AFRICA HEALTH AGENDA INTERNATIONAL CONFERENCE 2019

CONFERENCE REPORT

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Republic of Rwanda
Ministry of Health

Theme: **2030 Now: Multi-sectoral Action to Achieve Universal Health Coverage in Africa**

Subthemes: **Access | Quality | Financing | Accountability**

Location: **Kigali Convention Centre, Kigali, Rwanda**

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Compiling Team:

Josephat Nyagero | Donald Odhiambo | Betty Muriuki | Mercy Mutua

Editorial Team:

Elizabeth Ntonjira | Ceciliah Kimuyu

Layout and Design Team:

Anthony Muninzwa | Maumau Njuguna

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ACRONYMS AND ABBREVIATIONS

AEL	Amref Enterprises Limited
AHAIC	Africa Health Agenda International Conference
APCA	African Palliative Care Association
CBHI	Community-Based Health Insurance
CHW	Community Health Worker
CPD	Continuous Professional Development
ECSACON	East, Central and Southern African College of Nursing
FBO	Faith-Based Organisation
FCAS	Fragile and Conflict-Affected Settings
FGM	Female Genital Mutilation
GE	General Electric
GHS	Global Health Strategies
GoK	Government of Kenya
GoR	Government of Rwanda
GoU	Government of Uganda
GSK	GlaxoSmithKline
HMIS	Health Management Information Systems
HPCA	Hospice Palliative Care Association of South Africa
ICD	Institute of Capacity Development
KEHPCA	Kenya Hospices and Palliative Care Association
MDGs	Millennium Development Goals
MNCH	Maternal, Neonatal and Child Health
MoH	Ministry of Health
NCD	Non-Communicable Disease
NHWA	National Health Workforce Accounts
OSF	Open Society Foundations
OSIEA	Open Society Initiative for Eastern Africa
PCAR	Palliative Care Association of Rwanda
PCAU	Palliative Care Association of Uganda
PHC	Primary Health Care
PHCPI	Primary Health Care Performance Initiative
PNFP	Private Not-For-Profit
R4D	Result for Development
RBC	Rwanda Bio-medical Centre
SDC	Swiss Agency for Development Cooperation
SDGs	Sustainable Development Goals
SPARC	Strategic Purchasing Africa Resource Centre
SRHR	Sexual and Reproductive Health Services
UHC	Universal Health Coverage
USP	United States Pharmacopeia
WEF	World Economic Forum
WGH	Women in Global Health
WHO	World Health Organisation
WHPCA	World-wide Hospice Palliative Care Alliance

FOREWORD

Since 2015, the Africa Health Agenda International Conference (AHAIC) has established itself as Africa's premier forum on African health issues providing an opportunity to mobilise continental leadership, including the private sector, in investing in the continent's health sector. The AHAIC conference is designed to showcase examples of transformation in action, to share lessons and models, and to promote the policies, programs, and investments needed to drive change in the health supply chains across the continent.

In 2019, in collaboration with the Rwandan Ministry of Health, we co-hosted the 3rd edition of the AHAIC at the Kigali Convention Center in Kigali, Rwanda on March 5-7. The main conference was preceded by a Youth Pre-conference (March 3-4) which was attended by more than 350 youth. The conference was opened by Dr Diane Gashumba, the Rwandan Minister for Health and Guest of Honour, following a brief video-link message from the WHO Director General for Health, Dr Tedros Adhanom Ghebreyesus. The three-day conference brought together more than 1,800 delegates, among them scientists and researchers, leaders from government, multilateral agencies, the private sector, civil society, development partners, youth, advocates for health, as well as delegates from 49 countries to discuss, debate and share the latest scientific knowledge and evidence for achieving the vision of Universal Health Coverage (UHC) in Africa. Organised around the theme '2030 Now: Multi-sectoral Action to Achieve Universal Health Coverage in Africa', the conference focused on four sub-themes – **Access, Quality, Financing** and **Accountability**. The specific objectives were to bring together diverse stakeholders to address how Africa can accelerate progress towards UHC, exchange scientific knowledge and best practices on how new research, innovation and political commitments can solve Africa's health challenges and advance UHC and identify and discuss gaps and challenges in implementing UHC in Africa, as well as share home-grown solutions to address these challenges.

Several announcements milestones were realised during the conference:

- President Paul Kagame received the UHC Presidential Champion award for his relentless political leadership and accountability to advance UHC in Rwanda and serving as an example for the region while Ethiopia's then Minister of Health, Dr Amir Aman, was also recognised for efforts to strengthen Primary Health Care, receiving the UHC Ministerial Champion award
- Amref Health Africa and Results for Development launched the Strategic Purchasing Africa Resource Center (SPARC), a new resource centre to help African countries get more value for money from health spending
- The Women in Global Health (WGH) Africa Regional Hub was launched to drive greater gender equity in global health leadership in Africa
- Civil society consultations for the UHC UN High Level Meeting jointly carried out with the Civil Society Engagement Mechanism of the UHC2030 platform to inform the UHC Political Declaration

- Private sector consultations on UHC to inform the private sector position paper on the UHC Political Declaration
- Parliamentarians from Ghana, Kenya, Rwanda, Senegal, Tanzania and Zambia launched the 'Kigali UHC Communiqué' committing to advance Universal Health Coverage in their countries, including by strengthening health systems, addressing health inequities, supporting community health and ensuring universal access to immunization.
- i-PUSH, an initiative of Amref Health Africa and PharmAccess Foundation, was launched at the conference with the aim to leverage mobile technology to directly connect women to health care financing, quality health care and information empowerment.
- The inaugural Excellence in Health Journalism Awards were presented by the Africa Media Network on Health, recognising health champions in the media. The award ceremony honoured journalists who have demonstrated outstanding merit in health reporting and launched a new curriculum for journalist education in health.I wish to give special thanks to the Ministers of Health who attended the AHAIC 2019 conference, Hon. Diane Gashumba, Rwanda, Hon Sicily Kariuki, Kenya, Hon Amir Aman, Ethiopia, Hon Sarah Opendi, Uganda and Dr Jean Pierre Nyemazi, Permanent Secretary, Ministry of Health, Rwanda.

I wish to give special thanks to the Ministers of Health who attended the AHAIC 2019 conference, Hon Diane Gashumba, Rwanda, Hon Sicily Kariuki, Kenya, Hon Amir Aman, Ethiopia, Hon Sarah Opendi, Uganda and Dr Jean Pierre Nyemazi, Permanent Secretary, Ministry of Health, Rwanda.

I would like to also thank all our distinguished speakers and partners, without who, this conference would not have been a success.

We believe that Health is a right, and we must all ensure that services are universally available, accessible, affordable, acceptable and of quality, and that they are provided without discrimination. There is no one-size-fits-all model for UHC; however, we must strengthen South-South learning and collaboration between countries.

Though the road to Universal Health Coverage is winding and rough, Africa can find her own unique journey there informed by her context. This is what AHAIC2019, tried to answer and indeed offered much food for thought for African Governments, their citizens and their partners.

We won't turn back and see you all in 2021!

Dr Githinji Gitahi

Group CEO | Amref Health Africa

OVERVIEW

The Rwandan Ministry of Health and Amref Health Africa co-hosted the 3rd edition of the Africa Health Agenda International Conference (AHAIC) at the Kigali Convention Center in Kigali, Rwanda on March 5-7, 2019. The conference was opened by Dr Diane Gashumba, the Rwandan Minister for Health and Guest of Honour, following a brief video-link message from the WHO Director General for Health, Dr Tedros Adhanom Ghebreyesus.

The three-day conference brought together more than 1,800 delegates, among them scientists and researchers, leaders from government, multilateral agencies, the private sector, civil society, development partners, youth, advocates for health, as well as the media from 49 countries to discuss, debate and share the latest scientific knowledge and evidence for achieving the vision of Universal Health Coverage (UHC) in Africa. The conference, organised around the theme '2030 Now: Multi-sectoral Action to Achieve Universal Health Coverage in Africa', had four sub-themes – Access, Quality, Financing and Accountability. The objectives of the conference were to:

1. Bring together diverse stakeholders to address how Africa can accelerate progress towards UHC.
2. Exchange scientific knowledge and best practices on how new research, innovation and political commitments can solve Africa's health challenges and advance UHC.
3. Identify and discuss gaps and challenges in implementing UHC in Africa, as well as share home-grown solutions to address these challenges.

Preceded by a Youth Pre-conference (March 3-4, 2019) attended by more than 350 youth, AHAIC 2019 was convened with the generous support of **GlaxoSmithKline (GSK), Swiss Agency for Development Cooperation (SDC), Takeda Pharmaceuticals, Philips, General Electric, Access Accelerated, Global Health Strategies, Elsevier, Result for Development (R4D), Amref Flying Doctors, and the Strategic Purchasing Africa Resource Centre (SPARC) among other partners**.

Pre Conference Webinars

The AHAIC 2019 organising committee held a series of webinar sessions as part of the activities building up to the conference. The topics were selected based on their educational and informational capacity to trigger intellectual and practical dialogue on UHC across Africa and beyond. The topics included: 1) Workers, not Volunteers: Integrating Community Health Workers into African Health Systems to Achieve UHC; 2) Enhancing Governance and Accountability at National, Regional and Global Levels to Achieve Universal Health Coverage; and 3) The role of Public-Private Partnership in the Attainment of Universal Health Coverage in Africa. The organisers selected guest speakers from among subject-matter experts with mastery, experience and capacity to engage their audiences.

Pre Youth Conference

The second AHAIC Youth Pre-Conference was held on March 3-4, 2019 at the Kigali Convention Centre. Over 400 young leaders and professionals from 24 countries were in attendance from across Africa and beyond. Events leading up to the pre-conference included a road-fest with a caravan of 36 youth travelling through East Africa, collecting views from over 400 youth on UHC.

The AHAIC 2017 Youth Pre-conference concluded with the declaration by participants that there should be 'Nothing about us without us'. Building on the momentum of that conference, the focus of the 2019 convening was on putting into action, priorities identified by the youth in 2017. In the end, a position paper consolidating the views of the youth on UHC 2030 was produced and will contribute to the High Level Meeting on UHC in September, 2019.

The African continent is currently undergoing major demographic changes due to the rapid rate of population growth and the gradual decrease in child and maternal mortalities. The continent's population is estimated to increase from about 1.2 billion people in 2015 to 2.2 billion people in 2050. The increase in the young and working age population is expected to spur productivity and reduce the dependency burden in the region, in the long term enabling countries in Africa to harness the demographic dividend for sustained and accelerated economic development.

In this context, Africa's development can be guaranteed only if policy makers invest in the youth, and if the youth invest in their self-development and work together. 'The game is changing' and youth will be seeking to have a seat at the table where decisions are made, or to create platforms from which they can speak and be heard.

The **Youth4UHC** movement was launched at AHAIC 2019 to enable young people to share best practices and strategies and to support youth organisations and networks to influence national and regional consultation processes related to the SDGs leading up to the September 2019 UN discussions on UHC. The conference produced a position paper underpinned by several principles, including the fact that health is a human right that must be accessible, affordable and available to all, and that UHC can best be achieved if young people are fully engaged as partners and leaders. The youth committed to playing their role in accelerating progress towards UHC in their countries, in Africa and globally through advocacy and accountability and taking part in development of health policies in their countries.

Key recommendations and asks from the Youth Pre-conference included political commitment to increase investments in health; to facilitate growth of technology for increased access to health services; and to ensure multi-stakeholder representation in the UHC process. To ensure that no-one is left behind, they called for meaningful youth engagement on UHC and the strengthening or creation of youth advisory committees and UHC youth ambassadors. They also asked for capacity building for young people to advocate and hold governments accountable for the delivery of UHC and governments to improve the provision of quality services specifically designed for the youth, particularly sexual and reproductive health services, as well as mental health care. Increased investments in primary health care should also enhance accessibility of youth-friendly services.

Hackathon

Y-ACT (Youth in Action), in partnership with Planned Parenthood Global and its partner, RAHU, Uganda, organised an intense 24-hour hackathon – the Youth4UHC Movement Design Challenge. The event aimed to catalyse the achievement of UHC by generating disruptive ideas that can transform and improve the health of young people in Africa.

The three top contenders were selected from 30 youth leaders from diverse backgrounds: ***1) MWANA***, an application that delivers pertinent Sexual and Reproductive Health Services (SRHR) information to young people in a fun and engaging approach; ***2) TECH FOR POLICY***- an application that provides a social media platform for linking communities with policy makers; and ***3) YOUTH PARLIAMENTARY*** – an application that enables a movement of young people from all over Africa, under one umbrella, 'the parliament', to push their advocacy agenda.

Innovations Market Place

The Innovations Marketplace provided a platform for 12 innovators from across Africa and beyond (See Annex B) to showcase innovations and technologies that are improving health outcomes and fast-tracking the attainment of UHC goals. The forum included an Innovators' Café – an interactive platform where innovators gave brief talks and engaged with stakeholders and potential partners.

AHAIC Awards

On behalf of the AHAIC 2019 Organising Committee, Dr Githinji Gitahi, Amref Health Africa's Group CEO conferred the UHC Presidential Champion Award on President Paul Kagame of Rwanda in recognition of his leadership in the country's progress towards attaining UHC.

Prof Miriam Were, Chancellor, Moi University, Kenya; Dr Diane Gashumba, Minister for Health, Rwanda; Senait Fiseha Alemu, a Health Extension Worker from Ethiopia; and Nice Nailantei, Amref Health Africa Global anti-FGM Ambassador received awards for Women Champions in Global Health.

Young Researchers' Scholarships

With the support of both Access Accelerated and Amref Health Africa, the latter awarded full and partial scholarships to 56 young researchers to attend the conference, selected from 91 applicants from 15 countries (*See the list under Annex J*).

Africa Hub of Women in Global Health

Dr Roopa Dhatt, Executive Director and Co-Founder of Women in Global Health, and Dr Gitahi signed a memorandum of understanding for the Africa Hub of Women in Global Health, which will be housed at Amref Health Africa. The secretariat will be headed by Dr Frasia Karua, the General Manager of Amref Enterprises Limited, and will provide a platform for dialogue, advocate for gender equality in global health leadership, foster gender-transformative leadership and support women's agenda in policy-making at the highest levels.

Media

The three-day conference received extensive media coverage. This included 112 articles published by top-tier media outlets, press releases shared with 1,136 journalists in Africa, North America, Europe and Asia, active reporting by CNBC Africa, video broadcasts across 20 countries, 150,000 visitors to the conference website and more than 156 million hits on Twitter.

OPENING CEREMONY

Masters of Ceremonies: Dr Magnifique Irakoze and Hellen Nomugisha

Dr Jean Pierre, the Permanent Secretary in Rwanda's Ministry of Health welcomed all participants and said that the conference was aimed at ensuring that governments and health actors "***put people first***".

Dr Githinji Gitahi, the Group CEO of Amref Health Africa thanked the Government of the Republic of Rwanda for hosting the conference whose focus was on the Universal Health Coverage (UHC) agenda for Africa. He said that with only 12 years to the end of the Sustainable Development Goals (SDGs), Africa ought to be impatient about getting solutions to its health problems. He called on conference participants to find answers to why so many people were still being left behind; particularly why 30,000 people in Africa were being driven into poverty, on a daily basis, by the high cost of health; why Africa's health systems remained fragile when the solutions were well known; why girls continued to get pregnant due to lack of reproductive health education and services; and why half a million children continued to die every year from vaccine-preventable diseases and 800 women from preventable causes. He concluded that people were dying because there was no resolve to save them and invited the conference participants to step up and make that decision at AHAIC 2019. He noted that Primary Health Care (PHC) was central to this conversation, adding that UHC was about equity not equality, and about reaching and bringing those who have been left behind to the front through improved physical access to and increased investment in health.

Dr Githinji announced the awarding of the UHC Presidential Champion Award to President Paul Kagame in recognition of his leadership and accountability for UHC in Africa, and for the progress made on UHC in Rwanda. He said that in awarding President Kagame, the AHAIC Organising Committee had recognised the devastation brought to Rwanda's infrastructure and health system following the 1994-1996 genocide and subsequent efforts by the Government of Rwanda (GoR) to revamp the country's economic development including the Community-based Health Insurance (CBHI) model established by the Government

aimed at improving its population's health-seeking behaviour, improved health outcomes and decline in poverty levels. Rwanda, he explained, is today one of the few developing countries to achieve a near-universal health insurance coverage.

He noted that Rwanda's health care services had increased by 107% while its health expenditure was keeping with the Abuja Declaration's target of 15.4% of the total government budget. Dr Githinji hailed Rwanda's political commitment and financial prioritisation of health, which was responsible for a 50% reduction in the cost of health to patients.

Dr Diane Gachumba, Rwanda's Minister for Health received the award on behalf of the president.

Addressing the conference via video link, Dr Tedros Adhanom Ghebreyesus, the Director-General of the World Health Organization (WHO) noted that Africa has made progress politically and economically, as well as in the improving health of its people. Whereas life expectancy in Africa has increased by almost 10 years as the continent became more prosperous, inequality remains a major issue. He said that the best way to ensure that everyone access health services without the risk of catastrophic health expenditure is through UHC, founded on strong primary health care. This requires governments to take a holistic approach that does not leave the burden with the health sector. He confirmed that UHC would be a key agenda at the United Nations General Assembly in September 2019 and therefore an opportunity to rally political support behind an accelerated UHC in Africa. The Director-General commended President Paul Kagame for his leadership towards improving health care in Africa.

Dr Diane Gashumba, while delivering the keynote address recognised the award given to President Kagame, whom she described as a people-centred leader. She cautioned African leaders to be careful to sustain the gains made in health.

She said that AHAIC 2019 provided the conference participants with an opportunity to explore ways of accelerating progress made in health in order to attain UHC. She added that key to this discussion was domestic financing for health, which has increased marginally in most African countries, leaving many people with limited access to health services. She reminded leaders and stakeholders to heed President Kagame's call, made at the AU Summit in February 2019 to translate political commitment into measurable and achievable actions. Dr Gashumba concluded by declaring AHAIC 2019, officially opened.

PRE-PLENARIES

Pre-Plenary I: **Health and Morality**

- Master of Ceremony: **Hellen Nomugisha, President, African Youth and Adolescent Network on Population and Development (AFIYAN)**
- Chair: **Prof Marion Mutugi, Vice Chancellor, Amref International University**
- Presenter: **Prof Philip Cotton, Vice Chancellor, University of Rwanda**

Prof Philip Cotton noted that the question of morality had become a barrier to accessing health and that health care providers had let their biases determine individuals that they considered deserving of health services. These labels ran the gamut from patient's mental health status, sexual orientation, persons who inject drugs and persons living with HIV/AIDS, to dressing, race, ethnicity, weight and those who had terminated pregnancy.

