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FRAMEWORK FOR PROVISION OF ESSENTIAL HEALTH SERVICES THROUGH STRENGTHENED DISTRICT/LOCAL HEALTH SYSTEMS TO SUPPORT UHC IN THE CONTEXT OF THE SDGS

Report of the Secretariat

EXECUTIVE SUMMARY

1. In the context of the sustainable development agenda, the focus of Sustainable Development Goal 3 (SDG 3) is on ensuring healthy lives and well-being for all at all ages. Several international declarations recognize the district health system as an important vehicle for achieving universal health coverage (UHC) where everyone gets quality care when needed without incurring financial hardship, including the October 2018 Declaration of Astana on primary health care.

2. A district health system refers to a network of organizations and health facilities that provides equitable, comprehensive and integrated health services to a defined population. Member States have made progress in district health system reforms, but their health systems are at different stages. On average, the African Region provides only 48% of the health services that could be potentially provided, due to gaps in the availability of health services at health facilities as well as in the capacity of health facilities to deliver the requisite services.

3. National health systems in the African Region are beset by various issues and challenges, including: shortage of resources; poor organization and management; poor governance; limited capacity for data and information; inadequate medicines, health commodities and supplies; limited health service packages; weak referral systems; and poor and inappropriate health infrastructure. On the other hand, there have been advances in technology, including the development of new medicines and vaccines, and digital health.

4. A framework for provision of essential health services through strengthened district/local health systems to support UHC in the context of the SDGs has been developed. The framework has the following objectives: to guide Member States to strengthen and sustain district health systems in order to provide essential health services; and to articulate priority actions to enable Member States to deliver essential health services that respond to individual and community needs across the entire lifecycle. It sets targets and milestones and priority interventions to guide Member States on ways of ensuring the delivery of quality health services to all through a proposed set of priority interventions and actions that address the issues and challenges encountered.

5. The Regional Committee is requested to examine and adopt the priority interventions and actions proposed in this Framework.

CONTENTS

ANNEX

ABBREVIATIONS

CHPS	Community-based Health Planning and Services
CHW	community health worker
DHS	District health system
HRH	human resources for health
PHC	primary health care
RC	Regional Committee
SARA	Service Availability and Readiness Assessment
SDGs	Sustainable Development Goals
UHC	universal health coverage
WHR	World Health Report

INTRODUCTION

1. The district health system (DHS) is a network of organizations and health facilities that provides equitable, comprehensive and integrated health services to a defined population.[1] Essential health services are services that are based on population needs as opposed to the basic package of health services that are resource-based.

2. The Declaration of Alma Ata in 1978 defined the health district as the vehicle of primary health care (PHC) to achieve the ultimate goal of health for all. The Fifty-sixth and Fifty-seventh sessions of the Regional Committee for Africa adopted orientations on revitalizing health services using the PHC approach in 2006, and resolutions on health systems strengthening including for a well-functioning DHS for universal access in 2007, respectively. The Ouagadougou Declaration of 2008 called for strengthening of health systems using the PHC approach. The importance of the DHS was recognized by the Harare Declaration of 1987 and reaffirmed by the DHS review meeting in Dakar, Senegal in 2013.[2] PHC and the role of the DHS were reiterated at the International Conference on PHC in Astana in October 2018.

3. The Declaration of Astana on PHC in 2018 reaffirmed the importance of PHC and the central role of the community in achieving universal health coverage (UHC) and contributing to the attainment of the Sustainable Development Goals (SDG). The operational framework of the Declaration provides good grounds for strengthening the DHS.

4. However, DHSs are at different stages across and within Member States. One of the key observations from the (2013–2016) Ebola virus disease outbreak in West Africa[3] and the one in the Democratic Republic of the Congo (2018–2019) is the absence of essential services delivery during and after public health emergencies as a negative consequence of the non-existence of a robust and resilient DHS.

