The majority of countries in Africa still have not implemented many measures required to achieve universal access to health care such as social protection, without which the goals of PHC cannot be completely realized.

A strong civil society is critical to PHC, as community organizations are vital stakeholders in defining and demanding appropriate and equitable services, and ensuring accountability. Civil society in many African countries remains uncoordinated and thereby unable to fulfill their full potential.

Decentralized budgeting, decision-making, and planning are vital aspects of the PHC model; communities, clinics, and sub-national administrations must be involved in prioritizing locally relevant health problems and services. Decentralization of the health sector in many African countries, however, is often only partial.

PHC involves multiple stakeholders – including those outside the health sector - working in coordination, and committing to a common set of shared principles. In some countries, inter-ministerial cooperation is not efficiently managed.

Many countries still experience supply-chain bottlenecks including inefficient tendering procedures, and weak forecasting mechanisms for essential RMNCH supplies which can result in stockouts. The shortage of medicines and technologies in facilities discourages people from utilizing the public health system, driving them instead to private providers.

The human resources crisis in Africa is one of the biggest challenges to the realization of PHC on the continent. Without a clear strategy on the recruitment, training, retention, and incentivization of health workers – especially in rural areas – it will be difficult for African countries to achieve PHC goals and objectives.

Figure 1: Components of Best Practices in PHC
**Strategies and Best Practices**

- Implement country-appropriate models promoting universal access to health care, such as social health insurance or micro-insurance schemes (e.g. Chad, Ghana, South Africa, Rwanda).
- Implement targeted, evidence-based, cost-effective essential interventions, commodities, and guidelines for RMNCH. These should span the continuum of care from adolescence and pre-pregnancy through infancy and childhood. They should cover community-level health promotion, services, and referral systems, as well as primary-level facilities and referral systems (e.g. Niger).
- Provide education subsidies for RMNCH trainees tied to enforceable agreements to serve in remote areas. Recruit students from rural communities and locate RMNCH training facilities nearby. Use incentives (e.g. hardship allowance, free housing, paid leave) to attract health workers with expertise to hardship posts. Create professional development opportunities and supportive supervision (e.g. Tanzania, Uganda).
- Align national budgets, strategies, and partnership support to PHC goals. Prioritize a horizontal, integrated, health systems approach. Committing to provision of services and promotion of health as close to the household as possible is a primary mission of many national health strategies (e.g. Democratic Republic of Congo, South Africa).
- Restructure health governance to create closer ties to communities and greater engagement of civil society. Make national health data open access and disseminate it sub-nationally. Prioritize evidence-based decision-making, performance-based financing, participatory research methods, and priority setting. Social audits, scorecards and equity gauges help ensure the health sector is closely accountable to the community (e.g. Ethiopia, Rwanda, South Africa, Zimbabwe).
- Leverage non-health sector actors for equity gains in RMNCH. Provide platforms for multi-sectoral coordination, legislation, regulation, and planning and priority-setting processes (e.g. Sierra Leone).

**Case Study: Ethiopia**

Ethiopia is fast registering impressive successes in extending affordable primary health-care services across the country. Through the Health Extension Programme (HEP), the government has worked to fill gaps in access to care throughout its extensive and often hard to reach rural communities by recruiting and training women as paid frontline health workers. These women, recruited from the local communities in which they will work, complete a 1-year training course, which includes fieldwork, before taking up their posts. They train families in hygiene and other public health practices, deliver a defined package of basic services, and serve as role models for girls—a vital service in a country where under-age marriage is still common. Nurses in the program provide additional and complementary services at local clinics.

The HEP sought to deploy two salaried health extension workers at each village health post aiming at training 30,000 Health Extension Workers. Since its introduction, the HEP has surpassed its HEW target and has contributed significantly to the improvement of health outcomes. The HEP has yielded an increase in the proportion of women who have utilized family planning, antenatal care, and HIV testing. Coverage of publicly-funded health care has risen from 61% in 2003 to 87% in 2007, whereas total coverage—including services provided by private health facilities—has grown from 70% to 98% over the same period.

**Key Opportunities**

- The Joint Learning Network for Universal Health Coverage is a platform for countries to exchange experiences and information about the implementation of health financing reforms.
  www.jointlearningnetwork.org
- There is now a clear set of globally-recognized essential interventions, commodities, guidelines, and training manuals for RMNCH that have been proven to achieve significant and rapid progress in RMNCH outcomes.
- CapacityPlus is developing tools to help governments cost out and plan for health worker training and retention schemes.
  iHRIS Retain is a software tool to cost retention strategies at different levels to determine the feasibility of interventions and budget for implementation. A rapid retention survey toolkit helps countries assess health worker satisfaction. Opportunities exist to ensure new tools are closely tied to RMNCH health human resources needs.
  http://retain.ihris.org/retain/
- Between 2008-2013, the World Health Organization has provided a framework and toolkit for the monitoring and analysis of health systems strengthening, as well as a health systems digital library serving as a repository for evidence, tools, and guidelines on health systems strengthening.

**References**