The providers were passing value judgements that oppressed, discriminated against and criminalised patients, and by stigmatising patients in this way, health workers driven by fear, biases and religious beliefs were further wounding patients and denying them health services.

The stereotypes conveyed the message that certain categories of patients were unworthy of care and treatment.

Conclusion and Recommendation

- It is not possible to attain UHC in the context of discrimination and stigma.
- Health workers must surmount their fears and prejudices and preference offer patient-centred care. Empathy should be brought back to health service delivery.

Pre-Plenary II: **Ethical considerations in UHC; Quality and Distributive Justice**

- Chair: **Christelle Kwizera, Managing Director, Water Access Rwanda**
- Presenter: **Prof Marion Mutugi, Vice-Chancellor, Amref International University**

Prof Marion Mutugi noted that it is estimated that 10-25% of women of reproductive age in Africa (200 million women) suffer infertility, yet childlessness has not received much attention in conversations on reproductive health and UHC. After they get married, it is expected by both society and the individual that the couple will have children. When this does not happen, blame is laid on the woman for barrenness, sometimes leading to exclusion and divorce. Society has prescribed its own solutions, while modernity offers new, expensive interventions. Society metes out injustice against women, putting the onus of fixing the problem on them, and subjecting them to stigma and marginalisation. Modern solutions, on the other hand, are commercialised and commodified.

In general, 70% to 85% of infertility cases can be treated, with In-Vitro Fertilisation (IVF) providing a solution in 3% of the cases. But a lot of questions surround the social and modern solutions: Is infertility a state of ill-health and if so, why is it not covered by health insurance companies? How is IVF regulated? What are the policy frameworks around it? How well is it legislated? Should embryos that are not used in IVF procedures be used for research or discarded? When a surrogate mother is engaged to help a barren woman have a baby, how is the latter protected?

When a barren woman marries another woman in a cultural context, who is the wife and who is the husband? Whose name is written on the birth certificate as the mother or father of the baby?

Conclusions and Recommendations

- The delay in finding a solution to infertility continues to take a heavy social and financial toll on women.
- While infertility remains a challenge for many, there is no equity in care for those affected, nor are there laws and regulations that are responsive to the plight of women. Legislation should be enacted to address the gaps in the provision of infertility care services.
- Medical insurance covers should be expanded to address the financial distress of childless couples or women trying to have children.
- More advocacy is needed on issues surrounding reproductive health services for childless couples or women.

Pre-Plenary III: **Ethical Considerations in UHC**

- Chair: **Elie Mandela, Country Advisor, Johnson and Johnson, Rwanda**
- Presenter: **Dr Stephen Ombok Muhudhia, Consultant Paediatrician, Nairobi Hospital, Kenya**

Dr Stephen Ombok Muhudhia said that ethical consideration entails doing what is right. UHC is the right thing to do, but the question is how to do it right. Trust is the currency for development, advocacy, and for Universal Health Coverage. Because health care is a scarce resource, prioritising of resources should be done in the interest of communities. However, corruption presents a threat for the success of UHC.

All decisions made have a moral dimension, suggesting that ethical considerations should be at the hub of decision. The themes that need to be paid attention to on the journey to UHC include: equity in access to health care; improving quality of health care so that it is good enough to make a difference; maximising benefits to the community; and strengthening accountability.

To this end, three key ethical considerations must be made in the delivery of UHC: 1) Health care is a moral enterprise; 2) Health sees patients as individuals; and 3) Health care is a scarce resource, but it is one that all citizens can enjoy. He pointed out that the barriers to UHC are poor prioritisation of use of limited funds allocated to health service delivery; decision-making that does not involve communities; and corruption.

Conclusions and Recommendations:

- Rwanda's success in the journey towards UHC is a testament to the fact that ethical considerations are essential.
- Decision-makers must have the best interests of the community at heart; while those who use health services should also do so responsibly.

PLENARIES


AFRICA
HEALTH AGENDA
2019
5-7 MARCH 2019
KIGALI, RWANDA
2030 Now:Multi-Sectoral Action to Achieve Universal Health Coverage in Africa

Cross-Generational Discussion Panel

Moderator: **Marie-Claire Wangari: Vice-President, Internal Affairs, InciSoN (International Surgical Students Network**

Panellists:

- **Dr Diane Gashumba, Minister for Health, Rwanda**
- **Dr Ian Askew, Director, Reproductive Health and Research, WHO**
- **Dr Githinji Gitahi, Group CEO, Amref Health Africa**

This session discussed four requests emanating from the AHAIC Youth Pre-Conference (March 3-4, 2019). The four asks were: 1) The need for meaningful inclusion of youth in UHC discussion; 2) The need to build the capacity of the youth to engage in UHC dialogue; 3) The need to address shortcomings in the provision of quality Sexual And Reproductive Health Services (SRHR) services for youth in Africa; and 4) The investment needed to enable youth to participate in key decision-making forums. The session concluded that:

- The youth should be part of discussions, decision-making and implementation of UHC.
- Young people should be made responsible for mobilising their peers to hold government accountable for provision of services, and finding or creating platforms to get their voices heard.
- The youth should be empowered to organise themselves at community level, particularly with regard to sexual and reproductive health issues.
- Leaders must create spaces for youth to engage in decision-making on issues that affect them.

Fireside Chat

- Moderator: **Michel Sidibe, Executive Director, UNAIDS**
- Speaker: **Dr Jean Kagubare, Deputy Director of Global Primary Health Care, Bill & Melinda Gates Foundation**

Primary health care (PHC) is the foundation of a good health care system given that it handles 80% of all health needs; it is the first point of contact between communities and the formal health system, and the key to achieving UHC. Unfortunately, most African governments spend less than 40% of their health budgets on it, while the rest goes to secondary and tertiary care. The panel agreed that a comprehensive assessment of PHC was necessary to informing planning.

Community health is a major part of PHC, and has the potential to make health care accessible to all. Whereas many African countries have shown the political will to strengthen community health as indicated in their national strategies, this must be followed by a deliberate political choice to invest in it. Going by the success of Community Health Worker (CHW) programmes in Rwanda, Ethiopia and Liberia, African countries should recognise and integrate CHWs into the formal health system.

The session noted that successful PHC programmes require people-centred leadership, well designed and implemented primary health care models, and new technologies such as portable scanners. Communities should be able to access quality and affordable health care in line with the guiding principles of UHC. This can only happen once the capacity of health workers has been built and citizens empowered to advocate for their health needs, discuss their health issues with duty bearers and hold them to account.

Conclusion and Recommendations:

- Governments must prioritise investment in PHC, which is currently funded through out-of-pocket; scale up best practice models; and improve the reach of quality services especially in hard-to-reach regions and fragile settings.
- Governments should partner with the private sector to make science, technology medical drugs and equipment affordable and accessible to all.
- Stakeholders should explore risk pooling options to provide health insurances and governments should provide health subsidies to enable the very poor to afford health services.
- Stakeholders should adopt the use of technology in disease surveillance.
- Political and technical teams should interface to building strong health system.

Panel Discussion:

Moderator: **Dr Giorgio Cometto, Coordinator, Human Resources for Health Policies and Standards, WHO**

Panellists:

- **Hon Sarah Opendi, Minister of State for Health (General Duties), Uganda**
- **Rogerio Ribeiro, Senior Vice-President, Global Health Unit, GlaxoSmithKline (GSK)**
- **Farid Fezoua, President and CEO, General Electric (GE) Africa and GE Healthcare Africa**
- **Dr Patrick Ndimubanzi, Minister of State for Primary Health Care, Rwanda**
- **Dr Sanele Madela, Founder and CEO, Expectra 868 Health Solutions, South Africa**
- **Beatrice Nyindebera, Community Health Worker, Rwanda**

Dr Sarah Opendi discussed Uganda's experience in establishing PHC, which the Government of Uganda adopted in the 1980s. The process required a paradigm shift alongside the establishment of the necessary frameworks. This culminated in the 1999 National Health Policy, which guided PHC reforms and decentralisation of health services which were provided free of charge at the local level. The system was previously characterised by unethical practices such as illegal charging for services and absenteeism of health workers, challenges that are being addressed using technology, such as a clocking system for health workers. Staffing levels are currently at 76%. Health facilities are procuring medicines and commodities from the National Health Stores, even though the procurement budget is not enough.

Dr Patrick Ndimubanzi discussed the role of Community Health Workers (CHWs) in PHC, using Rwanda's example. Following the genocide in 1994, Rwanda sought to rebuild its decimated health system by developing one that was affordable and best suited to the country's needs. This was the genesis of Rwanda's successful CHW model. Success factors included: i) People-centred strategies and policies, with the community as stakeholders, not just receivers; ii) Leadership that brings everyone together, including civil society, international community, private sector and government; iii) accountability; and iv) Local financing (over 50% domestic financing solutions).

Whereas technology has played a key role in monitoring service delivery to ensure sustainability, the major challenge remains maintaining the quality of services.

Rogerio Ribeiro outlined the role of the private sector in increasing access to health care through i) Access and pricing policies to make medicines and vaccines accessible to all; ii) Working in partnerships to make science and technology sustainably available to those who need them, such as the malaria and TB vaccines; and iii) Helping partners to create platforms that increase community access to vaccines and medicines.

Farid Feroza discussed the role of the private sector in promoting innovations and adoption of technology through private-public partnerships for PHC. He noted that, although PHC is at the heart of a strong health care, secondary or tertiary institutions are better equipped than PHC institutions, creating a gap in linkages and continuum of care. As a solution, GE has designed business and delivery models for primary and referral care, rebuilt a referral system for both communicable and Non-Communicable Diseases (NCDs), and improved quality of care through capacity building of health care workers, communication, through adapting technologies such as the portable ultrasound and electrocardiogram machines.

He noted that strong partnerships with local communities were critical to ensure sustainability of both quality and access, and scaling up models.

Speaking on citizen advocacy, Dr Senele Madela said that empowering communities to take responsibility for their own health was vital to the success of PHC and to achieving UHC. Involving the community in delivery of health services and decision making gives them ownership and trust in the services. CHWs are a crucial element in this process as they provide information on basic prevention interventions and also on NCDs and link people to health centres for necessary treatment and management. It is important to provide quality health services at community level in order to attract and maintain the trust of the community.

Beatrice Nyindebera gave an account of her experiences as a CHW, and the changes she has seen in the community as a result of the CHW system in Rwanda. Before the CHW programme, there were no linkages between the communities and health facilities, and services were far from the people. The programme, which started with a limited package of services, has expanded over the years to provide basic health services to thousands of people. For such a programme to succeed, there should be a strong, seamless connection between the referral system and the community health insurance scheme, while the government should provide disease surveillance equipment, continuous training and supervision for the CHWs.

Conclusion and Recommendations:

- Beyond political will and commitment, political action is necessary to make PHC work.
- Governments should provide a legal framework to guide implementation of PHC to ensure sustainability and continuity.
- For PHC to succeed in Africa, it is essential to have human resources for health, investment in technology and innovation, and properly resourced and supported CHW structures.

PLENARY 2: **INTER-MINISTERIAL PANEL ON ACHIEVING UNIVERSAL HEALTH COVERAGE**

The panel brought together African ministers of health to take stock of progress since Tokyo International Conference of African Development (TICAD) VI and map out a vision for what it will take to achieve UHC targets in their countries.

Co-Moderators:

- **Dr Jeanine Condo, Director General for the Rwanda Biomedical Centre**
- **Michel Sidibe, Executive Director, UNAIDS**

Panellists

- **Hon Dr Patrick Ndimubanzi, Minister of State for Health, Rwanda**
- **Hon Sarah Opendi, Minister of State for Health, Uganda**
- **Hon Dr Rashid Abdi Aman, Chief Administrative Secretary, Ministry of Health, Kenya**
  Prof Mengesha Admassu, Executive Director, International Institute for Primary Health Care, Ethiopia

Dr Patrick Ndimubanzi discussed Rwanda's successful community-based approach to health care. He pointed out that the process was time consuming and therefore called for patience and consistency coupled with political and community engagement. Models must be tailored to the unique needs of each country, with key principles for success being solidarity, where those who are healthy pay for those who are not; co-payment for those seeking services; constant monitoring to guide adjustment where necessary; and easy access to health facilities. Rwanda had seen an increase in the number of people seeking skilled services, and a significant reduction in the cost of health care to families.

According to Dr Rashid Aman, Kenya started its UHC journey with a pilot programme in four counties aimed at developing a model for the country. The pilot included access to commodities, suspension of user fees, building up of infrastructure and establishment of subsidy programmes. Close to 75% of residents of the four counties are registered for the programme, and the use of health services has increased by more than 100%.

On the role of the private sector, Dr Sarah Opendi said achieving UHC required heavy investment, particularly in infrastructure to make services easily accessible to communities. In Uganda, 86% of the population is within 5km of a health facility; this has been achieved through partnership with the private sector, which provides 50% of health care in the country, and with faith-based organisations, which provide 15%. Private sector is key in promoting research, innovation solutions and digital health, which the Government has been keen to tap into, for instance in Health Management Information Systems, disease surveillance and procurement systems. Being such a key player, governments should involve private sector in policy making on health and ensure a conducive environment for them to operate in.

Prof Mengesha Admassu discussed the role played by Health Extension Workers (HEWs) in the quest to attain UHC in Ethiopia. HEWs play a critical role in preventing illness and promoting health within communities in Ethiopia and thereby contribute greatly to the reduction in the burden of preventable diseases.

For the programme to succeed, the government established a system whereby HEWs with a minimum primary school education and drawn from the communities they serve go through a one-year, 16-unit training programme following which they are absorbed into the workforce to ensure retention.The HEW programme helped Ethiopia to meet Millennium Development Goals (MDGs) 4, 5 & 6.

Conclusions and Recommendations:

- UHC is an attainable vision that requires the commitment of both governments and communities to make it happen.
- The models in Rwanda and Kenya have demonstrated that Community-Based Health Insurance (CBHI) succeeds where political leadership engages with communities. Countries that want to implement CBHI must carefully set premiums, engage community with information, and contextualise models to their situations.
- The largest investment in UHC is leadership, partnership, commodity supply chain and accountability. UHC must involve the private sector, which is driving social transformation.
- Private sector should lead in innovation and application of technology to respond to gaps in UHC delivery.
- Whereas CHWs play an essential role in health promotion and preventing diseases; it is important that they are well trained and remunerated.

PLENARY 3: **FINANCING UNIVERSAL HEALTH COVERAGE IN AFRICA**

Close to two decades ago, African Heads of State committed to allocating 15% of total public expenditure to the health sector, launching the Abuja Declaration. Today, only a handful of countries in the region have reached or surpassed the target. The session explored successful strategies for domestic resource mobilisation, partnerships that are sustaining and transforming the funding landscape in Africa, and new financing strategies that are paving the way for financial autonomy in Africa.

Fireside Chat

- Moderator: **Dr Angela Nyambura Gichaga, CEO, Financing Alliance for Health**
- Speaker: **Yacine Sambe Diouf, Programme Manager, Cooperation and External Funding Department, Ministry of Economy and Finance, Senegal**

UHC allowed everyone, no matter their economic status to access quality health services. To be successful, as in the case of Senegal, UHC requires high-level political and financial commitment. Ministries of Finance play a critical role in moving countries towards UHC through incremental investment in health, infrastructure, food security (and nutrition), education and access to information and services.

Whereas most countries aspired to provide quality health care for all; limited resources, competing priorities for domestic financing remained a hurdle. It is important to engage Ministries of Finance as technical advisors in the process of UHC, to make realistic financing requests (incremental rather than lump-sum allocations) and to demonstrate results and impact for the monies allocated. Development is multi-sectoral and it needs to be coordinated.

Conclusion and Recommendations:

- Governments should have an agency that focuses on the delivery of UHC for women and children.
- Governments in Africa should prioritise UHC, provide incremental budget allocations for health, and develop an evaluation framework to monitor financial allocations and how the money is spent.
- Development partners should align their work to government priorities rather than implementing competing vertical disease programmes.

Panel Discussion:

Moderator: **Nathaniel Otoo, Executive Director, Strategic Purchasing Africa Resource Centre (SPARC).**

Panellists:

- **Dr Solange Hakiba, Deputy Director-General, Rwanda Social Security Board**
- **Hon Dr Robert Kuganab Lem, Member of Parliament, Ghana**
- **Marijke Wijnroks, Chief of Staff, The Global Fund to Fight AIDS, Tuberculosis and Malaria**
- **Monique Dolfing, CEO, PharmAccess.**
- **John Kinuthia, Lead Research Analyst, International Budget Partnership Kenya**

The session explored successful strategies for domestic resource mobilisation, partnerships that are sustaining and transforming the funding landscape in Africa, and new financing strategies that are paving the way for economic autonomy in the continent.

Dr Hakiba discussed the journey of establishing Rwanda's Community Health Insurance Fund (CHIF) to reduce the cost of health in the country and achieve UHC. Getting community buy-in and building confidence in the CHIF required extensive civic education and a multi-sectoral approach to ensure that people could access the services and the insurance. All this was backed by political will, with President Kagame rallying stakeholders to support the initiative.

Hon Robert Kuganab Lem emphasised the importance of building political consensus on health and ensuring that national health plans outlive governments. Ministries of Health should lead the way for political parties to follow in order to ensure consistent investment in health across transitioning of political regimes. The health agenda and its financing should not be driven by politicians.

John Kinuthia discussed how the public should be engaged in budgeting for UHC. He highlighted the importance of budget transparency – giving the public right and relevant information to enable them to engage; building public capacity for reading and understanding budgets; fitting these activities into the budget cycle; and discussing budget priorities with the people, thus giving them the real power of decision-making.

Monique Dolfing described Pharm Access's journey towards innovative health financing and using technology to advance access to health care in Africa. She said that it was important to combine public and private funding to improve the quality of services and streamline the supply chain. The digital revolution, led by the private sector, had opened up access to health services, mainly through eHealth and mobile money transfer, enabling cheap and transparent disbursement of funds for health care, and putting control of and access to health care in the hands of more people.

Despite rebasing of several African countries from low income to middle income status, and the consequent reduction in development assistance, a WHO Health Report shows that external funding still meets a large part of financing for health in lower income countries, as domestic resources are increasing at a lower rate while external funding is decreasing.

