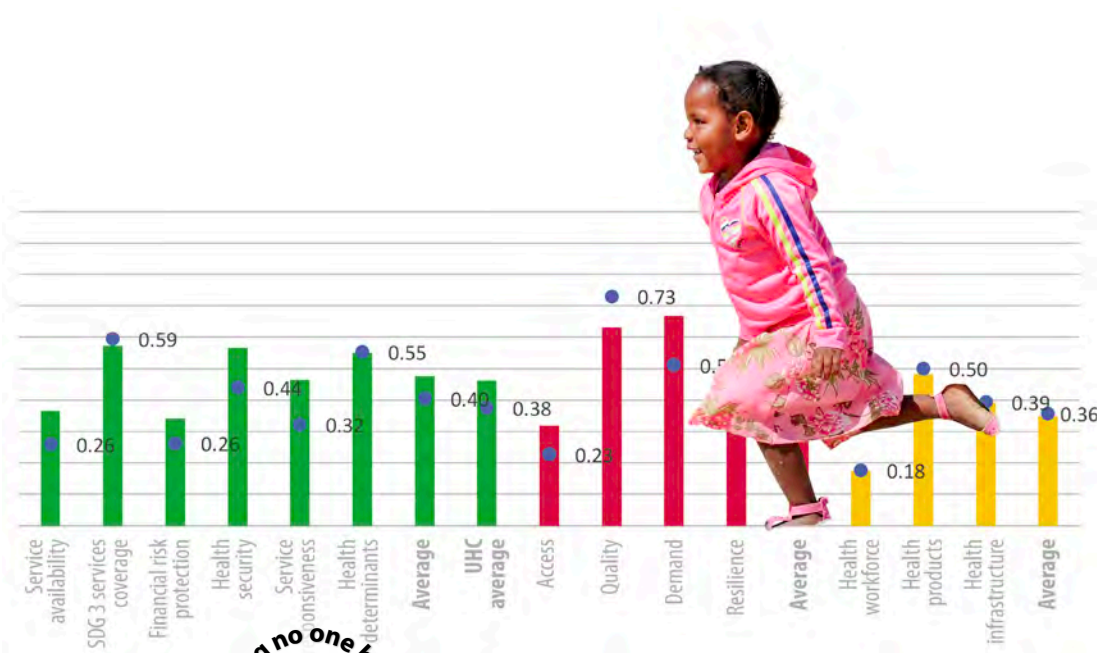


Implementing HEALTH OBSERVATORIES in the WHO African Region



A country toolkit for action



Framework of Actions
for UHC in the context of the SDGs
IMPLEMENTATION TOOLKIT SERIES



Implementing health observatories in the WHO African Region

A country toolkit for action



Framework of Actions
for UHC in the context of the SDGs
IMPLEMENTATION TOOLKIT SERIES

Implementing health observatories in the WHO African Region: A country toolkit for action. Leaving no one behind in Africa

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Abbreviations and acronyms

ADW	AFRO Data Warehouse
AHO	African Health Observatory
GHO	Global Health Observatory
HSS	Health system strengthening
M&E	monitoring and evaluation
MPHO	medic products of human origin
NHO	National health observatory
RC	Regional committee for Africa
SDGs	Sustainable development goals
UHC	universal health coverage
WHO	World Health Organization

Background

Health observatories are online tools that are used to bring together various stakeholders with different skills and capacities in order to respond to common problems. In the African Region, the observatory concept was first implemented in 2011 with the establishment of the African Health Observatory (AHO), further to recommendations from the 2008 Ouagadougou and Algiers declarations¹, subsequently endorsed at the Fifty-eight and the Fifty-ninth session of the Regional Committee for Africa (RC58, RC59). The African Health Observatory was seen as an online repository of reliable data, information and knowledge for decision makers with, as its core function, the assessment of progress and performance of priority health indicators for the Region. The AHO has three key components: A web portal; the AFRO Data Warehouse (ADW); and a networking platform. It was envisioned that the AHO would perform four functions:

1. **Marshalling** all relevant data on health available at the national level, by developing a platform for gathering and organizing relevant data sets from various sources.
2. Data **analysis** and synthesis, integrating data into a comprehensive view of health and its determinants.
3. **Sharing** data and health information to support decision making. This includes sharing of analysis reports and linkages with other platforms
4. **Networking**, to build partnerships and provide coordination between multiple stakeholders involved in the health system.

In 2012, at the Sixty-second session of the Regional Committee for Africa (RC62), the WHO Regional Office for Africa was asked to support countries in establishing national health observatories (NHOs). NHOs are to serve as a one-stop-shop for all relevant health data and information at the national level, and are expected to carry out the same function as the AHO. During a first phase, nine NHO prototypes were developed. Lessons from this effort were used in a second phase that is still ongoing, with eight new NHOs supported in Burkina Faso, Cameroon, the Democratic Republic of the Congo, Ghana, Kenya, Rwanda, Uganda and the United Republic of Tanzania. The concept, however, is still facing several challenges, as highlighted below.

