Chapter 9:
Toward Universal Health Coverage in Africa -Achieving MDGs with equity, and beyond

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1. Health in Africa: Steady Improvement

The African continent, particularly Sub-Saharan Africa (SSA), continues to be the focus of global health discourse today. Approximately, 1/5 of global tuberculosis deaths, 1/2 of child and maternal deaths, 2/3 of deaths due to AIDS-related causes and 90% of malaria deaths are concentrated in SSA, which counts for only slightly more than 10% of the global population (Table 1).

Table 1. Disease burdens (Share of Sub-Saharan Africa in global health issues)

	Under 5 Deaths 2011 [a] (thousands)	Maternal Deaths 2010 [b] (thousands)	Deaths from AIDS 2010 [c] (thousands)	Deaths from Tuberculosis 2011 [d] (thousands)	Deaths from Malaria 2010 [e] (thousands)
World	6,914	287	1,800	990	660
SSA	3,370 *	162 *	1,200 *	220 **	596 **
Share of SSA	48.7%	56.4%	66.7%	22.2%	90.3%

* Sub-Saharan Africa, ** WHO African Regional Office member states

Sources a: Childinfo. [http://www.childinfo.org/mortality_ufmrcountrydata.php](accessed on Nov 10, 2012)
b: WHO, UNICEF, UNFPA, The World Bank. Trends in maternal mortality: 1990 to 2010. Geneva; WHO: 2012.
c: WHO, UNAIDS, UNICEF. Global HIV/AIDS response: epidemic update and health sector progress towards universal access: progress report 2011. Geneva; WHO: 2011.
d: WHO. Global tuberculosis report 2012. Geneva; WHO: 2012.
e: WHO. World malaria report 2013. Geneva; WHO: 2012.

Howev er, many African countries have witnessed an accelerated reduction of maternal and child mortality in the last decade. According

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to the latest estimates by UN agencies, the average annual rate of reduction (AARR) in under-five mortality, for which 4.4% or more is required to achieve MDG 4 (reduction of child mortality by 2/3 between 1990 and 2015), increased from 1.5% (1990 – 2000) to 3.1% (2000 – 2011) in SSA. The AARR for maternal mortality, for which 5.5% or more is required to achieve MDG 5 (reduction of maternal mortality by 3/4 between 1990 and 2015), increased from 1.4% (1990 – 2000) to 3.9% (2000 – 2010). As a result, there are significant reductions in the number of deaths both of children and mothers. The number of children who die before the age of five in SSA decreased from 3.8 million in 1990 to 3.3 million in 2011 despite the increase in the number of births. The annual number of mothers who die of pregnancy-related complications in SSA decreased from 192,000 in 1990 to 162,000 in 2010 (Table 2).

Table 2. Accelerated progress (Changes in child and maternal mortality in SSA)

	Before	Recent
AARR in under five mortality [a']	1.5% (1990-2000)	3.1% (2000-2011)
AARR in maternal mortality [b']	1.4% (1990-2000)	3.9% (2000-2010)
Number of under five deaths [a]	3.8 mil. (1990)	3.3 mil. (2011)
Number of maternal deaths [b]	192,000 (1990)	162,000 (2010)

Sources a: Childinfo. [http://www.childinfo.org/mortality_ufmrcountrydata.php] (accessed on Nov. 10, 2012).
a': Author's calculation using data from the same source as a.
b: WHO, UNICEF, UNFPA, The World Bank. Trends in maternal mortality: 1990 to 2010. Geneva; WHO: 2012.
b': Author's calculation using data from the same source as b.

Progress was also made in infectious disease control. The number of new HIV cases in SSA has continued to decline since the mid-1990s. The annual number of deaths due to AIDS-related causes in SSA peaked at 1.7 million in 2005 and has been declining ever since, even though a better chance of survival increased the number of people living with HIV from 20.5 million in 2001 to 22.9 million in 2010. The number of malaria cases in the WHO Africa region stood at 174 million in 2010, down from the peak of 191 million in 2005. The number of malaria deaths peaked at 748 thousand in 2004 and has been declining ever since.