The Global Fund's sustainability transitioning and co-financing policy, said Marijke Wijnroks, seeks to sustainably support countries through this process. Funders must coordinate support for countries as they go through the transition process. It is also important to ensure efficiency of health expenditure, and whether it benefits those most in need.

Conclusion and Recommendations:

- Governments should establish regulatory frameworks for private sector investment in health.
- Countries must strive for efficiency in collection, use and tracking of resources for UHC, whether donor or domestic financing.
- Healthcare benefits should be purchased strategically to ensure that the most vulnerable are reached.
- Mobile and digital technology should be used strategically to enhance UHC in Africa.
- Ministries of health, not politicians, must drive the health agenda to guarantee sustainability of programmes.
- Members of the public should be well informed about the budget and their capacity built to engage in the budgeting process as primary stakeholders.
- African governments should boost domestic resource mobilisation by increasing taxes on products that are harmful to health.
- The public sector should learn from and partner with the private sector to harness the latter's strategic purchasing capacity and governments should provide the private sector with a conducive environment to enable the latter to increase their investment in health care delivery.
- Countries should have a poverty reduction strategy for all stakeholders to work from, with a mutual accountability framework and joint indicators to track progress.

PLENARY 4: **ACCESS TO CARE: REACHING THE LAST MILE**

Achieving 'health for all' in Africa means paying close attention to the needs of low-income, migrant and marginalised populations. The session explored innovative solutions to increasing access to medicines and services, health worker empowerment and key interventions that are allowing countries to respond meaningfully and effectively to the health care needs of the hardest-to-reach, most vulnerable populations in Africa.

Master of Ceremony: **Christelle Kwizera, Managing Director, Water Access Rwanda**

Fireside Chat on Political Accountability

- Moderator: **Raj Kumar, Founder and Editor-in-Chief, Devex**
- Speakers: **Senait Fiseha Alemu, Health Extension Worker in Ethiopia and Hon Eugene Mussolini, Member of Parliament, Rwanda**

Health Extension Workers (HEWs) are a formally trained cadre in Ethiopia who are paid for their services and are accountable to both the communities they serve and the health centres to which they are attached. Senait Alemu cited lack of transport and electricity as major challenges to their operations – HEWs walk for up to two hours to visit their clients, and most community members also walk to the health facilities. The panel shared the view that governments in Africa should train CHWs, equip them with the tools they need to work and remunerate them.

Hon Mussolini observed Rwanda had learnt from Ethiopia's community-based health model and has managed to reach its own health goals using a solid network of CHWs operating at the household level.

The CHWs in Rwanda are compensated through performance-based financing - an accountability system based on key indicators related to their work; are encouraged to join income-generating cooperatives; and are given the tools they need to work including mobile phones, solar panels and treatment kits.

In a survey, 93% of them indicated that they would work even without the incentives because of the satisfaction they received from the trust of the community and recognition from the authorities.

Conclusion and Recommendations:

- To be effective and accountable, CHWs must be equipped with the necessary tools for their work.

Panel Discussion

Moderator: **Raj Kumar, Founder and Editor-in-Chief, Devex**

Panelists:

- **Magnus Conteh, Executive Director, Community Health Academy, Last Mile Health**
- **Ronald de Jong, Executive Vice-President, Philips**
- **Barbara Profeta, Regional Health Advisor, Horn of Africa, International Cooperation, Embassy of Switzerland, Nairobi**
- **Prof Francis Omaswa, Executive Director, African Centre for Global Health and Social Transformation**
- **Francois Karagwa Xavier, Executive Director, Umbrella Organization of Persons with Disabilities in the Fight against HIV/AIDS and for Health Promotion, Kigali**
- **Margaret Kilonzo, Community Health Worker, Kibera, Nairobi, Kenya**

Magnus Conteh said that a strong community health programme anchored on a professional community health work force was essential to facilitate access to health care for people living in challenging situations – 'The Last Mile'. He gave the example of Liberia, where the national community health assistance programme has reached over 1.2 million marginalised people. Success factors include partnering with governments and engaging with communities for ownership and sustainability of the interventions.

Ronald de Jung emphasised the importance of organisations being aware of the challenges in society and working to find innovative solutions, if they wished to remain relevant. Innovation is needed in products, technology, operations, financing and business models and in partnerships. Reaching the last mile constitutes a moral obligation and requires united leadership from all sectors.

Donor support, said Barbara Profeta, is not just about injecting money into challenging situations, but about relevant funding. In fragile states, where formal health systems are not operational, other indigenous organisations organically step in, a fact that demonstrates community resilience and their ability to adjust to the circumstances. She explained that these are often business organisations, which are good at navigating complex environments, unlike governments, which tend to take a linear approach even to complex situations. Donor engagement should take account of the realities on the ground in order to make an effective contribution to reaching the last mile first.

Tackling the last mile first should begin with the individual and their families. Prof Francis Omaswa pointed out that most people's bodies were well functioning systems, which they disorganised through their own actions, leading to illness. If individuals were educated on how to stay healthy, infections and NCDs could be prevented. Health is made at home and only repaired in health facilities. Ministries of health must therefore make health literacy a priority.

Francois Karagwa Xavier underlined the importance of including vulnerable groups such as those living with disability in the quest for UHC. Focus should be on removing barriers by enhancing social acceptability of all people, ensuring physical accessibility and removing financial barriers by making services affordable for all. Political will and commitment are needed to make this happen.

Margaret Kilonzo has been a CHW in the informal settlement of Kibera for over 20 years. She is in charge of 100 households with a population of 500 people and her duties include identifying health problems in the households, referral, follow-up, defaulter tracing, health education and mobilisation for health campaigns. The focus of the CHWs' work is preventive health and as result, home deliveries are now rare, most children are fully immunised, the physical environment in the slum has improved, and stigma and discrimination have reduced. However, despite their crucial role in reaching the last mile, CHWs in Kenya receive no pay, and have no medical insurance.

Conclusion and Recommendations:

- To cover the last mile first, we need strategies for reaching neglected populations such as urban slums, elderly people, men, the disabled, immigrants and patients in palliative care. Investments made in the last mile will lead to savings in secondary care.
- Remunerating CHWs will transform the work they do and contribute significantly towards UHC.
- Good leadership and governance in health means ensuring delivery of quality health for all.
- The entire continuum of care is key; while focus on primary health care is important, secondary and tertiary care should not be neglected.

PLENARY 5: FOCUSSING ON QUALITY AND INNOVATION

Increasing access to health services alone is not enough to improve health outcomes – access must go together with a deliberate focus to improve quality of care. About five million people in lower and middle-income countries die every year due to preventable conditions, significantly more than the 3.6 million who die from not having access to care. The TED-style session focused on what it takes to sustainably improve quality of care.

TED-Style Session

Moderator: **Dr Waruguru Wanjau, Medical Officer and Public Health Consultant**

Speakers:

- **Dr Stephen Mutwiwa, Country Director, Jhpiego, Rwanda**
- **Dr Charles Akimen, Co-founder, Mobicure, Nigeria**

Dr Stephen Mutwiwa cited the WHO definition of health as state of complete social, physical and psychological wellbeing, as opposed to the absence of disease. But design of health systems today seems to be stronger in addressing the absence of health, rather than in generating or promoting health. This is reflected in the training of health workers and data generated by health management information systems. We need to rethink the design of our health systems.

Dr Charles Akhimien said that improved access to mobile technology and the internet in Africa provided an opportunity to both solve pressing health issues and advance UHC. He cited the examples of Omomi, a mobile application that links pregnant women to doctors in real time, and provides life-saving maternal information; and mypaddi, which has been has been effective in connecting young people to health professionals and providing them access to accurate sexual and reproductive health information.

Panel Discussion

Moderator: **Dr Waruguru Wanjau, Medical Officer and Public Health Consultant**

Panellists:

- **Prof Serigne Magueye Gueye, President, West Africa College of Surgeons, Senegal**
- **Dr Mariam Dahir, Public Health Research Specialist, Somalia**
- **Dr Ian Askew, Director, Reproductive Health and Research, WHO**
- **Dr Frasia Karua, General Manager, Amref Enterprises Limited**

Prof Gueye categorised surgery as an essential component of UHC in view of the rising rates of NCDs, injury and complications in childbirth. Universal access to surgical services requires not just theatres and equipment, but also amenities like electricity, water and skilled personnel. The shortage of surgical expertise can be overcome through training of mid-level health providers in emergency obstetric care and essential surgery.

Drawing on her experience in Somalia and Somaliland, Dr Dahir said that adequate training of doctors, availability of drugs and equipment, addressing harmful social and cultural practices, and building accountability and proper governance systems are some of the cost-effective changes that can make significant impact on the quality of health care in fragile states. It is also vital for government to make investments in acceptability and efficiency of care over and beyond the availability of health services.

Dr Ian Askew emphasised the important role of research in improving the quality of health services. Whereas UHC should focus on both the coverage and quality of services, health managers should define what quality means to both the users and the health system. However, there are no clear measures of quality to help health systems know whether or not they are offering quality services.

Dr Frasia Karua discussed how social enterprises could be a catalyst for providing quality health services in the rural areas. Social enterprises must be designed to reap maximum social and financial returns while closing gaps in health care provision. For the product or service to be useful, it should be sustainable, tailored to the needs of the community, link the community to the formal health sector and be scalable.

Conclusions and Recommendations:

- Health systems must set minimum standards of quality to aspire for, which should be informed by user feedback and expectations.
- The level of quality that a health system provides depends on the resources available and the system's drive to reach excellence.
- Essential surgical skills should be taught to every health professional if UHC is to be realised. Quality standards must be set right from the training schools.
- Health coverage should not be pursued at the expense of quality health care. The two should be handled simultaneously.

Panel Discussion on Accelerating Progress toward UHC: Leveraging Innovation & Technology

The session showcased demonstrable innovations in health care systems, data and delivery that are leapfrogging progress towards UHC across the continent.

Moderator: **Dr Priya Baasubramaniam, Senior Public Health Scientist & Director UHC-RNE Initiative, Public Health Foundation Of India**

Panellists:

- **Miss Claire Morris, International Programmes Director, Babylon Health**
- **Benjamin Noti, Robotist, Founder and CEO, Mint Innovations, Ghana**
- **Simon Berry, Co-founder and CEO, Cola Life, Zambia**
- **Israel Bimpe, Head of National Implementation, Zipline International, Rwanda**
- **Dr David Fleming, Vice-President, Global Health Programmes, Path**

Claire Morris: Babylon Health, a UK-based digital health company, provides end-to-end primary health care services in Rwanda that include triage, consultation, prescription and referral over the phone. The service is integrated with the Rwanda health system and 450 clinics and laboratories across the country. Over two million Rwandans are registered, with about 2,500 consultations daily.

Benjamin Noti: Mint Innovations specialises in robotics and artificial intelligence. It uses robots as a tool for therapy to enable autistic children to perform basic activities. The technology is still in development, based on research on the needs of autistic children.

Simon Berry: Diarrhoea is the second-biggest infectious killer of children. Recommended treatment is with Oral Rehydration Salts and Zinc, but only 10% of those who need this treatment use it. Cola Life has adopted the design, marketing and distribution principles used by Coca Cola to make diarrhoea treatment more aspirational, affordable and accessible.

Israel Bimpe: Zipline International uses drones to support the supply chain by distributing medical products, including blood and vaccines. Orders are sent via a web portal to distribution centres in either western or eastern Rwanda, the product is dropped by a drone to the health centre. The system has helped to improve supply chain efficiency by reducing wastage and stock-outs.

Dr David Fleming: Frugal innovation is the key to moving forward to UHC. For instance, working with the governments of Zambia and Tanzania, PATH has developed an electronic immunisation registry that tracks every child's vaccination schedule, doses received, and vaccine stocks needed daily at the health centres. The patient-level data optimises delivery of care and helps governments to figure out how to reach those who are unreached.

Conclusions and Recommendations:

- Evidence generated from life-saving innovations should be used to influence global and government policies.
- The key to sustainable innovations is to embed them in national health systems and innovations that have been proven to be effective should be scaled up.
- Digital solutions offer unlimited opportunities to advance primary health care and UHC.

PLENARY 6: STRENGTHENING MULTI-SECTOR PARTNERSHIPS TO ACHIEVE UHC IN AFRICA

Health is not a silo. Transitioning from a fragmented approach to health care towards a more integrated, big-picture vision requires increased collaboration across sectors and disciplines. Even beyond health, bringing together diverse sectors such as education, agriculture and environment will ensure a holistic approach to improving the determinants of health and strengthening health systems. The session sought to map out the unique role that different sectors need to play to advance UHC in Africa.

Ted-style Talk

- **Moderator: Dr Amit N Thakker, Chairman, Africa Health Business**
- **Speaker: Dr Kibachio Joseph Mwangi, Head of the Division of Non-Communicable Diseases, Ministry of Health, Kenya**

Dr Kibachio emphasised that governments must take the driver's seat in the UHC journey, ensure that everyone is on board and heed the voice of the people. Access to health care has to be about equity; priority should therefore be given to those who have the most pressing needs. UHC is not a government or political project; it is a right, not a favour, and must be institutionalised. It is a simple concept that should not be medicalised, and instead of being illness-based, should be measured by heath. Nor is it a Ministry of Health affair: there are more determinants of health outside the MOH than within, and UHC can only be achieved using a multi-sectoral approach.

Panel Discussion

Moderator: **Dr Amit N Thakker, Chairman, Africa Health Business**

Panellists:

- **Anuradha Gupta, Deputy CEO, Global Alliance for Vaccines and Immunizations (GAVI), the Vaccine Alliance**
- **Erogbogbo Temitayo, Director of Advocacy, MSD for Mothers**
- **Thomas B Cueni, Director General, International Federation of Pharmaceutical Manufacturers and Associations**
- **Dr Richard Pendame, Regional Director for Africa, Nutrition International**

Anuradha Gupta explained that GAVI arose out of a public-private partnership (PPP) experiment that combined the innovation and efficiencies of the private sector with the public sector's political will and country ownership in order to facilitate the implementation and scale-up of vaccination. In addition, private sector offers unique knowledge and experience to market and build demand for health services. PPPs can help to leapfrog health development as demonstrated by Rwanda, which has been able to reach 96% of its children with the whole range of life-saving vaccines.

A multi-sectoral approach to development enables countries to reach unreached populations. For example, working with civil society organisations bridges service delivery gaps in fragile states where there is little trust in government.

MSD for Mothers is a 10-year initiative by Merck and Co. Inc. to reduce maternal mortality globally. Erogbogbo Temitayo said that in Africa, MSD invests in catalysing engagement of other private sector partners in strengthening various aspects of the maternal health delivery system. Success in implementation and scaling depends on government's creation of a policy environment that allows private sector engagement. At the same time, is important to mobilise and strengthen local capacity to deliver health care.

Thomas Cueni highlighted the issue of proliferation of fake medicines, which he described as a shameful, criminal business. Industry players need to work together with ministries of health and local communities to counter the menace. UHC must be institutionalised at national level, and draw on global, private sector and community expertise to address inefficiencies in the health system, including the supply chain.

Dr Richard Pendame pointed out that more than 50% of diseases treated in health facilities were caused or influenced by malnutrition, despite the existence of cost-effective interventions: one dollar invested in nutrition has an economic return of US$16.. The focus of UHC should be on preventive and not just curative services in delivery of quality health care, nor should it be medicalised but must include other sectors and interventions, like nutrition, that are critical to its success. Mainstreaming nutrition into UHC requires the leadership of national and sub-national government.

Conclusions and Recommendations:

- Last mile availability of commodities and services for mothers is doable through partnerships.
- Government leadership and partnerships with the private sector are important pillars for scaling up innovations and technology for UHC. Innovation should be about both ideas and technology.
- Pharmaceutical companies need to act in an ethical and responsible business manner based on the global code of conduct in order to earn the trust of the public and health practitioners. Medicines have to be of proven quality in order not to compromise patient safety.

PLENARY 7: WOMEN LEADERSHIP IN GLOBAL HEALTH: INTERNATIONAL WOMEN'S DAY CELEBRATION

The last day of AHAIC 2019 fell on the eve of International Women's Day. The panel discussion explored closing the gender gap, doing things differently, and women as change-makers.

Moderator: **Dr Roopa Dhatt, Executive Director and Co-Founder, Women in Global Health**

Panellists:

- **Dr Amina Jama Mahmoud, Founder, Women in Global Health, Somalia Chapter**
- **Katja Iversen, CEO and President, Women Deliver**
- **Prof Miriam Were, Member, Vice-Chancellor, Moi University, Kenya**
- **Cynthia Simantoi, Anti-Female Genital Mutilation Ambassador, Kenya**

Katja Iverson urged leaders to listen and learn from those who use the health system before taking action. She said it was the users, the communities, who knew best what was needed to strengthen the system and who in fact drive change in communities. A combination of solutions, gender and age disaggregated data, testimonials and leadership at different levels are the recipe for successful, solution-focussed advocacy. In addition, using data to argue the case for investment in women is a game-changer in advocacy for the rights of women. Ultimately, investing in girls and women benefits the whole system.

Dr Amina Mahmoud noted that women health professionals in the fragile state of Somalia often work in isolation. Women in Global Health is very useful for these and other health professionals because it provides a platform to connect them to each other and others on the global hub for mentorship, support, partnership and collaboration.

Prof Miriam Were said that empowerment programmes should begin at household and community levels. While it is vital to promote the wellbeing of women in Africa, it is equally important to engage men too to improve the overall quality of life and ensure that no one is left behind. In addition, women should build up their caring capacities so that compassion is at the heart of the right to health – in provision of services, in relationships, and in dealing with people irrespective of age, gender, social status or cultural background.

Cynthia Simantoi said that more than 200 million women worldwide have been subjected to Female Genital Mutilation (FGM) and that every year an additional three million women are at risk of undergoing the cut. Such harmful-cultural practices continue to diminish the health benefits for women and must be addressed. Change must begin within the communities, using existing structures.

