', carers', families' and communities' perspectives as participants in, and beneficiaries of, trusted health systems that are organized around the comprehensive needs of people rather than individual diseases, and respects social preferences. People centred care also requires that patients have the education and support they need to make decisions and participate in their own care and that carers are able to attain maximal function within a supportive working environment. People-centred care is broader than patient and person-centred care, encompassing not only clinical encounters, but also including attention to the health of people in their communities and their crucial role in shaping health policy and health (Framework on integrated, people-centred health services. http://apps.who.int/gb/ebwha/pdf_files/WHA69/A69_39-en.pdf?ua=1)

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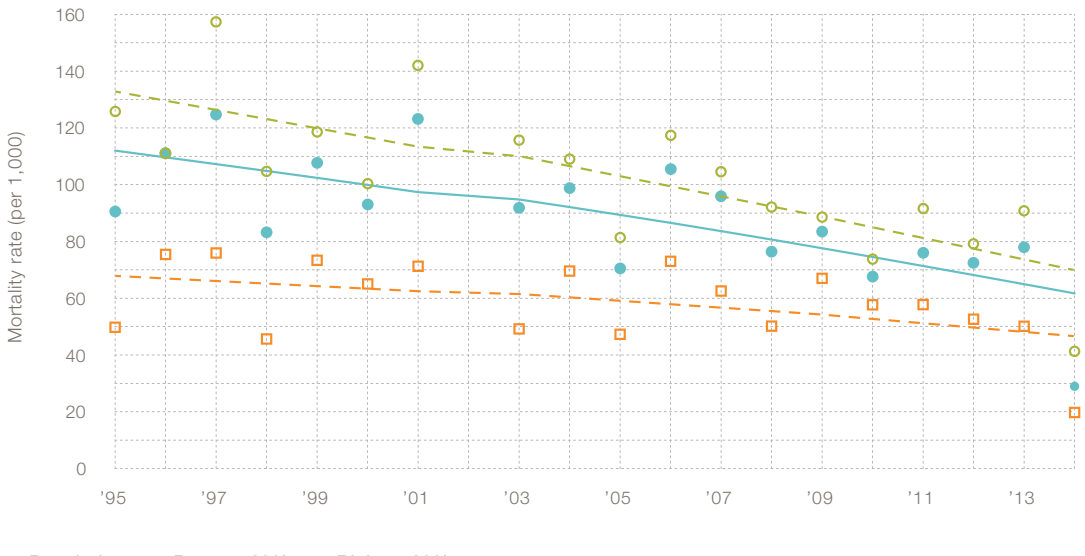
Appendix

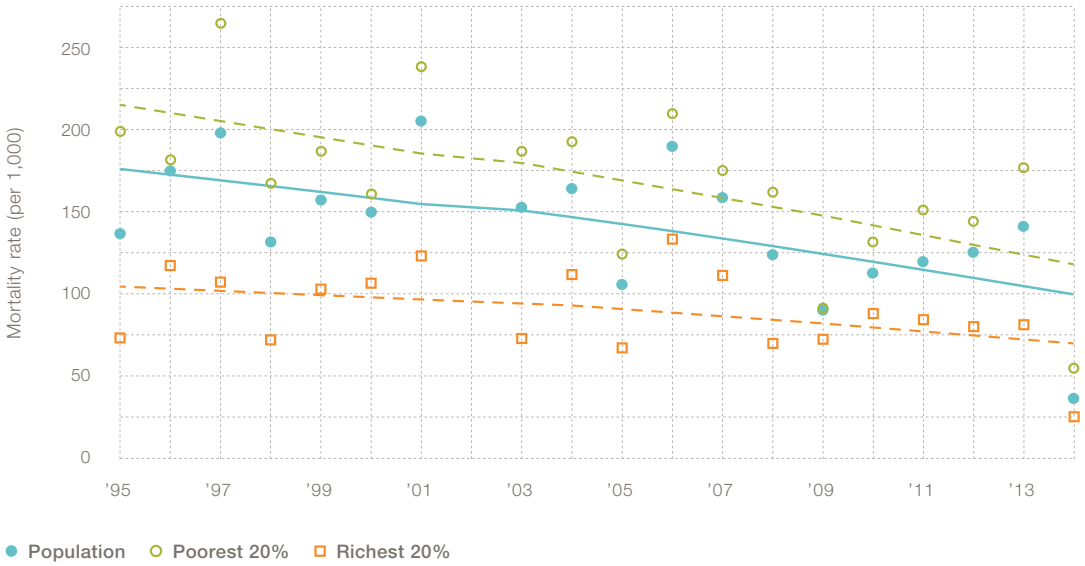
AFRICA EXPERIENCED SIGNIFICANT DECREASE IN INFANT MORTALITY BETWEEN 1995 AND 2014 *fig. A1*

