



# UHC ACCOUNTABILITY IN SUB SAHARAN AFRICA

**A desk review of  
Botswana, Kenya, Namibia and Togo**

**BY AMREF HEALTH AFRICA.**

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**The study is based on a document review of the country contexts, the status of Universal Health Coverage (UHC) implementation, existing accountability mechanisms and health financing for UHC in Botswana, Kenya, Namibia and Togo.**

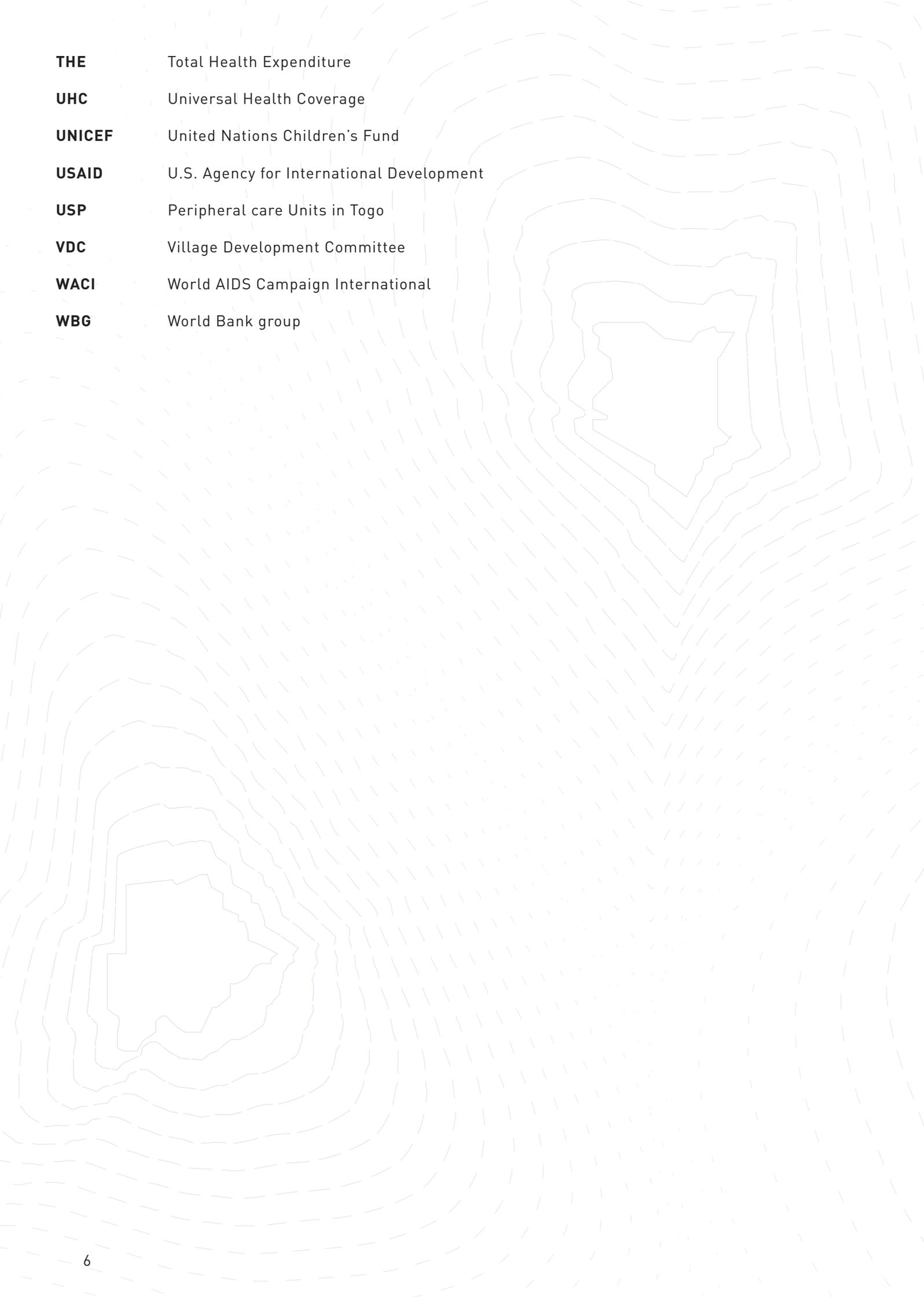
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# Acronyms

<b>ACS</b>	African Collaborative for Health Financing Solutions
<b>AIDS</b>	Acquired Immunodeficiency Syndrome
<b>ALC</b>	Accountability Learning Collaborative
<b>CCM</b>	Country Coordinating Mechanisms
<b>CDOH</b>	County Department of Health
<b>CHR</b>	Centre Hospitalier Regional
<b>CHU</b>	Central Hospitalier Universitaire
<b>CNSS</b>	National Social Security Fund
<b>CRF</b>	County Revenue Fund
<b>CRT</b>	National Pensions Fund
<b>CSO</b>	Civil Society Organization
<b>DHMT</b>	District Health Management Teams
<b>E4A</b>	Evidence for Action
<b>EmONC</b>	Emergency Obstetric and Newborn Care
<b>FBO</b>	Faith-Based Organization
<b>GBV</b>	Gender-Based violence
<b>GDP</b>	Gross Domestic Product
<b>GHE</b>	Government's Health Expenditure
<b>HALE</b>	Health Adjusted Life Expectancy
<b>HAPLUCIA</b>	Haute Autorité de Prévention et de Lutte contre la Corruption et les Infractions Assimilées
<b>HENNET</b>	Health NGOs Network
<b>HERAF</b>	Health Rights Forum
<b>HFC</b>	Health Facility Committee
<b>HFMC</b>	Health Facility Management Committee
<b>HiAP</b>	Health in All Policies
<b>HISP</b>	Health Insurance Subsidy for the Poor
<b>HLCC</b>	High Level Consultative Committee
<b>HRH</b>	Human Resource for Health
<b>HSSF</b>	Health Sector Services Fund

<b>IHSP</b>	Integrated Health Services Plan
<b>IMF</b>	International Monetary Fund
<b>INAM</b>	National Institute of Health Insurance
<b>ISW</b>	Informal Sector Workers
<b>KEPH</b>	Kenya Essential Package for Health
<b>KHP</b>	Kenya Health Policy
<b>KII</b>	Key Informant Interview
<b>LGBTQI</b>	lesbian, gay, bisexual, transgender, queer and intersexed community
<b>MAFs</b>	Medical Aid Funds
<b>MNH</b>	Maternal Newborn Health
<b>MOH</b>	Ministry of Health
<b>MoHSS</b>	Ministry of Health and Social Services
<b>MOHW</b>	Ministry of Health and Wellness
<b>MOLG</b>	Ministry of Local Government
<b>MTEF</b>	Medium-Term Expenditure Framework
<b>NAMFISA</b>	Namibia Financial Institutions Supervisory Authority
<b>NDP5</b>	5th National Development Plan
<b>NDPs</b>	National Development plans
<b>NGO</b>	Non-governmental Organization
<b>NHA</b>	National Health Accounts
<b>NHIF</b>	National Health Insurance Fund
<b>NHIS</b>	National Health Insurance Scheme
<b>NMBF</b>	National Medical Benefit Fund
<b>OOP</b>	Out-of-Pocket
<b>PHC</b>	Primary Healthcare
<b>PHM</b>	People's Health Movement
<b>PSEMAS</b>	Public Employee Medical Aid Scheme
<b>SDG</b>	Sustainable Development Goals
<b>SNFS-CSU</b>	National Strategy for Health Financing to Universal Health Coverage
<b>SSA</b>	Sub-Saharan Africa
<b>SSC</b>	Social Security Commission
<b>SWAp</b>	Sector-wide Approaches



<b>THE</b>	Total Health Expenditure
<b>UHC</b>	Universal Health Coverage
<b>UNICEF</b>	United Nations Children's Fund
<b>USAID</b>	U.S. Agency for International Development
<b>USP</b>	Peripheral care Units in Togo
<b>VDC</b>	Village Development Committee
<b>WACI</b>	World AIDS Campaign International
<b>WBG</b>	World Bank group

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# EXECUTIVE SUMMARY

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This desk review has been undertaken for the African Collaborative for Health Financing Solutions (ACS), a five-year (2017-2022) USAID-supported project. The project's overarching goal is to advance the implementation of health financing policies that support movement towards UHC in Sub-Saharan Africa (SSA). ACS formed the Accountability Learning Collaborative (ALC) with the goal of generating evidence and promoting learning about accountability for informed action towards UHC. ACS brings together a broad range of stakeholders – people from diverse sectors and across countries who work at the national, regional, and local levels for peer learning – to share challenges and formulate solutions.

The study analyzed the country contexts of **Botswana, Kenya, Namibia and Togo** to establish how national health policies and practices tackle issues of universal health coverage. The analysis is tilted towards UHC in two aspects: health financing and how it promotes equitable access, and whether there exist any explicit national accountability mechanisms for UHC. The country specific context analysis is followed by a discussions section which tries to weave together recurrent trends and patterns across countries, including key points of divergence. The final section, which follows, concludes the desk review and makes recommendations, based on the analysis.

Major findings are that, first, all the countries reviewed in this study have made commitments towards the achievement of **Universal Health Coverage** goals. In tandem with this, countries have developed policy frameworks and plans to coordinate and direct the health sector towards attaining the UHC goals.

Secondly, in each country, the government, or more specifically, the public sector is the major investor and provider of health services. Of the four countries reviewed, Botswana and Namibia are leading in terms of the level of **Total Health Expenditure (THE) contribution** by government. Botswana has surpassed the Abuja target on health

expenditure, while Namibia comes close to meeting this target.

Thirdly, each of the four countries reviewed has a **national health insurance plan**. These health insurance plans are aimed at addressing health financing inequities and reducing catastrophic health expenditures for users of health services. However, this intention has not been adequately addressed by any of the four countries reviewed. In Botswana, for instance, the predominance of the private sector as the main provider of health insurance leaves huge sections of the population however financial protection does not pose a challenge as citizens are not denied services if they are not able to afford.

Fourth, there are huge urban-rural disparities in **access to and utilization** of healthcare. All countries reviewed have not adequately addressed the urban-rural divide. Kenya intended to address this through devolution, but the effects are yet to be fully realized.

Fifth, each of the four countries relies largely on bureaucratic **performance-based** mechanisms of accountability. The literature reviewed for this study hardly mentions or references citizen accountability mechanisms in Universal Health Coverage in any of the countries studied. What forms of social accountability exist are neither specific to UHC, nor generally to the health sector.

Based on the analysis, the following recommendations can be made. First, CSOs need to undertake **coordinated** advocacy towards inequitable health financing. Secondly, CSOs need to generate **evidence** on what is working, where governments are failing, and on feasible policy solutions for fast-tracking UHC. Thirdly, advocacy on **accountable** use of resources also needs to be undertaken. In this, CSOs will need research, collaboration and networking to navigate through the often closed spaces of governments' policy processes. For CSO advocacy on UHC accountability to be effective, CSOs need to develop their capacity for engagement with government on policy issues. Such advocacy will require resources – human, financial and institutional networks – and CSOs must appropriately invest in developing these.