Conclusions and Recommendations:

- While it is vital to promote the wellbeing of women in Africa, it is equally important to engage men too.
- UHC cannot be achieved without first addressing the hurdles to health-seeking behaviour.
- The foundation of the right to health is compassion at both individual and community level. It is important to strengthen this component of healthcare

ORAL PRESENTATIONS

SUB THEME 1: **ACCESS**

TRACK 1.1: ADDRESSING CULTURAL, SOCIAL AND AGE BARRIERS TO ACCESSING HEALTH SERVICES IN AFRICA

Chair: **Dr Emmanuel Luyirika, African Palliative Care, Uganda**

Co-Chair: **Aisa Muya, Amref Health Africa, Tanzania**

Presenters:

- **Stephen Ogweno, Stowelink, Kenya - Tech 4 Health, myHeart KE Mobile Application: Innovative Ways to Reach the Millennials with Health Messages on Lifestyle Practices; Lucky Gondwe, Village Reach: "Contraceptives are for Adults not Girls" Perspectives on Contraceptive Access for Malawi's Adolescents**
- **George Kimathi, Amref Health Africa, Kenya - Targeted Men Engagement for Improved Hygiene and Sanitation in Samburu County, Kenya**
- **Nwene Hycenenthe, Institute of Medical Research and Medical Plant Studies, Cameroon - Intermittent Preventive Treatment (IPTp-SP) of Malaria in Pregnancy: Coverage and Factors Associated with its uptake in the Bamenda Health District**
- **Jannette Van Dijk, SolidarMed, Zimbabwe - Change in Utilisation of Hospital Health Care Services in Rural Masvingo, Zimbabwe: In Search of Determinants**

Numerous barriers prevent communities in Africa from accessing health services. They include lack of information on prevention and treatment of NCDs and myths surrounding their causes; absence of relevant sexual and reproductive health information and youth-friendly services, including access contraception; fear of seeking services and poor decision-making based on social misconceptions and myths. Other barriers are fear of stigma and social rejection, and gender stereotyping such as belief in some communities that construction of latrines is a women's role. Limited knowledge and skills of health workers, poor staff attitudes towards patients and long waiting times also affect the health-seeking behaviour of communities, as do the cost of transport and distances to the facilities. In addition, the reputation of the health providers and availability of medicine and diagnostics determine decisions to seek services. When a condition seems untreatable at the closest health facility, some patients seek alternatives such as traditional healers.

Conclusions and recommendations:

- Technology is a powerful tool for UHC, particularly for providing health information and encouraging behaviour change.
- Use of technology for health information and services should be scaled up, including use of simple phones.
- •Online health services should include mental health counselling.
- Policy makers must ensure that health workers are trained on intermittent preventive treatment and measures to encourage early start of ANC are put in place.
- The limited resources available for health must be allocated carefully to make services accessible, affordable and responsive.
- Stakeholders must address the need for youth-friendly sexual and reproductive health services. Male involvement is critical for Water, Hygiene and Sanitation interventions.

TRACK 1.2 LEVERAGING TECHNOLOGY AND INNOVATIVE MODELS OF SERVICE DELIVERY TO ACCELERATE ACCESS

Chair: **Israel Bimpe, Zipline**

Co-Chair: **Diane Mukasahaha, Rwanda**

Presenters:

- **Daniel Bingi, Makerere University, Uganda - GIS Integrated Mapping of Correlated Factors to Identify Cervical Cancer Hotspots**
- **Niels Buning Philips, The Netherlands - A Neonatal Resuscitation Skills Retention Solution with Proven Impact in Low Resource Settings**
- **Pauline Irungu PATH, USA - Modeling the Impact of Harmonised Regulatory Systems on Lives Saved in Eastern and Southern Africa**
- **Alinafe Kasiya, VillageReach, Malawi - An Uncommon Collaboration: How Chipatala Cha Pa Foni Journeyed from Innovation to Scale**
- **Stephen Ogweno, Stowelink/NCDAK, Kenya - myHeart KE Mobile Application: Innovative Ways to Reach the Millennials with Health Messages on Lifestyle Practices**
- **Tom Marwa, Kenyatta University, Kenya - The effects of HIV Self-Testing Kits in Increasing Uptake of Male Partner Testing among Pregnant Women Attending Antenatal Clinics in Kenya: A Randomised Controlled Trial**
- **Richard Lester, WelTel, Canada - Digital mHealth to support individualised and differentiated HIV care models (WelTel Predict)**

Technological innovations have the capacity to improve service delivery. This session discussed a number of innovations with remarkable health outcomes, some of which had been published in peer reviewed journals. These included an innovation by Weltel Canada that sends weekly messages to HIV/AIDS patients inquiring about their health status using a digital mHealth system. A randomised control trial carried out in Kenya showed that the system was effective in improving HIV viral suppression as a result of improved patient adherence to treatment and retention in care.

The study complemented the mHealth system with a differentiated care model that cascades the continuum of care and treatment according to the needs of persons living with HIV/AIDS. The session discussed myHeart, a mobile application (App) that targets youth with behaviour-change messages on NCDs. The App relays reminders on daily basis to encourage youth to practice healthy habits. An evaluation of myHeart showed an increase in awareness of and adoption of healthy lifestyles among the treatment cohort, compared to both the control group and baseline figures. The session also discussed the Augmented Infant Resuscitator (AIR), an innovation designed to reduce the major cause (46%) of new-born deaths - Birth Asphyxia, predominantly caused by inadequate capacity of health workers to properly ventilate new-borns. As such, AIR is designed to cost effectively aid heath care providers by improving and retaining their infant resuscitation skills.

Conclusions and recommendations:

- New-born deaths can be prevented by empowering birth attendants to effectively ventilate babies at birth. Programs such as Helping Babies Breathe (HBB) have proven effective. However, HBB falls short of sustained impact because ventilation skills decay rapidly, and significantly over time.

- In Africa, lack of harmonised regulatory processes is a critical barrier to timely access to essential medicines. Different regulatory processes result in delays for researchers and manufacturers, who must navigate multiple regulatory systems to register the same health product across multiple countries. Regional regulatory harmonisation could accelerate this review timeline by 40% to 60%.

TRACK 1.3: STRENGTHENING AND RE-DESIGNING PRIMARY HEALTHCARE CENTRES TO DELIVER INTEGRATED, PEOPLE-CENTRED HEALTH SERVICES

Chair: **Prof Stella Anyangwe, Global Health Expert, South Africa**

Co-Chair: **Richard Butare, MSH, Rwanda**

Presenters:

- **Mulindwa Alex, Amref Health Africa, Uganda - Client referral feedback: A community quality improvement initiative to improve facility deliveries at Sanga HC III in South West Uganda**
- **Brigid Waliuba Wangila, Plan International, Kenya - Community link desks as a best practice in strengthening community-facility health service delivery: A case study of USAID Nilinde OVC Project**
- **Sabine Musange, University of Rwanda, Rwanda - "It helped us to love our job:" Reactions from nurses and midwives to group antenatal and postnatal care in Rwanda**
- **Albert Orwa, Philips East Africa, Kenya - Innovation for strengthening primary health care delivery in sub-Saharan Africa**
- **Winnie Munene, Amref Health Africa, Kenya - Innovative PHC delivery to underserved populations in Kenya - CURAFA**
- **Marie Rose Kayirangwa, Jhpiego - Effectiveness of competency based training for a successful integration of Early Infant Male Circumcision (EIMC) in Maternal Neonatal and Child Health services in Rwanda**

The session discussed a number of initiatives for strengthening PHC, drawing from examples in Uganda, Rwanda and Kenya.

The presenters highlighted the Community Link Desk as a best practice in linking communities with health facilities.

To address the HRH gap, the link desk is manned by CHWs who are responsible for coordinating services between the community and health facility. The CHWs manning the desk are provided with job aids, supportive supervision through monthly meetings to review their referrals and transport allowance. The session also discussed a cluster randomised study of group antenatal and postnatal care (ANC and PNC) services. The women were grouped based on their gestational length (due date) while midwives and nurses developed plans to ensure that specific topics were covered and lab tests carried out.

The study compared the results before and after the intervention and showed that there was an improvement in mothers' knowledge and attitude towards facility delivery and danger sign, they developed trust towards the health provider/ nurse and they spread the word about the health facility in the communities.

Conclusions and recommendations:

- The Community Link Desk model has demonstrated to increase awareness and access to ANC and PNC services by women attended to by a skilled health professional. The drawback for the model is increased workload for the health workers (nurses and midwives), which needs to be addressed.

TRACK 1.4: PRIORITISING INITIATIVES THAT REACH VULNERABLE, HARD-TO-REACH AND MIGRANT POPULATIONS WITH ESSENTIAL HEALTH SERVICES

Chair: **Prof Laetitia Nyirazinyoye, University of Rwanda, College of Medicine and Health Sciences**

Co-Chair: **Boniface Hlabano, Amref Health Africa, Malawi**

Presenters:

- **Spenser Huchulak, SolidarMed, Zambia - Need for Universal Housing Coverage in Health: Evidence for a Housing Cooperative for Rural Health Workers in Zambia**
- **Eric Twizeyimana, University of Rwanda, Rwanda - Reaching the Community Of Vulnerable Population: Promoting Regular Screening to Fight Against Non-Communicable Diseases (NCDs) in Kirehe District, Rwanda.**
- **Brian Otienom, Alfajiri, Kenya - Health Services Integration: Use of Art as the Driver to Attaining the 90:90:90 Global Targets through Integrating Mental Health into HIV Programs in Nairobi County.**
- **Harriet Mugisha, Amref Health Africa, Uganda - Reaching grassroots "Is sub granting worth it?" A Case Study of Health Systems Advocacy Project.**

The session discussed a number of initiatives in Zambia, Kenya and Rwanda that aim to improve access to health services for hard-to-reach populations. The Zambian example was cited as an innovative solution to the shortage of houses for health workers in hard-to-reach locations, which has been linked to staff absenteeism. Zambia has provided housing for health staff through the SolidarInvest model, a fund that builds houses and rents them to health staff.

The health workers are able to pay the rents using a housing allowance paid by the Ministry of Health (MoH). The income received from rent is reinvested as a social enterprise. In Rwanda, the MoH engaged medical students to provide NCD screening services in resource-limited settings. The presenters discussed a case study that seeks to reach grassroots through the provision of sub-grants to Community Based Organisations (CBOs).

The CBOs are strengthened to conduct policy advocacy with government to enhance the provision of SRHR services and improvement in resource allocation for health.

Conclusions and recommendations:

- Governments should ensure quality health services in rural and hard-to-reach locations by rolling out innovative models such as housing models that attract and help retain health workers, installation of water points in health centres and using art to pass key health messages.

TRACK 1.5: ENGAGING THE PRIVATE SECTOR AND FORGING MEANINGFUL PUBLIC-PRIVATE PARTNERSHIP FOR ACCELERATED ACCESS TO HEALTH

Chair: **Dr Maggie Chirwa, One Family Health, Rwanda**

Presenters:

- **Joshua Limo, Kenya Association for the Prevention of Tuberculosis and Lung Disease, Kenya - Assessment of private health care provider capacity for the provision of tuberculosis care and treatment services: Case of selected Gold Star Network and Tunza franchised facilities in Kenya.**
- **Mloelya Paul, Amref Health Africa, Tanzania - Water and Sanitation for Health and Economic Improvements: A case of RAIN Project in Serengeti District, Mara Region, Tanzania.**
- **Ian Wanyoike, Intrahealth International, Kenya - Public Private Partnerships (PPP) to increase availability of health workforce to drive Universal Health Coverage: The case of the Afya Elimu Fund.**
- **Francis Aila, Ministry of Health, Kenya - Improving access to nutrition services in Homa Bay County, Kenya.**
- **Aloysius Ssennyon, Makerere University, Uganda - Government resource contributions to the Private-Not-For-Profit Sector in Uganda: Evolution, adaptations and implications for Universal Health Coverage.**

The session discussed a number of projects featuring Public-Private Partnerships in the East Africa Region. The example of the partnership between the Government of Uganda and the Private Not for Profit (PNFP) sector provided a good example of government providing funding for faith based organisations and the private sector.

The government contributions include conditional grants, equipment, secondment of staff and credit lines for drugs. The government intervention was in response to the closure of the only health facilities run by PNFPs in certain hard-to-reach locations.

The session discussed the fact that in most countries, the decline in government subsidy leads to an increase in user fees to cover the increasing cost of operations, while donor funding is unsustainable.

This creates a vicious cycle because increasing user fees means services become unaffordable and therefore inaccessible.

Conclusion:

- Partnership between governments and non-state actors is vital to the attainment of UHC.

TRACK 1.6: ENSURING ACCESS TO APPROPRIATE, SAFE, ELECTIVE AND EMERGENCY SURGERY AT ALL HEALTH FACILITY LEVELS

Chair: **Dr Jane Carter, Amref Health Africa, Kenya**

Co-Chair: **Dr Shiphrah Kuria, Amref Health Africa, HQ**

Presenters:

- **Getnet Gedefaw, Woldia Univeristy - Surgical site infection following obstetrics surgery: A cross sectional study, Ethiopia.**
- **Yvonne Opanga, Amref Health Africa - Availability and Readiness of Level 4 hospitals for Surgical Services in Kenya: Preliminary findings.**
- **Edwin Ernest, Jhpiego - Introducing the use of the WHO Surgical Safety Checklist in Remote Settings in Tanzania.**
- **Tanya Muchemi, Tawamu Solutions - Preference and Knowledge Level on Indications of Caesarean Sections in Urban Mothers: The Case of Jamaa Mission Hospital, Nairobi-Kenya.**

Most populations in Africa lack access to safe, affordable surgical and anaesthesia services. High rates of surgical site infection are reported following obstetric surgeries.

Countries use various interventions such as the World Health Organization's surgical safety checklist and mentoring of healthcare workers to improve access to safe surgery.

The checklist and other international tools can be customised to the local context – there is no need to reinvent the wheel. Of paramount importance is that the patient should always come first.

Conclusions and Recommendations:

- It is possible for resource-limited settings to introduce and sustain correct use of the WHO surgical safety checklist;
- Continued monitoring and evaluation are important to show whether increased use of the surgical safety checklist leads to decreased death rates and post-operative complications;
- Health professionals have to be trained on surgery procedures and checklists but also on leadership to reinforce correct practices, improve surgical access, safety, quality and for better monitoring and evaluation;
- Integrate surgery checklist into national policies;
- Leadership and mentorship are important skills for surgical teams to increase patient safety, thus reducing morbidity and mortality related to surgery, and to raise the volume of surgeries done;
- Monitoring and evaluation, as well as quality control assurance of surgical programmes must be institutionalised.

SUB THEME 2: **QUALITY**

TRACK: 2.1: ENHANCING MONITORING AND MODELS FOR QUALITY ASSURANCE TO ENSURE QUALITY OF HEALTH SERVICES

Chair: **Prof Fredrick Wabwire, Makerere University, Uganda**

Co-Chair: **Dr Ngambe Tharcisse, King Faisal Hospital, Rwanda**

Presenters:

- **Janet Mambulas, Amref Health Africa, Malawi - Addressing Contextual Factors Affecting Quality of Maternal Health Services in Malawi's Health Sector.**
- **Dr Emma Works, Hôpital GynécoObstétrique et Pédiatrique, Cameroun - The Ecology of the HGOPY Intensive Care Unit: Lessons for Picture of Contemporary Nosocomical Infection.**
- **Vincent Aboagye, University of Education, Ghana - Prevalence of Parasitic Contamination of Ready-to-eat Vegetable Salad in Accra Metropolis, Ghana.**
- **Lydia Kuria, Amref Health Africa, Kenya - Towards Zero MTCT on HIV: A Case of Kibera Community Health Centre in Kenya.**
- **Getrude Namazzi, Makerere University, Uganda - Improving Quality of Services Delivery for Care of Pre-term Babies: Lessons from Pre-term Birth Initiative in Eastern Uganda.**

Shortage of skilled staff, poor infrastructure and inadequate funding affect quality and equity of care offered in the health centres providing maternal care. Quality of care is also compromised by the substantial burden of nosocomial infections, or hospital-acquired infections (occurring in a patient after at least 48 hours' admission) in Africa, mainly caused by bacterial and fungi contamination. Healthy food choices can also be the source of food-borne illnesses, such as fecal contamination of vegetable salads, if quality of hygiene in the preparation process is not guaranteed. Quality of services is compromised by limited numbers of skilled staff, as well as stock-outs of essential medicines and supplies. However, well-coordinated and integrated intervention models that focus on patients, health workers and the health system have been shown to improve quality of care and reduction of infection, such as prevention of HIV transmission from mothers to babies. In addition, training of health workers to reduce common causes of mortality, including complications relating to pre-term births has shown to increase uptake of health care services.

Conclusions and recommendations:

- Integration of interventions is key for improved service delivery and reduction of facility-based pre-term mortality.
- Accelerated reduction in neo-natal mortality should be coupled with continued technical support from paediatricians.
- Leadership and local support are critical for creating ownership, addressing systems bottlenecks and motivating staff.
- Health workers should be adequately skilled and motivated to provide direct patient care.
- Proper disinfection needs to be conducted regularly in health facilities.
- It is important to invest in education of street vendors on safe and hygienic food handling practices.

TRACK 2.2: STRENGTHENING HUMAN RESOURCES FOR HEALTH AND HEALTH LEADERSHIP MANAGEMENT AND GOVERNANCE TO IMPROVE CAPACITY FOR DELIVERING QUALITY HEALTH SERVICES

Chair: **Dr Pierre Dongier, MSH, Rwanda**

Co-Chair: **Aletta Jansen, Amref Health Africa, the Netherlands**

Presenters:

- **Anna-Grace Katembo, Amref Health Africa, Tanzania - Addressing the Challenge on Human Resource for Health Enrolment through Community Promotion in Lake and Western Zones, Tanzania.**
- **Sathy Rajasekharan, Jacaranda Health, Kenya - A low-cost Sustainable Model for Nurse Mentorship that Saves the Lives of Mothers and Babies.**
- **Chelsea Matson, Training Programs in Epidemiology and Public Health Interventions Network, Kenya - Improving Public Health Management Strengthens Capacity for Quality of Care in Kenya: Evaluation Findings of IMPACT Kenya.**
- **Jacob Albin, University of Saskatchewan, Canada - Improving Managerial Supervision of Nurses: The Case of a Ghanaian Teaching Hospital.**
- **Rachel Jones, Jacaranda Health, Kenya - A Model for Nurse Mentorship and Coaching for Midwifery.**
- **Amanda Banda, Wemos, The Netherlands - The Health Workers for all Coalition, A Global Initiative for Health Workers Advocacy by Civil Society Organisations.**

Africa has 24% of the global disease burden, but has access to only 3% of the global health workforce. There is an urgent need to increase the enrolment, recruitment, deployment and retention of nurses and midwives especially in rural areas if UHC is to be attained. The persistent deficit in enrolment of nursing and midwifery students to health training institutions is majorly due to failure to meet academic requirements for enrolment, lack of school fees and unfavourable application modalities.