5. In line with the triple billion target of the Thirteenth General Programme of Work (GPW 13), namely one billion more people benefitting from universal health coverage, one billion more protected from health emergencies, and one billion more enjoying better health and well-being, essential health services must reach all populations. This calls for a stronger and more functional DHS.

6. The proposed framework is intended to guide Member States in the African Region to revitalize and enhance the capacity of the DHS to facilitate the achievement of UHC.

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1 Health systems strengthening glossary. (https://www.who.int/healthsystems/hss_glossary/en/index3.html, accessed 20 February 2019).

2 Community of Practice Health Service Delivery (2014). Renewing health districts for advancing universal health coverage in Africa. Report of the regional conference "Health districts in Africa: progress and perspectives 25 years after the Harare Declaration" 21-23 October 2013, Dakar, Senegal. (https://www.health4africa.net/wp-content/uploads/Dakar-Conference-Final-Report.pdf. Accessed 12 February 2019).

3 Marie-Paule Kieny et al (2014). Health-system resilience: reflections on the Ebola crisis in western Africa. World Health Organization. Bulletin of the World Health Organization 2014; 92:850. doi: https://www.who.int/bulletin/volumes/92/12/14-149278/en/.

CURRENT SITUATION

7. Member States have embarked on reforms to strengthen the DHS to improve service delivery, resulting in better access to quality services and enhanced community participation. For example, Ghana has rolled out the community-based health planning and services (CHPS) initiative[4] and Malawi and Uganda have a district health performance improvement programme.[5] Ethiopia, Lesotho, Malawi, Rwanda, and Uganda have embarked on the utilization of community health workers (CHWs), with varying strategies. Rwanda and South Africa have introduced family physicians in the DHS.[6] In addition, South Africa has also undertaken PHC re-engineering and introduced the "Ideal Clinic" framework. Cabo Verde has extended specialist services through integrated telemedicine and the eHealth programme.[7]

8. According to the WHO AFRO State of Health report (2018), the Region currently provides an average of 48% of health and health-related services that could potentially be provided. It avails only 36% of the essential services needed by the population to attain UHC, while population access to these services is at 32%. Inequities abound between and within Member States, while financial risk protection is at 34%.[8]

9. Service availability and readiness assessments (SARA) in nine Member States[9] showed significant gaps in the availability of services in health facilities and in the capacity of facilities to provide the services. For instance, the percentage of facilities that indicated the availability of basic surgery was less than 50% in most of the Member States. Readiness of the facilities as measured by the availability of tracer items such as human resources, equipment, and medicines was particularly low. Almost none of the facilities in the Member States had all the tracer items that were considered to be particularly important for offering specific services. Furthermore, compared to the global situation, the health worker density in the African Region per 10 000 population for nursing and midwifery personnel was on average 12.4 versus 28.6, and for physicians, it was 2.7 versus 13.9[10] for the period 2007–2013. Meanwhile, inequity in resource allocation and expenditure has been observed at subnational level with negative consequences on service availability and accessibility.[11,12]

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4 Nyonator FK et al (2005). The Ghana Community-based Health Planning and Services Initiative for scaling up service delivery innovation. Health Policy and Planning; 20(1): 25–34.

5 MOH Malawi., District Health Performance Improvement Evaluation report 2016, (https://www.unicef.org/evaldatabase/index_93776.html, accessed 24 April 2018).

6 MOH South Africa, The contribution of family physician to district health services, (http://reference.sabinet.co.za/document/EJC173164, accessed 24 April 2018).

7 Delloite (2018). Evaluation of projects of telemedicine and E-Health Network in Cabo Verde for the Period 1011 – 2017 – Final Report.

8 World Health Organization (2018). The state of health in the WHO African Region: an analysis of the status of health, health services and health systems in the context of the Sustainable Development Goals, Brazzaville, WHO Regional Office for Africa.