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# CHAPTER 1: BACKGROUND

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## Introduction

The African Collaborative for Health Financing Solutions (ACS) is a five- year (2017-2022), USAID-supported project with the overarching goal of advancing implementation of health financing policies that support movement towards universal Health Coverage (UHC) in Sub-Saharan Africa (SSA). ACS offers the technical support, facilitation, and coaching that countries need to make progress toward universal health coverage. It is led by Results for Development in partnership with the Duke Global Health Innovation Center, Feed the Children, Amref Health Africa, and Synergos.

One of ACS' pillars is to strengthen accountability so that UHC health financing solutions are designed, implemented, and tracked through a process that is evidence-based, transparent, and accessible. ACS formed the Accountability Learning Collaborative (ALC) with the goal of generating evidence and promoting learning about accountability for informed action towards UHC. ACS brings together a broad range of stakeholders – people from diverse sectors and across countries who work at the national, regional, and local levels for peer learning – to share challenges and formulate solutions.

## About the Accountability Desk Review

The Accountability Learning Collaborative (ALC) is conducting a mapping exercise of the UHC accountability landscape in sub-Saharan Africa to guide and inform the broader work of the learning collaborative. More specifically, the findings of this exercise will inform the capacity development efforts of ALC for countries covered under this collaborative. More specifically, the mapping exercise will seek to:

1. Identify the key stakeholders (government, Civil Society Organizations (CSOs), Youth etc.), networks and movements involved in promoting accountability within the health sector in the region.
2. Identify the strategies, approaches as well as platforms that have and/or can be (successfully) used to promote accountability
3. Identify existing gaps in promoting accountability by the various stakeholders' capacity to promote accountability through the various platforms.

The following research questions will guide the study, based on the above study objectives:

- A. Who are the major actors working towards greater accountability in the health sector in the region?*
- i. *How are these actors organized, what platforms exist and how inclusive and representative are they?*
  - ii. *What type of structures, policies and institutional arrangements do these actors target to seek change on with their activities?*
- B. What strategies are employed towards the push for greater accountability including social accountability?*
- i. *How relevant and applicable have these strategies been in achieving desired change?*
  - ii. *What other viable strategies could be used to improve and maintain citizen awareness,*

*empowerment and engagement around accountability for UHC?*

*C. What gaps (capacity, political, resources etc.) exist in pushing for the accountability agenda?*

- i. What are the root causes of these gaps?*
- ii. What are some of the feasible methods of addressing these gaps especially capacity gaps?*
- iii. What are some of the preferred ways of filling the gaps identified?*

The assignment will be coordinated by Amref Health Africa in consultation with the larger ACS team and stakeholders in ACS implementation countries. The body of evidence generated from the mapping exercise will inform future work of the ALC's efforts in strengthening the capacity of the different actors and stakeholders to engage in evidence-based accountability efforts.

## **Study Design**

The following additional steps were undertaken as part of the desk review and mapping exercise:

1. **Document Review:** More extended document reviews were carried out. The next phase of document review was more targeted, exploring specific themes in more depth, and plugging existing gaps in data so far obtained. The aim was to identify published and grey literature on the strategies used in accountability towards UHC, the contexts in which they have been used, and the attendant health and institutional outcomes. Organizations identified as part of the current document review were approached for their reports, research or policy briefs or other publications on UHC. Not much is currently published online by these organizations regarding their work on UHC accountability. It could be that this work is contained in organizational program reports, in unpublished policy and research work, and in other types of documents (i.e. videos). Requests were made to each of the organizations identified to provide any documents they might be having on UHC accountability. They were also asked to identify experts in their networks, and these were asked to recommend further documents. Additionally, citations mentioned in the literature so far reviewed were reviewed, and any other links in the literature explored. ALC partners were also approached and requested to recommend any further documents they may be aware of.
2. **Data Analysis and Report Writing:** A concise report was prepared and submitted to Amref Health Africa and the other ALC partners. Quantitative data was analyzed to generate estimates of various phenomena of interest. Qualitative data was arranged thematically and analyzed for recurring trends and patterns. Dominant themes were flagged out and explored further in depth. Data triangulation was relied on to develop deeper insight on dominant messages, themes and issues. The report was tailored to answer the mapping assessment objectives, and the study questions. Actionable recommendations were provided as part of the report – based on identified UHC accountability networks composition, geographical distribution and spread, strengths, opportunities and gaps.

## **Limitations**

There are certain limitations with the approach employed. First, only documents that were open access were reviewed in full. Even though few documents requiring subscription for access were encountered during the review, relying on open access documents only presents a methodological limitation.

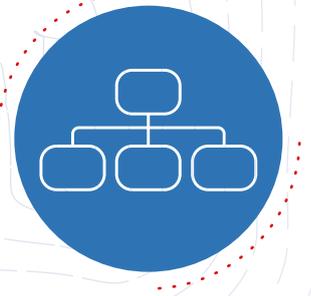
Secondly, only documents published in English were reviewed. This presents a challenge for Togo, where documents written in French could have provided a more nuanced picture.

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# CHAPTER 2: LITERATURE REVIEW

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## Structure and Organization of the Health Sector



### BOTSWANA

Botswana has a six-tiered health care delivery system: mobile stops, health posts, clinics (with or without maternity), primary hospitals, district hospitals and referral hospitals distributed over 29 health districts. Before 2009, health care provision at the different levels of the health system was the responsibility of both the Ministry of Health (MoH) and the Ministry of Local Government (MoLG). The MoH was responsible for running primary hospitals (formerly called health centers), district and referral hospitals.

The Ministry of Local Government (MoLG), through the District Councils, managed the clinics, health posts and mobile stops.<sup>1</sup>

Recent reorganization and the relocation of primary health care development expenditure from the Ministry of Local Government and Regional Development to the Ministry of Health and Wellness (MoHW) makes the MoHW the main public-sector health care provider in the country. This has given the MoHW the overall mandate for health policy formulation, regulation and norm setting, as well as setting standards and guidelines for health services. The District Health Management Teams (DHMT) facilitate communication with all clinics in the 27 health districts, the primary and/or district hospital, and other sectors within the district.<sup>1</sup> Botswana's healthcare services are primarily delivered through public health facilities; however, the private sector too plays a vital role. Health service delivery is pluralistic, with participation from public, private for profit and non-profit, and traditional entities. Public health infrastructure is widely distributed with facilities ranging from health posts to tertiary hospitals.<sup>2</sup>

An estimated 84 percent of the entire population in Botswana can access healthcare within a 5 km radius, and a further 11% live between 5 and 8 km from a facility. In essence, a total of 95% of the population live within an 8 km radius of a health facility. There are, however, urban and rural differences. For instance, 100% of the inhabitants of North East, Southern and Kgalagadi South live within 5 km of a facility, while in parts of Serowe, Bobirwa, Mahalapye and Gomare most inhabitants live within a radius of 8 km from a health facility.

By contrast, in Kweneng West and South East only 5% and 14% of the populations respectively lives within 5 km from a facility.<sup>3</sup>

The overarching plan, the National Vision 2036, is based on a series of medium-term plans. To streamline the management of the public sector, the Ministry of Finance and Economic Development established the Medium-Term Expenditure Framework (MTEF) in the 2016/17 fiscal year, with the aim of gradually adopting program-based budgeting. National Development Plans (NDPs) and strategic sector plans guide

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1 Evaluation of Norwegian Health Sector Support to Botswana, Final Report - Volume 1 / January 2012

2 Botswana National Budget Brief 2018 – UNICEF

3 Evaluation of Norwegian Health Sector Support to Botswana, Final Report - Volume 1 / January 2012

Botswana's health sector. The current plan, NDP 11, runs from April 2017 to March 2023. The plan includes various health sector priorities: strengthening health promotion interventions; household food security and nutrition; prevention of non-communicable diseases; universal coverage of essential health services; and promotion of mental health.<sup>4</sup>

Furthermore, the Integrated Health Services Plan for 2010-2020 (IHSP) also guides health sector strategic priorities. The IHSP aims to address the following key challenges: reducing shortage of health professionals; increasing and strengthening partnerships with the private sector and NGOs; scaling up utilization of essential health service packages; and redefining service delivery levels and delineating types of health services for each level. At the same time, the IHSP emphasizes bottlenecks related to shortage of health professionals and inequitable distribution of health professionals, predominantly in remote areas.

A critical plank of the IHSP is the delivery of an essential health service package, which is a set of health interventions that the Government is committed to making accessible to the entire population. Over the past years, the Government has invested substantial resources in healthcare services. The government took concrete actions towards achieving the IHSP health-financing goal of raising sufficient resources to deliver services efficiently with a focus on the needs of vulnerable groups. After education and general administration, the health sector receives the third largest share of government spending, averaging 11 per cent of total spending over the five years from 2013/14 to 2017/18.

## KENYA

Kenya devolved services (including health) in 2013 from a single central government to 47 new sub-national units, the county governments. The Constitution outlined a 3-year transition period for hitherto centralized national functions to be transferred to county governments. This window period was to allow for the creation of requisite capacities at the county level. However, the newly formed county structures were in a rush to consolidate their power and control over the lucrative health sector. In response to this pressure from the county governments, all county-related functions were transferred in June 2013, just four months after county level elections (held in March 2013). County governments had barely established the requisite structures to carry out these functions.<sup>5</sup> Consequently, transition from the national to county government has been marred by inconsistency, poor staffing of the system, management challenges and lack of coordination between the national and county governments. This rapid transfer of authority and responsibilities to county governments suddenly saddled them with the daunting functions of planning, budgeting, implementation, and management of health services for community and primary health care and referral up to county level.<sup>6</sup>

The health sector was the largest service sector to be devolved under this new governance arrangement. The rationale for devolving the sector was to allow the county governments to design innovative models and interventions that suited the unique health needs in their contexts, encourage effective citizen participation and make autonomous and quick decisions on resource mobilization and management issues possible.

Kenya has a mixed model of public and private provision of health services. The government owns 49 percent of the health facilities, while 16 percent are owned by private not-for-profit, and with the remaining 35 percent being owned by the private for-profit sector. Public sector provision is organized into four tiers, comprised of community health care (through level 1 community health units), primary health care (level 2 dispensaries

4 Botswana National Budget Brief 2018 – UNICEF

5 McCollum, et. al. (2018), Priority setting for health in the context of devolution in Kenya: implications for health equity and community-based primary care, *Health Policy and Planning*, 33, 2018, 729–742, doi: 10.1093/heapol/czy043

6 Leah Kimathi **Challenges of the Devolved Health Sector in Kenya: Teething Problems or Systemic Contradictions?** *Africa Development*, Volume XLII, No. 1, 2017, pp. 55-77

and level 3 health centers), secondary care (levels 4 and 5 county hospitals), and tertiary care (level 6 national referral and specialty hospitals). County authorities are responsible for providing services in levels one to five and national level is responsible for providing national referral services. Community health services form the first level in the health system and underpin Kenya's plan for attaining UHC.

County Departments of Health (CDOHs) coordinate and implement health sector activities within counties, manage resources for all public sector health facilities as well as community health and other non-facility-based public health programs. The MoH oversees tertiary care facilities and is responsible for developing national policies and plans.<sup>5</sup> In order to address some of the inequities between geographic regions, Kenya has introduced changes to resource allocation, through transfer of equitable share funding from central government to county governments, which takes into account each county's poverty level, along with an equalization fund for formerly marginalized counties. Formerly marginalized counties now benefit from higher levels of funding, along with the decision space to invest in health.<sup>8</sup>

In addition, other conditional grants from the national government, including reimbursements for removing user fees in primary care facilities and providing free maternity services—initially channeled directly to facilities — are currently transferred through the county revenue fund (CRF).