» Sample trends are based on Hodrick–Prescott filtering (smoothing parameter: 1600).
» Yearly points (circles and squares) are population weighted averages.

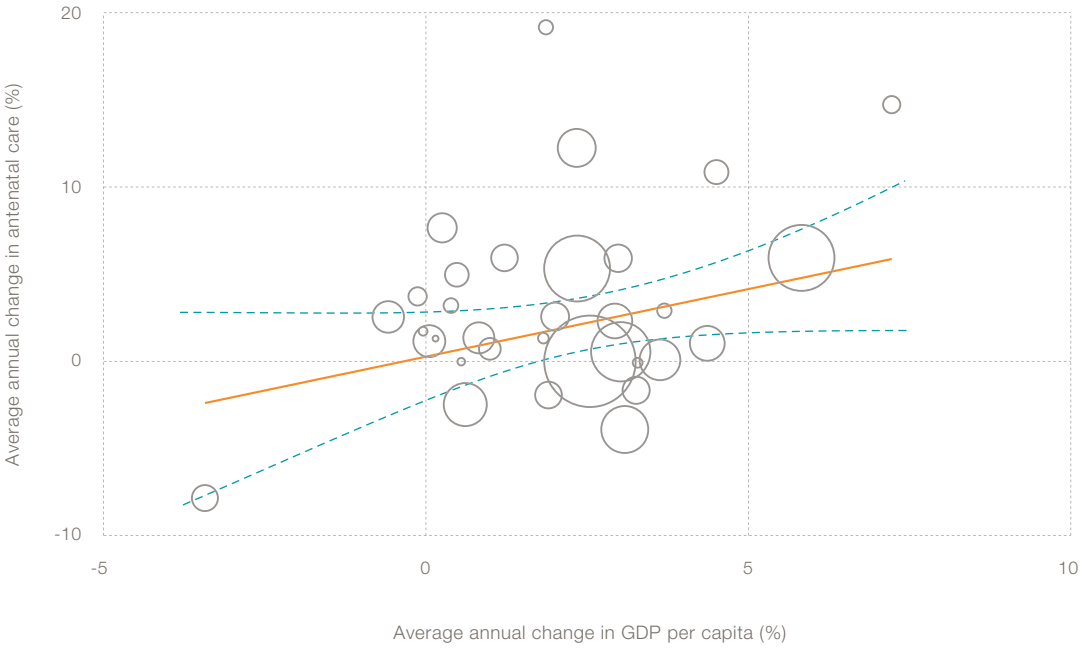


UNDER-FIVE MORTALITY IN AFRICA DECLINED BETWEEN 1995 AND 2014 *fig. A2*

» Sample trends are based on Hodrick–Prescott filtering (smoothing parameter: 1600) applied to yearly population weighted averages.
» Yearly points (circles and squares) are population weighted averages.