9 SARA surveys (Benin – 2015; Burkina Faso – 2014; Chad - 2015; Democratic Republic of the Congo - 2014; Ethiopia - 2015; Mauritania - 2016; Niger - 2015; Zambia - 2015; Zimbabwe - 2015. (https://www.who.int/healthinfo/systems/sara_reports/en/, accessed 25 January 2019).

10 World Health Organization (2016). Atlas of African Health Statistics 2016, Health situation analysis of the African Region. African Health Observatory. Brazzaville, Regional Office for Africa.

11 Maharaj Y, Robinson A and McIntyre D. (2018). A needs-based approach to equitable allocation of district primary healthcare expenditure in North West Province, South Africa. S Afr Med J. 2018 Feb 27;108(3):190-196. doi: 10.7196/SAMJ.2018.v108i3.12588.

12 Otieno M (2016). Resource allocation to health sector at the county level and Implications for equity, a case study of Baringo county. A research project submitted in partial fulfilment for the Requirement of an award for masters of science degree in Health economics and policy, university of Nairobi.

10. Twenty-six Member States[13] in the Region have developed national eHealth strategies, although their operationalization and scale up countrywide is still limited. However, Internet penetration among the African population was only 36.1% by 2018, a hindering factor to scaling up digital health.

ISSUES AND CHALLENGES

11. **Gaps in governance, leadership and management**: District health governance structures are faced with limited oversight, planning and management capacity. For example, there are challenges in the selection and orientation of the members of these structures, and ineffective linkage and communication with other institutions.[14] Despite efforts towards decentralization, the mandate and ability to make decisions at the operational level remain limited and the capacity to undertake the decentralized functions remains a challenge.[15] There is limited leadership and management training, mentoring and supervision at lower levels. Further, suboptimal intersectoral collaboration and private sector involvement negatively impact the DHS.

12. **Inadequate human resources for health**: The shortage of human resources and their poor distribution hinder access to quality health services.[16] Despite the acute shortage of human resources, some professional bodies are still reluctant to allow delegation of duty for certain critical services.[17] In some instances, this makes task shifting difficult to implement. Furthermore, epidemiological changes call for new skills that health workers may not have.

13. **Inadequate access to essential medicines, other health products and equipment:** Forty-three Member States[18] have essential medicines lists. While 17 Member States[19] have updated them during 2016–2019,[20] they are yet to be extended to cover diagnostics and medical devices. Only nine Member States[21] are locally manufacturing pharmaceuticals that are competitive and comparable to international standards and it is estimated that between 70% and 90% of medicines[22] consumed in sub-Saharan Africa are imported. The high cost of essential medical products increases out-of-pocket expenditure. Limited logistics and supply management systems weaken the overall health system's ability to respond to the health care needs of the population.[23] Poor quality and counterfeit products waste resources and cost countless lives.

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13 Botswana, Benin, Cameroon, Cabo Verde, Comoros, Côte d'Ivoire, Ethiopia, The Gambia, Ghana, Kenya, Lesotho, Madagascar, Malawi, Mauritania, Mauritius, Mozambique, Niger, Nigeria, Rwanda, Senegal, South Africa, Uganda, United Republic of Tanzania, Togo, Zambia and Zimbabwe.

14 IPAR Discussion Paper Series. An Assessment of the Delivery Capacity of the District Health Systems in Kenya Series (http://www.who.int/management/ An Assessment of the Service Delivery Capacity of the District Health Systems in Kenya.pdf, accessed 24 April 2018).

15 Alemu KT (2015). District Level Decentralization and Public Service Delivery in Ethiopia: Cases from Amhara region. International Journal of African and Asian Studies Vol 10, 2015: 24–38.