Strategies that have been used by civil society and governments include bonding, where students have their school fees paid on a contractual basis to study health courses; institutional development to encourage students to take up science subjects; training students through eLearning; service-based learning for attainment of knowledge and hands-on skills through formal, in-class training, on-the-job projects and mentorship; and nurse supervision models incorporating management functions and skills, communication and motivation for improved performance. Challenges faced by nurse supervisors need be addressed, including lack of incentives, guidelines, training and coordination as well as irregularity of supplies and brain drain.

Conclusions and recommendations:

- Improving managerial supervision of nurses enhances nurse supervision and UHC;
- Public health management training can improve the efficiency and effectiveness of health systems, better enabling these systems to deliver quality health services;
- A low-cost, sustainable model for nurse mentorship improves on-the-job skills and competences to save lives of mothers and babies;

- Coordinated advocacy by local and global CSOs is vital to alleviate the shortages of health workers;
- Multi-media approaches should be used to increase enrolment of nursing and midwifery students;
- Engage with the WHO on the review of the Global Code of Practice in International Recruitment of Health Personnel;
- Conduct an HRH analysis for advocacy use by both local and global CSOs with regular webinars;
- Promote accountability of governments and multilateral institutions on the implementation of global, regional and national HRH related commitments;
- Promote and support the engagement of community and national CSOs around the HRH agenda at global level;
- Influence the increase in investment in HRH in particular low and middle income countries.

TRACK 2.3: SMART DATA: USE OF HEALTH STATISTICS AND INFORMATION SYSTEMS TO INFORM QUALITY ASSURANCE

Chair: **Frances Longley, Executive Director, Amref Health Africa, UK**

Co-Chair: **Nadine Karema, PIH, Rwanda**

Presenters:

- **Khassoum Diallo, World Health Organization, Switzerland - Triangulation of Health Workforce Data: Comparisons Help Improving Data Quality, WHO.**
- **Peter Kaddu, Living Goods, Uganda - Community Health Worker Attrition in Uganda: A Case Study of Living Goods.**
- **Paula Kiura, Dalberg Research, Kenya - Enhancing and Visualising Health Data through Geography.**
- **Themba Ginindza, University of KwaZulu-Natal, South Africa - Projected Cervical Cancer Incidence in Swaziland using Three Methods and Local Survey Estimates.**
- **Grace Akot, Amref Health Africa, Uganda - Innovative District Driven Approaches to Improving the Quality of Malaria Data in Buhweju District in Uganda.**

Using local data is important for predicting and planning for health service needs, for decision-making and resource allocation. But lack of data has been a big problem for African health systems; in addition, access to any available accurate or reliable data is a challenge for proprietary reasons. There is need to invest in capacity building of health workers in data management and in innovative systems for quality assurance of the data. Having quality data facilitates planning for health services, HRH recruitment and deployment and guides in filling gaps in service delivery.

Lack of data hampers planning to fill these gaps. For instance, inadequate HRH data on attrition and recruitment hampers accurate planning, as does lack of data on the burden of cervical cancer.

Using Geographic Information Systems (GIS) improves decision-making based on location and use of health services, but there is need for quality and accessible data for the systems.

Conclusions and recommendations:

- There is need to invest in data management to inform policy, planning and resource allocation;
- More innovations should be encouraged and supported to ensure proper health service use;
- Governments and partners should invest in the use of GIS;
- Studies need to be done on attrition/retention of young CHWs, investment for sustainability, targeted support to CHWs is needed, recruit per local community;
- Data on the public, Private Not-For-Profit and Private For-Profit health workers must be captured for proper planning (include capacity, cadre, numbers and distribution).

TRACK 2.4: LEVERAGING CUTTING-EDGE TECHNOLOGY AND INNOVATION TO ENHANCE QUALITY OF CARE IN HEALTH FACILITIES

Chair: **Dr Kibachio Joseph Mwangi, MoH, Kenya**

Co-Chair: **Dr Mazarati Jean Baptiste, Rwanda Biomedical Center**

Presenters:

- **Kehinde Jimoh Abgaiyero, National TB and Leprosy Control Program, Nigeria - Innovative Real Time Reporting System Improves Healthcare Responses to Drug Resistance (DR-TB) in Nigeria.**
- **God Fred Acheampong, Kumasi Centre for Collaborative Research in Tropical Medicine, Ghana - Identification of Multidrug-resistant Salmonella Plasmid Variants using Polymerase Chain Reaction (PCR) Based Replicon Typing Technique in Ghana.**
- **Sarah Kosgei, Amref Health Africa, HQs - The Blended Approach to Training Front-line Health Workers: Towards Beating NCDs.**
- **Dorothy Murok, FHI 360, Kenya - Adapting to Technology to Support Mobile and Cross-Border Populations Access Health Services.**

Nigeria is ranked 7th of countries with the highest TB burden globally. However, shortcomings in the system have hampered quality and efficiency of care as test results are not reported in real time due to poor communication, there are frequent stock-outs of test cartridges and the quality of results is poor. GXAlert, a mobile-based software developed by System One, sends GeneXpert diagnostic results to key health system actors in real time, enabling quick enrolment of newly diagnosed patients in a DR-TB Treatment Programme. In Kenya, the need for health workers with knowledge and skills to manage the growing health challenge of Non-Communicable Diseases led to a project that sought to leverage on technology to enhance quality of care through training. Models of training used were face-to-face, eLearning and mLearning, which all effective. On the East Africa borders, there is a sizeable volume of trans-border access to health services that is not captured at point of care. Lack of data to inform decisions results in overstretched resources and frequent stock-outs at border health facilities, hampering effective service delivery. A harmonised digital health service delivery framework for the EAC region, aligned to respective national health systems, will improve access and continuity of health care.

Conclusions and Recommendations:

- Use of technology can eliminate human error in detecting DR-TB as cartridge forecasting is done automatically;
- GXAlert software strengthens surveillance, closes the gap between the cases diagnosed and treated and should be scaled up for sustainability;
- There is need to assess the calibre of trainees in order to determine the models of training to enable the achievement of the intended results of the training;
- A harmonised digital health service delivery framework needs to be developed and implemented in consultation with multi-sector stakeholders in EAC partner states' national and local levels to secure buy-in and ensure sustainability;
- Blood culture should be done for salmonella bacteraemia and observed for six days for effective results.

TRACK 2.6 ACHIEVING PATIENT-CENTRED QUALITY BY STRENGTHENING NON-CLINICAL CONTRIBUTORS TO QUALITY OF HEALTH SERVICES INCLUDING COMPASSION, CLEANLINESS AND TIMELINESS

Chair: **Edward Kamuhangire, MoH Rwanda**

Co-Chair: **Yasinta Bahati: Amref Health Africa, Tanzania**

Presenters:

- **Mutala Abdul Hakim, Kwame Nkrumah University of Science and Technology, Ghana - Can Integrated Obstetric Emergency Simulation Training Improve Person-Centred Maternity Care? Results from a Pilot Study in Ghana**
- **Jean Baptiste Sagahutu, University of Rwanda, Rwanda - Impact of ICF in Improving Knowledge, Attitudes and Behaviour regarding Inter-Professional Practice among Health Professionals in Rwanda**
- **Brenda Mubita, Amref Health Africa, Kenya - Achieving Respectful Care through Building Capacity of Health Workers And Community Members**
- **Mamaru Ayenew, Amref Health Africa, Ethiopia - Barriers to Quality of Care in Family Planning Service in the Primary Health Care Level: A Case of Jimma and East Wolega Zones, Oromia, Ethiopia**
- **Sabine Musange, University of Rwanda, Rwanda -"In the Group there was Something Extraordinary": Women's Perceptions of Group Antenatal and Postnatal Care in Rwanda**
- **Patience Afulani, University of California, San Francisco - Can Integrated Clinical Simulation Trainings Improve Person Centred Maternity Care? Results from a Pilot Project in Ghana**

Collaboration between health professionals provides an effective, non-clinical avenue to improve quality of health services by reducing medical errors and improving interpretation of health information.

The International Classification of Functioning (ICF), a bio-psycho-social model, provides a common language framework that has the potential to improve collaboration and communication between health workers and with patients.

Another non-clinical intervention is provision of group ante-natal and post-natal care, which fosters friendships among mothers and builds a support network for pregnant women and new mothers. Person-centred maternity care also improves health-seeking behaviour and outcomes by emphasising care that is respectful and responsive to women's preferences, needs, and values. Poor understanding of the need for respective maternal care by both health workers and community members is a key driver for the disrespect and abuse suffered by women, especially during labour and delivery.

Conclusions and recommendations:

- Adoption of the ICF as a framework to inform inter-professional practice could result in a more holistic approach to care;
- The findings from the ICF may contribute to improving health care delivery at all levels of the health system;
- Lack of finances and of partner support are barriers to women seeking ante-natal and post-natal care;
- Integrated training that gives providers the opportunity to learn, practise and reflect on provision of person-centred maternal care in the context of stressful emergency obstetric simulations could improve service delivery in low-resource settings;
- More community outreach to raise awareness among male partners and community members in general for ANC and PNC;
- Provision of person-centred maternity care should be integrated into clinical simulation trainings for health providers;
- Respective maternal care should be institutionalised.

SUB THEME 3: **FINANCING**

TRACK 3.1: EXPANDING FINANCIAL PROTECTION, INCLUDING FOR VULNERABLE POPULATIONS BY STRENGTHENING AND SCALING INNOVATIVE INSURANCE MODELS

Chair: **Anne-Marie Kamanye, Executive Director, Amref Health Africa in Canada**

Co-Chair: **Dr Nkechi Olalere, CHAI, Rwanda**

Presenters:

- **Issa Sematimba, Amref Health Africa, Uganda - Sustainable Water and Sanitation Services through WASH-Integrated VSLAs (Voluntary Savings and Loans) Groups in Northern Uganda.**
- **Adekunle Ademiluyi, 1University of Lagos, Nigeria - Universal Health Coverage Policy Reform in Benue State, Nigeria: Expanding Financial Protection for the Vulnerable Population.**
- **Anne Adah-Ogoh, Christian Aid, Nigeria - Knowledge, Attitude and Willingness to Participate in the National Health Insurance Scheme among Traders in Oyingbo Market, Lagos State, Nigeria.**
- **Fidelina Ndunge, Amref Health Africa, HQs - Enhancing Access to Healthcare through Mobile Health Innovations: the Case of Innovative Partnership for Universal Sustainable Healthcare (i-PUSH) programme in Nairobi and Kakamega, Kenya.**
- **Jim Ouko, Plan International, Kenya - Simplifying Health Financing for Vulnerable Populations towards UHC.**

Out-of-pocket expenditure creates a great challenge for millions of people in Africa with 30,000 people on the continent entering the poverty bracket each day due to health costs. The road to UHC requires financial protection for all, especially vulnerable populations and innovative models have been used to drive enrolment into government health insurance schemes across the continent.

In particular, use of technology-based platforms and CHWs has proven to improve access to and affordability of quality health services for women of reproductive age and children under five.

The push towards UHC can be enhanced by strengthening the response of social services systems and structures at county and community level to the welfare and protection of vulnerable populations, and by collaborating with grassroots structures to drive enrolment into health insurance schemes.

Grassroots savings and loans structures can also be used to finance health-related projects like construction of latrines or sanitary amenities.

Conclusions and recommendations:

- Technology is a driver towards achieving SDGs and delivering UHC;
- National Health Insurance Funds should accept small, frequent payments to cater for vulnerable groups;
- Governments must prioritise public awareness of health insurance through civic education;

- High internet penetration, vast network of CHWs and government commitment are necessary for successful roll-out of national health insurance schemes;
- Flexible savings schemes facilitate vulnerable populations to pay for health insurance, as opposed to monthly lump sum payments;
- Integrating community health insurance efforts that cater for the informal sector will ensure strong and effective national schemes.

TRACK 3.3 ACCOUNTABILITY AND ALIGNING PUBLIC FINANCING MANAGEMENT SYSTEMS FOR ENHANCED MONITORING OF RETURNS IN HEALTH CARE INVESTMENT

Chair: **Gilbert Biraro, Rwanda Biomedical Centre.**

Co-Chair: **Margaret Mungai, Amref Health Africa in Kenya.**

Presenters:

- **AKO-EGBE Louis, Ministry of Health, Cameroon - What Matters in Health Facility Performance in Performance-Based Financing: A Multiple Case Study Analysis of Health Centres in the South West Region of Cameroon.**
- **Amy Jackson, Options, Kenya - Making Sure the Global Financing Facility is Accountable to Community Needs.**
- **Richard Butare, Management Sciences for Health, Rwanda - The Price of Reaching Middle Income Status: Sustaining Household Protection from Paying the Bill in Rwanda.**
- **Tibebu Benyam, Yale GHLI, Ethiopia - Measuring Managerial Accountability in Primary Health Care in Ethiopia.**
- **Happiness Oruko, Amref Health Africa, Kenya - Double Pressure Advocacy, Does it Work? A Case Study of Health Systems Advocacy Partnership Project in Kenya.**
- **Lethia Bernard, PAI, Zambia - CSO Engagement in UHC Financing Policy Processes, Zambia**.

With the classification of several African economies from lower to middle income status, there has been a shift in traditional funding where an increase in GDP leads to a decline in eligibility for most external funding mechanisms based on income level and burden of disease.

But growth in GDP is not necessarily proportionate to the allocation of finances for health care. A financing advocacy strategy is required for effective implementation of UHC, starting with evidence, inviting ministries of health, honing most impactful opportunities, broadening the network and developing immediate action tool. Performance-Based Financing has the potential to improve healthcare services. No single context or health system factor is sufficient. The Global Financing Facility (GFF), too, can be a great success if civil society organisations are equipped to meaningfully engage in its set-up and implementation.

Indeed, by increasing civil society organisation participation, the Global financing facility can be accountable to community needs. Managerial Accountability in Primary Health Care (MAP) scoring is important for improving primary healthcare performance. It leads to an increase in awareness performance

Conclusions and Recommendations:

- Governments should increase public spending on health care;
- Ministries of Health should remap health districts and redistribute health centre populations;
- PBF stakeholders should ensure availability of necessary conditions e.g. pre-initiation grants;
- Health centres management should implement recommendations from supervisors;
- Civil society should be equipped with the right tools, information and platforms to participate in GFF and to share lessons learnt;
- Unified voices amplify advocacy efforts in reaching out to key decision/policy makers and legislators;
- Early planning for middle income economy status can be achieved by increasing domestic funding;
- Governments need to implement progressive, country-led transitional preparedness;
- Integrate MAPS with existing governance structures across levels of the primary healthcare system.

TRACK 3.4: PLANNING AHEAD: ADDRESSING THE EVER-GROWING HEALTH NEEDS OF POPULATIONS AND COST OF HEALTH SERVICES

Chair: **Prof Ellen Chirwa, Kamuzu University, Malawi**

Co-Chair: **Dr James Humuza, SPH, Rwanda**

Presenters:

- **Ellen Mkondya-Senkoro, the Benjamin William Mkapa Foundation, Tanzania - Human Resources for Health and Government Investment Priorities in Tanzania - Linking Together.**
- **Howard Akimala, Living Goods, Kenya - Investing in Community Health can Result in up to 9.4 Times Return on Investment in Kenya.**
- **Muganhiri Darren, University of Pretoria, South Africa - Major Top 10 Health Outcomes in Zambia and their Implications on Health Financing Over 25 years (1990 – 2015).**
- **Liberty Christopher, Kabale Women in Development (KWID), Uganda - Increasing District Budgets for Family Planning: Experience of Health Systems Advocacy Project in Kabale District.**

The session discussed the need for governments to plan ahead in order to cope with the ever growing demand for health services and rising costs. It noted the emerging health care needs posed by the rise in NCDs, over-stretched public funding and dwindling Aid for health. Participants agreed that there was need to explore new healthcare financing and delivery models in order to generate the best health outcomes using the available resources.

The presenters cited numerous initiatives across Tanzania, Uganda and Zambia, for instance, an innovative recruitment option in Tanzania that complements government initiatives by recruiting unemployed medical professionals, nurses (as health professional Fellows).

These cadres are remunerated from the existing financing schemes such as national health insurance funds and other specially created basket funds and programmes in coaching, mentoring and supportive supervision. The session also explored additional options for addressing the Human Resources for Heath (HRH) gap through: programmes that enable Medical Officers to set-up private clinics in underserved areas; creation of an enabling policy environment under Public Private Partnership agreements that increase investor access to underutilised infrastructure at subsidised rates – where the investors set up health facilities targeting underserved populations; the provision of financing for these start-ups through improved access to microfinance, loans and/or grant; and mobilising health workers through their respective professional associations.

Conclusions and recommendations:

- The rise of NCD morbidity and mortality calls for governments to invest in community health workers to support preventive strategies at community level and a bottom-up advocacy to bring about lasting health outcomes.
- Governments should form coalitions with other players in addressing growing health needs. "An effective coalition makes the call for action louder".

TRACK 3.5: COST-EFFECTIVE HEALTHCARE: MAXIMISING RETURNS FOR INVESTMENT IN HEALTHCARE AND TRANSITIONING FROM PASSIVE TO STRATEGIC PURCHASING

Chair: **Dovlo Delanyo, Previously WHO, Africa Regional Office**

Co-Chair: **Dr Richard Butare, MSH, Health Financing Team**

Presenters:

- **Themba G Ginidza, University of KwaZulu-Natal, South Africa - Cost Analysis of HPV-related Cervical Diseases and Genital Warts in Eswatini, Swaziland.**
- **Justus Ochieng Odeyo, Population Services Kenya - Integration of Private Health Facilities towards UHC.**
- **Diltoka Gideon Kevin, Ahmadu Bello University, Nigeria - Determinants of Household Out of Pocket Health Expenditure on Hospital Visit in Nigeria: Findings from the Nigerian General Household Survey Panel.**
- **Brenda Kituuma, Amref Health Africa, Uganda - Reducing the Cost of Medical Referrals through Medical Camps: A Case of Medical Camps in Kitgum Hospital, Uganda.**
- **Stephen Okumu Ombere, Maseno Univerity, Kenya - Social Protection for Inclusive Healthcare through Free Maternity Services in Kenya.**
- **Alison Mhazo, KNCV Challenge TB Project, Malawi - The Impact of Performance Based Financing on Maternal and Child Health Equity in Sub Saharan Africa: A Systematic Review.**

The session discussed a number of factors that either promote or hinder access to quality and cost effective health care. One of the major factors that may lead to catastrophic health expenditure for patients in Africa is hidden out-of-pocket expenses even in situations where governments offer free medical services. For example, a government offers free maternity services but does not consider the challenges and therefore expenses incurred in accessing these services are due to the infrastructural shortcomings and long distance to health facilities.