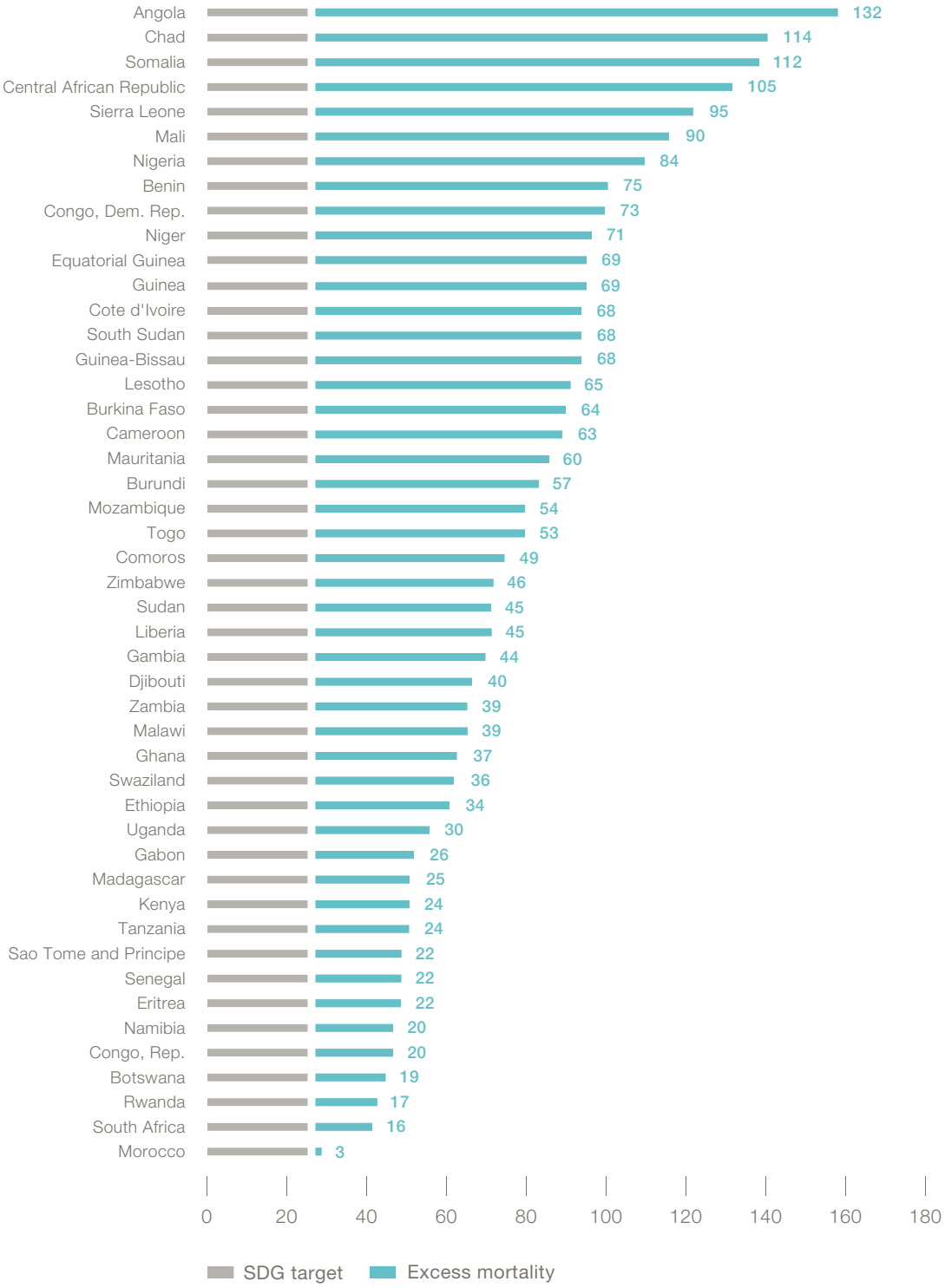


EXPANSION IN ANTENATAL CARE COVERAGE ONLY WEAKLY RELATED TO ECONOMIC GROWTH *fig. A3*



EXPANSION IN ANTENATAL CARE COVERAGE ONLY WEAKLY RELATED TO ECONOMIC GROWTH *fig. A4*

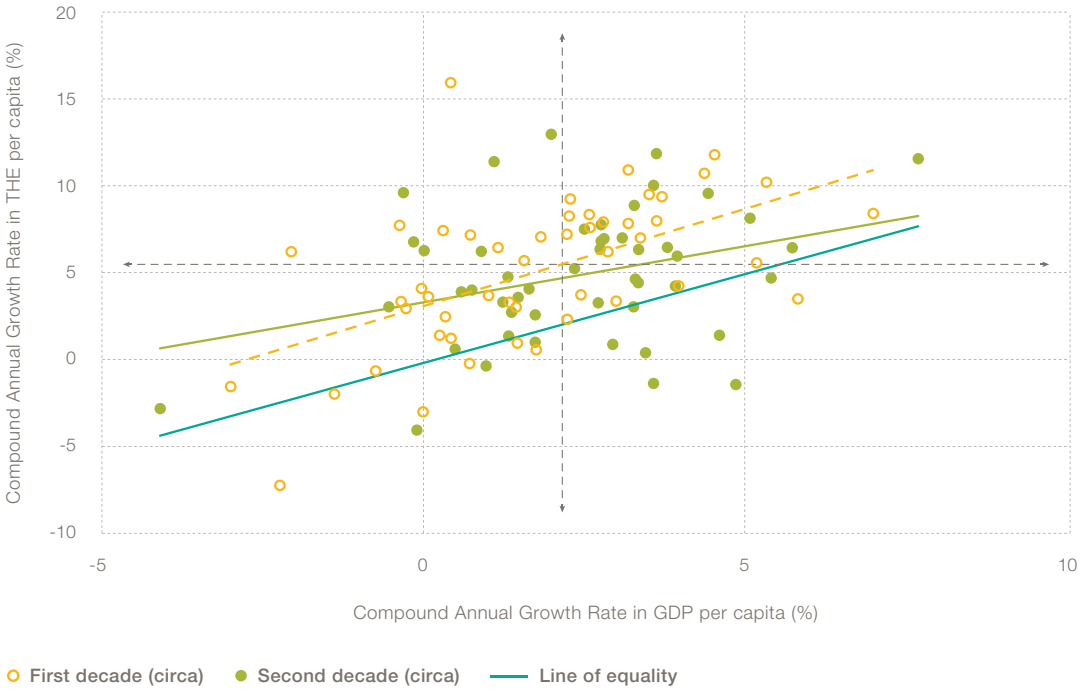
ACCELERATED PROGRESS NEEDED IN MOST COUNTRIES TO ACHIEVE THE UNDER-5 MORTALITY TARGET *fig. A5*