Such an arrangement, although aligned to the country's Public Financial Management Act and the Constitution, potentially leads to delays in funds transfers and undermines service delivery.

Health service delivery in Kenya is anchored on the Kenya Essential Package for Health (KEPH). It is based on a four-level system articulated in the Kenya Health Policy (KHP) 2014- 2030, which outlines Kenya's commitment to Universal Health Coverage. Kenya's national health policy is operationalized according to the Kenya Health Sector Strategic and Investment Plan (2014–2018). The Kenya Health Sector Strategic and Investment Plan III 2018–2023 (Draft) promotes the aspirations of the Kenyan Constitution and the Kenya Health Policy 2014-2030 by underscoring the attainment of Universal Health Coverage as the main sectoral priority and includes expansion and coverage of services for the last mile. The development of a unified health benefit package has been envisioned and the existing scope of services is expanded to include sub-specializations in various service areas including a renewed focus on primary health care.

The plan targets that by 2022, all persons in Kenya should have access to essential services for their health and wellbeing through an explicit essential benefit package, without the risk of financial catastrophe as a result.<sup>13</sup>

## NAMIBIA

Namibia is an upper-middle income country with a small population of around 2.5 million people. The country has made major progress in improving the standard of living for its population and reducing poverty.

Gender inequality is linked to disproportionately high levels of poverty and low-income status among Namibian women, their limited participation in political and economic institutions and high levels of gender-based violence (GBV). Namibia has pursued a policy of gender mainstreaming since 1995 and the National Health Policy Framework 2010–2020 emphasizes the need to address gender issues in relation to access to health services. National frameworks require all government ministries to integrate issues of gender, equity and human rights into public policies, strategies and operational planning. In addition, the Harambee Plan identifies youth, young women in particular, as key target beneficiaries for development, while the draft Health in All Policies (HiAP) strategy proposes four themes as entry points: Child Welfare; Women's Well-being; Remote and Rural Services and Housing.

The government has a commitment to health as a fundamental human right and has restructured the health system by integrating racially divided communities into one healthcare system. Namibia's total health

expenditure (THE) as a percentage of gross domestic product (GDP) and per capita health expenditure are comparatively high relative to other sub-Saharan African countries. More than 93% of its THE is generated from domestic resources.<sup>7</sup>

Namibia's development blueprint, Vision 2030, places emphasis on a country that is free of the diseases of poverty and inequality; and in which the majority of citizens lives healthy lifestyles and enjoy equal access to a comprehensive preventive and curative health service. Likewise, the constitution of the Republic of Namibia emphasizes equitable access to basic social welfare and health care as a right of every citizen.

The Ministry of Health and Social Services (MoHSS) has adopted a primary healthcare (PHC) approach to the delivery of healthcare services, based on the four pillars of health promotion, disease prevention, curative services and rehabilitation services. The health sector is managed under the National Health Policy Framework 2010–2020 and a range of Acts, including the Public Health and National Environmental Health Act (2015), International Health Regulations (ratified 2007) and the Hospitals and Health Facilities Act (1994).

The health system is dominated by the public sector in terms of financing, service delivery and coordination. The healthcare infrastructure network consists of 295 clinics, 47 health centers, 30 district hospitals, three intermediate hospitals, one national referral hospital and nine Sick Bays, as well as various social welfare service points, private hospitals and clinics. It also has about 1,150 outreach points. The public health sector is structured in a three-tier hierarchy with national, regional and district levels. The national level is responsible for policy formulation, regulation, planning, management development and giving support for service provision to the entire health sector; whereas the regional directorates are responsible for regional-level oversight and service delivery.

The MoHSS is the manager and provider of public health services in Namibia. It operates a four-tiered health service delivery system consisting of PHC sites, district hospitals, intermediate hospitals and a referral hospital. Clinics are staffed by nurses and pharmacy technicians or assistants. Besides government, faith-based organizations and non-governmental organizations, as well as the private sector, continue to play a key role in the provision of health services. The private sector is sizeable, with 844 private health facilities, 72% of the doctors and a little less than 50% of registered nurses<sup>8</sup> The private sector is mainly concentrated in the urban areas.

The Ministry of Health and Social Services (MoHSS) in its mission seeks to provide integrated, affordable, accessible, equitable, quality health and social welfare services that are responsive to the needs of the population. This is restated in the Patient Charter, which aspires for equity of access to public health and social care services. Similarly, the National Health Policy Framework underscores that health and social welfare services will be affordable, and the principle of equity and fairness will underpin the commitment expressed in the policy framework, with special attention given to the needs of vulnerable groups. In line with this intention, the MoHSS has begun laying the groundwork for establishing universal health coverage in the country.<sup>9</sup>

## TOGO

The health sector in Togo is pyramidal in structure, with three levels of care. These include central, intermediate and the peripheral levels. The peripheral facilities form the base of the pyramid, comprising 35 health districts. This level is responsible for the planning, implementation, monitoring and evaluation of

7 National Health Accounts, Botswana 2013/2014

8 <https://phcfm.org/index.php/phcfm/article/view/2242/3566>

9 WHO Namibia Country Cooperation Strategy III 2018-2022: *Accelerating Progress Towards Universal Health Coverage*

health sector policy.

It is also charged with mobilizing communities and local stakeholders, including traditional practitioners. The middle of the pyramid constitutes the intermediate or regional level and corresponds to six health regions. At the top of the pyramid, commonly called central or national level, comprises the office of the minister of health and its central directorates. The Togolese public health system comprises large hospitals (Central Hospitalier Universitaire (CHU), Centre Hospitalier Regional CHR) and smaller ones (USP). The two types of hospitals are distinguished by the number of people hospitalized. The small hospitals are typically not authorized to hospitalize patients but are required to transfer patients to the larger hospitals for inpatient care. Among the larger hospitals are university hospitals (CHU), regional hospitals (CHR) and district hospitals (HD or HP).

The state budget allocated to the health sector has been dominated by a small proportion of government expenditure on health (approximately 5%), low disbursement, and under-mobilization of internal resources. Almost half (51%) of all health spending is out-of-pocket expenditure by households through the direct payment system involving user fees, or cost recovery, and the purchase of medicines by patients. At 26%, overall access and utilization of services among targeted populations in Togo remains low. Further, nearly 12% of the population in urban and rural zones cannot access health care services for financial reasons. This rate ranges from 4.8% to 13.8% across regions. More than 15% of women have no access to health care services due to financial reasons, compared with 10% of men.

## Progress towards UHC

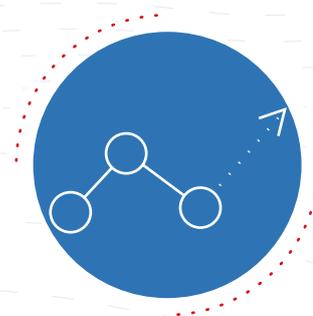
### BOTSWANA

Botswana could meet its Universal health coverage (UHC) targets, if the government undertakes the right measures towards this. The country has exceeded the Abuja target of 15% of government funds spent on health, and has a low out-of-pocket spending, which accounts for 4% of total health expenditure. Botswana Government's financing of health services currently stands at 65% of total health expenditure.<sup>10</sup> Even though the Government's Health Expenditure (GHE) per capita has remained relatively constant since 2005, financing for health has also been boosted by the growth of private health insurance.<sup>11</sup>

The government has encouraged the growth of private health insurance providers, with Private sector funding steadily increasing from 21% to 28%, as a share of total health expenditure. Companies and individuals contribute approximately 39% of health funding; donors account for 7%, including on- and off-budget support.<sup>12</sup> The greatest challenge to UHC remains in rural areas, where improved access has not necessarily translated to utilization of high-quality services.

Private insurance schemes constitute 39 percent of Botswana's pooled health expenditure. Although these schemes cover just 17% of the population, they have grown rapidly as a source of health expenditure. There are nine insurance schemes in the country; the largest three cover 88% of the beneficiaries, so a number of the pools are insufficiently large to effectively spread risk or lower operational costs.

As Botswana's health system continues to move toward UHC, additional bold steps will be required to guarantee equitable access to such services through partnerships with the private sector. Despite broad



10 Botswana Declaration on the Universal Health Coverage (UHC), Speech by Honorable Mr. Biggie G. Butale, The Assistant Minister of Health & Wellness, At the 71st World Health Assembly, In Geneva, Switzerland, 21st May 2018

11 Health Financing Profile, Botswana, 2016 (USAID Health Policy Project)

access to health facilities, there is potential for improving utilization of services and high-quality interventions.

The infrastructure for advancing UHC goals exists, but the achievement of UHC is likely to be hampered by limited health insurance coverage. Limited health insurance coverage among the general population and those in employment, coupled with inequitable allocation of financial resources between curative services and cost-effective public health interventions are likely to deter efforts towards expanding health services coverage. These disparities are likely to constrain expanding cost-containing strategies for population-based health services geared towards disease prevention and health promotion interventions. Inequitable financial allocation between curative and population-based health services further derails initiatives to tackle Social Determinants of Health.<sup>12</sup>

The government is considering ways to expand coverage through the private sector, including compulsory enrollment of public employees in these schemes and contracting out. Employers in both the public and private sectors already heavily subsidize employees' health insurance, so mandating enrollment for private companies is likely to face resistance. Botswana has made strong efforts to extend coverage under the public system to rural areas through mobile services. The current system of tax-financed health services has been successful in pooling risk, somehow contributing to reductions in catastrophic expenditure and promotion of equity in health.<sup>12</sup>

## KENYA

To achieve UHC, the Government of Kenya has developed the "Roadmap towards Universal Health Coverage 2018-2022" and identified key strategic interventions and priorities in a bid to solve these challenges. The Roadmap sets the UHC goals and aspirations for Kenya. It recommends strategic interventions and priority areas of implementation to achieve UHC. The document specifies the role of the different players/enablers in achieving UHC. In addition, it details the monitoring and evaluation plan as well as the communication plan for UHC. The Roadmap will ensure that the sector is working towards common UHC goals in a synchronized manner. It is expected to result in reduced duplication of efforts and enhanced resource efficiencies. KEPH focuses on meeting the needs of an individual through the entire life cycle. Other policy initiatives developed by the government to fast-track the achievement of UHC include the UHC Domestic Resource Mobilization Blueprint, which provides a roadmap for Ministry of Health to address key financial challenges in order to ensure sustainability of the healthcare system in the country. It is a key reference document for domestic resource mobilization for health in Kenya.

The government currently accounts for the largest proportion of health spending, even though Kenya is far from fulfilling the Abuja target of 15% of total government budget allocation to the health sector. Health financing has been identified as a critical policy orientation to achieve the goal of Kenya National Health Policy 2014-2030. Inherent to the health financing policy is the removal or minimization of all financial barriers hindering access to services for all persons requiring health and related services; guided by the concepts of Universal Health Coverage and Social Health Protection.

Other than funding, other key challenges facing the sector include shortage of human resources for health delivery, infrastructure, low levels of research and development, fragmented supply chains and low levels of health insurance coverage.<sup>13</sup> Although Kenya has shown improvement in the coverage of essential health services, major gaps persist. Disparities between urban and rural communities are stark for access to family planning, antenatal care services, and vaccination coverage, which remains too low overall. Just 63 per cent of Kenyans have access to government health services located within an hour of their homes, and greater

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12 Mbogo and McGill, op.cit.

