Improving access to health care
Key points

- Countries have polices and strategies in place that guide investment decisions and activities of all stakeholders. Comprehensive monitoring and evaluation frameworks and other means of monitoring performance, such as joint annual reviews, bring together all stakeholders permitting inclusive assessment of sector performance and discussion of resource allocation.

- Comprehensive human resources for health planning is being promoted in countries. Strengthening education and training of health workers is crucial, but so is providing viable, adequately supported positions to ensure that graduates are absorbed in the health system when they complete their training.

- Several approaches to reducing financial obstacles to accessing health care have been taken by countries, such as removing financial barriers to ensure equitable access, especially direct payments (user fees); providing financial coverage for people who cannot afford to contribute; making prepayment compulsory; and establishing large risk pools.

- Countries are developing and implementing national medicine policies and plans to improve access to essential medicines.

- External quality assessment of public health laboratories in almost all countries has enabled laboratories to improve their diagnostic performance.

- Efforts are underway to reach all people who need health care, when they need it, and where they need it, by scaling up efforts at universal coverage for example by using innovative approaches such as mobile clinics based on trains, and increasing service delivery through community workers.

- Several countries have put in place policy and strategic frameworks to improve their national health information systems, their national and health-facility data sources, as well as data management and dissemination. Innovative platforms such as the African Health Observatory and national health observatories support the strengthening of national health information systems.

- Research and the use of research findings are facilitated when driven by demand and when policy-makers and researchers work as allies accountable to one another. EVIPNets of researchers and decision-makers in some countries have collated evidence and prepared policy briefs that are being used in a policy dialogue with policy-makers.
6. Improving access to health care

Strong health systems are fundamental to maintaining good health throughout the life cycle and managing threats to health. Although immunization and other interventions described in earlier chapters have saved millions of young lives, millions more are still dying because weak health systems are failing to deliver the interventions that work. In many countries in the Region, health systems have been weakened by the ravages of war, economic crises and debt, among other things, that have led to drastic loss of staff and failure to maintain buildings, technology and supplies. However, in the past decade, enormous efforts by governments, international partners, technical agencies, researchers and other stakeholders committed to improving the health of the African people have been applied to strengthening their health systems.

Are these efforts paying off? Specific outcomes used to evaluate the effectiveness of health systems include antenatal care coverage, percentage of births attended by skilled birth attendants, child immunization rates, proportion of children brought to a health-care facility for specific treatments, and the rate at which family planning needs are being met. These have all been discussed in earlier chapters. It is clear that although some countries have effectively reduced child and maternal deaths by improving access to skilled care and prevention services, there are still too many gaps in the Region. One of the biggest is the gap between the level of services enjoyed by the wealthiest and the lack of access for the poorest.

Difficult geography, lack of specialist health-care workers and poor infrastructure make it difficult to deliver the preventive, diagnostic and curative services people in Africa need to achieve good health. This chapter looks at the elements needed for a functioning health system, such as leadership and governance, human resources, health financing, information and research, access to medicine and health technologies, and service delivery. As each element of the health system is discussed, approaches and innovations that have been successful in the African context are described to show what has worked to strengthen health systems in the Region.
Leadership and governance

Leadership and governance refers to the role the government plays in supporting provision of health care and its relationship to all others whose activities impact on health. Governments should direct resources, health system performance and stakeholder activities towards achieving health system goals, in a transparent, accountable, equitable manner responsive to population needs. To achieve this, strategic frameworks combined with effective oversight must be put in place. Partnerships bringing together all actors need to be established and within these, inclusive participation should be ensured with roles and responsibilities for the different actors spelt out. Monitoring, regulation and accountability mechanisms also need to be put in place.

All countries in the Region have polices and strategies in place and these guide the investment decisions and activities of all stakeholders. Partnerships have been strengthened in several ways: public–private partnerships are in place in 37 countries, while 25 countries have signed compacts. Public–private partnerships spell out areas of collaboration and the roles and responsibilities for each partner. Compacts, defined as “a negotiated and signed time-bound agreement in which partners commit to implement and uphold the defined priorities outlined in the country health strategy”, encompass more partners, including international partners, civil society and governments. An example of such strengthened alignment is the Millennium Development Fund established in Ethiopia in 2007, which has been joined by 14 international partners who channel their support through a common funding mechanism.

Accountability requires transparent and comprehensive means of monitoring and evaluating health systems. Currently, 14 countries in the Region have such comprehensive monitoring and evaluation frameworks. Other means of monitoring performance include joint annual reviews, which have been institutionalized in 37 countries as shown in Fig. 6.1. Joint annual reviews bring together all stakeholders, permitting inclusive assessment of sector performance and discussion of resource allocation.