The steady progress in health improvements was founded on the bold policy initiatives of African countries to strengthen the health systems to ensure physical and financial access to essential health services. Rapid expansion of high impact health interventions fueled by an increase in development assistance also contributed, as is described in a later section. For example, the Community-based Health Planning and Service program in Ghana, Health Extension Program in Ethiopia, and Health Surveillance Assistant in Malawi are good examples of country initiatives in improving physical access to essential health services of the underserved population. Cases such as the Mutuelles de Santé (Community-based Health Insurance Scheme) in Rwanda and the National Health Insurance Scheme in Ghana are gaining international attention as examples of publicly organized financial protection schemes which achieved high population coverage in low income settings in SSA. Performance-based financing is being introduced in many countries as a strategy to increase service coverage and quality, triggered by success stories from Rwanda and Burundi.

It is generally recognized that improvement in health will increase the academic performance of children and productivity of adults. There are some studies which indicate linkage between an increase in life expectancy with an increase in GDP. Improvement in health will reduce the cost of medical expenditures, therefore minimizing the risk of impoverishment due to high expenses. Health is the foundation for human security. The TICAD V process, in principle, needs to be built on those achievements in the past decade and should promote the continuation and further expansion of many good works which have already been started in Africa.

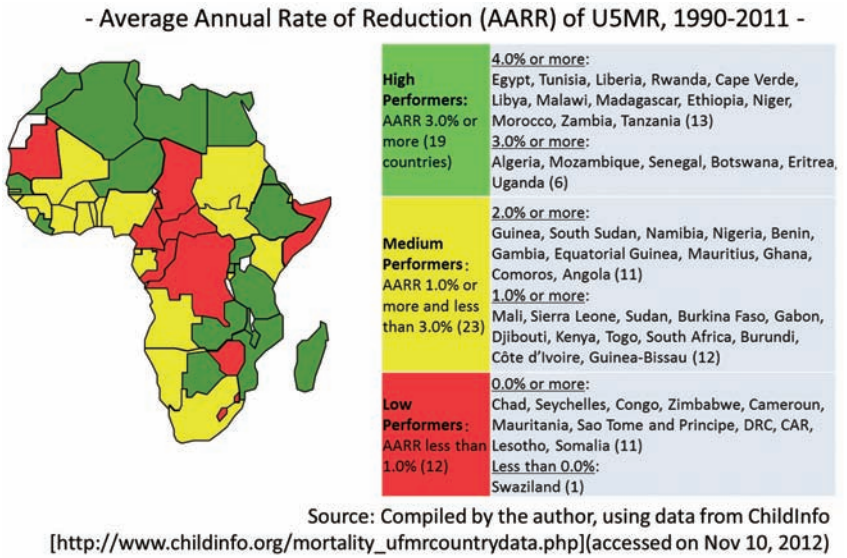
2. Health in Africa: Remaining/Emerging Challenges

Even though there is a clear indication of a steady improvement in health in Africa, there is a large disparity in the pace of progress. Many countries in SSA continue to struggle in ensuring physical access to essential health services to the population. Ensuring financial protection especially for the poor is the common challenge for both SSA and North African countries.

As for MDG 4, only about 1/4 of the countries in Africa (13 out of 54),

including all five countries in North Africa, are likely to achieve the target (Figure 1). While AARRs of those 13 countries for 1990 – 2011 exceeds 4.0%, about 2/3 of the countries (35 out of 54) fall short of 3.0% and can be classified as medium or low performers.

Figure 1. Progress toward MDG 4

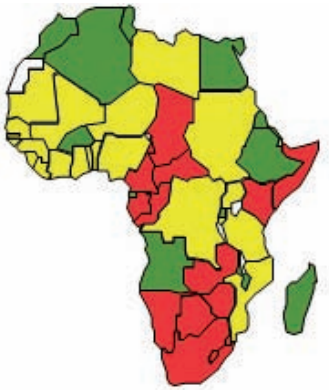


Source: Compiled by the author, using data from ChildInfo [http://www.childinfo.org/mortality_ufmrcountrydata.php](accessed on Nov 10, 2012)

The prospect for the achievement of MDG 5 is more challenging. There are only four countries which exceed AARR of 5.5% and 3/4 of the countries (39 out of 52 for which internationally comparable data is available) do not even reach 4.0% (Figure 2).[1]

1. Taking into consideration the situation, it is quite relevant to keep health-related MDGs even beyond the target year of 2015, at least for the countries in SSA, in order to maintain the current momentum.