13 Innovative Health Financing Models for Universal Health Coverage in Kenya

distance to a facility is a significant factor in decreased demand for healthcare in the country. Health facilities are unequally distributed across the forty-seven counties. In Turkana County for example, some residents in the far-flung corners of the county have to travel for two days to access a health facility.<sup>14</sup> As a result, health indicators are much below average, compared to other counties.

The trend in healthcare financing has been changing over the last 5 years. Government overall revenue and expenditure have seen significant year on year increase in the past 5 years – finally passing the threshold of 20% of GDP in 2016/17. While the increase is approximately 80%, the percentage of healthcare spending as a proportion to the total government spending has hovered around 2.5% over the same period.

The County government expenditure on health as a proportion of the overall county government spending also rose from 5.26% (2013-14) to 19.28% (2016-17). County government expenditures have also seen a year on year increase, at a rate faster than the increase in national government expenditures. Notably, health expenditures at national and county governments have shown an increasing trend in absolute terms, but are stagnant in real terms at an average of 5% of total government expenditures (20% for county expenditures).<sup>14</sup>

The government launched the Health Sector Services Fund (HSSF) in 2010 to expand the supply of healthcare and strengthen primary healthcare by supplementing user fees and the county allocations. The HSSF is a revolving fund that provides direct cash transfers to primary health care facilities that include dispensaries and health centres. Local communities are represented by the Health Facility Management Committee (HFMC) and are expected to manage the funds received and prioritize their use according to health needs. The HSSF mobilizes additional resources from the government and its development partners to improve service delivery. It ensures expeditious and direct cash transfers to primary health facilities run by the government and faith-based organizations, and supports an equitable distribution of resources.

More importantly, the HSSF empowers local communities to take charge of their health by actively involving them through the HFMCs in the identification of their health priorities, and in the planning and implementation of initiatives responsive to the identified priorities. The HSSF has been critical in improving the physical infrastructure of health facilities in far flung counties, even though the allocation is minimal and is pegged on the number of clients and the level of the facility. As a result, level 4 and 5 facilities get more money while levels 1 to 3, which are closest to the people, get very little allocation.<sup>15</sup>

The primary funding for healthcare comes from three sources: public, private (consumers) and donors.

Consumers are the largest contributors, representing approximately 35.9 per cent, followed by the Government of Kenya and donors at around 30 per cent each. Paradoxically, the majority of those who opt for public health care are the poorest who cannot afford private care. This bracket of the population spends more than 40 per cent of non-food expenditure on healthcare. Needless to say, healthcare can be a major source of financial distress for Kenyans. Out-of-pocket (OOP) payments are a major barrier to access to health services, and close to two million Kenyans are plunged into poverty through unexpected out of pocket expenditures on healthcare. In essence, co-payments do not reflect patients' ability to pay; and fragmented health financing arrangements create challenges for pooling, increase costs for administration, and incentivize inefficiencies.

To cushion poor Kenyans from debilitating income shocks occasioned by out-of-pocket payments, the government has initiated health insurance schemes towards this purpose. For instance, Health Insurance Subsidy for the Poor (HISP) piloted by the government in 2014 seeks to offer financial protection to Kenya's poorest citizens. This program provides a comprehensive package of outpatient and inpatient services to the neediest families in Kenya, both in public and accredited private facilities. Likewise, the Health Insurance

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14 Leah Kimathi **Challenges of the Devolved Health Sector in Kenya: Teething Problems or Systemic Contradictions?**

*Africa Development*, Volume XLII, No. 1, 2017, pp. 55-77

15 Leah Kimathi, op.cit

Program for the Elderly and People with Disabilities is based on a cash transfer program, with an annual budgetary allocation of 500 million Kenyan shillings. It is designed to purchase health insurance coverage through the National health insurance Fund (NHIF). Beneficiaries are entitled to a package similar to those in formal employment who are covered by the NHIF.

Three mechanisms guide purchasing functions in the health sector. First, national and county governments purchase healthcare services from public healthcare services that they own. Specifically, the national Ministry of Health (MoH) owns three tertiary care hospitals and pays for services through global budgets. County governments own primary and secondary care health facilities and pay for these services through line budgets, health worker salaries and supply of commodities. Secondly, the National Hospital Insurance Fund (NHIF), Kenya's social health insurer, contracts both public and private healthcare facilities to provide services to registered members. Thirdly, private and community-based health insurance (CBHI) schemes contract public and private health service providers to provide services to members.<sup>16</sup> Purchasing arrangements are largely passive; there is no purchaser- provider split and provider payments are ill defined.

The Kenya Health Policy and the Kenya Health Sector Strategic and Investment Plan III 2018- 2023 highlight the need to improve health systems efficiency and quality. They also prescribe a benefit package of services that should be provided to Kenyans: KEPH. However, there is no explicit linkage between the policy prescriptions and what the NHIF does in practice. For instance, the NHIF's benefit package has not been guided by KEPH. The government of Kenya has made a specific policy decision to, among others, expand health insurance coverage among the population through the NHIF as a means to achieving UHC. However, NHIF only accounts for 4.6% of current health spending, compared to 10.7% by private insurance.<sup>17</sup> To date, the fund has 7.3 million principal contributors and has grown membership to about 22 million members who include contributors' dependents.

Membership to the NHIF is compulsory for all formal sector workers, and voluntary for the informal sector. In practice, however, NHIF is only mandatory for salaried employees, whose employers remit the monthly premium (set on a graduated scale linked to salary levels) to NHIF. The salaried employees' premium is calculated on a graduating scale of between Ksh 150 and 1700 monthly. The insurer does not have a way to automatically collect contributions from those who are self-employed or work in the informal sector. For such households, membership is therefore effectively voluntary and involves a flat premium (currently set at KES 500 or \$5 per month for a household). Currently an estimated 20% of the population is actively enrolled in NHIF (approximately 88.4% of all persons with health insurance in Kenya), compared to 3% with private health insurance.

Several programs have been developed under the NHIF including the Health Insurance Subsidy Program for the poor, the elderly and persons with severe disabilities; and Linda Mama program (free maternity services), which provides cover for four visits of antenatal care, delivery, postnatal care, and complications during pregnancy and care for the infant for a period of one year.<sup>14</sup> Besides, there is also the Students medical cover which includes inpatient and outpatient services, dental, optical, local road ambulance and emergency air rescue services for students in public secondary schools.

NHIF covers a range of inpatient and outpatient services, which it purchases from contracted public and private providers. It introduced an outpatient package for civil servants in 2012, which it extended to all members in 2015 along with an increase in premiums. Currently, NHIF offers two main insurance schemes: the civil servant scheme for government employees, and a general scheme that covers everyone else. This latter scheme includes all formal sector employees not employed by the government, informal sector members,

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16 Munge K, Mulupi S, Barasa EW, Chuma J. A critical analysis of purchasing arrangements in Kenya: the case of the National Hospital Insurance Fund. *Int J Health Policy Manag*.2018;7(3):244-254. doi:10.15171/ijhpm.2017.81

17 McCollum, et. al. (2018), op.cit

and households sponsored by the government. It pays primary care facilities for outpatient services using a capitation method, and hospitals for inpatient services through a mix of case-based rates, fee-for-service, and per diems. In compliance with the NHIF Act, all payments are made directly to health facilities. Notably, the ability of facilities to retain and spend those funds has changed as a result of devolution.

A study on the purchasing arrangements in the health sector established that the MoH lacks clear structures to provide oversight of the NHIF.<sup>18</sup> The authors observe that accountability seemed to be more concerned with financial performance than with other aspects of purchasing activities such as quality of services received by members or responsiveness of the NHIF to complaints. The NHIF's quality assurance mechanisms included the use of pre-contracting accreditation, contractual specification, regular inspection, complaints and feedback handling, and the advancement of loans to facilities to improve services. Contractual documents lacked elements that were critical to influencing provider behavior to the benefit of the purchaser. For example, even though NHIF contracts with facilities require the latter to employ standards and treatment guidelines provided by the MoH, the evidence from Kenyan hospitals suggests that there is poor adherence to passively provided guidance.

The NHIF Act does not provide for feedback or complaints mechanism for beneficiaries or members. Admittedly, the NHIF board of directors is drawn from key stakeholders including labor unions, and provisions of the public officer ethics Act should cover some of these concerns. The NHIF additionally has an email address and phone contact on its website provided for use by beneficiaries. The toll-free number provided by the organization rarely works, and not all users have access to email. Most critically, the NHIF does not seem to have any effective public forum for reporting performance.<sup>19</sup>

## NAMIBIA

Namibia's commitment to achieving UHC is articulated in the 5th National Development Plan (NDP5) for 2017-2022 which projects that by 2022, all Namibians will have access to quality health care. The NDP5 aims to increase the Health Adjusted Life Expectancy (HALE) from the current 59 to 67.5 years by 2022, and decrease mortality for mothers and children. To achieve this objective, the Ministry of Health has identified three strategic pillars for the health sector:

- i. people's wellbeing;
- ii. operational management; and
- iii. talent management.

As part of this commitment, there have been several improvements to service delivery since 2010, including the provision of more clinics and hospitals and introduction of new services, such as cardiac services in referral hospitals and nuclear medicine capabilities in the north.

The health sector is financed from different sources: government general revenues, government transfers and employee contributions to the public employee medical aid scheme (PSEMAS), contributions and premiums to private medical aid funds (MAF) paid by employers and employees, donor financing, and out-of-pocket payments made by patients who seek care. Together, these sources constitute total health expenditures (THE).

The government is the largest funder of healthcare, at 54%. Employers contribute 11% of THE, primarily by making contributions to private medical aid schemes on behalf of their employees. Both employer and

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18 livMunge K, Mulupi S, Barasa EW, Chuma J. A critical analysis of purchasing arrangements in Kenya: the case of the National Hospital Insurance Fund. *Int J Health Policy Manag.*2018;7(3):244–254. doi:10.15171/ijhpm.2017.81

household prepayment contributions have increased, with households now paying 16% of THE through prepayment schemes. Although financial risk protection has improved, OOP expenditure, excluding prepayment schemes, has also increased from 6% to 11% in the most recent two rounds of the National Health Accounts (NHA). OOP spending primarily comprises access to curative health services (mostly private), although a larger proportion (13%) is dedicated to pharmacies. Donor contributions have declined to 8%, in line with the donor transition.

Overall access to healthcare is good, with 76% of the population living within a 10 km radius of a health facility. On average, in rural areas, there are about 5780 people per PHC clinic and 58 825 people per district hospital.<sup>19</sup> Nevertheless, hospitals suffer from overcrowding and long waiting times, as a large number of people bypass clinics and health centers closer to home and go directly to hospitals that are perceived to offer a higher quality of care. Furthermore, Namibia has one of the highest Gini coefficients in the world, and the society is highly unequal. In addition, the size of Namibia, combined with a low population density, makes it challenging for the health sector to provide universal access to quality health services across the country. The recent economic downturn has put fiscal pressure on the government and heightened the need for spending efficiency. Although government spending on health has been consistently close to the Abuja target of 15%, health outcomes remain poor.<sup>20</sup>

The distribution of private health facilities is uneven. A small number of large, successful private providers own hospitals and clinics that offer high-quality services concentrated in Windhoek and Swakopmund. These providers compete for a small high-income clientele that either can afford to pay out-of-pocket or, more commonly, are covered by a health insurance scheme. There also exists a large number of small-scale providers—typically nurses—in private consulting rooms who struggle to remain financially viable and whose quality varies. They are located in both urban and peri-urban areas as well as throughout the country and usually serve a lower- to middle-income clientele.<sup>21</sup> The segment of the population with the least access to health services are the most hard to reach, and this include women and girls, rural inhabitants, adolescents, marginalized indigenous communities (such as Ovahimba, San), the lesbian, gay, bisexual, transgender, queer and intersexed community (LGBTQI) community, people with disabilities and people in correctional facilities.