The session highlighted the issue of efficiency and effectiveness of a country's health care delivery system as contributing to the attainment of a country's health targets. The presenters pointed out that contrary to expectation; the cost and quality of health care services do not often go hand in hand and even when patients are able to access services through risk pooling mechanisms, the quality of services may be poor. The session discussed evidence from a number of projects in Nigeria and Kenya that show that aggregation and automation of services generate efficiencies, which in turn translate to improved quality and reduction of cost of service to both users and providers. The presenters cited the Ugandan example where the use of comprehensive, integrated outreach service models had led to a reduction in the cost of referral services for both the users and providers. Despite the maxim that evidence should inform decision-making, lack of sufficient evidence remains a hurdle to decision making and even when there is evidence, it does not necessarily translate to policy and practice. The session underlined the need for a study to generate evidence to inform policymakers of the need for greater investments in health. This is needed to ensure sustainability in the context of diminishing donor funding as a result of changes in the donor environment.

Conclusions and recommendations:

- Governments and other health providers can achieve cost effectiveness and therefore sustainability through proper resource allocation. For instance, preventive health services such as immunisation are cheaper than curative services; improving access to services is more cost effective than referrals; aggregation and automation of primary health care service providers reduce cost of care, improve quality and catalyse UHC.
- In pursuit of UHC, policymakers should consider performance-based financing to reduce out of pocket expenditure. This can be achieved through analysing the type of services reaching specific population segments in order to determine the financial contribution needed and evidence-based, cost-effective models to adopt. This evidence should be translated into policy.
- The private sector and civil society should engage beneficiary communities to lobby for a pro-people approach to health service delivery.

TRACK 3.6: LEVERAGING TECHNOLOGY AND MOBILE PENETRATION TO SCALE UP FINANCIAL PROTECTION FOR POPULATIONS

Chair: **Dr Alice Lakati, Amref International University**

Co-Chair: **Innocent Mucheti, RISA, Rwanda**

Presenters:

- **Donald Mogoi, Ministry of Health, Kenya - University Health Coverage: Use of M- Jali for Targeting for Health Insurance, Laikipia County Kenya.**
- **Ann Munene, Amref Health Africa, Kenya - Improving Efficiencies through Electronic Cash Transfers to Reduce Catastrophic Costs among Drug Resistant TB Patients in Kenya.**
- **Nicole Spieker, PharmAccess Foundation, Kenya - The Innovative Health Exchange Platform M-Tiba can help Leapfrog Access to Better Care.**
- **Henry Marwa, PharmAccess, Tanzania - Ensure Sustainability of Community Insurance Scheme through Digitalization of Scheme Administration.**

With majority of citizens not enrolled for national health insurance cover in Kenya and many countries across Africa, the cost of treatment and care can be catastrophic. In addition, there are conditions like TB that have high non-medical costs. Furthermore, although solutions exist for prevention of maternal and child deaths, mortality rates are still high because access to care is hampered by reasons such as lack of finances and poor quality of care at health facilities. Cash transferred to patients through the public sector does not reach patients in time, nor does the NHIF cover all treatment. For instance, while treatment for TB is covered, DR TB is not, yet it is on the rise. CHWs have proved to be efficient agents for enrolment of households to NHIF while digital technology provides an efficient way to manage cash transactions for patients. TIBU Cash, a web-based system, assists in cash transfer and management of an up-to-date list of patients. M-TIBA, a mobile solution, connects those who pay for health services to service providers.

Conclusions and recommendations:

- Community health workers are a critical element of the health work force and can promote uptake of health insurance cover;
- Using technology for payment of TB patients is faster and more efficient, and patient records are up-to-date;
- M-TIBA technology can provide a wide range of data for decision-making, including referrals, tests performed and drugs given;
- A study needs to be done on return on investment for technologies such as TIBU Cash and M-TIBA;
- Enrolment to NHIF should be made mandatory and local leaders to be put on the system.

SUB THEME 4: **ACCOUNTABILITY**

TRACK 4.1 **LOOKING BACK: TRACKING PROGRESS AGAINST HEALTH COMMITMENTS MADE BY AFRICAN LEADERS**

Chair: **Dr Juliet Bataringaya, WHO, Rwanda**

Presenters:

- **Jacob Alhassan Albin Korem, University of Saskatchewan, Canada - The Path to Universal Health Coverage: Comparing Progress in Ghana and Rwanda.**
- **Jack Chola Bwalya, University College Dublin (UCD), Ireland - Trust in Government, Quality of Democracy and Willingness to Pay more Tax to Increase Spending on Public Healthcare in the SADC Region.**
- **Jacob Alhassan Albin Korem, University of Saskatchewan, Canada - Tracking Nigeria's Glacial Progress Towards Universal Health Coverage.**
- **Yolanda Moyo, PATH, South Africa - Developing an Accountability Framework for Tracking Policy Implementation.**

In April 2001, most African governments committed, in the Abuja Declaration to allocate "...at least 15% of their annual budget to improve the health sector". However, a review by the WHO in 2011 found that only two countries, Rwanda and South Africa had achieved the targets. Out-of-pocket expenditure in most countries is way above the 20% benchmark for UHC. Besides, there is a huge gap between the actual government health expenditure per capita and the recommended government health expenditure per capital of US$86 and overreliance on donor funding. Data from various reports shows that citizens can be willing to pay more taxes to increase health budget allocation, but true political will is also required to demonstrate accountability in fund mobilisation, allocation and spending for health. Indeed, there is little transparency and accountability on health budgets and expenditure, and no tracking tools and frameworks. UHC benchmarks should be translated to grassroots level leadership, accompanied by public dialogue on the attainment of UHC targets and implementation of the agreed policies.

Conclusions and recommendations.

- Individual socio-economic factors and trust influence citizens' willingness to pay more taxes in order to increase access to health care, macro country level factors, such as quality of democracy, do not;
- Accountability frameworks should be simplified for local communities to understand and be able to challenge leaders on health budget allocation, priorities and spending;
- The slow progress towards UHC is leaving the most vulnerable populations behind;
- Members of the public should be involved in policy formulation so that they can hold their leaders accountable;
- Benchmarks for UHC such as the Abuja Declaration should be translated to local contexts. For example 15% of national budget should translate to more than 15% of national expenditure;
- Strong political will is required to increase government financing for health and implementation of policies that aim at reducing equity gaps;

- Countries should develop accountability frameworks that can be simplified for use at different levels, right to the grassroots.

TRACK 4.2 SOCIAL ACCOUNTABILITY AND THE "UNHEARD" VOICE OF CITIZENS: ACTIVATING COMMUNITIES TO DEMAND THE RIGHT TO HEALTH

Chair: **Dr Meshack Ndirangu, Country Director, Amref Health Africa in Kenya**

Co-Chair: **Rachel Akimana, Imbuto Foundation, Rwanda**

Presenters:

- **Sarah Njenga, London School of Economics and Political Science, United Kingdom - Social Accountability Mechanisms in Health Financing: A Qualitative Study of Universal Health Coverage in Rwanda.**
- **Giulia Perrone, University of Essex, England - Towards UHC: Raising Unheard Voices through the Universal Periodic Review Process.**
- **Courtney Tolmie, Results for Development Institute, USA - When, Where, and How Does Social Accountability Improve Health? Evidence from a Mixed-Method Multi-Country Impact Evaluation.**
- **Titus Kiptai, Amref Health Africa, Kenya - Use of Imonitor+ ATM Kenya Alert System to Strengthen Social Accountability in Kwale, Vihiga and Homabay Counties, Kenya.**
- **Arthur Chibwana, Christian Aid, Malawi - Use of Evidence to Enhance Transparency, Accountability and Influence Financial Resource Allocation in the Health Sector.**

Co-governance in public service is important for the delivery of health services, backed by accountability models to ensure that funds are used for what they are meant for. Through social accountability, citizens and civil society organisations can advance health and human rights issues and engage with policy makers. For UHC, success factors include political will, adherence to long-term policy and a clear understanding by citizens of the issues and how they can engage policy makers. The Universal Periodic Review process, whose objectives was to increase the WHO's engagement on the right to health and create a space where CSOs can advance issues relating to human and mental health rights, provided an opportunity for unheard voices to be heard at the macro level.

Whereas community participation is key, it is up to duty bearers to ensure that it is as effective as possible by giving guidance. By engaging community members in promotion of preventive and curative interventions at the household and facility levels, countries can be able to prioritise areas of improvement in health. Thus, empowerment of communities to demand their rights leads to improvement in health service delivery and improved responsiveness at various levels of budget allocation.

Conclusions and Recommendations:

- Engaging community in promotion of preventive and curative interventions can help health administrators to prioritise areas of improvement in health;
- Empowering communities to demand their rights leads to improvement in health service delivery;
- Social accountability does not necessarily improve health outcomes. There is need to test social accountability models before implementation;
- Financial resource allocation in the health sector should be influenced by evidence to enhance transparency and accountability;

- In-depth budget analysis should be used to provide better insight to leadership on improving health delivery;
- There is no one-size-fits-all comprehensive and responsive system of social accountability.

TRACK 4.3: MEASURING ACCOUNTABILITY: LEVERAGING HEALTH INFORMATION SYSTEM TO ENHANCE AND MONITOR IMPACT

Chair: **Robert Banamwana, UNFPA Rwanda**

Presenters:

- **Elizabeth Wangia, Ministry of Health, Kenya - Performance Monitoring for Increased Accountability at the Ministry of Health.**
- **Francis Olok, Amref Health Africa, Uganda - Use of Coverage Tables with a Year To Date (YTD) Formula to Measure and Report Project.**
- **Sarah Malaba, Living Goods, Kenya - Ensuring Accountability at the Last Mile to Deliver High Quality Care.**
- **Joel Arthur Kiendrébéogo, Results for Development, USA - Developing a Comprehensive Framework to Help Accountability Interventions Accelerate Progress towards UHC.**
- **Khassoum Diallo, World Health Organization, Switzerland - Health Workforce Data Monitoring, Ensuring Accountability Through Implementation of National Health Workforce Accounts.**

The session defined accountability as delivering what one has committed to. The panel said that accountability was about assessing the success factors and bottlenecks that enable or frustrate the achievement of the said commitments. Given that performance monitoring is essential for accountability, the meeting explored various avenue of performance monitoring at health facility and community levels, and at project levels.

The session highlighted the following approaches to performance monitoring at the health facility level: use of performance contracts to monitor the output of health workers, rapid results initiative, regular performance audits, compiling both a master health facility and community units' list, use of score cards such as facility performance monitoring score card (auto generated from DHIS), RMNC scorecard.

The session highlighted the importance of ensuring that health officials carryout monthly monitoring of key indicators, ensuring that the systems are interoperable and user-friendly.

The session discussed the use of low-cost technology (mHealth) by CHWs to reach the important last mile. Options here include providing CHWs with mobile telephones with built in workflows (task list) and algorithms that guide CHVs, allow managers to monitor disease burden, quality of services, workload, worker performance and enhance supportive supervision. Such technology should be made interoperable with MoH systems to enable policymakers to track what CHWs are doing in real time. There is however need to enhance interoperability of systems to strengthen MOH systems.

The session discussed an innovation in the measurement of project performance through addressing the traditional risk of masking poor performing when measuring individual indicators. The approach adopts a year-to-date (YTD) formula to reduce the variation between programmatic and financial performance measurements.

Diallo highlighted the need to strengthen HRH data at both county and global levels. He said that WHO in consultation with the countries developed the National Health Workforce Accounts (NHWA), which is aimed at progressively improving the availability, quality and use of data on health workforce to support UHC, the SDGs and other health objectives. He said that WHO had developed the Global Strategy on Human Resources for Health: Workforce 2030 and the member states committed to providing annual HRH reports against a set of indicators.

Conclusions and recommendations:

- Governments should take ownership of technology to enhance sustainability, particularly in scaling up low cost technologies;
- Technology provides an avenue for CHW to reach the last mile while also enabling their supervisors to monitor their performance and ensure their accountability;
- Health stakeholders need to advocate for both greater use of data for decision making and improved financial allocation for monitoring and evaluation;
- The implementation of NHWA by WHO member states means that they will have good HRH data for decision-making while enabling them to share best practices and benchmark with neighbouring countries.

POSTER PRESENTATIONS

A total of 173 high quality posters were presented during the three-day conference. The following are the key findings and recommendations:

Key findings

- Knowledge at the household level is essential for improved health outcomes.
- Self-collection of vaginal samples for HPV testing can improve access to cervical cancer prevention. The approach has can greatly improve population level screening and treatment coverage.
- Implementation of Kimormor[1] model contributed to an improvement in uptake of Maternal New-born and Child Health (MNCH) services in resource-constrained pastoral communities of Kibish sub-county in Kenya. In addition, partnership across sectors and community mobilisation are vital for MNCH service uptake. ANC1 attendance for women improved from 34% in October 2016 to 81% in April 2017.
- Continuous mentorship and education is essential in equipping midwives with new skills to efficiently meet their client's expectations.
- Stakeholder's involvement during the piloting of health service delivery projects is important to ensure that social concerns are factored into project design.
- Initiatives that promote healthy living at primary schools play an important role in preventing NCDs in the long term.
- Formation of a community-based health advocacy and awareness program led to a 30% reduction in typhoid cases over three years and 15.5% reduction in the costs of hygiene-related diseases.
- Task-sharing between health facilities and CHWs helped to scale up hypertension screening and linkage of patients to treatment.
- Mass drug administration with a target of 80% of the population in a community has been shown to be effective in eliminating trachoma. This is effective if it is supported by behaviour change activities such as cleanliness and environmental improvements.
- Digital Labour and Delivery Solution is a digital Application that supports intense monitoring during the intrapartum phase of labour when a pregnancy that is considered low-risk may quickly progress into complications and even death. The App provides the opportunity to improve the efficiency and effectiveness in the management of patients during intrapartum and subsequently in the referral of patients within and between facilities.

[1]Kimormor - this model places the (pastoralist) community at the centre of mobilization and provision of health services. This has been shown to result in improved health services, education, self-registration and health seeking behaviour.

Recommendations

- The Points-of-Care model has been shown to be effective in improving disease awareness and ensuring availability, accessibility and affordability of health services;
- The self-collection of vaginal samples for HPV testing is a best practice that should be scaled up;
- Problem solving led by hospital management and supported with minimum funding is a pragmatic and well accepted approach;
- Devolved governments (at sub-national level) can increase the use of MNCH services among the pastoral communities by adopting the Kimormor model;
- The formation of Work Improvement Team enables midwives to get continuous mentorship and education at the workplace;
- Primary schools should mainstream the promotion of healthy living courses on NCDs as a way to address the lifestyle related causes of NCDs. Empowered pupils make effective community behaviour change agents.
- Proper community hygiene is the most cost-effective intervention for preventing and controlling illness;
- Projects implementing task-shifting from health workers to CHWs should include strategies for reaching men with hypertension screening services and linking them to treatment.

PARTNER-LED SESSIONS

Partner-led sessions offered an opportunity for partners to design and host break-out sessions that would take a deeper dive into the discussions initiated during the main plenaries. A total of 47 partners submitted their requests and participated in concurrent sessions, which gave them the opportunity to lead discussions in their areas of expertise, allow participants to hear from community leaders working on the ground and foster solution-oriented identification, dialogue and outcomes – see details in Annex F.

Capacity Building Skills Lab/Workshop Series

This was a five-part research skills lab/workshop series that was jointly organised by Amref International University (AMIU) and Elsevier with the aim of building the capacity of young researchers and policy makers on selected research processes. See the workshop session details in Table 1 below.

Table 1: Capacity Building Skills Lab/Workshop Series

No.	Organisation	Title of Session	Instructors
1	Amref International University	Validity in Research: A Skills Clinic Workshop	Prof Marion Mutugi and Dr Alice Lakati
2	Elsevier	Getting Published: An Author Workshop	Christine Aime Sempe and Dr Pius Kabututu Zakayi
3	Amref International University	Writing a Good Abstract for a Conference	Dr Josephat Nyagero and Prof Marion Mutugi
4	Elsevier	Moving Research from Publishing to Policy!	Yap Boum and Anne Roca
5	Elsevier, The Lancet Global Health and Epicentre	Is the preponderance of English a barrier to scientific communication? Defining the way forward – *to be presented in French*	Anne Roca

CLOSING CEREMONY

At the close of AHAIC 2019, an award ceremony was held to recognise the contributions of women leaders who have dedicated their lives to advocating for better health in Africa. The session also served as the official launch of the Africa Hub of Women in Global Health to carry forward conversations initiated at the conference and accelerate action to advance health and wellbeing of girls and women in Africa.

Facilitator: **Desta Lakew**

Dr Roopa Dhatt, Executive Director and Co-Founder, Women in Global Health, and Amref Group CEO Dr Githinji Gitahi, signed an MOU for the Africa Hub of Women in Global Health, which will be housed at Amref Health Africa. The secretariat will be headed by Dr Frasia Karua, the General Manager of Amref Enterprises Limited.