Figure 2. Progress toward MDG 5



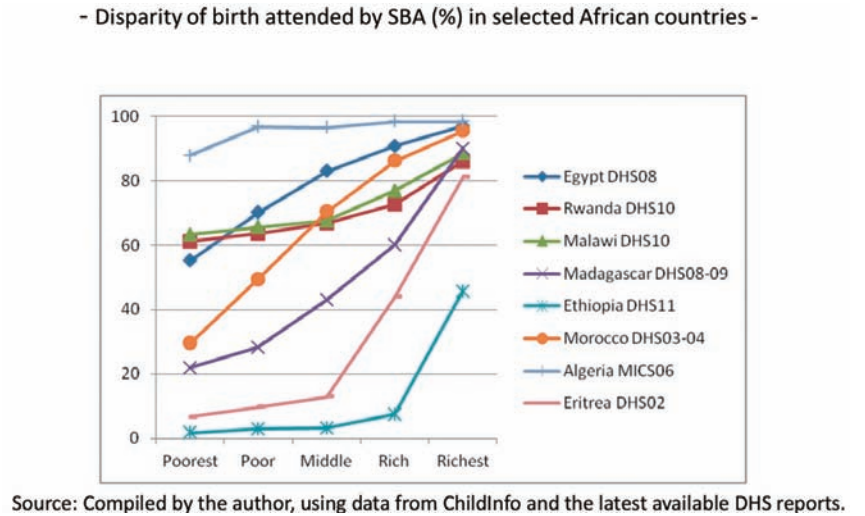
High Performers: AARR 4.0% or more (13 countries)	5.5% or more: Equatorial Guinea, Eritrea, Egypt, Morocco (4) 4.0% or more: Ethiopia, Rwanda, Angola, Madagascar, Cape Verde, Malawi, Burkina Faso, Tunisia, Algeria (9)
Medium Performers: AARR 1.0% or more and less than 4.0% (24)	3.0% or more: Benin, Sao Tome and Principe, Togo, Mali, Niger, Guinea, Gambia, Uganda, Tanzania, Mozambique, Senegal (11) 2.0% or more: Côte d'Ivoire, Nigeria, DRC, Libya, Ghana, Comoros, Liberia, Mauritania (8) 1.0% or more: Sierra Leone, Djibouti, Guinea-Bissau, Burundi, Sudan (incl. South Sudan) (5)
Low Performers: ARR less than 1.0% (15)	0.0% or more: Gabon, Mauritius, Kenya, Zambia, CAR, Namibia (6) Less than 0.0%: Cameroun, Swaziland, Somalia, Botswana, Lesotho, Chad, South Africa, Zimbabwe, Congo (9)

Source: Compiled by the author, using data from ChildInfo [http://www.childinfo.org/maternal_mortality_indicators.php] (accessed on Nov 10, 2012)

Increased disparity in health status and health service utilization within countries is emerging as another equity challenge. According to UNICEF, in SSA, 76% of births in urban areas are attended by skilled birth attendants (SBAs) compared to only 40% in rural areas. Disparity among different income groups is also significant, with 85% of the births among the richest 1/5 of the population attended by SBAs, compared to only 27% for the poorest 1/5. According to available data, health disparity among different income groups tends to be larger among the countries with low service coverage, even though a relatively large disparity can be found even in some countries with high service coverage.

Figure 3 compares both inter- and intra-country disparity in use of essential health services, measured in proportion of births attended by SBAs, according to income groups. These are the countries identified as high performers for both child and maternal mortality reduction in the preceding analysis. The figure reveals a classic pattern of unequal health care use by income level. When the country is in an early stage of development, service use is low and disproportionately concentrated in the richest segment of the population (like in Ethiopia and Eritrea). As average service use increases, an increase in the middle and poorer segments of the population is observed (like in Madagascar, Morocco and Egypt); however, the disparity in the poorest segment persists (like in Algeria).