Only 18% of the population is covered by medical aid funds. The remaining 82% of the population are covered by the public health system or out-of-pocket (OOP) expenditure in the private sector. Very limited cross-subsidization occurs between the rich and the poor. The existence of parallel health systems reflects the general wealth gap in the country. The 36% of THE that is spent on private health care caters for only 18% of the population, while the remaining 64% covers the other 82% of the population (mostly informal workers, the unemployed, and other vulnerable populations).<sup>10</sup>

The country has substantial wealth inequality across the population, which affects the ability of individuals and households to afford healthcare. These inequities in health financing reduce the prospects of Namibia achieving its Universal Health Coverage targets. Other inequalities in Namibia are evident in the country's high income inequality, high unemployment rate and variable access to and completion of education. These have a direct and indirect impact on the ability of households to afford healthcare or health insurance. This is compounded by the structure of many health insurance schemes, which favours wealthier populations. This is best exemplified by high annual premiums paid, rather than installment payment options and reimbursement mechanisms. The annual premium payments imply that healthcare must first be paid for OOP.

Moreover, the public employee medical aid scheme (PSEMAS) is an extra-budgetary public entity that covers health care for government employees and their families. There has been an increasing trend of government

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19 <https://phcfm.org/index.php/phcfm/article/view/2242/3566>

20 Namibia Public Expenditure Review Health Sector Public Expenditure Review, The World Bank, May 31, 2019

21 Namibia Health Financing Profile 2016 (USAID Health Policy Project)

and public employees substantially increasing their allocations to PSEMAS to finance health coverage. As a result, PSEMAS revenues have more than doubled since 2012. Government financing to PSEMAS introduces inequity in health financing towards the general population as it amounts to one-quarter of government health expenditures, but PSEMAS members represent only 12.5% of the population. Since April 2019, the Namibian government has doubled employees' contribution to PSEMAS; however, this increase does not address the inequity of financing of PSEMAS.

The government has been considering creating one risk pool for the employed population that can be expanded over time to include the entire population. It has also established a Special Fund to cater for the needs of the under-served who cannot afford specialist treatment, either in the private sector locally or abroad. Several health financing reform options are also being considered, which include establishing a National Medical Benefit Fund (NMBF) within the Social Security Commission (SSC) as a risk pool for the employed population that could be expanded over time to cover the entire population. Options on how to leverage the private sector for UHC and mechanisms for raising additional revenues for health are equally being explored by the government.

Health insurance is an important component of health service utilization in Namibia, but inequities in the coverage of these insurance schemes means that many individuals could be at a disadvantage when accessing healthcare. Specifically, women and those with lower levels of education and wealth are less likely to be covered by health insurance. The regulatory and financial supervisory function of medical aid funds (MAFs) is with the Namibia Financial Institutions Supervisory Authority (NAMFISA). NAMFISA can instruct MAFs that are financially unsound to take steps to rectify the situation, amend its rules, and ultimately to dissolve any MAF that fails to comply.

The Namibian Association of Medical Aid Funds (NAMAF) controls and coordinates the establishment and functioning of medical aid funds. NAMAF publishes billing guidelines linked to the procedure codes to calculate benchmark tariffs based on which MAFs reimburse healthcare providers for services rendered to members. However, NAMAF's benchmark tariffs are not mandatory, and providers do not have to adhere to them. Also, the co-payment charged to insured patients is not regulated, and providers are free to charge any level of co-payment in addition to the tariff charged to MAFs. As a result, MAFs and providers have no incentive to efficiently manage their operational costs, as they can easily shift healthcare expenditures to co-paying insured patients.

Health insurance does not appear to lower health payments for the insured compared to patients without insurance. Since providers can charge any amount as co-payment to insured and uninsured patients, some providers (particularly specialists) charge significantly more than the benchmark tariffs recommended by NAMAF. In addition, several providers do not claim directly from MAFs and PSEMAS. Rather, patients pay the provider directly and then claim to get reimbursed. This lack of price regulations partly explains the existence of extremely high out-of-pocket payments by insured patients who live in a household with all members insured with MAFs or PSEMAS. It also means that insufficient insurance regulation leads to ineffective financial protection of members against the financial risk of ill-health.

The Government's record of good financial accountability has facilitated consistent support from major international donors. However, since Namibia was reclassified as an upper- middle-income country, donor funding has decreased significantly. Several funders have pulled out completely and those remaining, like the Global Fund, have drastically scaled down their assistance. In an unfavorable global economic climate and with high health costs, resources are not matching the burden of disease and this has adversely affected community-led health services, school health and Human Resource for Health (HRH) plans in particular. This and the health financing inequities, in addition to the high out-of-pocket expenditures might compromise Namibia's ability to achieve her UHC targets.

The National Health Policy 2009-2013 articulated the development of different solidarity mechanisms to extend health insurance and access to community-based health insurance, or *mutuelles*, and for better management of health subsidies. An estimated 6% of the population is covered by some type of health insurance. Social insurance programs in Togo include agencies that cover old age pensions, disability, family allocations and health insurance to workers in the public and formal private sectors. In 2011, legislation calling for the establishment of a national health insurance scheme targeting civil servants, central administration staff, local collectivities, para-public agencies, and retired public sector workers was passed.

The National Health Insurance Scheme (NHIS) began paying for the health services in 2012, with approximately 300,000 people covered. The scheme is managed by the National Institute of Health Insurance (INAM). NHIS aims to provide quality health care along with financial protection to enrolled households by covering risks associated with diseases, non-occupational accidents and maternity. NHIS is a mandatory health insurance which covers civil servants, civil servant retirees, and up to five dependents—spouse and four children aged 21 or under. The rate of co-insurance paid by members varies depending on the type of service. This mandatory health insurance scheme is financed by monthly premium contributions set at 7% of the basic monthly salary split equally between the state employer and the main insured person. Services in public health facilities are covered by INAM; private health facilities, pharmacies, and eye care facilities can apply for accreditation.

Coverage of the informal sector through INAM has not begun yet, and a marginal number of these individuals (almost 2% of the population) are covered through other forms of private health insurance. Despite reforms to the contributory system covering the formal sector and improvements to the system supporting the poor, the majority of the population remains at risk of the financial implications of health shocks. A significant portion of this population could provide some form of premium payments. *Mutuelles* are being developed on the basis of professional organizations or local entities sharing geographic proximity.

Roughly 90.4% of Togolese workers operate in the informal sector and account for between 20 and 30% of Togo's Gross Domestic Product. Despite their importance to the Togolese economy, informal sector workers (ISW) do not have a health insurance scheme. The social protection scheme in Togo is offered by the National Social Security Fund (CNSS) and the National Pensions Fund (CRT). Private sector workers depend on the CNSS while civil servants depend on the CRT. The benefits cover only three domains namely: households with children, pensions (invalidity, old age, death and the survivors), workplace accidents and occupational diseases. In theory, the law establishing the national health insurance scheme extends social protection to those working in the informal sector. In practice, however, it is yet to be applied by the CNSS. In order to meet the requirements of universal health insurance, INAM plans to extend its services in the coming years to informal sector workers and vulnerable population.<sup>22</sup>

According to its current national health policy, the government of Togo is working toward effective management of public health and hospital facilities, in particular, controlling the cost of services, improving the attendance of health facilities and the quality of services at all levels, as well as the implementation of the National Strategy for Health Financing to Universal Health Coverage (SNFS-CSU). It is also addressing the challenges related to the uneven distribution of health infrastructure and the shortage of staff, particularly in rural areas, so as to improve the health condition of rural populations.

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22 Djahini-Afawoubo, DosseMawussi; Atake, Ezzo-Hanam (2018) : Extension of mandatory health insurance to informal sector workers in Togo, *Health Economics Review*, ISSN 2191-1991, Springer, Heidelberg, Vol. 8, Iss. 22, pp. 1-13, <http://dx.doi.org/10.1186/s13561-018-0208-4>

About 68.74% of Togolese are vulnerable to poverty, which exposes them to health shocks. Moreover, roughly 73.9% of Togo's rural population lives below the poverty line making it one of the world's poorest countries. The 2013 Demographic and Health Survey showed that in Togo more than 28% of children aged 6–59 months were suffering from chronic malnutrition and 6.5% from acute malnutrition. Other studies showed that the vulnerability of Togolese children is exacerbated by their lack of access to health and education.<sup>23</sup>

People who cannot afford to pay out of pocket for services buy drugs sold on the street, which are often harmful to their health. At the same time, many of these people, especially in the rural areas, turn to traditional healers.<sup>24</sup> The number of visits to hospitals has fallen drastically since 1990: from 60% in 1990, to 31% in 2010, according to available health statistics. Consequently, the main services offered at the health facilities are underused. The inequities in access to and utilization of health services have led some to claim that "Togo is known to have one of the worst health-care systems in West Africa. Access to services in public hospitals has become something like a lottery. Especially those who have neither health insurance nor cash at hand are doomed to die in this hazardous system – but wealthy people are at risk too".<sup>25</sup>

Wealthy individuals and those living in urban areas usually seek medical care from private hospitals. Since most Togolese people are poor, it is difficult for them to access private health facilities. In addition, data from most of private health facilities are unavailable. The private health sector in Togo is characterized by non-observance of norms and standards in its functioning; unequal geographical distribution; expensive medical care; unavailability of data; and little involvement in the implementation of preventive programs. The sector is poorly regulated, especially in terms of the geographical location, and is not always taken into account in planning service delivery. The uncontrolled development of informal private practice is fueled by unemployed graduates, public sector workers, and even people without any real expertise, the persistence of several public drug distribution channels, and the lack of control over compliance with service quality standards and procedures.

## History on Social Accountability efforts



### BOTSWANA

Little exists in the published literature on how civil society holds government accountable on its UHC commitments in Botswana. In fact, even the literature on accountability in the health sector is very sparse. What exist are accounts of accountability in the country overall, and few examples of how social accountability works in localized contexts, and not necessarily on health nor on UHC. That said, Botswana has a broad framework of third generation watchdog institutions in the form of the anti-corruption body, the ombudsman, the independent electoral commission and the relatively elaborate and independent media.

The constitution empowers the auditor general, accountant general and the parliamentary committees to inspect and report on the state and use of public accounts in all government departments and parastatal organizations. Apart from ensuring the observance of all laws relating to the use of public funds, the Auditor General has the duty to ensure that all necessary precautions are put in place and any improprieties are

23 Esso-Hanam Atake, Health shocks in Sub-Saharan Africa: are the poor and uninsured households more vulnerable? Health Economics Review (2018) 8:26 <https://doi.org/10.1186/s13561-018-0210-x>

24 Cited in Esso-Hanam Atake, 2018, Analysis of the Technical Efficiency of Public Hospitals in Togo: A non-Parametric Approach, Research Paper Number 357, African Economic Research Consortium

25 <https://www.dandc.eu/en/article/togo-whether-person-gets-health-care-or-not-depends-personal-wealth>

reported to parliament.<sup>26</sup> It is to be expected that these oversight functions extend to the health sector, and by extension to the commitments that the government has made towards UHC. What is probable is that existing accountability mechanisms are heavily tilted towards horizontal, bureaucratic frameworks of accountability, with little direct citizen involvement.