16 The Implication of Shortages of Health Professionals for Maternal health in Sub-Saharan Africa.

17 Zachariaha, R, et al (2009). Task shifting in HIV/AIDS: opportunities, challenges and proposed actions for sub-Saharan Africa. *Transactions of the Royal Society of Tropical Medicine and Hygiene (2009) 103, 549–558.*

18 Essack, SY, 2017. Antimicrobial resistance in the WHO African region: current status and roadmap for action. Oxford Public Health Journal, [Online]. Mar; 39(1): 8–13.

19 Benin, Burkina Faso, Burundi, Cameroon, Central African Republic, Congo, Côte d'Ivoire, Guinea-Bissau, Kenya, Madagascar, Mozambique, Niger, Nigeria, Senegal, Sierra Leone, South Africa, United Republic of Tanzania.

20 Internal database of Health Technologies and Innovation Unit, Health Systems and Services Cluster, World Health Organization, Regional Office for Africa, 2916–2019.

21 Algeria, Cameroon, Côte d'Ivoire, DRC, Ethiopia, Ghana, Kenya, Nigeria, South Africa.

22 McKinsey Global Institute. Should Sub-Saharan Africa Make Its Own Drugs? https://www.mckinsey.com/global-themes/middle-east-and-africa. Accessed, 5 April 2019.

23 Prashant Yadav (2015). Health Product Supply Chains in Developing Countries: Diagnosis of the Root Causes of Underperformance and an Agenda for Reform, Health Systems & Reform, 1(2): 142–154, DOI: 10.4161/23288604.2014.968005.

14. **Lack of essential health care packages:** Member States have developed basic health packages.[24] However, they face challenges in defining, costing, implementing and monitoring the delivery of essential health packages.[25]

15. **Weak referral systems:** The health service referral system plays a central role in determining access to services and most Member States have developed referral policies. However, the referral systems are often non-functional due to inadequate health resources, transportation and communication infrastructure, finance, and social capital. [26]

16. **Limited availability and utilization of data:** Despite progress made in health information systems, availability and utilization of data and information, including electronic health records at the operational level remain limited.[27] Civil registration and vital statistics systems are limited/non-existent; data from peripheral health facilities tend to be incomplete and reported late. Challenges include limited skills in data analysis and management and use for local planning and decision-making.

17. **Inadequate engagement of communities**: Despite evidence pointing to the value of genuine community–health sector partnerships to develop health services for rural communities,[28] inadequate community engagement, accountability and demand generation still contribute to poor district health service provision.[29] Communities are often not provided useful information and opportunities to express their opinions and contribute to decision-making.

18. **Suboptimal health service quality:** The quality of health services is compromised by several factors. These include, in addition to the gaps earlier mentioned, poor water supply systems and waste disposal that are often a source of health facility-associated infections.[30]

THE REGIONAL IMPLEMENTATION FRAMEWORK

Vision, Goal, Objectives, Targets and Milestones

19. **Vision:** All people at all ages have equitable access to quality essential health services that respond adequately to their needs in the context of UHC.

20. **Goal:** To have well-functioning district health systems providing essential health services in all Member States.

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[24] Otieno M (2016). Resource allocation to health sector at the county level and Implications for equity, a case study of Baringo county. A research project submitted in partial fulfilment for the Requirement of an award for Master of Science degree in Health economics and policy, university of Nairobi.

[25] Freddie Ssengooba (2004). Uganda's minimum health care package: rationing within the minimum? (http://www.bioline.org.br/pdf?hp04005. Accessed on 25 February 2019)

[26] Padmore Adusei Amoah and David R. Philips (2017). Strengthening the Referral System through Social Capital: A Qualitative Inquiry in Ghana

[27] Odekunle FF, Odekunle RO and Shankar S (2017). Why sub-Saharan Africa lags in electronic health record adoption and possible strategies to increase its adoption in this region. Int J Health Sci Vol 11, No 4: 59–64

[28] Preston RG, et al. (2010). Community participation in rural primary health care: Intervention or approach? Australian journal of primary health. 16. 4–16. 10.1071/PY09053.