TOTAL HEALTH EXPENDITURE HAS GROWN MORE RAPIDLY THAN GDP *fig. A6*

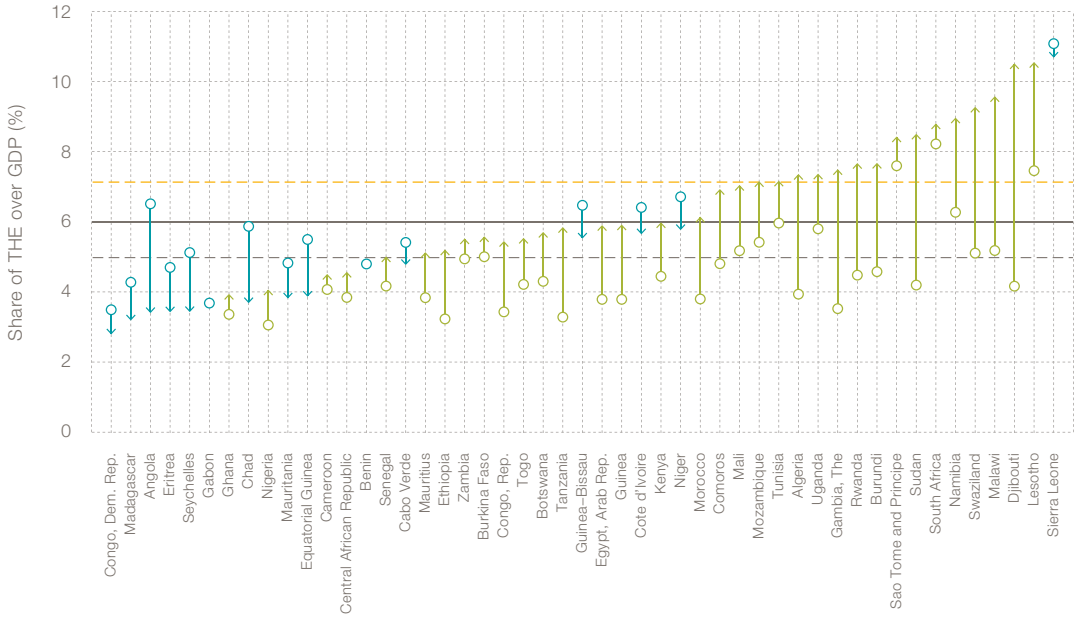
» Compound annual growth rates are calculated between 1995 (or earliest value) and 2014 (or latest value) as (EV/BV)^(1/n)–1 where EV is the end value, BV is the starting values, and n is the number of periods.