The Botswana health system is heavily centralized. All government hospitals report to the Ministry of Health headquarters. One study reviewed for this report highlights lack of national performance standards in public hospitals, which contributes to variability in performance, and this occurs in a context in which the majority of the medical doctors in Botswana come from different countries, with different training backgrounds. The study noted ongoing efforts to establish management structures at district level to take over responsibility for health service delivery, which could potentially address existing challenges of over centralization.

However, the study also observed that even if the health sector is decentralized, some forms of oversight and accountability mechanisms would still be necessary to ensure that the hospitals continue to respond to national health priorities.

To its credit, the MoH does have a high number of stakeholders working in different areas in the health sector. However, the mechanisms for engaging these stakeholders are seen to be weak. There is lack of a forum that brings stakeholders together to promote a coordinated approach for harnessing their contribution to health sector development. One study cited past unsuccessful efforts to establish a stakeholder forum. For instance, there is in the private sector the High Level Consultative Committee (HLCC) which brings in the private sector players including practitioners and suppliers of various health commodities. The HLCC meets quarterly and is chaired by the Minister of Health. The HLCC has the potential to act as a good platform for harnessing private health sector contribution, but it is viewed to have limited focus on issues of strategic importance. Overall, there is inadequate involvement of stakeholders in planning for the health sector particularly at a strategic level, and they are usually asked to contribute to plans very late in the planning process.<sup>27</sup>

In localized contexts, structures for community participation exist, but their potential is yet to be fully exploited. Structures for participation at village level typically include the chieftaincy, the Village Development Committee (VDC) and the village health committee. The VDC's function is to identify and prioritise village needs, providing a forum for contact between the villagers and the politicians and local authorities. The VDC reports all development issues at traditional meetings, called kgotla. Participation by community members happens in instances where free labor is needed, such as in the construction of a health facility. Very little consultation on community needs and plans is done. Even where consultation with and participation of the general population through the village health committees does exist, such as in VDCs, and village-based meetings, the consultation may not really be accessible to the majority of the community.<sup>28</sup>

## KENYA

There is a dearth of published evidence with regard to how the youth and women's networks influence UHC accountability, and indeed of any organized and coordinated CSO efforts to demand social accountability for UHC. What exist are localized examples of social accountability, and not necessarily on UHC. Kenya's Health

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26 David Sebudubudu, *The impact of good governance on development and poverty in Africa: Botswana - A relatively successful African initiative*, African Journal of Political Science and International Relations Vol. 4(7), pp. 249-262, October 2010, Available online at <http://www.academicjournals.org/ajpsir> ISSN 1996-0832 ©2010 Academic Journals

27 Seitio-Kgokgwe, et.al., *Assessing performance of Botswana's public hospital system: the use of the World Health Organization Health System Performance Assessment Framework*; Int J Health Policy Manag 2014, 3(4), 179-189

28 Lisa Lopez Levers, F Innocent Magweva, Elias Mporofu, *A literature review of district health systems in east and southern Africa: Facilitators and barriers to participation in Health*, EQUINET DISCUSSION PAPER 40

NGOs Network – HENNET and Amref Health Africa –launched the Social Accountability Platform for Health to map and coordinate social accountability activities towards UHC on 6 December 2019.<sup>29</sup>

The HENNET led platform will collect and disseminate resources and tools on social accountability, aid in holding the government accountable, as well as developing and implementing the platform’s roadmap. Additionally, Health Rights Forum (HERAF) and World AIDS Campaign International (WACI) Health led other CSOs in March this year in convening the first ever conference on Enhancing Social Accountability in Kenya’s health sector. The meeting provided a platform for key stakeholders to share experiences, challenges, and lessons learnt, including progress towards UHC.<sup>30</sup>

At the national level, Kenya developed a Social Accountability Manual in 2015 to, among other things, guide County Health Management Teams (CHMTs), partners working to improve health services, health workers, including community health workers and other health stakeholders. The Manual is also intended to respond to the needs and wants of communities, and aspirations of service providers, including health care providers, in their desire to provide services that are responsive to the client needs as envisaged in Vision2030 (Government of the Republic of Kenya 2007), the Kenya Health Policy 2013-2030 (Ministry of Health 2014) and as enshrined in the Constitution and the County Government Act 2012.<sup>31</sup>

Examples of documented social accountability endeavors in the health sector include evaluations of the effectiveness of health committees in Kenya. For instance, in a recent systematic review, Danhoundo et. al. (2018) report their findings based on a review of eight articles using health committees as an example of social accountability approach. In this particular study, six of the cases reviewed reported overall success.<sup>32</sup> In these cases, dialogue and engagement between the service delivery system and communities occurring via health facility committees in six districts proved to be a significant factor for improving certain health indicators. The review cites poor capacity for data management and lack of community-targeted initiatives having been identified by the study authors as limiting factors.

In the same study, the authors review a mixed methods study conducted in one Kenyan district, in which it was found that citizens perceived patients’ rights charters as useful to providing information regarding their local health facility and assisting them with budgeting. Of the four facilities covered under that study, two high ranking and two low ranking, it was revealed that sixty-six percent of service users reported being aware of the local facility service charter, while the proportion of those who had seen the facility service charter was lowest among one of the two high ranking facilities (50%) and highest among one of the two low ranking facilities (72%). The study authors hypothesized that this might have been because people reported paying attention to the charter only if they experienced a problem with their service, as is the case with low ranking facilities. Service charters tend to be written either in English or Kiswahili, which might be a limitation at lower level facilities where service users might either be illiterate, or are unable to understand either language.

Commenting on the evidence from social accountability in the health sector in Kenya and other countries reviewed, Danhoundo et.al. highlight a number of factors that determine successful social accountability interventions. These include engaging different sectors and stakeholders, namely community members and health facility staff; ensuring social accountability tools are locally- and contextually-based; fostering trust between citizens and leaders; having clear roles, standards, and responsibilities of those involved in the

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29 <https://newsroom.amref.org/news/2019/12/kenyan-health-organisations-launch-social-accountability-platform-for-universal-health-coverage/>

30 <https://wacihealth.org/enhancing-social-accountability-in-kenyas-health-sector-a-uhc-perspective>

31 Ministry of Health (2015) Implementers’ Manual for Social Accountability in the Health Sector: for County Health Managers and Other Health Stakeholders Nairobi, Ministry of Health, Republic of Kenya

32 Danhoundo et al. Improving social accountability processes in the health sector in sub-Saharan Africa: a systematic review, BMC Public Health (2018) 18:497 <https://doi.org/10.1186/s12889-018-5407-8>

accountability process; having financial and technical support from experienced groups; and involving citizens and community meaningfully in the process. They identify limiting factors to include lack of motivation from citizens to participate in the implementation of social accountability; fear of reprisal for speaking out; lack of funding and strategic expertise; the amount of time it takes to develop, plan, implement, and evaluate social accountability projects; and lack of government involvement.

In another study examining an appropriate accountability measurement framework and tool for health initiatives, Adriane Martin Hilber, et.al. (2019), conclude that there is limited understanding of what processes lead to results and under what conditions public officials and those in power will respond to accountability efforts.<sup>33</sup> They counsel that to understand how accountability works, there is need for more monitoring and evaluation around the accountability process itself, and those working in/with accountability to engage in more self-reflection on what results they contribute to, how and why progress is (or is not) made towards increased accountability. Likewise, Derick W. Brinkerhoff and Dheepa Rajan (2017) identify as limiting factors lack of clarity and/or consistency regarding roles responsibilities of health facility management committees in Kenya, conflicting perspectives among stakeholders of those roles and responsibilities, difficulties in maintaining engagement of community volunteer members, insufficient resources, skill requirements for community members and providers, and weak connections between committees and the larger community.<sup>34</sup>

## NAMIBIA

Namibia has a national patient charter which specifies the rights of service users and articulates the kind of quality and treatment they should expect and receive while interacting with health service providers. The charter does not however provide room for collective or community-based mechanisms for demanding accountability from service providers. Namibia has a good track record in accountability; the Mo Ibrahim Index of African Governance gave the country a score of 81 in 2012 and this subsequently improved to 83.9 in 2016.<sup>35</sup> Furthermore, Transparency International recognizes Namibia as the third most transparent country in Africa, while on the global level it ranks 53 out of 176 countries on Transparency International's 2016 Corruption Perception Index. Domestically, however, public service delivery remains a challenge as the public perception index reflects a low rate when it comes to the satisfaction of Namibians with public service delivery. Sixty-five percent of Namibians have expressed their dissatisfaction with Government efforts to fight corruption (Ibid).

Namibia has a three-tier mechanism for coordination and implementation of SDGs within the framework of the NDP5. This consists of the Development Partners Forum at the highest level to provide coordination oversight; a multi-stakeholder National Steering Committee composed of senior officials from both government and development partners at implementation level to provide tracking of implementation; and lastly the coordination of all developments pertaining to SDGs, through the NDP5 vehicle, which rests with the NPC as the Secretariat. One drawback of Namibian public service is the high concentration of authority at the center, which makes the system suboptimal for speed and accuracy of service delivery.

Moreover, CSO involvement in policy and accountability processes is minimal, partly due to weak internal capacities, but also due to vagueness or confusion regarding the roles CSOs are expected to play. There is, however, informal and mostly ad hoc collaboration around policy formulation between ministries and CSOs. Many CSOs have chosen a partnership model and work hard to maintain a cordial relationship with select ministries. The process is not always perfect; sometimes CSOs are consulted early in the process and

33 Adriane Martin Hilber, et.al. 2019, he development of a new accountability measurement framework and tool for global health initiatives, *Health Policy and Planning*, 2020, 1–10 doi: 10.1093/heapol/czz170

34 Derick W. Brinkerhoff & Dheepa Rajan *Accountability, Health Governance, and Health Systems: Uncovering the Linkages Technical Report* · December 2017

35 Namibia Voluntary SDG National Review 2018

sometimes late. Sometimes they are given too little time to respond, and at other times they find it difficult to present a coherent point of view due to their own internal weaknesses.