[29] MOH Tanzania (2015). Decentralized local Health Services in Tanzania, (https://www.urban.org/sites/default/files/publication/51206/2000215-Decentralized-Local-Health-Services-in-Tanzania.pdf, accessed 24 April 2018)

[30] World Health Organization (2018). Handbook for national quality policy and strategy: a practical approach for developing policy and strategy to improve quality of care.

21. **Objectives**

The objectives of the framework are to:

(a) Provide guidance to Member States to strengthen and sustain district health systems in order to provide essential health services.

(b) Articulate the priority actions to enable Member States to deliver essential health services that respond to individual and community needs across the entire lifecycle.

22. **Regional targets**

By 2030

(a) All Member States have functional health committees and management teams[31] at the district and lower levels.

(b) At least 80% of Member States have essential health services available to 80% of the population.

(c) At least 80% of Member States have established health facility-community linkages in 80% of districts.

(d) At least 85% of Member States have established a community health workforce with over 80% national coverage.

23. **Milestones:**

By 2023

(a) All Member States have defined essential health service packages;

(b) At least 50% of Member States have essential health services available to 50% of the population;

(c) All Member States have functional District Health Teams[32] in at least 50% of the districts;

(d) At least 25% of Member States have established a community health workforce with over 80% national coverage.

By 2026

(a) At least 60% of the Member States have essential health services available to 80% of the population

(b) All Member States have functional District Health Teams in at least 70% of the districts.

(c) At least 50% of Member States have established a community health workforce with over 80% national coverage.

[31] The management team at the district is called the District Health Management Team (DHMT). It refers to a group of technical persons with different professional backgrounds working together to guide, oversee and coordinate health care services in a district. Its composition varies from country to country.

[32] The District Health Team refers to the health technical team in the district that is responsible for implementation of health services.

By 2028

(a) At least 70% of the Member States have essential health services available to 80% of the population
(b) All Member States have functional District Health Teams in at least 85% of the districts.
(c) At least 80% of Member States have established a community health workforce with over 80% national coverage.

GUIDING PRINCIPLES

24. **Ownership**: Governments and their stakeholders will pursue an inclusive and participatory approach to planning and implementation to ensure country ownership.

25. **Right to health:** The people's right to health, enshrined in countries' constitutions will be upheld by improving universal access to quality health services and ensuring that no one is left behind.

26. **People-centredness:** The design and delivery of health services will primarily take into consideration the needs and expectations of clients and their families.

27. **Community empowerment:** All efforts will be made to ensure that the communities have adequate information, knowledge and skills to fully engage as equal partners in health.

28. **Synergy:** The efforts of the different stakeholders will be harnessed during planning and implementation to ensure that they are mutually enhancing and complementary.

29. **Continuum of care:** Health delivery systems will ensure that there is no break in the services needed by individuals and families, and also ensure effective referral systems within and between levels of health care facilities.

30. **Efficiency:** In the spirit of value for money, both provision and use of services will be rationalized to ensure maximum output for the least amount of resource input.

PRIORITY INTERVENTIONS AND ACTIONS

31. **Enhancing capacity for governance, leadership and management:** Member States will review the existing district-level oversight, leadership and management structures in order to identify and plan to address gaps. They will build the capacity of leadership and management at all levels through regular training, orientation and mentoring. Furthermore, they will develop appropriate policies and mechanisms to decentralize health system functions, responsibilities and powers to the district/operational level and strengthen their operational and managerial systems. There is need to review or establish health management teams at district and lower levels and to ensure that there is a reinforcing relationship between the executive and implementing arms of the health service delivery systems. Member States will strengthen supportive supervision and establish a leadership development programme for health workers with potential talents.

32. **Improving capacity for evidence-based decision-making and monitoring and evaluation of district health services:** Systems will be put in place for generating good quality data and capacity will be built for analysis and utilization of data for decision-making to address gaps identified by data and information system assessments. A monitoring and evaluation framework for DHS performance with clear indicators and targets will be designed and implemented on an annual basis.