Figure 3. Disparity by economic status

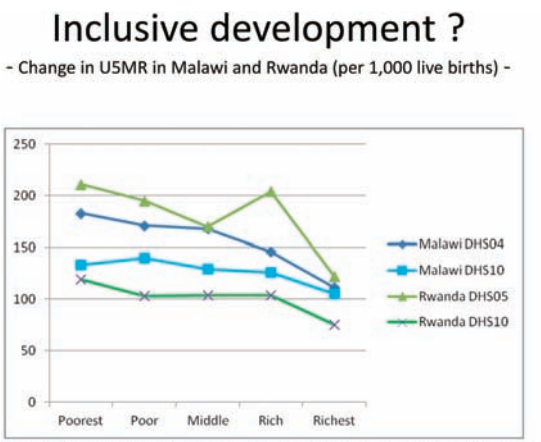


Source: Compiled by the author, using data from ChildInfo and the latest available DHS reports.

It is striking to note the significance of disparity in utilization of essential health services by income level in these countries. In fact, the level of service use for the richest segment is almost the same regardless of the national average. Explicit targeting and strong political commitment is needed to address such inequality to realize truly inclusive development (Box 1).

Box 1: Inclusive development in the making? Cases for Rwanda and Malawi

The two countries in Figure 3, Rwanda and Malawi, show a different and clearly more equitable pattern in utilization of essential health services. Even though they might have an advantage in physical access due to high population density, both governments made a strong commitment to improve the delivery of essential services. At the same time, both countries adopted measures to remove financial barriers for the poor and needy either by insurance or fee exemption.



Source: Compiled by the author, using the data from respective DHS reports.

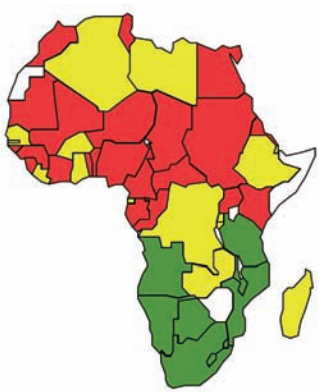
The figure above compares the changes over time in the under-five mortality rate (U5MR) by income groups for those two countries, using a series of Demographic and Health Survey (DHS) data. In both countries, the poorer segments of the population are benefiting proportionately more in terms of child mortality reduction, which means that the income disparity in U5MR is reducing over time. Similar patterns are observed in other countries like Ghana, Zambia and Tanzania. Even though further analysis is needed on diverse country experiences and causal relations with the choice of health policies, efforts to ensure physical and financial access to essential health services by the poor may be a policy instrument which can effectively realize inclusive development, one of the core goals for TICAD V.

Health financing is also emerging as a major development challenge. The Task Force on Innovative International Financing for Health Systems suggested that a health expenditure of 44 US dollars per capita on average is required in order to achieve adequate population coverage

with essential health services in low and middle income countries for the achievement of health-related MDGs. While 11 countries in SSA spent more than 150 US dollars per capita on health in 2009, seven countries spent less than 20 US dollars per capita.

According to the WHO, the risk of impoverishment due to high medical bills significantly increases when the proportion of out-of-pocket payment (OOP) to total health expenditure (THE) exceeds 20%. In the 25 African countries out of 51 countries for which internationally comparable data is available, OOP occupies 40% or more of THE (Figure 4). Without proper intervention, there is a risk that the proportion of OOP in THE increases as economic development continues in Africa. It is important to note that a high proportion of OOP and the risk of impoverishment due to high medical bills are serious problems even in some of the North African countries such as Egypt, Morocco and Tunisia, where physical access to essential health services is less of a problem. The risk of impoverishment due to high medical bills, together with the lack of other social safety nets, could be a threat to social stability in those countries.

Figure 4. Financial risk



Less Risk: OOP less than 20% (10)	Less than 10%: Seychelles, Botswana, Namibia (3) Less than 20%: Malawi, Angola, Swaziland, Mozambique, Tanzania, South Africa, Lesotho (7)
Medium Risk: OOP 20% or more and less than 40% (16)	Less than 30%: Algeria, Equatorial Guinea, Gambia, Rwanda, Cape Verde, Zambia, Ghana (7) Less than 40%: Djibouti, Madagascar, Liberia, Libya, Senegal, DRC, Burkina Faso, Ethiopia, Burundi (9)
High Risk: OOP 40% or more (25)	Less than 50%: Tunisia, Niger, Benin, Kenya, Mauritania, Sao Tome & Principe, Comoros, Togo (8) Less than 60%: Uganda, Gabon, Eritrea, Mali, Congo, Morocco, Mauritius, Egypt(8) 60% or more: Nigeria, CAR, Cameroun, Sudan, Guinea-Bissau, Chad, Côte d'Ivoire, Sierra Leone, Guinea (9)

Source: Compiled by the author using data from WHO. WHO global health expenditure atlas. WHO, Geneva).