Structurally, there are various opportunities for interaction between CSOs and elected leaders. Parliament conducts outreach programs into the regions, where members of Parliament and the Parliamentary leadership consult with the public. A standing committee system aims to fulfil the oversight function of the legislature over the executive. As part of their operations, they conduct public hearings on a regular basis within which public input is possible. There are currently seven oversight Parliamentary Standing Committees that are assigned to oversee government ministries and departments, and that provide opportunities for input by the public and CSO.<sup>36</sup>

## TOGO

Togo has put in place many of the necessary institutions and laws that are foundational for good governance. However, it lags behind peers on the effective implementation of this framework, as evidenced by perception surveys of the population and users. The Togolese government has established several important institutions to tackle corruption, including the anti-corruption agency (HAPLUCIA, Haute Autorité de Prévention et de Lutte contre la Corruption et les Infractions Assimilées) that became operational in 2017. New anti-corruption legislation has also been adopted or is under preparation, including a requirement of asset declarations for all civil servants who are professionally or politically exposed to risks of corruption. The challenge is now to enforce the anti-corruption legislation.<sup>37</sup>

Despite steady improvements since 2005, Togo ranked low on the Worldwide Governance Indicators in 2015, although it performed above average for low-income countries, on all indicators except government effectiveness. The scope and success of reform efforts have been limited, however, by a highly centralized governance system and the lack of strong, independent institutions that could ensure a more open and equitable distribution of resources. The highly centralized nature of Togo's governance framework leads to inequality between those close to the power structure and those outside of it, and subsequently affects how resources are allocated among regions of the country. Decision-making remains highly centralized, and the decentralization agenda — which could introduce greater accountability and more equitable allocation of resources and service delivery at the regional and local level — has lagged.<sup>38</sup>

Stakeholder consultations carried out during the preparation of the World Bank's 2016 SCD (2014 to 2016) and the CPF (2016 and 2017) to inform the World Bank group (WBG's) strategy are indicative of the general state of social accountability in the country. During these consultations, participants agreed that weak governance underlies many development challenges in Togo. They expressed a desire for more equitable distribution of public resources, for grievance and accountability mechanisms, for greater participation of non-state actors in development decisions, and for strengthened judicial services. Perceptions of corruption in the public sector were high, and weak capacity among public servants was seen as a constraint to improved service delivery. Civil society participants sought assurances that WBG financing for Togo would be closely monitored and not diverted. They also requested greater support from the WBG to help CSOs play an oversight role.

At much lower decentralized levels where the majority of the population interacts with services, there are structures whose functionality is still sub-optimal. For instance, at these levels, the Président de la Délégation Spéciale serves an intermediary role between government and the community. The Président de

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36 Namibia EU Country Roadmap for Engagement with Civil Society Final Report 2014 - 2017

37 2019 International Monetary Fund (IMF) Togo Country Report No.19/205

38 International Development Association International Finance Corporation Multilateral Investment Guarantee Agency Country Partnership Framework for Republic of Togo for The Period Fy17-Fy20 April 20, 2017

la Délégation Spéciale is required to justify his decisions to the prefect and the central government (upward accountability), as well as to international donor organizations, and also to local chiefs, CDQs, CSOs and the population (downward accountability). However, it is essential to point out that his justification obligations towards citizens and civil society actors are mostly informal and not mandatory. When informing citizens and civil society actors about his decisions and actions during meetings, he does so rather on a voluntary basis and is not obliged to release all necessary and reliable information. It is common for citizens to be given the opportunity at these meetings to question public officials' decisions and actions. Despite these attempts to strengthen the civil society oversight of the municipal budget, the population and CSOs lack opportunities to take formal measures against local authorities in the absence of local elections.<sup>39</sup>

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## CHAPTER 3: ASSESSMENT FINDINGS

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This chapter presents the key desk review findings on the status of accountability actors, stakeholders, approaches and tools as well as existing gaps in promoting accountability in Botswana, Kenya, Namibia and Togo.

### **Accountability stakeholders and actors**

Numerous CSO networks exist at national and regional levels in Africa. Some of these networks have an exclusive focus on health, while others work on health alongside other development issues. A USAID study conducted in 2014 on regional health networks identified 27 regional networks in East Africa, 20 in West Africa, 14 in Southern Africa, and 4 virtual networks. Of these 18 were identified as CSO coalitions, 11 as health professional associations, and 2 as networks of high level policy makers. Not included in the USAID inventory but also active, particularly on UHC is the People's Health Movement (PHM), which is an umbrella body of CSO networks active in primary healthcare. This study also identified 66 potential national and regional networks on health across the continent, with a majority based and operating at country level. A list of potential CSO and professional health networks to be interviewed as part of this mapping exercise is provided as an annex.

There are other potential groups with the potential to drive accountability towards UHC. Artists and musicians, for instance, enjoy a huge following among Africa's youthful population. They are role models for many, and politicians and society in general rely on them to popularize certain messages or perspectives. However, the literature does not clearly mention their role, or importance. Another group that is popular are bloggers who tend to shape opinions on certain issues. They do not specifically target health or UHC accountability, but they are important in agenda setting, and in sustaining debates where mainstream media may have lost interest.

### **Accountability approaches and tools**

The government seems to be the primary driver of accountability mechanisms across health systems in Africa. This could be partly because health care is perceived to be a public good, but also because the space for civil society advocacy in most African countries is still constricted. African governments' accountability is enforced predominantly via the executive/cabinet and legislature/parliament, with the judiciary acting as the referee,

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39 Anita Breuer, et.al. (2017), Decentralisation in Togo The contribution of ICT-based participatory development approaches to strengthening local governance, Discussion Paper / Deutsches Institut für Entwicklungspolitik ISSN 1860- 0441

where interpretation of laws is required, or where sanctions have to be determined. Governments, through their line ministries (including Ministry of Health) operate a vertical accountability continuum, with service providers sitting at the bottom, and managers and key decision makers at the top. The latter set and monitor performance standards and policies, which the former are expected to execute. Parliaments in Africa play a watchdog role, in addition to their traditional lawmaking responsibilities. Health Committees, Public Accounts Committees, and Public Investment Committees or their different variants in most African countries provide accountability oversight over the health and related sectors in African countries. In certain cases, these committees are linked to sub-regional and pan-African oversight committees, that provide an additional leverage.

Constitutions provide the legal and constitutional accountability framework and sector specific legislation, and policies additionally provide for the establishment of institutions and systems for operationalizing accountability. While Constitutions may not list the full range of mechanisms, they typically provide for the establishment of organs that oversee both political and managerial accountability.

In most African countries, these typically include, for political accountability, parliament, the cabinet, the judiciary, and the ombudsman (currently operational in a majority of African countries), and institutions such as the auditor general's office to provide additional independent accountability. African Civil society groups have occasionally used resort to constitutional means through targeted litigation to demand accountability for UHC.

Certain mechanisms foster partnerships between the state and non-state constituents. Such partnerships are typically driven by the government and include time-bound specially commissioned mechanisms as well as long-term arrangements. The **Country Coordinating Mechanisms (CCMs)** are country-level partnerships aimed at generating health sector priorities for purposes of obtaining funding from the Global Fund (and potentially, other partners). They aim to harness local level technical expertise through country-level partnerships, collective engagement and accountability. **Sector-wide Approaches (SWAs)** in Tanzania, Malawi, Zambia, DRC among others typically allow funders to put money in a common basket for the health sector and address identified challenges together, thereby ensuring a match between policy priorities, technical capacity and output expectations. Reporting is then done to show funders how resources were used. In Malawi, for instance, the SWA unit carries out annual and bi-annual reviews to show individual funders where their money was used.

At lower levels of health systems, a number of countries make provisions for mostly internal performance and financial accountability mechanisms, where citizen groups may be involved as health facility committee (HFC) members. Lodenstein et al. (2017) document such an arrangement in health interventions in the DRC, Guinea, and Benin. They observe that health sector strategies and sector strengthening plans made explicit reference to HFCs performing both an internal accountability function of improving relationships between the health facility and increasing health services uptake by the community, as well as an external function of entrenching community involvement and monitoring of health service quality delivery. They conclude, however, that in each of the three countries, the central role assigned to HFCs in most official documents as well as in training manuals is related to the "inward" role of supporting the health facility and health workers, with little evidence of external accountability roles by HFCs.

Services charters (in the case of health sector, Patients' Rights Charters) have also been used in localized settings across African countries. These include a range of commitments by various public sectors (in the case of health, a country's health ministry) through its workers to improvement of service delivery and increased citizen involvement in decision-making about service delivery. Charters are one of three strategies used to advance the rights of patients, the others being legislative, either specifically applied to patient rights, or the inclusion of patient rights in general health legislation. Patients' Rights Charters are framed as guidelines that target the relationship between health professionals and users of health services and can be seen as

a vertical accountability mechanism. A. Martin Hilber et al. (2016) in a mapping study of accountability for maternal and newborn health in Africa further identify scorecards as one of the methods used in promoting accountability for health service quality at local levels, noting that adaptation and implementation of local maternity dashboards in a Zimbabwean hospital helped to drive clinical improvement.

Similarly, **Evidence for Action (E4A)** program (2011–2015), a DFID funded project, used scorecards to assess and improve maternal and newborn health services. The intervention study evaluated the effectiveness of engaging multiple, health and non-health sector stakeholders at district level to improve the enabling environment for quality emergency obstetric and newborn care (EmONC) in Ghana. Results showed a marked growth in a culture of accountability, with heightened levels of community participation, transparency, and improved clarity of lines of accountability among decision-makers. The study further reports that the breadth and type of quality of care improvements were dependent on the strength of community and government engagement in the process, especially in regard to more complex systemic changes. The authors conclude by noting that engaging a broad network of stakeholders to support Maternal newborn Health (MNH) services has great potential if implemented in ways that are context appropriate and that build around full collaboration with government and civil society stakeholders.

## Existing gaps in promoting accountability

It needs pointing out that from the literature, it is still not clear how local level processes of accountability link to national processes. A number of studies<sup>40</sup> detail local level processes that use citizen report cards, patient charters, and health committees at community levels. Even less clear from the literature is how synergies are built across local-national-regional level accountability processes. International accountability frameworks provide the basis of national level target setting and indicator reporting, but links to national and regional level processes remain weak. For instance, as of 2011, only six out of the 55 African member states so far have been able to meet and surpass the 15% target of annual budget for health improvement as set out in the Abuja Declaration. As of 2011, six countries have been able to meet and surpass the 15 percent target<sup>41</sup>

In Kenya, the health sector in nearly all counties is currently plagued with monumental challenges ranging from capacity gaps, human resource deficiency, lack of critical legal and institutional infrastructure, rampant corruption, and a conflictual relationship with the national government. At the national level, poor management and inefficiencies in resource distribution have largely contributed to poor working conditions at the county level including delays in salary payments. The net effect of these challenges is the stagnation of healthcare and even a reversal of some gains, according to health indicators.<sup>6</sup>

In Botswana, an estimated 83% of the general population and 58% of employed individuals do not have medical insurance coverage.<sup>42</sup> This points to inequitable allocation of financial resources for health services, an indication of marginalization of population-based health care services (i.e. diseases prevention and health promotion). Moreover, even though there is low out-of-pocket spending for health in Botswana at 4.2%, high risk of Catastrophic Health Expenditure amongst the poor population group remains, which is a reflection of the gaps in the country's health financing policy towards achieving UHC goals.

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40 Danhoundo et al., op. cit.; see also Scott and Gilson, *International Journal for Equity in Health* (2017) 16:159 DOI 10.1186/s12939-017-0660-5; Barker et al. *Implementation Science* (2016) 11:12 DOI 10.1186/s13012-016-0374-x; Uzo-chukwu et al. *International Journal for Equity in Health* (2018) 17:100 <https://doi.org/10.1186/s12939-018-0807-z>

41 <https://www.devex.com/news/health-funding-in-africa-how-close-is-the-au-to-meeting-abuja-targets-81567>

42 Mbogo and McGill, *Perspectives on financing population-based health care towards Universal Health Coverage among employed individuals in Ghanzi district, Botswana: A qualitative study*, *BMC Health Services Research* (2016) 16:413

# CHAPTER 4:

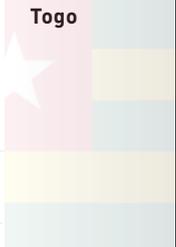
## DISCUSSIONS AND CONCLUSIONS

This section identifies recurrent patterns and divergences across the country contexts, and weaves these to paint an illustrative portrait of the UHC landscape in Africa. A number of common trends are discernible.