33. **Defining, costing and mobilizing resources for essential health service packages:** Essential health service packages will be defined to cover the entire life course and will be based on needs rather than availability of resources. Once costed, a resource mobilization plan will be developed and incorporated in the district and national budgets. A stronger focus on domestic resource mobilization is critical.

34. **Building the capacity of health workers to deliver the essential health service package:** This will include assessment of skills gaps and on the job training. Training institutions will ensure that training curricula cover the knowledge and skills relevant for delivering the essential health service package. It is critical to establish and conduct continuous work-based training and apprenticeship and also explore task shifting for critical services where the specialized capacity is low.

35. **Enhancing access to essential medicines, other health products and equipment:** The capacity of the districts will be built through training and mentoring on quantification of medicines and health product needs, as well as skill-building in procurement and supply chain management. Districts will also be equipped with electronic logistics management systems linking the lower health facilities with the district and central stores. Transport for distribution of medicines and health supplies will be provided with adequate budgets.

36. **Ensuring person-centred health service delivery:** This will involve development of service delivery models that respond to the needs of the users, putting in place mechanisms to obtain client expectations of services and providing feedback. The service delivery models will adapt to special settings like for urban, displaced and nomadic populations. The health infrastructure will be reviewed to align it with current and anticipated health care needs and technological innovations. The districts will ensure that the key role played by hospitals in the district health system, not only for referral but also for capacity building, supervision, quality assurance and mentoring, is promoted. It will also include provision of wellness clinics, physical exercise facilities and introduction of service booking systems to reduce congestion and client waiting time.

37. **Strengthening the health referral system:** Specific health facilities will be designated as primary and secondary referral facilities, with the district hospitals acting as secondary referral facilities. Such facilities will have the requisite staffing, equipment and logistics with functional communication and transport systems and a central command will be established for coordination and management of referrals at the district level. Mechanisms will be put in place to ensure feedback both to the referring and referral facilities. For populations with low access to services, it is critical to assess their infrastructure needs and make appropriate procurements to support telemedicine and eHealth to enable them benefit from specialist service hospitals.

38. **Enhancing the use of digital health:** Building on the ongoing efforts to develop eHealth policies and strategies, and working in association with ministries responsible for ICT, the health sector will invest in infrastructure development and in the capacity of the health facilities to utilize eHealth and mHealth to facilitate health service delivery and service monitoring and reporting.

39. **Empowering households and communities:** All efforts should be made to provide health information in appropriate form, channels and places to the different population groups, including through social media and national health observatory platforms. It will be important to sensitize households and communities on their rights to health and their critical role in health and well-being and put in place mechanisms to enable communities to demand accountability in service delivery and use of resources.

40. **Establishing and strengthening community health committees:** The structures of community health committees at various levels will be defined and as much as possible; they will be representative of the key population groups in the community, and will involve nongovernmental and community-based organizations. Community health committees will receive appropriate orientation and guidance and the relationship between the community health committees and the management of the health facilities will be clarified. Health facility teams will reach out and engage the community structures in planning and managing health services. Where community health worker (CHW) programmes exist, they will be assessed and ways will be identified to scale them up and improve their effectiveness.

41. **WHO** will develop and review tools, guidelines and manuals for strengthening district health systems, monitoring of DHS performance and for defining and implementing essential health service packages. This will be in line with the Framework for health systems development towards universal health coverage in the context of the Sustainable Development Goals in the African Region. In addition, WHO, in liaison with other development partners, will provide technical support for capacity development of leadership and management of DHS, strengthen partnerships for country support, including South-South cooperation, and support Member States to mobilize resources for enhancing the capacity of district health systems to deliver essential health services.