Dr Gitahi presented awards to women champions in global health:

- **Senait Fiseha Alemu, Health Extension Worker from Ethiopia.**
- **Nice Nailantei, Amref Health Africa Global anti-FGM Ambassador.**
- **Prof Miriam Were, Chancellor, Moi University.**
- **Dr Diane Gashumba, Minister for Health, Rwanda.**

COMMUNIQUE

Africa Health Agenda International Conference Declaration

WE, the participants from government, private sector, civil society, parliamentarians including youth advocates, media, health professionals and community representatives attending the third Africa Health Agenda International Conference (AHAIC) in Kigali, Rwanda from March 3-7 and comprising more than 1,800 participants from 49 countries;

HAVING shared progress and strategies on how Africa can accelerate attainment of Universal Health Coverage (UHC) under the AHAIC 2019 theme - 2030 Now: Multi-sectoral Action to Achieve Universal Health Coverage in Africa;

TAKING cognisance of the Sustainable Development Goal (SDG) targets and specifically that identifies UHC as one of the best ways to achieve the other eight health targets; the commitments made at the sixth Tokyo International Conference on African Development (TICAD VI) of 2016 rallying multi-sectoral collaboration to achieve UHC; the first World Health Organisation Africa Health Forum held in Kigali in 2017 at which African health leaders committed to keeping UHC as the overarching approach to attaining SDG3; and the 2018 Declaration of Astana, through which countries vowed to strengthen-their primary health care (PHC) systems as an essential step towards achieving UHC;

NOTE with concern that 18 years after African governments committed to allocating 15% of their annual budgets to health, only very few countries have done so;

THAT Fragile and Conflict-Affected States in particular have neither the budget nor the political or governance capacity to meet this commitment;

THAT whereas 85% of diseases can be prevented and/or treated at primary health care level, governments continue to allocate most of their health expenditure to secondary and tertiary care with little or no attention to critical areas like nutrition, despite the concomitant increases in vulnerability to infectious and non-communicable diseases, stunting, child mortality and economic losses of up to 10% of GDP; that whereas African leaders committed at the 2019 African Union Summit to increase domestic investment in health, the exorbitantly high cost of seeking health care continues to relegate 30,000 Africans to poverty daily;

THAT while Africa accounts for 11% of the world's population, 3% of the global health workforce and 1% of global health investment, it has a disproportionate 24% of the global disease burden.

WE therefore resolve that achieving UHC calls for: increasing access to health services in Africa for everyone, everywhere starting with the last first; improving the quality of services and availability of essential medicines and technology to ensure that all health care interventions are safe and effective; establishing mechanisms to guarantee adequate and sustainable publicly-led financing to avert financial hardship; strengthening accountability to safeguard transparency and efficiency at all levels and specifically people-led accountability; and improving health systems performance, leadership, governance and return on investment.

OUR CALL TO ACTION

EQUITABLE ACCESS

1. **Community Health Workers (CHWs): WE** note that community participation and ownership are the driving forces behind Universal Health Coverage, and laud the CHW models in Rwanda, Ethiopia and Liberia, which have demonstrated that adequate training, leadership, remuneration and integration of CHWs into the health system lead to improved health outcomes. **WE** therefore call on governments to make CHWs an integral and remunerated part of the formal health workforce.

2. **Indigenous Businesses:** In recognition of the important role played by indigenous businesses in enhancing sustainability of health services, especially in fragile states, **WE** call on governments to foster partnerships with and make local and other private sector players an integral part of the health system, with public sector leadership.

3. **The Youth:** Given that 70% of Africa's population is below 30 years old, it is imperative for governments to enact policies that address the needs of this segment of the population. **WE** support Youth4UHC, a youth-led movement launched at this conference with the aspiration of empowering the youth to meaningfully engage policymakers in co-creating solutions to their health needs, obtaining information and accessing sexual and reproductive health services. Nothing about the youth without the youth!

4. **Social determinants and non-discrimination:** WE acknowledge the need to address the social, political and commercial determinants of health, particularly gender inequalities, which deny disadvantaged groups equitable access to services. WE call on governments to put in place the necessary legal and policy frameworks to address the underlying determinants of risk and vulnerability among those left behind.

QUALITY

1. **Quality health services:** The success of UHC hinges on the provision of quality services to all, regardless of their social-economic status, starting with primary health care. **WE** call on governments, private sector and civil society to strengthen health systems, innovative partnerships in health, and Leadership, Management and Governance; increase the number of adequately trained health care workers; and establish performance and social accountability structures for patient and provider feedback as key elements of driving quality.

2. **Nutrition: WE** recognise the centrality of nutrition in reproductive, maternal, neonatal, child and adolescent health as well as Non-Communicable Diseases, and call on governments and all stakeholders to incorporate nutrition in the basic package of health services for UHC.

3. **Technology and Innovation: WE** acknowledge the importance of new technology for innovating and advancing health and that private sector engagement is necessary to foster the adoption of accessible and affordable science, technology and innovation to address challenges in health and accelerate attainment of UHC. **WE** call on governments and all stakeholders to put in place the requisite regulatory frameworks to enable the integration of technology into the health system.

FINANCING

WE reiterate that financing of Universal Health Coverage must be led by public resources:

1. **Health Financing: WE** call on governments to accelerate investment in health in order to reduce out-of-pocket costs to below 20% of total health expenditure; progressively fulfil their commitments to the Abuja Declaration; improve the efficiency with which resources are used through strategic purchasing; and establish monitoring mechanisms for tracking progress on these commitments. **WE** urge development partners to align to country priorities and reduce fragmentation of Official Development Assistance for health in line with the Global Action Plan.
2. **Innovative Financing:** We appreciate the successful Community-Based Health Insurance model implemented in Rwanda, which demonstrates that a multi-stakeholder risk-pooling model can be an effective avenue for financing UHC. **WE** call on governments, private sector and communities to jointly explore and implement innovative financing models, policies, legislation and resource allocation models for financing UHC. **WE** urge governments to implement innovative tax-based models - such as levying taxes on products that are harmful to health - and to plug loopholes that enable tax evasion.

ACCOUNTABILITY

1. **Transparency and Accountability: WE** call on governments to adopt suitable accountability frameworks and monitoring mechanisms for investments in UHC and to enhance transparent, inclusive and participatory budgeting. **WE** call on duty bearers to provide the right information and create mechanisms to enable local populations to take ownership of their health. **WE** call on civil society to self-coordinate their accountability efforts to ensure alignment with country and global UHC monitoring frameworks.
2. **Political Accountability: WE** call on parliamentarians and other political leaders to exercise their legislative, citizen mobilisation and representation, and oversight roles to ensure implementation of regional and global commitments that will move countries towards UHC.
3. **Inclusivity: WE** call on governments to ensure that the essential package of services provided under UHC is evidence-based, taking into consideration gender equity and other persistent vulnerabilities to guarantee broad ownership and inclusivity.

CONCLUSION

Health is a development investment, not expenditure. We must have confidence in relevant, home-grown innovations, bringing them to scale and creating more synergy across sectors. We have created a blueprint for UHC in Africa. We call on governments to go beyond political will and to take action on global, regional and local commitments, ensuring that no one is left behind.

Health is a right, and we must ensure that services are universally available, accessible, affordable and acceptable and of quality, and that they are provided without discrimination. There is no one-size-fits-all model for UHC; however, we must strengthen South-South learning and collaboration between countries.

All partners must prioritise achievement of UHC, align their activities with government strategies and plans, coordinate their efforts and jointly monitor and report on progress. Young people and communities should self-organise, participate in discussions on UHC and demand their right to health.

This Communique should feed into the multi-sectoral contribution to the UN High Level meeting on UHC in September 2019.

To download the AHAIC 2019 Communique (FRENCH; ENGLISH}.

Following the reading of the AHAIC 2019 Communique by Dr Waruguru Wanjau and Dr Magnifique Irakoze, Rwanda's Minister for Health, Dr Diane Gashumba, officially closed the conference

FINANCIAL REPORT

Africa Health Agenda International Conference 2019 received **US$1.3 Million** as sponsorship and participants registrations fees, **US$ 1.5 Million** was the expenditure towards organizing the conference which led to a total deficit of **US$0.2 Million.** (*see below illustration*)

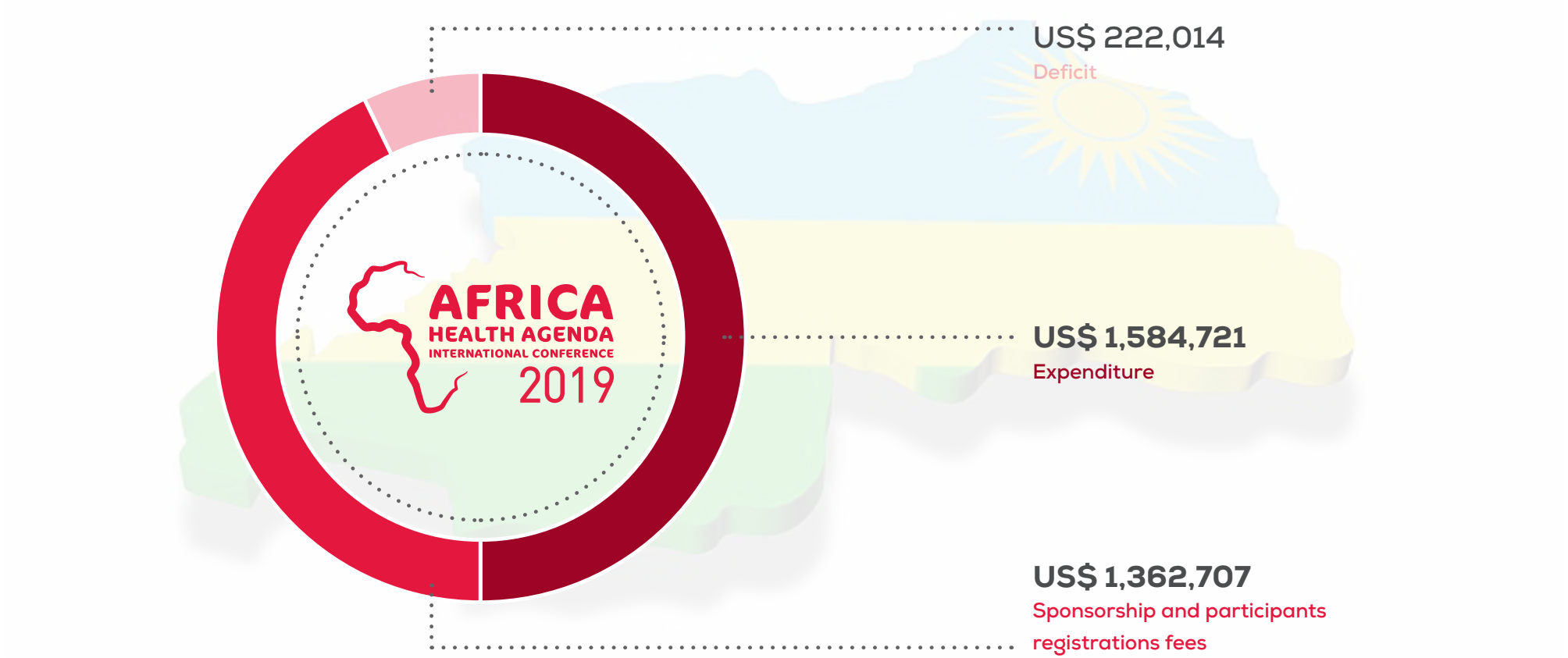

PHOTO GALLERY

For more photos of the Conference, CLICK HERE


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ANNEXES

Annex A: Sponsors

Platinum sponsors

- GlaxoSmithKline - GSK
- Swiss Agency for Development Cooperation - (SDC)

Gold Sponsors

- Access Accelerated
- Amref Flying Doctors
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- Medtronic Foundation
- Norvatis
- UN Foundation
- RAI Amsterdam Convention Centre
- NCD Alliance
- PATH
- Stop TB
- University of Rwanda

Innovation Sponsors

- Babylon
- Biomeriuex
- Planned Parenthood
- Public Health Palliative Care International - PHPCI

Annex B: List of Innovators who participated in the Innovation Marketplace

No.	Innovator	Innovation	Country
1.	Lexlink	Afya Kit (*Mobile-based health facility supervision tool for new and expectant mothers*)	Kenya
2.	Tech Care for All	Tele-medicine (ReMeDI) – telemedicine platform that allows for the obtaining of clinical and psychological parameter	Kenya
3.	Biomerieux	Multiplex Molecular Syndromic Testing – France Multiplecular Syndromic testing: Transforming early detection of outbreaks	France
4.	Babylon Rwanda	Babyl (*Digital Health Platform that facilitates medical diagnosis without need to visit a health facility.*)	Rwanda
5.	MERCK	CURAFA (*Cure and Afya*) Points of Care	Kenya
6.	NCD Alliance	Advocacy, Capacity Building and Knowledge Exchange	Switzerland/United Kingdom
7.	IPPF	Advocacy	United Kingdom
8.	Primary Health Care Performance Initiative	Advocacy & Monitoring & Evaluation of Primary Care Systems	United States of America
9.	Grand Challenges	AIR Device (*Augmented Infant Resuscitator*)	Uganda
10.	Innovate 4 Life	Innovation Hub & Business Incubator	Kenya
11.	Jacaranda Health	Model for Affordable Maternity Services – Private maternity clinics in peri-urban areas offering affordable services	Kenya
12.	MUSO Health	Proactive Community Case Management	Mali

Annex C: **Organising and Scientific Committee Members, GHS Team**

C1. Organising Committee

1. Dr Diane Gashumba, Minister for Health, Republic of Rwanda - Co-Chair
2. Dr Githinji Gitahi, Amref Health Africa - Group CEO and Co-Chair
3. Ms Mette Kjaer-Kinoti, Amref Health Africa - Chief Programmes Officer
4. Dr Meshack Ndirangu, Amref Health Africa - Country Director
5. Ms Desta Lakew, Amref Health Africa - Fund Raising
6. Dr Josephat Nyagero, Amref Health Africa - Technical Lead, Research
7. Dr Joachim Osur, Amref Health Africa - Director, Regional and Field Offices
8. Ms Elizabeth Ntonjira, Amref Health Africa - Head, Global Corporate Communications
9. Ms Evalin Karijo, Amref Health Africa – Director, Youth Advocacy
10. Ms Rose Wambui Mungai, Amref Health Africa - Finance Manager
11. Ms Gloria Nyanja, Amref Health Africa - Co-Chair, Youth Pre-Conference
12. Ms Emma Gituku, Conference Coordinator

C2. Scientific Committee

No.	Name	Designation	Role
1	Dr Josephat Nyagero	Technical Lead - Research, Amref Health Africa Headquarters	Chair
2	Prof Joachim Osur	Director of Regional Projects and Field Offices, Amref Health Africa	Vice-chair
3	Prof Stella Anyangwe	Global Health Expert/Epidemiologist, Pretoria, South Africa	Member
4	Prof Fred Wabwire-Mangen	Programme Director, Health Services Research at Makerere University School of Public Health, Uganda	Member
5	Roberta Rughetti	Head of Programmes, Amref Health Africa in Italy	Member
6	Dr Pauline Bakibinga	Associate Research Scientist, African Population and Health Research Center, Kenya	Member
7	Dr Jane Carter	Director, Clinical and Laboratory Services, Amref Health Africa	Member
8	Prof Kato Njunwa	Director of Research, Innovation and Postgraduate Studies, University of Rwanda	Member
9	Dr George Kimathi	Director, Institute of Capacity Development, Amref Health Africa	Member
10	Dr Shiphrah Kuria	Regional Programme Coordinator, Amref Health Africa Headquarters	Member
11	Dr Lilian Mbau	NCD Programme Specialist, Amref Health Africa Kenya	Member
12	Mr Johnstone Kuya	National Coordinator, SRHR Alliance Kenya	Member
13	Ms Evalin K Karijo	Youth Advocacy Director, Amref Health Africa	Member
14	Prof Jean Bosco Gahutu	Director of Research and Innovation at the College of Medicine and Health Sciences, University of Rwanda	Member
15	Dr Moses Alobo	Programme Manager, Grand Challenges Africa, African Academy of Sciences	Member
16	Dr Christopher Were	Medical Director East Africa at GlaxoSmithKline	Member
17	Emma Gituku	AHAIC Coordinator, Amref Health Africa	Member
18	Jessicar Claris	Research Assistant, Amref Health Africa	Member
19	Mercy Mutua	Research Assistant, Amref Health Africa	Member

Annex D: **Abstract Track Reviewers**

No.	Name	Affiliation	Country
1	Aanu' Rotimi	Health Reform Foundation of Nigeria	Nigeria
2	Anne Adah-Ogoh	Christian Aid	Nigeria
3	Bara Ndiaye	Amref Health Africa	Senegal
4	Bello Arkilla Magaji	Department of Community Health, CHS, UDU Sokoto	Nigeria
5	Blessing Mberu	Africa Population Health Research Center	Kenya
6	Charles Muruka	Self (Individual)	Kenya
7	Chikezie Nwankwor	University of Nigeria	Nigeria
8	Christian Mugabo	University of Rwanda	Rwanda
9	Daniel Mwai	University of Nairobi	Kenya
10	David Njuguna	Ministry of Health	Kenya
11	Deborah DiLiberto	McMaster University	Canada
12	Dennis Matanda	Population Council Kenya	Kenya
13	Dennis Wanyama	Amref Health Africa	Kenya
14	Derrick Bary Abila	Makerere university	Uganda
15	Edna Osebe	Amref Health Africa	Kenya
16	Edward Ikiugu	Marie Stopes Kenya	Kenya
17	Elizabeth Wala	Amref Health Africa	Kenya
18	Enock Marita	Amref Health Africa	Kenya
19	Evalin Karijo	Amref Health Africa	Kenya
20	George Kimathi	Amref Health Africa	Kenya
21	Gershim Asiki	Africa Population Health Research Center	Kenya
22	Gertjan van Stam	Great Zimbabwe University	Zimbabwe
23	Getnet Gedefaw	Woldia University	Ethiopia

24	Getrude Nyaaba	University of Amsterdam	Netherlands
25	Hildah Essendi	Population Services Kenya	Kenya
26	Iboro Nelson	Department of Economics, University of Uyo	Nigeria
27	Ibukun Abejirinde	Institute of Tropical Medicine	Belgium
28	Jackson Safari	Amref Health Africa	Kenya
29	James Ngumo Kariuki	Kenya Medical Research Institute	Kenya
30	Jane Carter	Amref Health Africa	Kenya
31	Janet Muriuki	IntraHealth International	Kenya
32	Jelle Stekelenburg	Medisch Centrum Leeuwarden, Universitair Medisch Centrum Groningen, Rijksuniversiteit Groningen	Netherlands
33	Joel Fred Nsumba	Brace Consults Uganda Limited, International Health Sciences University & Amref Health Africa in Uganda	Uganda
34	John Ngángá	Amref Health Africa	Kenya
35	John Njuguna	Department of Health Services, Nyeri County Government	Kenya
36	Johnstone Kuya	Sexual And Reproductive Health and Rights Alliance	Kenya
37	José Manuel Besares López	One Young World	Mexico
38	Josephat Nyagero	Amref Health Africa	Kenya
39	Leonard Cosmas	World Health Organization	Kenya
40	Leticia Buluma	Amref Health Africa	Kenya
41	Lewis Munyi	University of Science and Technology	Kenya
42	Lilian Mbau	Amref Health Africa	Kenya
43	Mable Nangami	Moi University	Kenya
44	Marlene Joannie Bewa	University of South Florida College of Public Health	United States
45	Martin Muchangi	Amref Health Africa	Kenya
46	Matheka Cyrus	Government of Makueni County	Kenya
47	Meghan Holohan	Social Solutions/USAID	United states
48	Micah Matiangí	Amref Health Africa	Kenya