Table 1. Key challenges with implementing the observatory functions in the African Region

Function	Status	Issues / challenges faced by the observatory
Marshalling	<ul style="list-style-type: none"> ◆ Reliance on the Global Health Observatory for data, with duplication of GHO contents by the AHO ◆ Country data are incomplete and not updated ◆ WHO cross program collaboration in the African Region is not leading to real-time data sharing 	<ul style="list-style-type: none"> ◆ No mechanism for real-time / regular surveillance for new data ◆ Reliance on country mechanisms to update new data, which is not always given priority ◆ Inadequate capacity to carry out surveillance for new data across the Region ◆ Obsolete and rigid software ◆ Weak capacity for data validation ◆ No effective links with some data sources– such as research institutions, civil registration systems, others ◆ Inadequate mechanisms for sharing data within WHO – use of Hinari / GIFT, data from disease programs, etc.
Analysis	<ul style="list-style-type: none"> ◆ Primarily ongoing data synthesis ◆ Focus is on specific indicator trends, not on integrated analyses 	<ul style="list-style-type: none"> ◆ Limited capacity for analysis, with focus limited to reproducing statistics ◆ No agreed integrated analysis lines – in line with UHC and SDGs
Sharing	<ul style="list-style-type: none"> ◆ Passive sharing (reliant on visits to the web portal) 	<ul style="list-style-type: none"> ◆ Country profiles produced from the data, but irregularly updated
Networking	<ul style="list-style-type: none"> ◆ Passive networks, with limited interaction or technical discussions 	<ul style="list-style-type: none"> ◆ Networks are missing some key institutions / individuals ◆ People

¹ Ouagadougou Declaration on Primary Health Care and Health Systems in Africa: Achieving Better Health for Africa in the New Millennium. Brazzaville: WHO Regional Office for Africa; 2008 and The Algiers Declaration: Ministerial Conference on Research for Health in the African Region. Brazzaville: WHO Regional Office for Africa; 2009.

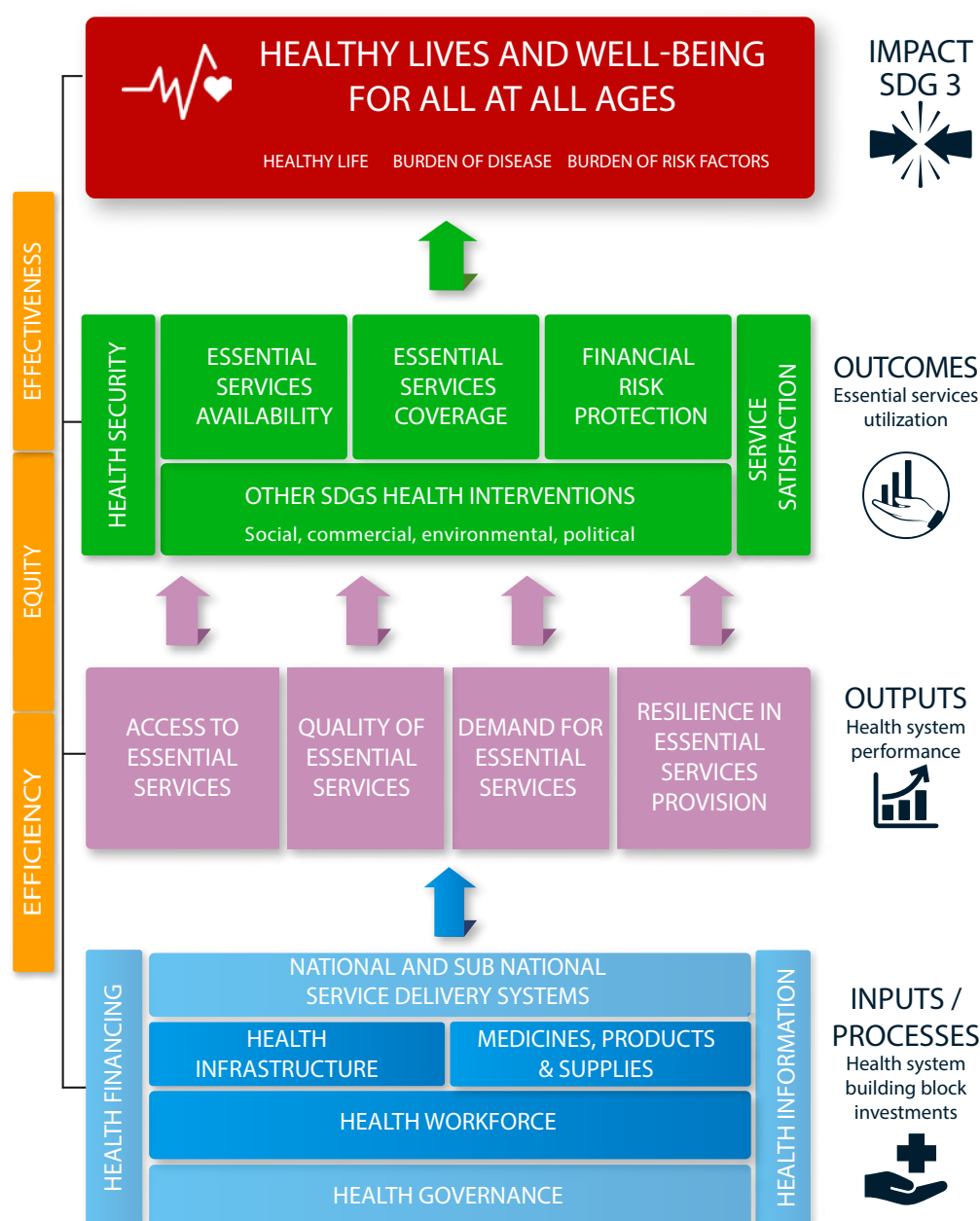
With the current focus on UHC, the need for health intelligence to inform a country's actions is more acute than before. As such, the AHO and NHOs need to be aligned with the expectations regarding the management UHC and SDGs knowledge. Reforms are being put in place to accelerate the use of observatories in the Region.