A recent study confirmed that there is a large disparity among low and middle income countries in terms of essential health service coverage,

not only in Africa. It is also suggested that broader health coverage generally leads to improved overall population health, particularly for the poor. Considering the achievements so far and the remaining and emerging challenges, it is increasingly necessary to focus on health system issues especially equality in access and financial protection, which, together, call for concerted efforts toward universal health coverage (UHC). It is expected that action toward UHC will further accelerate the progress toward health-related MDGs, more inclusively benefiting the poor and the socially disadvantaged. It is essential for most of the countries in SSA to address physical, financial and sociocultural barriers simultaneously. The absolute lack of human resources for health, one of the major issues brought up in TICAD IV, continues to constrain efforts toward UHC, even though countries are taking initiatives to improve the situation as sited in Section 1. The focus in North African countries should be given to the expansion of financial protection and better targeting of the poor.

In addition, there is increasing concern that non-communicable diseases (NCDs) and injuries are on the rise both in North African countries with advanced demographic and epidemiological transitions and the low income countries in SSA. These transitions also call for more resilient health systems with better financial protection. Transformation or re-organization of health systems and the active participation of communities will be needed to provide promotional/preventive services and long-term/rehabilitative care which requires a significant degree of self-management by patients.

3. Development Assistance for Health in Africa

In response to the global commitment to MDGs and the series of initiatives which came out of the G8 Summits and other political arenas, development assistance for health (DAH), particularly for SSA, significantly increased in recent years. Participation of non-traditional actors such as the Bill and Melinda Gates Foundation and the establishment of large-scale global health funding mechanisms such as GAVI and GFATM, together with the increase in bilateral commitment including emerging donors, contributed to the increase. According to estimates by the Institute for Health Metrics and Evaluation, DAH for SSA increased from 1.1 billion US dollars in 2000 to 8.1 billion US dollars

in 2010 in real terms. It is most likely that the rate of increase slowed down toward the end of the TICAD IV period.

The increase in DAH made a significant contribution in expanding the coverage of essential health services, which in turn contributed to the steady reduction of maternal and child mortality, and mortality and morbidity from major infectious diseases. Increased DAH contributed especially to expanding coverage of essential interventions related to focused health programs which address specific health conditions.[2] Coverage of such interventions as long-lasting nets for malaria prevention, artemisinin-based combination therapy for malaria treatment, anti-retroviral therapy for HIV-infected people, HIV counseling and testing, immunizations for children, together with other essential life-saving interventions, expanded remarkably in SSA supported by focused DAH.

The Government of Japan (GOJ) also significantly increased DAH to Africa based on the commitment made at TICAD IV. The total amount of grant aid and technical assistance provided for Africa since the Japanese fiscal year (JFY) 2008 amounted to 47 billion yen as of the end of JFY2011, surpassing the commitment of 43 billion yen. The GOJ through JICA supported the training of 203,671 health personnel by the end of JFY2010, against a commitment of 100,000, and improved 3,935 health facilities by the end of JFY2011, against a commitment of 1,000.[3]

JICA focused its assistance on the most challenging regions in Ghana (Upper West), Kenya (Nyanza), and Senegal (Tambacounda and Kedougou). What was originally started as a pilot scheme was scaled up to benefit the whole of Tanzania (regional health and hospital management). The scaling up of geographically focused assistance is also being undertaken in Kenya and Senegal. Regional hospital networks were upgraded through combined capital and technical support in Uganda. Information systems to monitor human resources for health were introduced in Tanzania and South Sudan that cover the entire nation for the first time in those countries. Regional networks for health systems management were strengthened through the partnership with the African Health Leadership and Management Network

2. It is estimated that 50% of global DAH is allocated to MDG6 (control of infectious diseases). Taskforce on Innovative International Financing for Health Systems, op cit.

3. Data provided by JICA (as of Nov. 2012)

(AHLMN), a network of higher training and research institutions in Africa with a focus on health systems management. A network in HRH management was established for Francophone countries. Assistance was also provided to improve the management of focused programs like HIV and AIDS control in Kenya, Tanzania and Zambia, and tuberculosis control in Kenya and Sudan, in collaboration with funding support coming from GFATM and other sources (Box 2).