Improving accountability and value for money has become a central issue. As a means to this end, some countries have implemented results-based financing (RBF) with positive results. However, to date, only Benin, Burundi, Comoros, Rwanda and Sierra Leone have implemented this on a national scale (Box 6.1)

Box 6.1. Burundi’s adoption of results-based financing (RBF)

Faced with challenges of underfunding; implementation of user-fee schemes with subsequent impoverishment; low utilization of services that were of poor quality; and poor health indicators; the Government of Burundi introduced fee exemptions for pregnant women and children less than 5 years of age in 2006. Although this led to a marked increase in health service utilization, the persistent underfunding for health by the government further compromised the quality of health services, with disgruntled health workers and subsequently reduced utilization rates. Official user fees were replaced by under-the-table payments.

RBF pilots were introduced in 2008. RBF is a health-financing strategy that links funding to outputs. The health facilities in the pilots received performance bonuses for both the quantity and quality of services delivered, and quantity indicators related to a basic health package, which included services that were exempted from the fee scheme.

The pilots produced positive results with an average increase of 50–60% for each indicator compared with the period before the introduction of RBF. RBF was scaled up to more provinces and a national RBF scheme was launched.
Innovative strategies to strengthen institutions and address long-term governance, harnessing the potential of management reforms to strengthen human resources for health, are needed in the Region. To achieve this, a regional roadmap for scaling up the health workforce has been developed for the period 2012–2025. This roadmap is a guide for countries to strengthen their human resources for health according to their needs and contexts. If well applied, the six strategic areas detailed in the roadmap (Box 6.2) will not only improve service delivery but also help countries reach the desired destination of “all people everywhere having access to a...
The health of the people: what works

skilled, qualified and positively motivated health worker equipped to serve those in need of care appropriately”. In the past decade, most countries have established human resources for health units in their ministries of health as a demonstration of their commitment to improving human resources for health governance. A health management tool has been used by countries to tailor health workforce requirements based on actual workload by applying the Workload Indicators of Staffing Need (WISN). This tool has been used in different parts of the world and in Africa as a means of establishing or reviewing staffing norms. Cameroon, for example, used the tool to revise its staffing norms for different levels of the system. The method was participative and used an evidence-based approach. Thereafter, the ministry of health used the results to advocate for more funding. Rwanda has also strengthened its system and improved outcomes, by using performance-based management and results-based financing.

African health workforce issues are often characterized as a lack of human resources in general. In fact some countries produce more staff than they are able to employ, but the limitation is due to capacity to pay, rather than the need on the ground. Underinvestment in the domains of training, deployment, creation of decent working conditions and proper management has negatively affected production, recruitment, equitable deployment and retention. This has led to growing migration from the public to the private sector, from rural to urban areas, and from the health sector to other sectors. It has also led to migration, both in and out of the Region, to more stable countries with better economic conditions, resulting in a seriously inequitable geographical distribution of skilled health workers at the global level (Fig. 6.2). Export of workers may also be part of intraregional cooperation; for instance Kenya has sent nurses to assist neighbouring countries such as Botswana and Namibia, notwithstanding their own shortages in rural areas.

Fig. 6.2. Skilled health personnel-to-population ratios (per 10 000 population) in the WHO African Region and globally, 2006–2013

What works?

Strengthening education and training of health workers is crucial but equally crucial is providing viable, adequately supported posts to ensure that the graduates are absorbed in the health system when they complete their training. Comprehensive human resources for health planning that links needs, production and utilization, matched with relevance and appropriateness of the mix of skills, is being promoted in countries. Linked to this is the need to have functional human resource information systems able to inform recruitment and deployment. Several countries such as Ghana, Kenya, Mali, Sierra Leone and the United Republic of Tanzania have improved their human resources for health information systems by computerizing their personnel data. The role that less-specialized cadres, such as community health workers, can play when given the relevant training and professional support has been significant. Putting those workers on performance-based contracts has yielded even better results.

Health workforce observatories based in ministries of health are platforms where valid information on the health workforce situation can be found and where policy discussion can be informed and conducted in a more neutral and objective manner. This is an important step towards improving the evidence base for advocacy, policy-making, strategic planning and capacity-building. The ability of human resources for health observatories to gather all relevant stakeholders and partners around the human resources for health agenda ensures best use of available resources and ways to close identified gaps.

Who pays for health care?

In too many countries in the Region, it is the poorest people who are paying proportionally most for health care. In 22 countries in the Region, household out-of-pocket expenditure makes up more than 40% of total health expenditure. Countries with a low level of public investment in health tend to have high levels of out-of-pocket payments (Fig. 6.3), which are a major hindrance to accessing health care. When families arrive at health centres with a dying child or a woman struggling to give birth, the fees demanded before care is given may consume all their ready funds, forcing them to borrow and pushing them into deeper poverty. The child may die while funds are being raised, further alienating the poorest groups from the health system. Future care might be sought from more trusted and less costly sources such as traditional healers or village “wise women”.

The Abuja Declaration of 2001 proposed that 15% of public expenditure be allocated to the health sector. However, progress towards this target has been slow and health spending continues to be seen as “consumption” rather than “investment”. Only five countries, Botswana, Madagascar, Rwanda, Togo and Zambia, have been able to achieve the target set in the Abuja Declaration – dedicating more than 15% of general government expenditure to health care and spending over US$ 44 per capita on health care. In 2006, the health financing strategy for the Region urged Member States to develop prepayment mechanisms to finance health services. Countries are gradually developing strategies to strengthen protection against financial risk and reduce out-of-pocket payments but progress has been slow.