Moving forward, the following sections describe the design and processes that are proposed to enable health observatories to support information and knowledge management for UHC and other health and health-related SDGs in the WHO African Region.

Focus of National Health Observatories

1. National health observatories should consolidate their work around the four domains and related dimensions of the HSS *Framework of Actions*².

Figure 1. Domains and dimensions from the Framework for health systems development towards universal health coverage in the context of the SDGs in the African Region (the Framework of Actions)



² Sixty-seventh session of the Regional Committee for Africa, Victoria Falls, Republic of Zimbabwe, 28 August–1 September 2017. Framework for health systems development towards universal health coverage in the context of the Sustainable Development Goals in the African Region. AFR/RC67/10. Brazzaville: WHO Regional Office for Africa; 2017. (http://www.afro.who.int/sites/default/files/2017-12/UHC%20framework_eng_2017-11-27_small.pdf accessed on 15 March 2018).

The dimensions around which the observatory is to be designed are shown below:

Table 2. Domains and dimensions of health observatories

Domain	Dimensions
Impact – Healthy life and well-being	Healthy life status
	Incidence, prevalence and mortality of disease conditions of national concern
	Incidence, prevalence and mortality contribution by major risk factors of national concern
	Morbidity and mortality information (burden of disease)
Outcomes – Health service outcomes	Availability of essential services (service availability by age cohort)
	Coverage of preventive, promotive and curative essential interventions addressing SDG 3 targets
	Financial Risk Protection
	Health security
	Coverage of social, economic, environmental and political SDG targets influencing health and well-being
	Responsiveness of available services to users' expectations
Outputs – Health system responsiveness	Access to essential services
	Quality of essential services
	Effective demand for essential services
	Resilience of the system to external shocks
Health system investments	Health workforce
	Health infrastructure , including transport, ICT and equipment
	Health products , vaccines, medical products of human origin (MPHOs) and traditional products
	Health governance and partnership arrangements
	Health delivery and organization systems
	Health information systems
	Health financing systems

- Observatories will provide three core products: Health statistics; health Information; and health intelligence. Each dimension outlined above will consist of relevant statistics, information and knowledge that is relevant.

Figure 2. Figure 2: National health observatories focus



- ▶ Health statistics identifies indicators to provide guidance on each dimension. A target of five or more indicators should be selected for each dimension. A menu of suggested indicators can be found in Appendix 1. For each indicator, the NHO will present trend and distribution data.
- ▶ Health information presents an analytical profile of the statistics for each dimension over five areas:
 - ◆ Consolidating an index for each dimension, with its trends and distribution
 - ◆ Contextualizing achievement in each dimension's index – by comparing it to demographic, social, political and cultural information
 - ◆ Predicting the achievement of a dimension in relation to its overall domain
 - ◆ Predicting the achievement of a dimension in relation to the next domain
 - ◆ Ascribing the achievement of a dimension to the overall health and well-being
- ▶ Health knowledge presents key intelligence products relating to a dimension. The se knowledge tools are of three forms:
 - ◆ Best / good practices relating to the dimension;
 - ◆ Policy briefs responding to critical policy questions relating to the dimension; and
 - ◆ Repository of tools and guidelines relating to the dimension of the *Framework of Actions*.

National health observatories outputs

A national health observatory should be providing the following products to a country:

1. Statistics products:
 - a. A comprehensive, up-to-date repository of data on all indicators selected by a country, organized according to the dimensions of the Framework of Actions. This should be the most comprehensive dataset of the country
 - b. Figured and maps on trends and distribution for the indicators selected by the country
2. Information products:
 - a. A comprehensive analytical profile for each dimension defined in the Framework of Actions, updated as statistics are updated
3. Knowledge products
 - a. A repository of policy briefs to respond to key policy questions or issues
 - b. A compilation of good and best practices relating to each dimension of the Framework of Actions
 - c. A repository of tools and guidelines relating to each dimension of the Framework of Actions

Process to make the health observatory components functional

Each country needs to plan and develop its own roadmap to build its observatory, in line with this comprehensive outline. An overview of the steps needed for this process is as follows:

- i) Identify / review the governance arrangements, focusing on oversight and management teams. These functions should be separated as shown below