First, social accountability for UHC in each of the countries is still nascent. The involvement of civil society, youth or women networks is minimal and not very well systematized. Governments have their own bureaucratic horizontal accountability mechanisms. Each government has its own set of national accountability institutions such as parliamentary committees, auditor generals, and anti-corruption agencies, among others. The idea that citizens ought to be involved in the planning and management of health service delivery is enshrined in policies and national constitutions, but minimally applied in practice. External accountability by governments tends to be towards donor agencies and international development partners.

Secondly, all the countries reviewed in this study have made commitments towards the achievement of Universal Health Coverage goals. In tandem with this, countries have developed policy frameworks and plans to coordinate and direct the health sector towards attaining the UHC goals. The matrix below is a summary of the organization the health sector, major policy frameworks and plans, and health financing for each country.

Country	Organization of the health sector	Main Policies and Plans	UHC Financing
<b>Botswana</b>	<ul style="list-style-type: none"> <li>Six-tiered health care delivery system</li> <li>Mobile stops, health posts, clinics (with or without maternity), primary hospitals, district hospitals and referral hospitals distributed over 29 health districts</li> </ul>	<ul style="list-style-type: none"> <li>National Vision 2036</li> <li>Medium-Term Expenditure Framework (MTEF) National Development Plans (NDPs)</li> <li>NDP 11 runs from April 2017 to March 2023</li> <li>Integrated Health Services Plan for 2010-2020 (IHSP)</li> </ul>	<ul style="list-style-type: none"> <li>Government's financing of health services currently stands at 65% of total health expenditure</li> <li>Low out-of-pocket spending for health at 4.2%, but huge inequalities</li> <li>Only 17% of the population covered by private health insurance schemes</li> </ul>
<b>Kenya</b>	<ul style="list-style-type: none"> <li>Public sector provision is organized into four tiers</li> <li>Level 1 community health units, level 2 dispensaries and level 3 health centers, levels 4 and 5 county hospitals, level 6 national referral and specialty hospitals</li> </ul>	<ul style="list-style-type: none"> <li>Kenya Health Policy (KHP) 2014-2030</li> <li>Kenya Health Sector Strategic and Investment Plan III 2018- 2023 (Draft)</li> <li>Roadmap towards Universal Health Coverage 2018-2022</li> <li>Kenya Essential Package for Health (KEPH)</li> </ul>	<ul style="list-style-type: none"> <li>The primary funding for health-care comes from three sources: public (30%), private (consumers 35.9) and donors (30%)</li> <li>NHIF only accounts for 4.6% of current health spending compared to 10.7% by private insurance</li> <li>Membership to the NHIF is compulsory for all formal sector workers, and voluntary for the informal sector</li> </ul>

Country	Organization of the health sector	Main Policies and Plans	UHC Financing
 <b>Namibia</b>	<ul style="list-style-type: none"> <li>The public health sector is structured in a three-tier hierarchy with national, regional and district levels</li> </ul>	<ul style="list-style-type: none"> <li>National Health Policy Framework 2010–2020</li> <li>Health and National Environmental Health Act (2015)</li> <li>International Health Regulations (ratified 2007)</li> <li>5th National Development Plan (NDP5) for 2017-2022</li> </ul>	<ul style="list-style-type: none"> <li>Health sector is financed by: government general revenues, government transfers and employee contributions to the Public Employee Medical Aid Scheme (PSEMAS)</li> <li>The government is the largest funder of healthcare, at 54%.</li> <li>Only 18% of the population is covered by medical aid funds</li> <li>National Medical Benefit Fund (NMBF) - planned</li> </ul>
 <b>Togo</b>	<ul style="list-style-type: none"> <li>The health sector is pyramidal in structure, with three levels of care.</li> </ul>	<ul style="list-style-type: none"> <li>National Development Plan (NDP) 2018-2022</li> <li>National Health Development Plan 2017-2022</li> <li>National Strategy for Health Financing to Universal Health Coverage (SNFS-CSU)</li> </ul>	<ul style="list-style-type: none"> <li>Almost half (51%) of all health spending is out-of-pocket expenditure by households</li> <li>Government expenditure on health is approximately 5%</li> <li>The National Health Insurance Scheme (NHIS) began paying for the health services in 2012</li> </ul>

Thirdly, there are huge urban-rural disparities in access and utilization of healthcare. All countries reviewed have not adequately addressed the urban-rural divide. Kenya intended to address this through devolution as a means to increase appropriation and accountability. While there exist pockets of success across certain counties in Kenya, in a majority of the counties, health service provision has been marred by inadequate allocation of resources to remote health facilities, corruption, and under-staffing of facilities. In Namibia, quality healthcare is concentrated in a few cities, and huge inequalities exist between urban and rural areas in the provision of health services, and in the protection offered through health insurance schemes.

Fourth, there exist localized examples of communities being involved in the management of and decision making in health services. The general picture emerging is that community involvement is used instrumentally, and not in ways that empower them to demand accountability for the range and quality of services provided. This gap in participation could be addressed through connecting localized community level participation in health service delivery decision making to national policy processes. There are isolated cases where, for instance, the use of health facility management committees in Kenya are mentioned in the literature. Other studies mention scorecards and other forms of community-based social accountability mechanisms.

However, the effectiveness of these remains largely untested, and participation remains highly localized and divorced from national CSO advocacy. Kenya has a vibrant civil society sector that has been actively involved in advocacy for greater transparency and equitable allocation and utilization of health resources. Even so, studies that examine the effectiveness of CSO advocacy on UHC in Kenya are rare.

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## CHAPTER 5: RECOMMENDATIONS

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1. The project should consider documenting successful and the not-so-successful case studies of CSO participation in social accountability for universal health coverage in Africa. Such case studies could identify the contexts shaping actors' actions; the relationships among actors involved in the processes of accountability; the underlying factors shaping success or otherwise of accountability processes; the extent to which social accountability shapes health outcomes particularly for the poor and marginalized, and useful lessons that can be drawn and generalized across contexts.
2. Inequitable health financing remains the greatest challenge and constraint to achieving Universal Health Coverage in Africa. The public sector remains the largest investor in the health sector, and the major provider of services. However, public investments and provision of health services is characterized by huge inequalities in the allocation of resources, and in the utilization of health services, with the inevitable result that health outcomes for the poorest segments of the population continue to be less than optimal. CSOs need to undertake coordinated advocacy towards inequitable health financing.
3. The involvement of civil society and by extension, citizen networks, in UHC accountability is still weak across many countries. CSOs need to generate evidence on what is working, where governments are failing, and on feasible policy solutions for fast-tracking UHC. Advocacy on accountable use of resources also needs to be undertaken. In this, CSOs will need research, collaboration and networking to navigate through the often closed spaces of governments' policy processes.
4. Across the board, CSO advocacy capacity is weak. For CSO advocacy on UHC accountability to be effective, CSOs need to develop their capacity for engagement with government on policy issues. Such advocacy will require resources – human, financial and institutional networks – and CSOs must appropriately invest in developing these.

# ANNEXES

## Annex 1

### List of CSO and Health Professional Networks on UHC

#### Kenya



Africa Alliance for Health, Research and Economic Development (AAHRED) Kenya

Health NGOs Network (HENNET)

AYWDN - African Youth with Disabilities Network

FEMNET - The African Women's Development and Communication Network

NARESA - Network of AIDS Researchers of Eastern and Southern Africa

RHANA - Reproductive Health Advocacy Network Africa

#### Uganda



HealthAid Uganda

Health Journalists Network in Uganda

Africa Foundation for Community Development (AFCOD-Uganda)

Center for Health, Human Rights and Development

AfriComNet - African Network for Strategic Communication in Health and Development

ANECCA - African Network for Care of Children Affected by HIV/ AIDS

ASHGOVNET - African Health Systems Governance Network

#### Tanzania



African Youth and Adolescents Network (AfriYAN Tanzania)

Tanzania Network of Community Health Funds

Tanzania National Network of People with HIV/AIDS (TANEPHA)

EAHRC - East African Health Research Commission

EAIDSNet - East African Integrated Disease Surveillance Network

EANNASO - Eastern Africa National Networks of AIDS Service Organizations

#### Rwanda



Rwandan Parliamentarians' Network on Population and Development

Rwanda Palliative Care & Hospice Organisation

## Burundi



Burundian Alliance for the Fight Against Tuberculosis and Leprosy  
CEFOPAD Burundi

## Ethiopia



REACH ETHIOPIA  
Center for Accelerated Women's Economic Empowerment

## Chad



Chad Public Health Association  
Chad Relief Foundation

## Cameroon



Cameroon Baptist Convention Health Services  
Cameroon TB Group  
CANTAM - Central Africa Network on TB, HIV/AIDS and Malaria

## Niger



Syndicat National des Agents de La Formation et de L'education du Niger

## Nigeria



Centre For Sustainable Access to Health in Africa  
Nigeria Network of NGOs  
Africa MNCH Coalition - Africa Coalition on Maternal, Newborn & Child Health  
Africa Public Health Parliamentary Network  
AHJA - African Health Journalists Association

## Benin



Coalition des OSC du Bénin pour la Couverture Universelle en Santé (COBCUS)



## Ghana

Alliance for Reproductive Health Rights

Centre for Community Livelihood Development (CCLD)

### **African Health Economics and Policy Association**

AMCOA - Association of Medical Council of Africa

INDEPTH Network



## Burkina Faso

Centre National de la Recherche Scientifique et Technologique, Burkina Faso

AfriYAN - African Youth and Adolescents Network on Population and Development



## Liberia

Public Health Initiative Liberia (PHIL)



## Sierra Leone

ChildHelp Sierra Leone

Health For All Coalition



## Senegal

CICODEV Africa

AFRICASO - African Council of AIDS Service Organizations

SWAA - Society for Women and AIDS in Africa

WANETAM - West African Network of Excellence for TB, AIDS, and Malaria

West and Central African AIDS Research Network



## Malawi

Coalition for Gender, HIV and AIDS Advocacy in Malawi (COGHAAM)

Patient and Community Welfare Foundation



## Namibia

ARASA - AIDS & Rights Alliance for Southern Africa



## Zambia

Centre for Infectious Disease Research in Zambia

ChildHelp Inc.,

ANAC - Africa Network for Associate Clinicians



## Zimbabwe

National Healthcare Trust

EQUINET - The Regional Network on Equity in Health in Southern Africa

Health Systems Research for Reproductive Health and Health Care Reforms in the Southern African Region



## Lesotho

Lesotho Network of AIDS Service Organizations



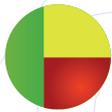
## South Africa

Network of African People Living with HIV, Southern Africa Region

Afrihealth Group

AIDS and Rights Alliance for Southern Africa

Community Development Foundation of South Africa



## Togo

WAHSUN - West African Health Sector Unions Network

## ***Virtual Network***

ALMA - African Leaders Malaria Alliance

APCDR - African Partnership for Chronic Disease Research