What works?

Several approaches to reducing financial obstacles to accessing health care include:

- ensuring equitable access by removing financial barriers, especially direct payments (user fees);
- providing financial coverage for people who cannot afford to contribute;
- making prepayment compulsory;
- establishing large risk pools.
Removing financial barriers
Many countries have removed user fees – some for all services while others have chosen to be selective, removing fees for vulnerable populations such as pregnant women and young children. For example, removing user fees for health care for children in Burkina Faso doubled attendance. The average increase attributable to the intervention in 12 districts was almost 2000 visits per year per centre, or 110%. It is important to note that removing user fees has increased access to services, but in some countries there have been unexpected negative effects.

Using government revenue to cover health costs
The few countries in the Region making substantial investments in health have been rewarded with increased access to health services and improved health outcomes. Botswana is one such country (Box 6.3). Other countries are using or considering putting health taxes on natural

Box 6.3. Health financing in Botswana
Botswana is one of the few countries in the Region to make a significant government investment in health. The current health financing system provides a high level of financial risk protection for its population compared with other countries in the Region. Botswana uses a tax-based system to cover the population for a wide range of services, and has one of the Region’s lowest levels of out-of-pocket spending on health at only 8% of total health expenditure. Government expenditure on health, at US$ 384 per capita is also considerably higher than the average (US$ 147 per capita) for other countries in the Region.
resource industries (e.g. mining) and other commercial activities.

Many countries are now raising money for health services through taxes on products known to damage health, such as tobacco, alcohol and petroleum products, and from fines for health-damaging activities such as environmental pollution and drink driving (Table 6.1). Such taxes and fines are used to curb use of health-damaging products and unhealthy behaviours, and hence should reduce the need for health services for the NCDs that develop as a result of substance use and other unhealthy behaviours. By using this money to finance health care, countries are achieving a double gain – better health finances and lower rates of NCDs. A review of 22 low-income countries found that if they raised tobacco taxes by 50% they could collectively raise US$ 1.42 billion.

**Making prepayment compulsory**

One of the countries that has made prepayment compulsory is Rwanda. In 2008, Rwanda enacted a law on compulsory health insurance and published it in the *Official gazette of the Republic of Rwanda*. This law sets out provisions relating to the creation, organization, operation and management of mutual health organizations within the strategy of extending health insurance coverage in Rwanda. It stipulates in section 33 that "Any person residing in Rwanda shall be bound to health insurance. Any foreigner entering the country or territory of Rwanda shall also be bound to health insurance within a time limit

### Table 6.1. Examples of financing strategies being used or considered by countries in the WHO African Region to finance health care

<table>
<thead>
<tr>
<th>Country</th>
<th>Levy on companies</th>
<th>Levy on currency/transactions</th>
<th>Tobacco/alcohol excise tax</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cabo Verde</td>
<td>–</td>
<td>–</td>
<td>Under debate</td>
<td>–</td>
</tr>
<tr>
<td>Comoros</td>
<td>–</td>
<td>–</td>
<td>Tobacco</td>
<td>–</td>
</tr>
<tr>
<td>Cote d’Ivoire</td>
<td>–</td>
<td>–</td>
<td>Tobacco tax specifically for HIV programme</td>
<td>Funds from UNITAID used for tuberculosis/HIV</td>
</tr>
<tr>
<td>Gabon</td>
<td>10% tax on mobile phone operators</td>
<td>1.5% profits tax on remittances</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>Gambia</td>
<td>–</td>
<td>–</td>
<td>Alcohol</td>
<td>Fines for environmental pollution</td>
</tr>
<tr>
<td>Ghana</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>VAT levy/payroll tax</td>
</tr>
<tr>
<td>Kenya</td>
<td>Petroleum products</td>
<td>–</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>Niger</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>Potential for raising taxes from mining has not yet been tapped</td>
</tr>
<tr>
<td>Sierra Leone</td>
<td>–</td>
<td>–</td>
<td>Alcohol</td>
<td>–</td>
</tr>
<tr>
<td>Swaziland</td>
<td>–</td>
<td>Currency transactions</td>
<td>Alcohol</td>
<td>Fines for drink–driving</td>
</tr>
<tr>
<td>United Republic of Tanzania</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>% of general tax. Earmarked for HIV to replace external aid</td>
</tr>
<tr>
<td>Zimbabwe</td>
<td>Company levy</td>
<td>–</td>
<td>–</td>
<td>–</td>
</tr>
</tbody>
</table>

VAT, value added tax.

not exceeding 15 (fifteen) days”. Currently, 92% of the population is covered by health insurance.