Table 3. National health observatory governance teams

Oversight team		Management team	
Purpose	Possible members	Purpose	Possible members
Provide overall oversight to the observatory, and disseminate its emerging products	<ul style="list-style-type: none"> ◆ Head: Highest level technical decision maker in the health sector ◆ Technical leads in health focused academic institutions ◆ Decision makers from external partners that support statistics, information or knowledge areas ◆ Decision makers from national institutions responsible for statistics ◆ Representative of civil society / the public 	Guide development of the observatory products	<ul style="list-style-type: none"> ◆ Head: MOH official appointed by the highest level technical decision maker ◆ Representatives from each MOH programme ◆ Representatives from each MOH system investment area ◆ Representatives of health focused academic institutions ◆ Representatives of external partners supporting statistics, information or knowledge areas ◆ Representatives from the national institute responsible for statistics

- ii) Convene the (revamped) oversight and management teams to review / agree on terms of reference to facilitate the operation of the observatory at least in its first year.
- iii) Identify member(s) of the management team with the overall responsibility for sections of the observatory. It is recommended to have five such members, each responsible for an area: statistics, information and the different knowledge products (policy briefs, best practices and consolidation of toolkits).
- iv) Deliberate and agree on the indicators selected for each dimension of the Framework of Actions by the management team. The choice of indicators should be informed by:
 - a. Whether it is an SDG monitoring indicator. All SDG monitoring indicators should be included, unless the country has decided not to report on a given indicator.

- b. Whether it is an indicator from the Global Reference List of 100 Core Health Indicators³. Where feasible, these should be included.
 - c. Whether it has already been identified by the country as an indicator for monitoring the sector. Appendix 1 provides a set of indicator choices for each dimension of the Framework of Actions.
- v) For each indicator selected, agree on the sources for the data and the method of collection.
- a. For many indicators, the country M&E process should have already identified the sources.
 - b. For indicators for which 'scores' are identified (See Appendix 2 for how to derive the scores), the key informants that will provide the information to generate the country scores should also be identified. It is recommended that these represent academia, MOH, other government institutions and the private sector.
 - c. An annual formal verification process should be specified, during which the data for all the indicators (including scores) are reviewed and confirmed as being representative of the country's results. This should be done by the management team.
- vi) Identify the persons in the management team to be responsible for defining and producing the analytical profiles and knowledge products.
- a. For each dimension of the Framework of Actions, responsible persons on the management team could contract out to knowledgeable firms / individuals the initial elaboration, then the subsequent updates (at least once per quarter) of the analytical profiles and knowledge products.
 - b. Policy questions from key decision makers should be collated from the oversight team. Policy briefs responding to each question (see outline in Appendix 3) should be assigned to different members of the management team, and their elaboration done with support of academic institutions.
 - c. Potential best practice areas for each dimension of the Framework of Actions should be identified and documented in line with the guidance in Appendix 4: Outline for documenting best practices.
 - d. The management team should coordinate the collation of all tools and guidelines available for each dimension of the Framework of Actions in the country.

³ Global Reference List of 100 Core Health Indicators (plus health-related SDGs), 2018. <http://apps.who.int/iris/bitstream/10665/259951/1/WHO-HIS-IER-GPM-2018.1-eng.pdf?ua=1>

ANNEXES

Annex 1 Menu of indicators for each domain and dimension of the Framework of Actions

Annex 1.1 Health impact domain: indicators for health and well-being for all, at all ages

Construct	Indicator
Expectation of life	Life expectancy
	Healthy life expectancy
Incidence of key health conditions	HIV
	Tuberculosis
	Cancer (all causes)
	Chronic obstructive pulmonary diseases
	Diabetes
	Stroke/CVD
	Road traffic events
Prevalence of key health conditions	HIV/AIDS
	Tuberculosis
	Malaria
	NTDs (total number of persons)
	Cancer (all causes)
	Chronic obstructive pulmonary diseases
	Diabetes
	Stroke/heart disease
Road traffic events	
Prevalence of key health risk factors to health	Alcohol abuse (adolescents)
	Obesity (children/adolescents)
	Physical inactivity (adolescents)
	Stunting (children)
	Tobacco use (over 15 years of age)
Annual deaths (mortality) due to key health conditions	HIV/AIDS
	Tuberculosis
	Malaria
	NTDs (total number of persons)
	Cancer (all causes)
	Chronic obstructive pulmonary diseases
	Diabetes
	Stroke/heart disease
Road traffic events	
Mortality rates	Maternal mortality rate
	Neonatal mortality rate
	Under 1 mortality rate
	Under 5 mortality rate
	Adolescent mortality rate
	Adult mortality rate
	Crude death rate

Annex 1.2 Health outcome domain: indicators for health and health-related services