49	Michael Lowery Wilson	University of Turku	Finland
50	Morris Kusotera	UK-National Health Service, UK-Prisons, UK-NMC	United Kingdom
51	Moses Alobo	Africa Academy of Sciences	Kenya
52	Mutuku Stephen Mutinda	National Aids Control Council	Kenya
53	Mwansa Nkowane	Independent Human Resources Expert	Zambia
54	Nzomo Mwita	Independent Monitoring and Evaluation	Kenya
55	Pauline Bakibinga	Africa Population Health Research Center	Kenya
56	Peter Ngure	Youth Advocacy, Amref Health Africa	Kenya
57	Peter Nyasulu	Stellenbosch University	South Africa
58	Peter Onyango	University of Nairobi	Kenya
59	Purity Mwendwa	Trinity College of Dublin	Ireland
60	Rachael Ambalu	Amref Health Africa	Kenya
61	Richard Lester	University of British Columbia	Canada
62	Roberta Rughetti	Amref Health Africa	Italy
63	Samuel Muhula	Amref Health Africa	Kenya
64	Sarah Karanja	Amref Health Africa	Kenya
65	Sharon Mokua	Kenya Medical Research Institute	Kenya
66	Shiphrah Kuria	Amref Health Africa	Kenya
66	Silvia Kelbert	Johns Hopkins Program for International Education in Gynecology and Obstetrics	United States
67	Stacie C Stender	Johns Hopkins Program for International Education in Gynecology and Obstetrics	South Africa
68	Stella Anyangwe	Independent Global Health Expert	South Africa
69	Stephen Ataro Ayella	Save the Children International	Somalia
70	Stephen Muchiri	USAID, Health Policy Plus	Kenya
71	Stephen Okumu Ombere	Maseno Univerity	Kenya
72	Stephen Tashobya	Makerere University	Uganda

73	Steven Wanyee	IntelliSOFT Consulting Limited	Kenya
74	Sylla Thiam	Sunu Sante Consulting	Senegal
75	Thomas Syre	James Madison University- Health Care Administration Program (Retired)	United States
76	Victor Adepoju	KNCV Tuberculosis Foundation	Nigeria
77	Vincent Aloo	Elizabeth Glaser Pediatric AIDS Foundation	Kenya
78	Walter Kibet	Amref Health Africa	Kenya
79	Wanjiku Kamau	Advocacy Accelerator	Kenya
80	Zaddock Okeno	Amref Health Africa	Kenya

Annex E: Rapporteurs

Session	Rapporteurs
Plenary sessions	Micah Matiang'i' (AMIU); Diana Mukami (ICD); Lilian Mbau (Kenya); Lilian Kamanzi (Uganda); Patrick Kagurusi (Uganda); Onome Ako (Canada); Joachim Osur (Regional); Shiphrah Kuria (Regional); Kenaw Gebreselassie (Ethiopia); Ronald Mawerere (Uganda; Mirre van Veen (The Netherlands); Veerle Ver Loren (The Netherlands); Dona Anyona (Regional); Martin Muchangi (Kenya); Anne Goretti Munene (Kenya); Kevin Omondi (Regional); Jackline Kiarie (ICD); Betty Muriuki (Independent); Marianne Hangelbroek (The Netherlands); Peter Waiganjo (AEL); Yeshitila Hailu (Ethiopia); Enock Marita (Kenya); Yvonne Opanga (Kenya)
Tracks	Rita Mutayoba (Tanzania); Serafina Mkuwa (Tanzania); Colleta Kiilu (ICD); Happiness Oruko (Kenya); Kenaw Gebreselassie (Ethiopia); Kioko Kithuki (Kenya); Oliver Mwalo (ICT); Judy Mwanzia (AMIU); Duncan Ager (Kenya); Diana Mukami (ICD); Anne Goretti Munene (Kenya); Fredrick Majiwa (Kenya); Nyerere Jackson (Tanzania); Aisa Muya (Tanzania); Sarah Karanja (Kenya); Lilian Kamanzi (Uganda); Mabel Jerop(M&E) Jacqueline Kiarie (ICD); Peter Waiganjo (AEL); Jane Sempeho (Tanzania); Vincent Ouma (Kenya); Mamadou Diouf (Senegal); Seraphina Mukuwa (Tanzania); Sintayehu Abebe (Ethiopia); Mercy Apanja (Kenya); Tonny Kapsandui (Uganda)
Communique	Mette Kjaer Kinoti (HQs); Dela Dovolo (Ghana); Patricia Vermeulen (The Netherlands); Florence Temu (Tanzania); Meshack Ndirangu (KCO); Fredrick Kateera (Rwanda), Kibachio Joseph Mwangi (Kenya); Elizabeth Ntonjira (HQs); Clarisse Musanabaganwa (Rwanda); Patrick Migambi (Rwanda);
Poster presentations	Vincent Magombo (Malawi); Joel Fred Nsumba (Uganda); Kassahun Negash (Ethiopia); Mirre Van Veen (The Netherlands); Madaliso Tolani (Malawi); Sintayehu Abebe (Ethiopia); Miriam Chege (Kenya); Jane Carter (AMIU); Boniface Hlabano (Malawi); Amos Nyirenda (Tanzania); Dorieke Kuijpers The Netherlands); Sarah Kosgei (ICD); Roberta Rughetti (Italy); Andrew Wabwire (Kenya); Veerle van Loren van Themaat (The Netherlands); Hajra Mukasa (Uganda); Benson Ulo (Kenya); Edwin Kilimba (Tanzania); Shiphrah Kuria (Regional); Elizabeth Wala (KCO); Marianne Hangelbroek (The Netherlands); Margaret Mugisa (Uganda); Gilbert Wangalwa (KCO); Kulule Mekonnen (Ethiopia)
Chief Rapporteur	Donald Odhiambo
Lead Rapporteur	Betty Muriuki

Annex F: Partner sessions held during the AHAIC 2019 in Kigali Rwanda

No.	Organisation	Title of Session
1	Africa Media Network on Health (AMNH)	Africa Media Network on Health (AMNH) Excellence in Health Journalism Award
2	African Institute for Development Policy (AFIDEP) and the African Academy of Sciences (AAS)	Expanding Leadership in Evidence Informed Decision-Making in Africa
4	African Palliative Care Association (APCA) and the World-wide Hospice Palliative Care Alliance (WHPCA) among other chapters	Putting Patient-Centred Care and Human Dignity at the Heart of Universal Health Coverage: the Central Role of Palliative Care
5	African Population and Health Research Center	How Can Health Systems Engage Communities to Achieve Universal Health Coverage?
6	African Population and Health Research Centre (APHRC)	Leaving No one Behind: The Journey to 2030 Starts Now
7	Amref Enterprises (i-PUSH)/ PharmAccess foundation	Innovative Partnership for Universal and Sustainable Health care (i-PUSH):
8	Amref Enterprises Limited/Takeda/ PHFI	Driving UHC in Asia and Africa through Community-led Innovation
9	Amref Health Africa Regional & Amref Flying Doctors Netherlands	Amref Health Africa WASH VISION
10	Amref Health Africa, Royal Philips, FMO Dutch Development Bank, Makueni County	Revolutionise Primary Care through Public Private Cooperation
11	Amref Health Africa-Netherlands, Royal Philips and FMO Dutch Development Bank	Private Investment in Community and Primary Care
12	Amref Netherlands	Public Primary Care in achieving Universal Health Coverage and SDG 3
13	Amref Netherlands	Turning a Global Momentum Into Local Action: The Role of Community Health Workers in Achieving Universal Health Coverage

14	BroadReach	How can organizations leverage technology to enhance access and collective accountability?
15	Buffet Foundation	Achieving UHC by Strengthening Sexual and Reproductive Health and Rights
16	City Cancer Challenge Foundation	The Power of Partnerships: Driving Sustainable Cancer Care Solutions in Cities
17	Deloitte, on behalf of FP2020 Core Conveners	A Discussion on Family Planning Post-2020
18	EHAI Nigeria	EASE Model for Community-Based Social Insurance Programme (CBSHIP): An Efficient Approach to Achieving UHC2030
19	Elsevier Foundation and Amref Health Africa	Catalysing African Health Tech Solutions in Africa: What's Needed To Generate and Scale Innovations?
20	Elsevier Health	Impact Medical Education and Clinical Practice with the Power of Clinical Key
21	European Parliamentary Forum on Population & Development (EPF), African Parliamentary Forum on Population and Development (FPA)	Role of Parliamentarians In Advancing UHC (MPs Session) MPs Consultation / Briefing on Parliamentarians UHC Handbook
23	General Electric (GE) Healthcare	Democratizing Healthcare Through Innovative Primary Healthcare Delivery Models
24	Global Health Strategies (GHS)	Immunization in Fragile and Conflict-Affected States (FCAS) in Africa: From conflict and fragility to investing in health – The Case of Immunization
25	GSK and the Institute of Capacity Development at Amref Health Africa	Harnessing the Role of Health Workers in Achieving UHC
26	Health Systems Advocacy (HSAP) Partnership (Amref Health Africa, ACHEST, Health Action International, Wemos and the Dutch Ministry of Foreign Affairs)	A Story Telling Event by African and International Civil Society: Dialogues to Accelerate the UHC Agenda at Local, National, Regional and Global Level
27	Institute of Capacity Development at Amref Health Africa	Enabling Continuous Professional Development for Mid-Level Health Workers in Africa
28	International Planned Parenthood Federation Africa Region (IPPFAR)	UHC: Leaving No One Behind. How Far Are We?
29	IntraHealth	SwitchPoint Exchange: Health Data, Activism, Art, Communication and Unusual Collaborations
30	Jhpiego	Client-Centered Primary Health Care: How Do We Get There?

31	Last Mile Health	Committing to Community Centred UHC: Advocacy in Action
32	NCD Alliance	UHC Responses to the Urgent Challenge of Multi-Morbidity and NCDs
33	Nutrition International	Nutrition as a Critical Component of Universal Health Coverage
34	PATH	Innovation in Action to Achieve Health for All
35	PATH and Amref Health Africa	Social Accountability for UHC
36	Primary Health Care Performance Initiative (PHCPI)	Advancing Primary Health Care: African Leadership and Accountability on the Road to UHC
37	Results for Development and Amref Health Africa	SPARC the Change: Bridging the Resource Gap for UHC in Africa through Strategic Purchasing
38	Roche East Africa	Integrating Cancer into UHC Agenda in Africa, Cancer Symposium
29	Sida/Regional SRHR Team, Embassy of Sweden, Lusaka; UNFPA East and Southern Africa Regional Office	Achieving UHC by Strengthening Sexual and Reproductive Health and Rights
40	Stop TB Partnership, The Global Fund and Amref Health Africa	High level TB Symposium: Translating Commitments Made at the United Nations High Level Meeting on Tuberculosis (UNHLM) into Country Actions
41	Swiss Development Agency, Roche, MSH	FCAS: Delivering UHC in Frontier Economies – Multi-sectoral Approaches
42	The development Research and Project Centre PACFaH@Scale Project (dRPC – PAS) Nigeria	Unlocking the Potential Universal Health Coverage as a Domestic Resource Base to Meet Child and Family Health Funding Gaps in Nigeria
43	UHC2030 / CSEM	Civil Society Consultation in Preparation for the High Level Meeting (HLM) on Universal Health Coverage
44	UN Foundation, UHC2030, World Economic Forum (WEF), UN Global Compact and Amref Health Africa	Why UHC Matters for Business: High-Level Private Sector Consultation
45	UNFPA	Launch of Youth-Led Accountability
46	United States Pharmacopeia (USP)	Expanding Access to Safe, Quality Medicines to Achieve Universal Health Coverage in Africa
47	VESTERGAARD and RBM	Achieving Malaria Elimination to Reach Universal Health Coverage

Annex G: **List of Participants**

For the list of participants, CLICK **HERE**

Annex H: **Book of Abstract**

For the Ibook of Abstracts, CLICK **HERE**

Annex I: **Young Researchers' Scholarship Awardees**

No.	Name	Affiliation	Country	Scholarship
1	Aboagye Vincent	University of Education, Winneba	Ghana	Full scholarship
2	Adekunle Z. Ademiluyi	University of Lagos, Nigeria	Nigeria	Full scholarship
3	Benson Bryceson Mringo	Hubert Kairuki Memorial University	Tanzania	Full scholarship
4	Bvuchete Munyaradzi	Stellenbosch University	South Africa	Full scholarship
5	Diltokka Gideon	Ahmadu Bello University,	Nigeria	Full scholarship
6	Getnet Gedefaw Azeze	Woldia University	Ethiopia, Addis	Full scholarship
7	Giulia Perrone	School of Law and Human Rights Centre, University of Essex, Wivenhoe Park, Colchester	Italy, Rome	Full scholarship
8	Godfred Acheampong	Kumasi Centre for Collaborative Research in Tropical Medicine	Ghana	Full scholarship
9	Jacob Albin Korem Alhassan	University of Saskatchewa, Canada	Ghana/ Studying in Canada	Full scholarship
10	Karl Njuwa	Ibal Sub-divisional Hospital, Oku, Northwest Region, Cameroon	Cameroon	Full scholarship
11	Liberty Christopher	Kabale Women in Development (KWID)- Amref funding	Uganda	Full scholarship
12	Lucky Gondwe	Village Reach	Malawi, Lilongwe	Full scholarship
13	Muganhiri Darren	University of Pretoria	South Africa/ Zimbabwe	Full scholarship
14	Mutala Abdul-Hakim	Kwame Nkrumah University of Science and Technology	Ghana	Full scholarship
15	Namanou Ines Emma	Faculty of Medicine and Biomedical Sciences, University of Yaoundé I, Cameroon	Cameroon	Full scholarship
16	Ngwene Hycentha	Institute of Medical Research and Medicinal	Cameroon	Full scholarship
17	Sarah Njenga	London School of Economics and Political Science	Kenya/ British (Reside in London)	Full scholarship
18	Stephen Ogweno	Kenyatta University	Kenya	Full scholarship
19	Stephen Okumu	Maseno/ University of Bern, Switzerland	Kenya	Full scholarship

20	Tanya Muchemi	Amref International University	Kenya	Full scholarship
21	Tao Issoufou	University of Oaugadougou	Burkina Fasso	Full scholarship
22	Themba Ginidza	University of KwaZulu-Natal	South Africa	Full scholarship
23	Elizabeth Wangia	MOH	Kenya	Partial scholarship, Excluding registration fee
24	Evelyne Mulunji	Ministry of Health	Kenya	Partial scholarship, Registration only
25	James Atito	Stretchers	Kenya	Partial scholarshi, Excluding flight
26	Joshua Limo	Kenya Association for the Prevention of Tuberculosis and Lung Diseases	Kenya	Partial scholarship, Excluding registration fee
27	Jyer Stiven	Association Congolaise pour le Bien Etre Familial – ACBEF, Congo	Congo	Partial scholarship, Registration only
28	Olivia Otieno	Network for Adolescents and Youths of Africa, NAYA	Kenya	Partial scholarship, Excluding registration fee
29	Susan Kivondo	Ministry of Health	Kenya	Partial scholarship, Registration only
30	Andrew Muhire	Rwanda Ministry of Health	Rwanda	Partial scholarship, Registration only
31	Basuayi Christine	Medical doctor	Rwanda	Partial scholarship, Registration only
32	Blaise Ntacyabukura	University of Rwanda	Rwanda	Partial scholarship, Registration only
33	Clement Byiringiro	University of Rwanda	Rwanda	Partial scholarship, Registration only
34	Diogene Rurangwa	Ministry of Health, Rwanda	Rwanda	Partial scholarship, Registration only

35	Edward Kamuhangire	Ministry of Health, Rwanda	Rwanda	Partial scholarship, Registration only
36	Emeline Umutoni Cishahayo	University of Rwanda	Rwanda	Partial scholarship, Registration only
37	Emile Tuyishime	Rwanda Ministry of Health	Rwanda	Partial scholarship, Registration only
38	Emmanuel Ndikubwayo	University of Rwanda, Kigali, Rwanda	Rwanda	Partial scholarship, Registration only
39	Eric Twizeyimana	Medical Students' Association of Rwanda, University of Rwanda	Rwanda	Partial scholarship, Registration only
40	Eugene Tuyishime	University of Rwanda	Rwanda	Partial scholarship, Registration only
41	Francine Umutesi	Director General, Rwanda Biomedical Centre	Rwanda	Partial scholarship, Registration only
42	Harerimana Ingabire Eliane	University of Rwanda	Rwanda	Partial scholarship, Registration only
43	Innocent Ndikubwimana	University of Rwanda	Rwanda	Partial scholarship, Registration only
44	Jean Baptiste Sagahutu	University of Rwanda, College of Medicine and Health sciences	Rwanda	Partial scholarship, Registration only
45	Jean Damascene Iyamuremye	Rwanda Biomedical Center	Rwanda	Partial scholarship, Registration only
46	Lauben Rubega	University of Rwanda, College of Medicine and Health Sciences	Rwanda	Partial scholarship, Registration only
47	Leopold Bitunguhari	Department of Internal Medicine, School of Medicine and Pharmacy, University of Rwanda	Rwanda	Partial scholarship, Registration only
48	Maguy Mbabazi	Department of internal medicine, School of Medicine, University of Rwanda, Kigali, Rwanda	Rwanda	Partial scholarship, Registration only
49	Ndahimana Jean d'Amour	Partners In Health	Rwanda	Partial scholarship, Registration only

50	Ngendahayo Emmanuel	University of Rwanda	Rwanda	Partial scholarship, Registration only
51	Ntambara Kanyangira Nelson	Kigali university teaching hospital	Rwanda	Partial scholarship, Registration only
52	Nyirabanguka Chantal	University of Rwanda	Rwanda	Partial scholarship, Registration only
53	Richard Kalisa	Ruhengeri hospital, Rwanda	Rwanda	Partial scholarship, Registration only
54	Rutayisire Benjamin	Ministry of Health, Rwanda	Rwanda	Partial scholarship, Registration only
55	Uwase Nadege Munyaburanga	Kigali Hope Association (KHA)	Rwanda	Partial scholarship, Registration only
56	Valens Maniriho	Ruhengeri Referral hospital	Rwanda	Partial scholarship, Registration only