Establishing risk pools
Mutual health organizations are voluntary organizations that provide health insurance services to their members and are usually owned, designed and managed by the communities they serve. They are important sources of resource mobilization and financial protection against devastating health care expenditures and increase financial access to care, promote equity through risk-pooling, and strengthen community solidarity and demand for quality care. Member households pay an enrolment fee, followed by regular payments to cover a membership-defined benefits package. After a waiting period, the members will be able to use health services for a small copayment. The rest of the health-care provider’s fee will be paid by the mutual health organization.

In the Region, particularly western Africa, mutual health organizations have sprung up with amazing speed, suggesting that communities recognize that the major barrier to getting health care is the out-of-pocket cost. A study on the effect of mutual health organizations on access to health care in Mali found that mutual health organization members are more likely to have their fever treated in a modern health facility, to use oral rehydration salts or seek care for children less than 5 years of age with diarrhoea, and to make at least four prenatal visits during pregnancy. Mutual health organization members are also more likely to sleep under an ITN during pregnancy and have children less than 5 years of age sleeping under ITNs.

In many countries, mutual health organizations have remained local solutions or pilot projects but Gabon has made an effort to establish a risk pools model. In 2007, Gabon initiated reforms in its health financing system to achieve universal health coverage. The reform culminated in the establishment of the National Health and Social Insurance Fund with a mission to ensure universal health coverage. The Fund receives its resources from special taxes paid by mobile telephone and money transfer companies. The Fund is also financed through social contributions by wage earners, independent workers, employers and state subventions. The authorities adopted a gradual approach to membership, starting in 2008 with the poorest, state employees in 2010, and private sector workers in 2013. The Caisse Nationale d’Assurance Maladie et de Sécurité Sociale resources for health have multiplied by approximately four in 3 years, from about 10 billion CFA francs in 2008 to more than 37 billion CFA francs in 2011. The pooling of funds facilitated access to the health services of various categories of populations such as the formal and informal sector, both the rich and the poor.

Access to essential medicines
Functioning health systems should have essential medicines available at all times in adequate amounts, in the appropriate dosage forms, with assured quality and adequate information, and at a price patients can afford. Access to essential medicines for malaria, HIV/AIDS and tuberculosis has improved in several African countries. However, the need for essential medicines for other communicable and noncommunicable diseases is growing.

Countries are developing, implementing and monitoring the implementation of national medicine policies and plans to improve access to essential medicines. By the end of 2013, 36 countries had adopted their national medicine policies and another eight countries had draft policies pending adoption. Pharmaceutical sector assessments, price and availability surveys and assessment of procurement and supply systems have yielded vital information including major challenges. These surveys found low availability of essential medicines in public health facilities; uncoordinated procurement activity; high prices of medicines;
price variations between generic brands across countries; poor transparency and weak governance for medicines. Most of the pharmaceutical products in countries were also imported.

In some countries local manufactures are upgrading their facilities to improve manufacturing standards. This can enhance sustainable supply of essential medicines and contribute to improving access. For example, some medicines produced by four African pharmaceutical manufacturers located in Kenya, South Africa, Uganda and Zimbabwe and one vaccine manufactured in Senegal have been prequalified by WHO.

Ensuring the quality and safety of medicines is equally important. However, the regulatory systems in most African countries remain weak and substandard/spurious/falsely-labelled/falsified/counterfeit (SSFFC) medical products are proliferating in the local markets. Some countries in the Region have reinforced their capacity and are participating in the WHO global surveillance and monitoring project through notification of suspected SSFFC medical products.

During the past 10 years, 26 countries have assessed their regulatory systems and implemented institutional development plans. Under the framework of the African Vaccines Regulatory Forum, 22 countries have strengthened their regulatory capacity. Burkina Faso, Mali and Niger reviewed their guidelines for marketing authorization and registered the new conjugate meningococcal A vaccine. Six medicine quality-control laboratories located in Algeria, Kenya, South Africa and the United Republic of Tanzania have been prequalified by WHO.

**Use of national essential medicine lists**

National essential medicine lists improve efficiency in procurement and supply management systems and rational use of medicines. Most countries in the Region have developed their national list of essential medicines and standard treatment guidelines for evidence-based selection, effective procurement, and supply systems and rational use of medicines. For example, through using the essential medicine list, Zambia improved the selection and procurement of life-saving medicines with district-level planners. Paediatric malaria medicines have become available in 88% of public health centres in pilot districts, against 51% in control districts.

**Traditional medicine**

Traditional medicine refers to knowledge, skills and practices based on the theories, beliefs and experiences indigenous to different cultures. Estimates show that traditional medicine is the main – and sometimes the only – source of health care for 80% of the people in the developing world. In 2000, countries in the Region agreed to integrate traditional medicine into their health systems, with the ultimate aim of enhancing collaboration and complementarity.
rity between practitioners of the two systems of medicine.

By 2012, 40 countries had developed national traditional medicine policies, 19 had strategic plans and codes of ethics, 29 developed regulations, six had established national practitioners’ councils, and 39 and 24 countries had established national offices and national programmes of traditional medicine in their ministries of health, respectively. Policies and regulations for the conservation of medicinal plants and for the protection of intellectual property rights and traditional medicine knowledge have also been developed in several countries. Acceptance of traditional medicine as part of mainstream health care is growing. For example, both Ghana and Mali have succeeded in establishing traditional medicine clinics in hospital settings. In addition, Ghana has selected 80 traditional medicine products for use in a pilot study in primary care in hospitals.