Dimensions	Indicator
Availability of essential services	Service availability index
	Population within 5km of a health facility
	Health facilities (per 10,000 population)
	Number of hospital beds (per 10,000 population)
	Mothers and newborns essential services availability score
	Childhood essential services availability score
	Adolescents essential services availability score
	Adults essential services availability score
	Elderly persons essential services availability score
	Number of trained health professionals per 10,000 population
Coverage of essential interventions	Health Promotion Interventions
	Demand satisfied with modern methods in women aged 15 – 49 years who are married or in a union
	Prevalence of smoking amongst adolescents
	Proportion of children stunted
	Alcohol consumed per capita (above 15 years old)
	Adolescent birth rate
	Exclusive breastfeeding rate
	Road traffic events
	Communicable disease control interventions
	Tuberculosis effective treatment coverage
	People with HIV receiving antiretroviral therapy
	Population at risk who sleep under insecticide-treated bed-nets
	Households with access to at least basic sanitation
	DTP-3 coverage
	Number of persons receiving interventions against NTDs
	Non communicable disease control interventions
	Prevalence of raised blood pressure
	Mean fasting plasma glucose (mmol/L)
	Cervical cancer screening in women aged 30 – 49 years
	Adults aged at least 15 years who had not smoked tobacco in the past 30 days
	Curative interventions
	Outpatient utilization rate (new OPD visits per person)
	Skilled birth attendance rate
	Children who are wasted
	Caesarian section rate
	Institutional mortality rate
	Financial risk protection
General Government Health Expenditure (GGHE) as % of Total Health Expenditure	
Out of Pocket spending as % of Total Health Expenditure	
Domestic financing as % of Total Health Expenditure	

Dimensions	Indicator	
Coverage of non-SDG 3 targets	Social determinants	
	Coverage (%) - All Social Assistance	
	Prevalence of stunting in children under 5 u (%)	
	Prevalence of wasting in children under 5 u (%)	
	Prevalence of overweight in children under 5 u (%)	
	Primary education, duration (years)	
	Lower secondary completion rate, total (% of relevant age group)	
	Primary completion rate, total (% of relevant age group)	
	Secondary education, duration (years)	
	Preprimary education, duration (years)	
	School enrollment, preprimary (% gross)	
	Female genital mutilation prevalence (%)	
	Economic determinants	
	Annualized average growth rate in per capita real survey mean consumption or income, total population (%)	
	GDP growth (annual %)	
	Unemployment, total (% of total labor force) (modeled ILO estimate)	
	Access to electricity (% of population)	
	Individuals using the Internet (% of population)	
	Proportion of seats held by women in national parliaments (%)	
	Environmental determinants	
	Proportion of population using improved drinking-water sources v (%)	
	Proportion of population using improved sanitation v (%)	
	People practicing open defecation (% of population)	
	Annual mean concentrations of fine particulate matter (PM _{2.5}) in urban areas x (µg/m ³)	
	Average death rate due to natural disasters y (per 100 000 population)	
	Political determinants	
	Mortality rate due to homicide z (per 100 000 population)	
	Estimated direct deaths from major conflicts aa (per 100 000 population)	
	Children in employment, total (% of children ages 7-14)	
	Completeness of birth registration (%)	
	Net official development assistance received (current US\$)	
	Service satisfaction	Dignity score
		Autonomy score
Confidentiality score		
Prompt attention score		
Access to social support networks score		
Quality of basic amenities score		
Choice of care providers score		
Health security	National Legislation, Policy and Financing score	
	IHR Coordination, Communication and Advocacy score	
	Antimicrobial Resistance (AMR) score	
	Zoonotic Disease score	
	Food Safety score	
	Biosafety and Biosecurity score	
	Immunization score	
	National Laboratory System score	
	Real Time Surveillance score	
	Reporting score	
	Workforce Development score	
	Preparedness score	
	Emergency Response Operations score	
	Linking Public Health and Security Authorities score	
	Medical Countermeasures and Personnel Deployment score	
	Risk Communication score	
	Points of Entry (PoE) score	
Chemical Events score		
Radiation Emergencies score		

Annex 1.3 Health output domain: indicators for health system performance

Dimension	Indicator
Access to essential services	Proportion of population living within 5km of a health facility
	Outpatient utilization per capita
	Inpatient admission per capita
	Health facilities per 10,000 persons
	In patient bed density
Quality of care during provision of essential services	General service readiness index
	TB cure rate
	Peri-operative mortality rate
	ART retention rate
	Institutional maternal mortality rate
Effective demand for essential services	Fresh still birth rate
	DTP dropout rate (DTP1 – DPT3)
	ANC dropout rate (ANC1 – ANC 4)
	ANC 1: SBA drop out (ANC1 – SBA)
	SBA : PNC dropout (SBA – PNC)
	DTP3: measles dropout (DPT3 – measles)
	TB treatment completion rate
ART adherence rate	
Health system resilience	Awareness score
	Diversity score
	Versatility and self-regulating score
	Deployment and mobilization score
	Transformation score