» The vertical (horizontal) dashed line represents the median of the GDP (THE) CAGR (2.1% and 5.5% respectively).

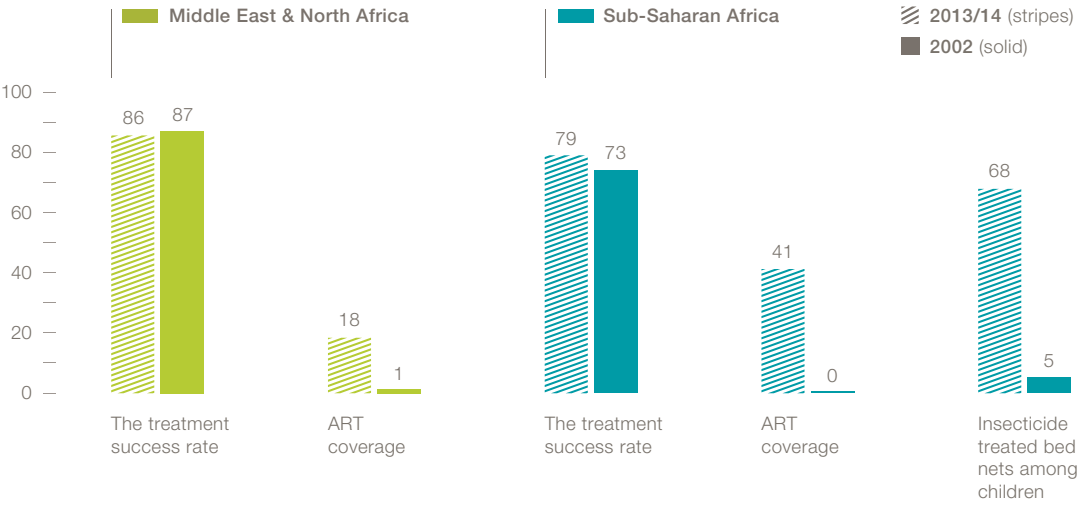


THE AS A SHARE OF GDP HAS INCREASED OVERTIME *fig. A7*

» Hollow (arrow) circles represent the average share of THE/GDP in 1995 (2014).
» The dashed gray line represents the sample average of THE/GDP in 1995 (4.8%).
» The solid gray line represents the sample average of THE/GDP in 2014 (5.9%).
» The dashed yellow line represents the average of THE/GDP in 2014 for the rest of the world (7.1%).