Strong government commitment and stakeholders’ willingness to collaborate translated into action is a key factor to integration of traditional medicine into national health systems. Some countries such as Mali, Senegal, Uganda and the United Republic of Tanzania have created formal networks of medical doctors and traditional health practitioners working together in patient diagnosis and treatment, patient referral and research. For example, the organization Promotion of Traditional Medicine (PROMETRA), based in Senegal, has for many years been promoting collaboration between modern and traditional systems of medicine (Box 6.4).

**Access to health technologies, including diagnostics**

Medical devices are articles intended for use in the diagnosis or cure, mitigation, treatment, or prevention of diseases or abnormalities in humans. Although medical devices are readily available, few countries in the Region can afford to purchase or use them. When devices are donated, appropriate use can still be a problem. There are gaps between needs and appropriate matching to conditions, and there is very little regulation governing the use of medical devices in the Region.

There is a severe lack of safe and appropriate diagnostic imaging services in large parts of the Region. A large number of images are of poor quality and are of no diagnostic use. Many are also misread. In other areas, imaging facilities are simply not available, or not functioning. Thus, disease diagnosis is usually based on clinical conditions, unsupported by radiological evidence, and treatment may therefore be inappropriate or even dangerous. The challenges are

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**Box 6.4. Promotion of traditional medicine (PROMETRA), Senegal**

At PROMETRA International’s Experimental Centre for Traditional Medicine (CEMETRA) in Fatick, Senegal, 450 member associations of traditional health practitioners from Sine, known as MALANGO, collaborate with western-trained medical doctors. An important characteristic of CEMETRA is that the health practitioners are officially recognized by the Government of Senegal but only authorized to treat patients within the centre. The medical doctor measures the patient’s vital signs, such as blood pressure, pulse, respiratory cycle, temperature, weight, etc., and makes a diagnosis after analysis of laboratory tests, but cannot take part in treatment. The role of the medical doctor here is to make an initial diagnosis and send the patient to the qualified traditional health practitioners.

After treatment, the traditional health practitioner sends the patient back to the modern medical unit to measure the impact of the traditional medicine treatment. Physical examinations and laboratory tests are carried out before and after the treatment, and the impact and outcome of treatment are determined by comparison of pre- and post-treatment laboratory results, vital signs and physical examination findings. This collaboration helped to reduce health workers’ scepticism and strengthened mutual appreciation, understanding and respect between practitioners of the two health systems of medicine.
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lack of awareness, resources, equipment and qualified staff.

Functioning national health laboratory services rely on quality diagnostics, effective disease surveillance and prevention of major emerging, re-emerging and endemic communicable and non-communicable diseases. In the Region, a shortage of qualified personnel; lack of essential laboratory supplies, infrastructure and equipment; and lack of national standards and systems for laboratory accreditation, proficiency testing, quality control and logistics are the main obstacles to early detection of epidemics such as haemorrhagic fever viruses (Ebola virus disease, Marburg virus, etc.) and both multidrug-resistant and extensively drug-resistant tuberculosis, among others. On the other hand, when laboratory or other diagnostic tools are available, incorrect interpretation of results is a common problem.

Organ transplantation demand has not been assessed but is certainly important in the Region. Transplantation activities are expanding slowly from pioneer countries such as Algeria, Ghana, Kenya, Mauritius, Nigeria and South Africa, where kidney transplantation is becoming more common. Several countries have shown interest in developing organ transplantation services, but a legal framework and regulatory issues need addressing.

Use of technologies

Paradoxically, rapid advances in health technology development have placed countries under intense pressure to import modern health technology. The proliferation of these technologies, resulting in a bewildering array of choices, creates demands that tax limited resources. Consequently, the introduction of technology is driven more by pressures from technology producers and users than by country needs. Therefore, there is a need for clear and comprehensive policies on health care technology.

Telemedicine is still at an early stage of development in the Region and most countries lack telemedicine facilities. The challenge is to ensure that telemedicine is widely used and disseminated to strengthen primary health care, train health-care workers, and improve national quality of care, including laboratory and diagnostic imaging services. There is a need for clear and appropriately adapted regulation for telemedicine and other medical technologies in the Region.

For the past 12 years an external quality assessment programme covering diagnosis of infectious diseases (HIV, tuberculosis, malaria and plague) has been provided to 81 national public health laboratories in 45 countries of the Region by the WHO Regional Office for Africa with the technical support of the National Institute for Communicable Diseases in Johannesburg, South Africa. Proficiency is tested and
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results shared with the laboratories, allowing them to improve diagnostic performance.