Annex 1.4 Health input/process domain: indicators for health system investments

Dimension	Indicators
Health workforce	Physicians density (per 1000 population)
	Nursing and midwifery personnel density (per 1000 population)
	Dentistry personnel density (per 1000 population)
	Pharmaceutical personnel density (per 1000 population)
	Laboratory health workers density (per 1000 population)
	Environmental and public health workers density (per 1000 population)
	Community health workers density (per 1000 population)
	Health management & support workers density (per 1000 population)
	Overall health worker attrition rate
	Health workforce attributes score
Health products, including vaccines and MPHOs	Diagnostics readiness
	Essential medicines readiness
	Pharmaceutical expenditure as percentage of Total Health Expenditure (THE)
	Pharmacists per 10 000 population
	Average number of medicines prescribed per patient contact in public health facilities
	Percentage of medicines prescribed in outpatient public health facilities in the national essential medicines list
	Percentage of medicines prescribed in outpatient facilities prescribed by international non propriety names
	Percentage of patients in outpatient public health facilities receiving antibiotics
	Percentage of adequately labelled medicines in outpatient public health facilities
	Blood donation rate per 1000 population
Health products attributes score	
Health infrastructure, including equipment, transport and ICT	Health infrastructure readiness
	Availability of basic amenities
	Availability of basic equipment
	Total density per 100 000 population: Hospitals
	Total density per 100 000 population: Health posts
	Total density per 100 000 population: Health centres
	Total density per 100 000 population: District/rural hospitals
	Hospital beds (per 10 000 population)
	Health infrastructure attributes score
Service delivery systems	Standards score
	Essential package score
	Supervision score
	Services organization score
	Services management score
	Service quality and safety score
Health governance	Organizational arrangement score
	Stewardship score
	Accountability score
	Policy and legal score
	Partnerships score
	Corruption control score
Health information	Data generation score
	Data validation score
	Data analysis score
	Information dissemination score
	Knowledge translation score
Health financing	Financing policy, regulatory and legal systems score
	Financial management and accountability systems score
	Institutional arrangements score
	Evidence generation for health financing score

Annex 2 Attributes for deriving scores across the Framework of Actions



Annex 2.1 Attributes relating to health and health-related outcomes

Availability of essential services score

Construct	Attribute
Pregnancy & newborn services	Antenatal care services
	Perinatal care services
	Care for the newborn
	Postnatal care services
Childhood services	Childhood immunization
	Child nutrition (under and over)
	Treatment and rehabilitation for common conditions afflicting children
	Primary school health services
	Promotion of childhood healthy lifestyles
Adolescent services	Adolescent sexual and reproductive health services
	Adolescent/youth friendly health services
	Secondary school health services
	Harm reduction services for prevention of drug and alcohol use
	Treatment and rehabilitation for common conditions afflicting adolescents
	Promotion of adolescent healthy lifestyles
Adult services	Screening for common communicable conditions
	Screening for common non-communicable conditions and risk factors
	Reproductive health services including family planning
	Promotion of adulthood healthy lifestyles
	Adult nutrition services
	Treatment and rehabilitation for common conditions afflicting adults
Elderly services	Annual screening and medical exams
	Elderly persons social support services
	Treatment and rehabilitation for common conditions afflicting older people

Health security score

1 No services <i>No plan to introduce the service</i>	2 Nascent services <i>Plans to introduce the services exist, but they have not yet been introduced</i>	3 Developing services <i>Services introduced, but poor access to hard to reach populations (no universal access)</i>	4 Developed services <i>Services introduced with universal access, but not fully financed domestically</i>	5 Sustainable services <i>Services introduced with universal access and fully financed domestically</i>
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Constructs	Attributes
National legislation, policy and financing	P.1.1 Policies to facilitate IHR NFP core and expanded functions and to strengthen core capacities incorporated within the national health sector plan (NHSP) P.1.2 The country ensures coordination of the legal and regulatory frameworks between sectors
IHR coordination, communication and advocacy	P.2.1 Annual updates on the status of IHR implementation to stakeholders across all relevant sectors conducted
Antimicrobial resistance (AMR) *	P.3.1 Designated laboratories have conducted detection and reporting of all priority AMR pathogens for five years with a system for continuous improvement P.3.2 Designated sentinel sites have conducted surveillance of infections caused by all priority AMR pathogens for five years with a system for continuous improvement P.3.3 Designated facilities have conducted all HCAI programs for five years with a system for continuous improvement P.3.4 Designated centres have conducted all antimicrobial stewardship practices for five years with a system for continuous improvement
Zoonotic disease*	P.4.1 Zoonotic surveillance systems in place for five or more zoonotic diseases/pathogens of greatest public health concern with system in place for continuous improvement P.4.2 Animal health workforce capacity within the national public health system and at all sub-national levels. This includes a plan for animal health workforce continuing education P.4.3 Timely (as defined by national standards) response to more than 80% of zoonotic events of potential national and international concern
Food safety	P.5.1 There is an effective (formal or informal) mechanism for rapid information exchange during suspected foodborne disease outbreak investigations between all the stakeholders/relevant sectors
Biosafety and biosecurity	P.6.1 Sustainable biosafety and biosecurity system is in place P.6.2 Country has a sustainable training program, train-the-trainers program, and common curriculum on biosafety and biosecurity
Immunization	P.7.1 95% of the country's 12-month-old population has received at least one dose of measles containing vaccine, as demonstrated by coverage surveys or administrative data; or 90% of the country's 12-month-old population has received at least one dose of measles containing vaccine covering more than 80% of all sub-national (districts/provinces) units P.7.2 Vaccine delivery (maintaining cold chain) is available in greater than 80% of districts within the country OR to more than 80% of the national target population
National laboratory system	D.1.1 In addition to achieving "demonstrated capacity", country has national system for procurement and quality assurance D.1.2 Demonstrated capability plus, transport specimens to/from other labs in the region; specimen transport is funded from host country budget D.1.3 Country has sustainable capability for performing modern molecular and serological techniques as part of a national system of sample referral and confirmatory diagnostics. D.1.4 Mandatory licensing of all health laboratories is in place and conformity to an international quality standard is required.
Real time surveillance	D.2.1 Using expertise to support other countries in developing surveillance systems and provide well-standardized data to WHO and OIE for the past five years without significant external support D.2.2 Country has in place an inter-operable, interconnected, electronic real-time reporting system, including both the public health and veterinary surveillance systems D.2.3 Systematic reporting; dedicated team in place for data analysis, risk assessment and reporting D.2.4 In addition to surveillance systems in country, using expertise to support other countries in developing surveillance systems