Box 2: Expanding service coverage through better management and coordinated investment: JICA's experiences

In Ghana, JICA partnered with the Ghana Health Service (GHS) in the scaling-up of Community-based Health Planning and Service (CHPS) in the Upper West Region, one of the most remote and disadvantaged areas in the country. CHPS was promoted by the government as a means to deliver essential health services to under-served communities; however, the expansion was slow due to multiple constraints. JICA provided technical assistance to the regional health office of GHS and other relevant stakeholders for strengthening capacity in program management and community mobilization, while supporting CHPS facilities and health centers and referral hospitals through the provision of medical equipment at the same time. This support was provided in alignment with government policy, support from other partners, and contributed to the accelerated expansion of CHPS coverage in the region.

In Tanzania, JICA worked with the National AIDS Control Programme (NACP) for quality improvement of HIV- and AIDS-related services. JICA's technical assistance facilitated the standardization of HIV testing and counseling and STI care and treatment services, involving all the major partners working in the area. The products were adopted by NACP as national standards and disseminated nationwide using grants from GFATM and by other collaborating partners. The project now assists the strengthening of the M&E framework through a combination of comprehensive supportive supervision and clinical mentoring, which cut across HIV- and AIDS-related services and programs. A similar approach was promoted in Madagascar.

Despite the steady expansion of essential life-saving interventions and improvement of health status, resources are not enough to deliver those interventions to all the people in need, particularly the poor. As African countries expand their health services to geographically and socioeconomically hard-to-reach population groups, the unit cost of service delivery is likely to increase, creating an additional burden on the

health systems. The progression of demographic and epidemiological transitions and the increase in NCDs and injuries can be another threat to the already over-stretched health systems of many African countries.

However, a further increase in DAH seems very challenging considering the current global economic situation, at least for the near future. While efforts to strengthen global solidarity to save lives and ensure access by all to essential health services in Africa should be continued, a paradigm shift is also needed in the TICAD V process. Firstly, DAH should be allocated more strategically and catalytically in a way to increase the allocation of domestic resources for health by African countries. As many countries in Africa are now experiencing stable economic growth and are able to benefit from a demographic bonus, health systems need to be strengthened with a long-term vision to establish functional and sustainable social protection mechanisms. Secondly, DAH should be provided in a way to improve the management of health systems and programs. There is growing attention globally regarding improving the productivity and efficiency of health sectors through better management, reflecting the difficult economic situation and escalation of medical expenses. A growing body of evidence is being produced that improvement in management can actually increase the outputs and improve the quality of health services (Box 3). Proper management of the pooled fund may become another area of development concern. Thirdly, DAH should be provided in a manner to encourage private investment in the health sector. The private sector is already a vital partner in the delivery of health services in many African countries. As economic growth continues, the prospect for regarding the health sector as an industry, i.e., source of income, innovation and employment, will increase. Even though the role of the public sector and government regulation is essential, particularly on the health financing side in order to achieve pro-poor health systems, an environment should be created to attract more investment from the private sector in service delivery and technological innovations.

Box 3: Improving service outputs through better management at the health facility level and beyond

JICA is working in partnership with Sri Lanka in applying management methodologies developed in Japanese manufacturing industries, i.e., 5S (participatory work environment improvement) – *kaizen* (continuous quality improvement) – TQM (total quality management), to improve hospital management in over 15 countries in Africa. One of the early pilot hospitals, Mbeya Referral Hospital in Tanzania, succeeded in reducing patient waiting times, reducing excessive supply stock, and increasing hospital income through better processing of insurance claims, through the implementation of self-motivated *kaizen* activities. In addition to the documentation of performance improvements through *kaizen* activities in various departments, the impact of the approach on health professional satisfaction and motivation is under evaluation.

JICA supported the management improvement of Nyanza Province in Kenya, working with local partners such as the Great Lakes University of Kisumu. The pilot districts demonstrated a significant increase in the utilization of essential health services, even though a rigorous assessment is needed to quantify the effect of project intervention. The positive changes in management practice were highly appreciated by the national government and efforts are now being made to scale-up the support to benefit the entire country in collaboration with other partners. In Tanzania, JICA-supported managerial capacity development of Regional Health Management Teams (RHMTs) was instrumental in triggering the regular allocation of funds to the RHMTs from budgetary support provided by other development partners.