To further strengthen laboratory services in the Region, the Regional Office and its partners, including the African Society for Laboratory Medicine and CDC, established the Stepwise Laboratory Improvement Process Towards Accreditation (SLIPTA), a stepwise process that enables public health laboratories in developing countries to reach the ISO 15189 standards that govern laboratory standards. Laboratories develop and document their ability to detect, identify and promptly respond to and report all diseases of public health significance that may be present in clinical specimens. SLIPTA started in 2012 with training of laboratory auditors and laboratory assessments. Since then, six laboratories in Kenya, Togo, Uganda and the United Republic of Tanzania have been accredited as having met ISO 15189 and 56 laboratories have been audited. More than 500 laboratories in the Region are on good track to meet ISO 15189 standards and accreditation.

Blood and blood products

Blood transfusion can be a life-saving treatment, whether it is for women haemorrhaging during or after childbirth, children with severe anaemia due to malaria and malnutrition, victims of trauma and accidents, or people with chronic diseases. When blood is not available at the time it is needed, reversible conditions can lead to death.

Considerable efforts have been made to improve access to safe blood and blood products. By 2012 almost all countries in the Region (45) had formulated a national blood policy, compared with 32 countries in 2006. However, only 31 countries have made progress with implementation of their blood policies. Just over half of the countries in the Region (24 countries) are now collecting 80% of their blood for transfusion from voluntary, non-remunerated blood donors and several countries have improved their voluntary blood donation rates considerably. Algeria, Cabo Verde, Eritrea, Mauritius and Nigeria have raised levels of voluntary donation from less than 50% to 80% and above.

Monitoring of blood for transfusion-transmitted infections has also improved, with 41 countries reporting that 100% of their blood supply had been tested for HIV, while 39 tested for hepatitis B virus and syphilis and 38 for hepatitis C virus. Thirty-three countries have a blood transfusion quality management programme in their blood transfusion services.

Patient safety

Health-care associated infection is a major patient safety issue in the Region. Although there are little data on patient safety issues in the Region, studies on hospital-wide health-care associated infections from some African countries report high infection rates (Mali 18.9%, the United Republic of Tanzania 14.8% and Algeria 9.8%). Patients undergoing surgery are the group most frequently affected. Most countries lack national policies on safe health-care practices. Inappropriate funding and lack of critical support systems, including strategies, guidelines, tools and patient safety standards, are major problems. There is a need for investment to enhance patient safety in all health-care services in the Region. To achieve this, countries need to:
- develop and implement national policies for patient safety;
- improve knowledge and learning in patient safety;
- minimize health-care associated infection;
- ensure safe surgical care;
- ensure appropriate use, quality and safety of medicines;
- strengthen surveillance and capacity for research on patient safety.
Activities to increase knowledge and change behaviour to improve patient safety include the WHO celebrates the SAVE LIVES: Clean Your Hands campaign and African Partnerships for Patient Safety, which facilitates partnerships between hospitals in developed countries and hospitals in the Region.

**What works?**

In 2008, WHO launched a global programme called “Safe Surgery Saves Lives” to improve patient safety. Senior surgeons and anaesthetists were brought together to develop ways to implement the surgical safety checklist in the Region. By December 2013, the surgical safety checklist had been successfully used in hospitals in Botswana, Mali, Namibia, Rwanda, Swaziland, Uganda and Zambia. The checklist has been successful where its use has been mandatory, where there has been strong support for it from hospital senior management, and where group discussions and regular meetings address issues arising from its use.

**Service delivery: reaching everyone**

Reaching all the people who need health care, when they need it, and where they need it, is particularly difficult in the Region where geography, poverty and limited human resources conspire against service delivery. Some countries are applying innovative approaches to bring scarce expertise to remote communities, such as the Phelophepa train in South Africa.
What works?

Increasing service delivery through community workers

Other countries, such as Ethiopia, Ghana and the United Republic of Tanzania, are strengthening the reach into communities by strengthening the numbers, capacity and financial support for community health workers, known as health extension workers. In Ghana, 92% of caregivers of sick children sought treatment from community-based agents trained to manage pneumonia and malaria and most sought care for their children within 24 hours of the onset of fever. In Zambia, a study on pneumonia and malaria found that 68% of children with pneumonia received early and appropriate treatment from community health workers, and that overtreatment of malaria significantly declined. In Ethiopia, workers deployed in remote communities delivered two and a half times as many treatments for childhood diarrhoea, malaria and pneumonia than all the facility-based providers in the same district.

Information: better data, better health care

A functioning health information system requires an integrated effort to collect, process, report, and use health information and knowledge to influence policy-making, programme action, and research.

Assessments of health information resources in several countries in the Region found policy weaknesses, including inadequate legislation, absence of a national strategic plan, and non-functioning coordination mechanisms. The institutional frameworks for health information are often found to be fragmented, with responsibility and ways for collecting health data divided across different ministries and disease-specific programmes, creating multiple parallel systems of data collection.

Core health indicators are required to assess change in three domains: determinants of health; the health system; and health status, including mortality, morbidity, disability and well-being. In several countries national minimum core indicators have been identified that also cover health-related MDGs. However, the increased demand for health information from international partners has led to a proliferation of indicators and often multiple excessive monitoring systems.