42. **Other development and implementing partners** will jointly support implementation of the national plans for strengthening delivery of essential health services through a functional DHS. Civil society organizations will enhance engagement of the communities and build their capacity for co-management and ownership of health programmes and increase the community demand for accountability. The contribution of the private sector will be enhanced though the building of a public-private partnership.

43. The Regional Director shall report to the Regional Committee on progress of implementation of the framework after every three years.

44. The Regional Committee is invited to adopt the actions proposed in this Framework.

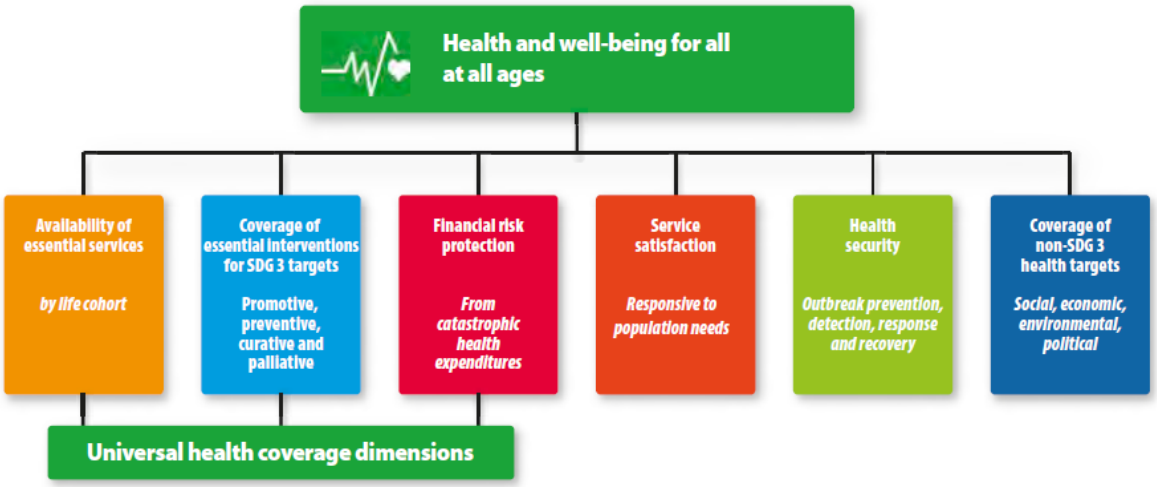
Annex: Extract from the chapter of the report on the State of Health in the WHO African Region on universal health coverage index

(Section 2 of Part 1 of the report: The status of health and health-related population outcomes in the African Region)

Attributes of effective health and health-related outcomes in the context of the SDGs

The state of health and well-being is a function of the levels of attainment of the dimensions related to outcomes – the health and health-related services desired by the population. For sustainable development, these services must be broad enough to cover all the populations, irrespective of their needs and locations. The six dimensions of health outcomes provide this breadth, irrespective of where a population is within the Region.

Figure: Dimensions of health and health-related services in the African Region



There is recognition that UHC is an umbrella target within SDG 3. UHC is based on universality and sustainability and is underpinned by principles of efficiency, effectiveness and equity spanning health system inputs and processes (interactions across the various building blocks) and health system performance outputs as measured by access, quality, demand and resilience of essential services. It is achieved in concert with health security, service satisfaction and other (non-health) SDG interventions:

(a) Universality ensures that all persons are targeted without any discrimination – leaving no one behind. It denotes a shift of focus from priority services to vulnerable populations to essential services for all, at all ages.

(b) Sustainability, on the other hand, ensures that gains can be maintained at least over a strategic planning cycle (3–7 years). It denotes a shift from short term project-driven results, to longer term developmental gains.

To understand the current state of health and health related services in the African Region, the scores of each of the six dimensions making up the health and related services are consolidated. The value of the consolidated score for the entire Region was 0.48. Given that a score of 1 represents the best possible attainment, this score is interpreted as the Region being able to provide only 48% of health and health related services that could potentially be provided to its population.