Taking into consideration the situation, it is quite relevant that the TICAD V process and its Plan of Action continue to focus on the achievements of health-related MDGs since most of the countries in SSA are unlikely to achieve those by 2015, even with the accelerated progress in the past decade. However, increased attention should be paid to the more equitable distribution of the progress to address the remaining and emerging disparities in utilization of essential health services.

UHC can be a unifying theme for the TICAD V process. It has a strong pro-poor focus by calling for equitable access to health services and better financial protection, a challenge common to countries in both North Africa and SSA. Achievement of UHC requires strong political

leadership and effective and efficient mobilization of domestic resources for health including the partnership with the private sector. It requires a coordinated effort of both national governments and development partners. By focusing on UHC, new development partners such as BRICS can be brought on board for coordinated DAH to Africa. As these are the countries which recently achieved UHC (e.g., Brazil and China) or which are currently in the process of achieving UHC (e.g., India and South Africa), their experiences are full of vital lessons for the African countries in question.

There are many challenges with UHC as a development agenda. Firstly, even though it has a universality as mentioned before, UHC needs to be promoted in accordance with the evolving capacity and resource constraints of individual countries. In accordance with the definition by the WHO, UHC should be regarded as a direction, rather than a definite goal.[4] There exists a large disparity among African countries in terms of their position toward UHC. Strategies tailored to the demographic, epidemiological, historical, political and economic context of each country should be deployed. In many countries in SSA, physical, financial and sociocultural barriers need to be addressed first, or simultaneously at least, with financial protection. In North African countries, financial access and better targeting of the poor should be prioritized.

Another challenge with UHC is measurement. Even though UHC is also attracting attention in the post-MDG discussion, there is no consensus yet on how to measure the progress toward UHC. Measures for UHC should probably be selected from health status indicators (i.e., MDG-like indicators), health service coverage indicators (e.g., proportion of births attended by SBAs and immunization coverage), and the indicators for financial protection (e.g., incidence of impoverishing health expenditure, proportion of OOP to THE) to capture its multiple dimensions.

UHC also faces a challenge because of its 'narrow' focus on healthcare rather than health itself. It is widely recognized that health is not produced by healthcare alone. Interventions regarding the social determinants of health are needed to address the root causes of ill health.

4. It is difficult to meet the entire health care needs of the population at an affordable cost even in developed countries. UHC is an endless endeavor.

Improvement in water and sanitation alone can have a significant impact on people's health particularly in the African context. It is important to make sure that those issues are adequately addressed in the discourse of the relevant sectors.

4. Japan's Actions in TICAD V Process

Japan's role in promoting UHC in Africa can be significant. Japan celebrated its 50th anniversary of the achievement of UHC in the form of universal health insurance in 2011. Japan's experience with UHC and its implications were published in a series of scientific papers for the benefit of a global audience. Japan played a major role in the global policy process to bring health systems strengthening onto development agendas through the G8 Toyako summit in 2008. There is a strong political leadership to promote UHC in the global health discourse and through the TICAD V process.

Financial capacity in increasing pooled funding and its population coverage is a key to progress toward UHC. Efforts to increase overall funding are needed. Japanese DAH is expected to play a catalytic role in the mobilization of domestic resources for UHC in Africa, depending on the evolving capacity of individual countries. However, an increase in funding alone will not be sufficient. Japanese DAH should also be provided in a way to regain a 'can do' attitude among political and technocratic leaders in Africa, which will be the moral foundation for the progress toward UHC.[5] UHC is a long-term endeavor which requires continuous fine tuning of complex elements. Country experiences, including the one of Japan, commonly pointed out a critical importance of the roles of national political and technocratic leaders in the entire

5. It was Professor Francis Omaswa, founding Executive Director of the Global Health Workforce Alliance (GHWA) and former Director General for Health Services of the Ministry of Health, Uganda, who pointed out the loss of the 'can do' attitude among political and technocratic leaders as a cause for slow progress in health development in Africa. He says, "many political and technocratic leaders lost the confidence and the 'can do' attitude that was prevalent just before and after independence." And then he maintains "the answer lies in growing a critical mass of individuals and institutions in each and every country that are active change agents, who are in the regular habit of using good evidence to support policy development by their governments and at the same time are able to hold their governments to account," and "the answer also lies in growing the capacity of ministries of health to act as good stewards of health systems." Omaswa F. Reclaiming the 'can do' attitude in the delivery of health services in Africa. Africa Health 2010; July: 7.

process. Building on the achievements and outcomes in the TICAD IV process, JICA can contribute to the capacity development of African leaders and financial mobilization for UHC through the following assistances:

(1) Capacity development for health systems management through regional networking and country-focused assistance

JICA can provide assistance for the capacity development of African countries in health systems management, through the creation of a regional knowledge base and through the strengthening of country institutions, organizations and individuals.