Constructs	Attributes
Reporting	D.3.1 Ability to identify a potential PHEIC and file a report within 24 hours, and similarly to the OIE for relevant zoonotic disease, with a multisectoral process for assessing potential events for reporting D.3.2 Timely reporting of a potential PHEIC to the WHO from district to national and international level and to the OIE for relevant zoonotic disease (based on an exercise or real event)
Workforce development	D.4.1 Country has capacity to send and receive multidisciplinary personnel within country (shifting resources) and internationally D.4.2 Three levels of FETP (Basic, Intermediate and Advanced) or comparable applied epidemiology training program(s) in place in the country or in another country through an existing agreement D.4.3 Public health workforce retention is tracked and plans are in place to provide continuous education, retain and promote qualified workforce within the national system
Indicators - preparedness	R.1.1 The national public health emergency response plan(s) is implemented/tested in actual emergency or simulation exercises and updated as needed. R.1.2 The national risk profile and resources are assessed regularly to accommodate emerging threats.
Emergency response operations	R.2.1 Exercises are conducted two or more times per year to test EOC activation R.2.2 Response plans are in place that describe scaled levels of response with resource requirements for each level and procedures for acquiring additional resources R.2.3 A follow up evaluation was conducted and corrective action plan was developed and implemented R.2.4 Appropriate staff and resources is in place in management of relevant IHR-related emergencies
Linking public health and security authorities	R.3.1 Public health and security authorities exchange reports and information on events of joint concern at national, intermediate and local levels using the formal MOU or other agreement (i.e., protocol) public health and security authorities engage in a joint training program to orient, exercise, and institutionalize knowledge of MOU or other agreements
Medical countermeasures and personnel deployment	R.4.1 Country participates in a regional/international partnership or has formal agreement with another country or international organization that outlines criteria and procedures for sending and receiving medical countermeasures AND has participated in an exercise or response within the past year to practice deployment or receipt of medical countermeasures R.4.2 Country participates in a regional/international partnership or has formal agreement with another country or international organization that outlines criteria and procedures for sending and receiving health personnel AND has participated in an exercise or response within the past year to practice deployment or receipt of health personnel
Risk communication	R.5.1 Continuous strengthening and growth of the system for risk communication R.5.2 Effective, regular and inclusive communication coordination with partners and stakeholders including definition of roles, sharing of resources and joint action plans R.5.3 All stakeholders engaged in robust and increasingly responsive collaboration to provide health advice, including addressing people's concerns and rumours; and address misinformation R.5.4 Communities are equal partners in risk communication process as evidenced by the review of a simulation exercise or tested by a real health emergency. R.5.5 Misinformation and rumours have little or minimum traction due to effective risk communication
Points of entry (PoE)	PoE 1 Trained personnel for the inspection of conveyances are available at designated PoE PoE 2 Evaluation and publication of effectiveness in responding to PH Events at PoE
Indicators – chemical events	CE 1 1 Adequately resourced poison centre (s) are in place CE 2 A chemical event response plan has been tested through occurrence of real event or through simulation exercise and is updated as needed
Indicators – radiation emergencies	RE 1 2A mechanism is in place to access health facilities with capacity to manage patients of radiation emergencies RE 2 Radiation emergency response drills carried out regularly, including the requesting of international assistance (as needed) and international notification

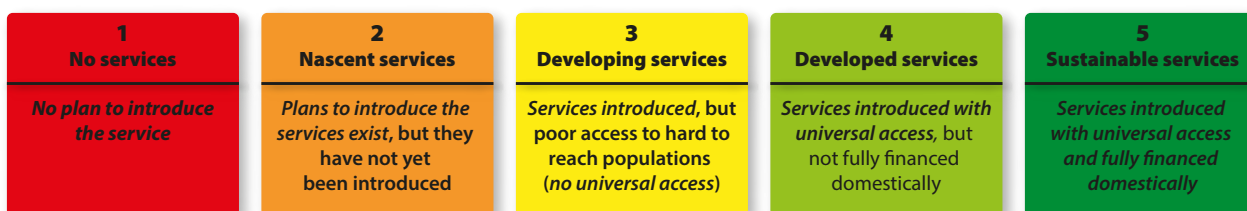
Client responsiveness and satisfaction attributes