There are major challenges related to weak data sources, including:
- the inadequate content, frequency, quality and efficiency of national health surveys;
- lack of birth and death registration and cause of death ascertainment (Fig. 6.4);
- unavailability of recent demographic data and statistics from censuses;
- weak surveillance and service statistics.

For example, trend data on the health-related MDGs are not available for several indicators and global reporting is often based on estimates rather than on empirical and timely data collection. Capacity for analysis and evaluation is lacking in many countries and decision-making may not be data-based.

Despite these constraints, several countries have made progress by putting in place adequate policy and strategic frameworks for improving their national health information systems, improving their national and health facility data sources, as well as data management and dissemination.

In most countries, electronic medical records are either not used at all, or used in some hospitals or health centres. In other sectors – private practice, traditional medicine and nongovernmental entities – electronic medical records are rarely used. In all countries of the Region, the ministry of health is the chief source of all types of knowledge used by clinical service providers.
What works?
Analysis of the knowledge gap and the state of research, information and knowledge management in the Region described above has paved the way for better approaches aiming to improve access to information and evidence. One such platform is the African Health Observatory (Box 6.5). Several countries are also establishing their own national health observatories.

e-Health

e-Health is the cost–effective and secure use of information and communication technologies for health and health-related purposes. The use of e-health solutions can enhance service delivery; develop the health workforce and improve performance by eliminating distance and time barriers; improve the availability, quality and use of information and evidence; and improve access to health information and knowledge.

Existing e-health solutions in the Region include national health observatories (see Box 6.5), enterprise resource planning for better management, and telemedicine and mobile health (m-health). Other examples are electronic medical records, electronic referrals and prescriptions, and distance learning and electronic resources (Box 6.6). A wide range of technologies and devices is used, enabling services such as mobile telephony, text messaging, teleconferencing, electronic mail and video-conferencing. Many initiatives have been launched in countries by both public and private sectors but the
The health of the people: what works

Box 6.5. The African Health Observatory: better information, better action on health

The African Health Observatory is a web-based platform with the objectives of improving the availability and use of information and evidence on health status and trends for policy dialogue, and for monitoring and evaluation of the implementation of national strategies and plans.

The observatory data and statistics platform offers the best available health-related data and statistics on the Region. It includes the Atlas of African health statistics, which is updated yearly, and comprehensive statistical health profiles for the Region as a whole and for each of the 47 countries in the Region.

Another platform offers comprehensive and analytical country health profiles to inform policy and decision-making on a wide range of areas: health status, health systems, specific programmes and diseases, health determinants and progress on the Millennium Development Goals (MDGs) and other internationally agreed goals. A key observatory publication is the African health monitor – a serial publication that comes out four times a year.

The observatory also offers a platform for networking and communities of practice. Members of communities learn and work together and strive to translate and use the best available evidence for policy-making and decision-making.

The observatory provides support to countries to establish their own national health observatories with similar functions and structure. Several countries are in the process of establishing national health observatories that will also serve as multistakeholder and collaborative platforms to strengthen national health information systems.

Further information can be obtained from the observatory website (www.aho.afro.who.int).

Box 6.6. Optimizing epidemic-prone diseases surveillance networks in Cameroon using information and communications technology (ICT)

Between 2010 and 2012, Cameroon distributed mobile telephones to 310 key personnel to enable them to communicate epidemiological information at no cost and thus improve the response to cholera, yellow fever, measles and polio epidemics. Staff who received the telephones were working in 181 districts and at all levels of the health system.

The pilot project proved very effective, thus in 2013 the initiative was extended to cover the entire country. The mobile network now comprises nearly 2000 members at all levels of the health system, all listed in a dedicated telephone directory.

As a result, coverage of the epidemic-prone disease surveillance network, which was 30% before the provision of the mobile telephones, reached 98% during the last week of 2013.

Readiness also increased from 6% to 77% on average for the same period. Use of the mobile network has permitted the use of deadlines for providing laboratory results to regions and health districts, enabling a quick response to outbreaks. The deadlines for investigating cases have also been reduced from 2 weeks to 48 hours.

Research

A health research system is the people, institutions and activities involved in the generation and dissemination of knowledge. It is an integral part of the health system and should produce evidence to inform the development and strengthening of the health system.

Governance of research has a fundamental influence on all the other functions. Only a few countries have successfully coordinated the support and involvement of development partners, the private sector and civil society to improve the research policy environment by developing health research policies, strategic plans, legislation and programmes. Policy-makers and decision-makers are not strongly active in national

success rate is not as yet clear, due to a lack of documentation and formal evaluations.