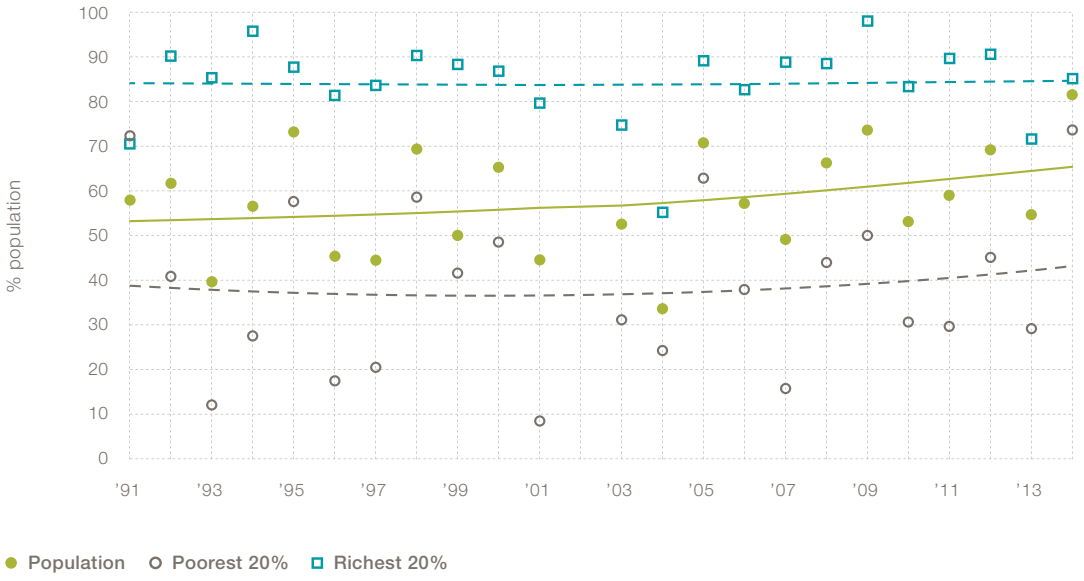


COVERAGE OF HIV/AIDS, TB AND MALARIA INTERVENTIONS IMPROVED OVER THE LAST DECADE BUT IMPORTANT GAPS REMAIN *fig. A8*



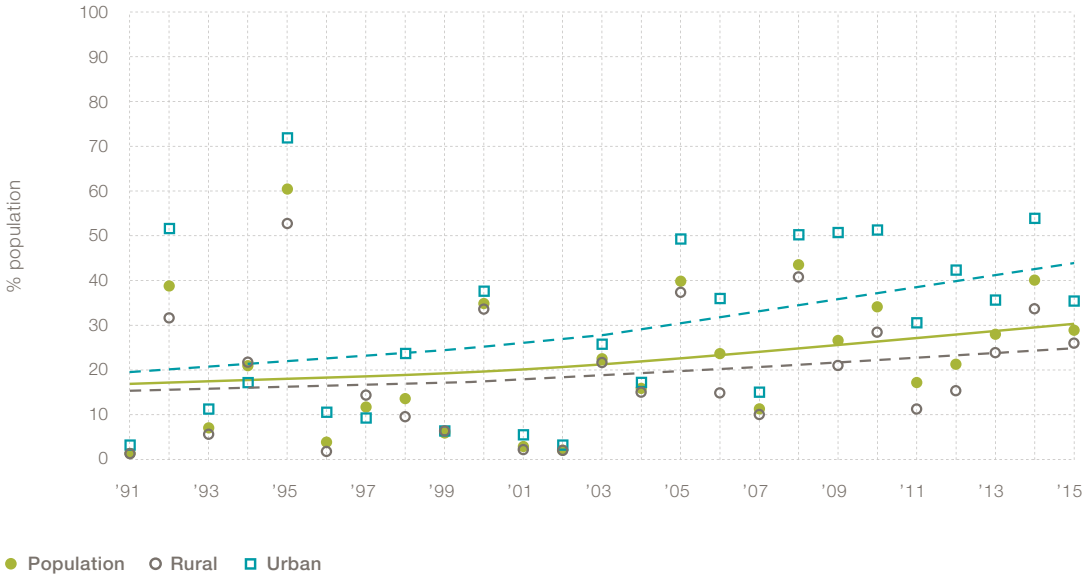
TRENDS IN ACCESS TO IMPROVED WATER SOURCE *fig. A9*

» Sample trends are based on Hodrick–Prescott filtering (smoothing parameter: 1600).
» Yearly points (circles and squares) are population weighted averages.



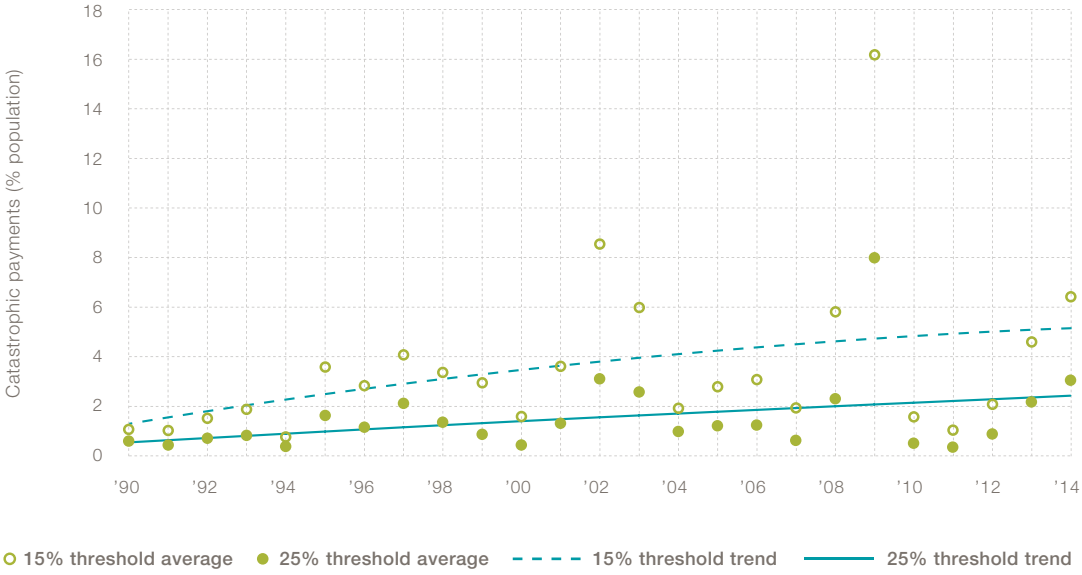
TRENDS IN ACCESS TO IMPROVED SANITATION *fig. A10*