JICA can contribute to creation of a regional knowledge base for UHC through, its ongoing partnership with AHLMN. AMREF as a host organization of AHLMN and JICA, in collaboration with the Government of Kenya, is now offering regional training on health systems management. The program has the potential to serve as a platform for knowledge sharing and informed policy choices for HSS and UHC. Opportunities exist to work with other development partners through Harmonization for Health in Africa (HHA) and other networks with similar objectives to broaden the impact.[6]

Improving health systems management at a country level can promote UHC through strategic planning, better targeting and more effective, efficient and accountable use of resources. Better health systems management can improve the performance of focused programs. Improving management can encourage decision making and problem solving at all levels of health systems, which cultivates professional satisfaction and motivation. JICA can extend the management assistance provided for national ministries of health and local health offices in countries like Kenya, Senegal and Tanzania to wider geographical areas or to other countries. In Kenya, for example, discussion among the relevant stakeholders is ongoing to scale up the management assistance provided to one province to the entire country, in line with the progress of decentralization under the new constitution. JICA can also support management improvement at the service delivery level, through the continued application of the 5S-*kaizen*-TQM approach in hospitals and other health facilities. These assistances are expected to contribute to

6. Other networks that have focused on UHC include the Joint Learning Network sponsored by the Rockefeller Foundation and SHIELD based in the University of Cape Town.

sustainable improvement in health systems performance when combined with financing interventions to incentivize better performance (i.e., performance/results-based financing) which are being tried and introduced in many countries in Africa.

(2) Capacity development for management of focused health programs targeting MNCH, infectious diseases and other emerging health needs

JICA can support countries with focused health programs, such as MNCH, major infectious disease control and other emerging health needs. Efforts should be made to produce synergistic effects with large-scale funding for focused programs coming from other development partners.

Despite the accelerated expansion of essential interventions for MNCH and infectious disease control in Africa, gaps in service use will remain. In addition to the financial contributions by GOJ to the global funding mechanisms such as GFATM and GAVI, JICA can support the strengthening of the program management capacity of the national and local institutions to deliver better services. Assistance such as the strengthening of country-led donor coordination mechanisms, standardization and harmonization of various technical guidelines and tools, integration and unification of M&E frameworks, conducting implementation research and impact evaluations, and the strengthening of laboratory capacity and external quality control mechanisms (for tuberculosis and other infectious disease control) can be provided as part of the efforts to improve program management.

(3) Facilitate mobilizing financial resources for UHC

In combination with the assistance to strengthen the capacity for both health systems management and focused programs management, JICA can provide assistance to mobilize financial resources for UHC in accordance with the evolving capacity of individual countries.

It is essential that the African countries take leadership roles and make political decisions to mobilize more domestic resources for health in order to move toward UHC. Sound government financing, either through a general budget and/or insurance schemes, is indispensable in order to maintain health systems accountable to the health needs of the poor and their financial protection. However, many African countries will continue to face fiscal constraints even with sustained economic

growth at least for the near future. There has been a remarkable increase in DAH to Africa, in particular to SSA. However, the major part of the funds is allocated to focused interventions such as HIV and AIDS, malaria, and other infectious disease control. Even though there are efforts to increase DAH allocation to the health systems strengthening, such as the establishment of a joint funding platform by GAVI, GFATM and the World Bank, the progress is slow.

JICA can provide financial assistance to eligible African countries through a best mix of grant and loan facilities in accordance with the evolving capacity of individual countries. Such assistance should be provided catalytically to facilitate government initiatives to increase domestic financing for health and expand pooled funding. It should be provided in a way to promote better management practices in government officials and health service providers. It should be catalytic to promote investment and innovations from the private sector. Combination with the support for management improvement, and coordination with support from other development partners is essential.

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