Internet users in the Region are estimated as 16 per 100 inhabitants, and mobile phone users at 63 per 100 inhabitants. In both cases, rates are lower in rural than urban areas. Very few countries have fibre-optic or satellite broadband connections.
### Fig. 6.5. Governance of health institutions conducting research in the WHO African Region, 2008

<table>
<thead>
<tr>
<th>Method of Appointment of Head of Institution (%)</th>
<th>Percentage</th>
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</thead>
<tbody>
<tr>
<td>Elected by shareholders of institution</td>
<td>1</td>
</tr>
<tr>
<td>Appointed by family owning/controlling institution</td>
<td>2</td>
</tr>
<tr>
<td>Elected by staff or faculty of institution</td>
<td>2</td>
</tr>
<tr>
<td>Elected by public or representatives of public</td>
<td>7</td>
</tr>
<tr>
<td>Appointed by political process, such as by minister</td>
<td>26</td>
</tr>
<tr>
<td>Appointed or elected by board of governors or trustees</td>
<td>50</td>
</tr>
<tr>
<td>Other</td>
<td>13</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Method employed for selection or recruitment of Heads (%)</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recommendations by board of governors or trustees</td>
<td>24</td>
</tr>
<tr>
<td>Recommendations by politicians or other policy-makers</td>
<td>32</td>
</tr>
<tr>
<td>Open call widely advertised</td>
<td>45</td>
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</tbody>
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<tr>
<th>Policies on ethics review (%)</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>Institutional policies on research ethics</td>
<td>51</td>
</tr>
<tr>
<td>Institutional policy on ethics of research by staff</td>
<td>51</td>
</tr>
<tr>
<td>Institutional policies on informed consent</td>
<td>58</td>
</tr>
<tr>
<td>Institutional policy on ethics by collaborators</td>
<td>79</td>
</tr>
<tr>
<td>National or international guidelines referred to</td>
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</tr>
</tbody>
</table>

<table>
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<tr>
<th>Policies on scientific review (%)</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Existence of written policies or guidelines on conflict of interest on scientific review committees</td>
<td>20</td>
</tr>
<tr>
<td>Existence of written policies or guidelines on scientific review of proposals</td>
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</tr>
<tr>
<td>Scientific review of proposed research not funded by the institution</td>
<td>73</td>
</tr>
<tr>
<td>Scientific review of proposed research funded directly by the institution</td>
<td>78</td>
</tr>
</tbody>
</table>

research agenda priority-setting. Only half of the health research institutions surveyed reported having a written policy requiring that researchers obtain the informed consent of research participants (Fig. 6.5).

Little or no money is allocated to health research in almost all the countries in Region. Although several research projects conducted in the Region, such as conjugate meningitis A, conjugate pneumococcal, and rotavirus vaccines trials (see Chapters 2 and 3 for more detail), were of critical importance in reducing the burden of diseases that affects the Region, they were externally funded. Continued dependence on external funds for research may not always align to regional priorities and may not be sustainable.

Research institutions in the Region have insufficient facilities and infrastructure: less than half have institutional websites, provide email addresses to research staff and have a library. There is a serious shortage of qualified staff engaged in health research. Although the majority of researchers are full-time staff, significant numbers also leave their institutions for various reasons, leading to shortages of experienced senior researchers.

In spite of these constraints, a significant amount of research is conducted and reported in regional and national journals, and as working paper series or unpublished manuscripts. However, the Region’s relative share of publications in international journals is low. Researchers have also not always been able to push for their evidence to be used to drive policy. While policy-makers tend not to base policy and practice on evidence, there have been notable exceptions as the discussion below indicates.

What works?

In Burkina Faso, a combination of *Fagara zanthoxyloides* and *Calotropis procera* (FACA), identified by traditional medicine practitioners, was subjected to rigorous research and development processes. FACA was analysed and found to have a combination of antisickling, anti-inflammatory, antipyretic properties that work against the principal symptoms of sickle cell anaemia. Consequently, approval has been given for use, large-scale production and exportation of FACA to other countries.

Research and use of its findings are facilitated when driven by demand, and when policy-makers and researchers work as allies accountable to one another. Following concern about malaria drug resistance, the Ministry of Health of Cameroon requested researchers and the knowledge translation team EVIPNet (Evidence Informed Policy Networks) of Cameroon to confirm or disprove the issue. The EVIPNet team collated evidence on the prevalence of malaria drug resistance from within and outside the country, and prepared a policy brief that was used in a dialogue with policy-makers, resulting in a change in policy for the drug used in the treatment of malaria in the country.

In conclusion, we know what works to achieve equitable access to care is a combination of financing, services delivery, availability and equitably distributed human resources for health, and availability of essential medicines, health technologies and diagnostics at all times, which must be backed by good governance and stewardship. All countries in the Region have developed policies and strategies that call for effective stakeholder coordination and harmonization and alignment of all available resources to ensure implementation. Each country can do something, some through larger reforms and others through more incremental actions, to strengthen their health system to cover large sections of their populations, with particular attention to the poor and vulnerable, in order to achieve the goal of universal health coverage. The priority is good policies and evidence-based strategies as well as knowledge generation and exchange of best practices between countries, with participation of other actors that are not traditionally involved in the health system, for example the ministries of finance, labour and social security and other ministries involved in management of factors related to social determinants.
Chapter 6  Improving access to health care

Bibliography