» Sample trends are based on Hodrick–Prescott filtering (smoothing parameter: 1600).
» Yearly points (circles and squares) are population weighted averages.



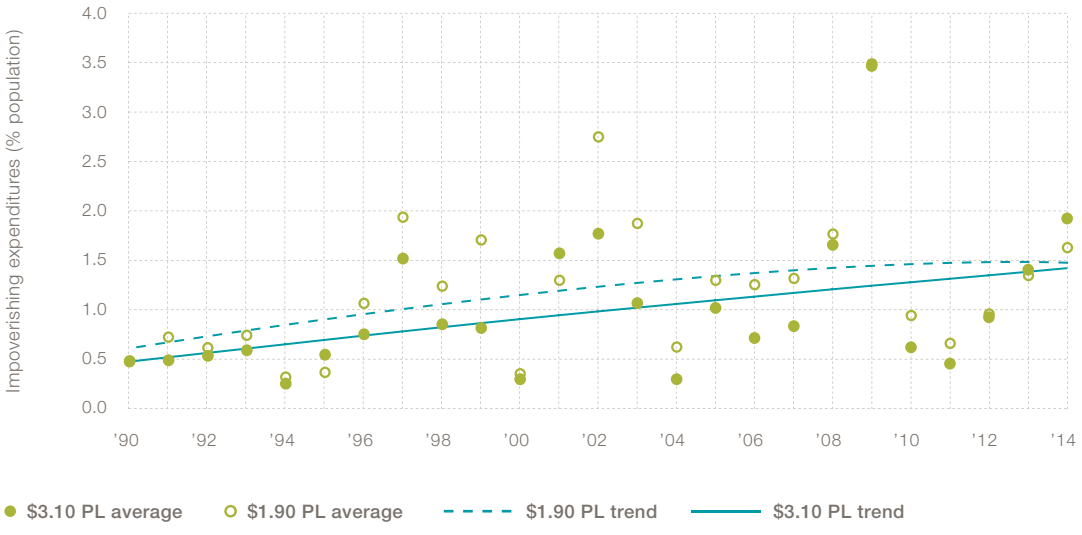
TRENDS IN CATASTROPHIC PAYMENTS FOR HEALTH *fig. A11*

» Scatter points are population weighted averages for each year.
» Hodrick–Prescott trends are extracted from the population weighted points.
» Catastrophic payments are defined as out–of–pocket health payments in excess of a specified proportion of total consumption.



TRENDS IN IMPOVERISHING EXPENDITURES FOR HEALTH *fig. A12*

» Scatter points are population weighted averages for each year.
» Hodrick–Prescott trends are extracted from the population weighted points.
» The incidence of impoverishing expenditure measures the proportion of households pushed below the poverty line because of out–of–pocket payments for health.



Sources

Figure 1:	WHO-GHED
Figure 2:	WHO-GHED
Figure 3:	Authors' analysis based on WHO-GHED
Figure 4:	IMF WEO
Figure 5:	WHO-GHED
Figure 6:	WHO-GHED and World Bank
Figure 7:	IHME
Figure 8:	DHS and MICS
Figure 9:	WDI
Figure 10:	WHO-GHED
Figure 11:	WHO-GHED
Figure 12a:	Household consumption surveys
Figure 12b:	Household consumption surveys
Figure A1:	DHS and MICS
Figure A2:	DHS and MICS
Figure A3:	DHS and MICS
Figure A4:	DHS and MICS
Figure A5:	WDI
Figure A6:	WHO-GHED and WDI
Figure A7:	WHO-GHED
Figure A8:	WDI
Figure A9:	DHS and MICS
Figure A10:	DHS
Figure A11:	Household consumption surveys
Figure A12:	Household consumption surveys

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