Construct	Attribute
Dignity	Persons are treated with respect during the care process
	The rights of persons with conditions that may potentially be associated with stigma are effectively safeguarded
	Persons are encouraged to discuss their concerns & needs freely, during the process of care
	Respect is shown for persons desire for privacy during the management process
Autonomy	Persons are provided with information on alternative management options
	Persons are consulted and their views considered in relation to their management preferences
	Patient consent is explicitly sought before testing or management is commenced
Confidentiality	Consultations between persons and providers is carried out in a manner that protects confidentiality
	Confidentiality of information provided by persons is preserved, except if needed by other providers to further the care process
	Medical records are preserved in a manner that ensures there is limited/no chance of their leaking to un-authorized users
Prompt attention	Persons are able to get to a facility offering services they need in under 30 minutes
	Persons will usually spend under 30 minutes at a facility before they receive services
	Persons will usually complete all the services they need within 2 hours of arriving at a facility
	Persons will usually spend an unnecessarily long time waiting for elective procedures
Access to social support networks	Patients/clients are allowed to receive guests during the care process
	Families and friends of Patients/clients are allowed to cater for their personal needs during the care process
	Patients/clients are allowed to involve themselves in religious activities during the care process
Quality of basic amenities	Health facilities are usually clean
	Food for Patients/clients is usually adequate for their nutrition needs
	Water and sanitation services for Patients/clients are usually adequate in the health facilities
	The linen and other personal items provided to Patients/clients is usually clean and appropriate
Choice of care providers	Patients/clients usually have a choice of providers in a given health facility
	Patients/clients usually have a choice of facilities providing their required services
	Patients/clients have the opportunity to freely seek a second opinion without fear of penalisation, if they desire
	Patients/clients have the opportunity to see specialists, if they desire to

Annex 2.2 Attributes relating to health system functionality

System resilience



Construct	Attribute
Awareness	Real time (under 1 year old) data mapping the health system assets – HR, infrastructure, commodities – that can be mobilized in the event of a stress event
	Real time (under 1 year old) mapping of potential health risks at the lowest level of the health system – health centre or community unit
	Functional epidemiological surveillance network regularly (weekly) reporting on status of potential disease events
	Regular (at least annual) predictive modelling of major health risks facing different populations done, and information shared with concerned parties
	Simulation exercises to mimic the logistics of the response to the 5 stress events of highest risk of occurrence conducted in the past 1 year
Diversity	Primary care facilities are providing at least 80% of the range of essential services they are expected to provide
	Physical, financial and/or social barriers hindering access to available essential services are known and minimized
	There is a clear strategy to scale up the provision of essential services currently not currently being provided
	Health facilities have basic capacities needed for provision of a broad range of essential services: <ul style="list-style-type: none"> • basic amenities: reliable power, water, sanitation, • basic equipment, • standard precautions for infection prevention, • diagnostic capacity, • essential medicines
	Staff are appropriately skilled, and supervisory systems functional enough to identify rare/uncommon events when they occur
Versatility and self-regulating	The primary care (front line) facilities have the needed technical capacity to identify and isolate a health threat
	There are mechanisms at the management level supporting health facilities to target local resources to an identified health threat without need for bureaucratic authorizations
	Health facilities are aware of, and able to put in place contingency mechanisms that allow continued essential service provision even when responding to a threat
	Sources of additional capacities (HR) that may be needed to respond to the threat are identified and procedures to bring these on board are known & agreed
Deployment and mobilization	There are functional mechanisms for communication and engagement with non-public health partners working within the areas of responsibility of primary care facilities – such as private sector, NGOs, CSOs, and others
	There are functional mechanisms for communication and engagement of primary care facilities with communities they are working within
	There are functional mechanisms for communication and engagement with health related sectors working within the areas of responsibility of primary care facilities – such as agriculture, transport, education, and others
	There are pre-agreed mechanisms for sharing of personnel, funds and capacities amongst stakeholders working within their areas of responsibility of primary care facilities
Transformation	There is regularly updated information on the state and performance of the health system
	There are agreed protocols to guide absorption of resources and skills mobilized during a response to an event into the routine system
	There are protocols to constantly monitor changing performance of the health system during a shock event
	There is guidance on comprehensive recovery planning based on assessment, and investment across the health system
	Process documentation and intelligence is planned and conducted during a shock event, to generate lessons

Annex 2.3 Attributes relating to health system investments



Health workforce

Construct	Attribute
Standards and norms	Recent (under 5-year-old) norms and standards covering all cadres
	Facility staffing needs are determined by formal workforce norms
	Functional mechanism for monitoring adherence to workforce standards
Policy and regulations	National and sub national workforce policy and strategy
	National and sub national comprehensive health workforce regulations
Planning	Short, and medium term HW plans incorporating all cadres
	HW recruitment is based on HW plans for all cadres
	Partner HW support informed by HW plans
Production	Rational HW production, informed by HW plans
	Recent (under 5 years old) HW needs assessment
	Regular pre-service curriculum review to align to HW needs
Recruitment and deployment	Recruitment of new HWs is guided by HW plan
	Recruitment of new HWs is done in line with HW norms
	There exists a process for prioritization of recruitment of HWs, informed by focusing on most disadvantaged areas
Leadership and Governance	Oversight of HW by governments is effective in ensuring productivity & motivation
	Comprehensive national HW accounts
Productivity	Clear and functional productivity improvement strategies
	Clear and functional retention and motivation strategies

Health products, including vaccines, MPHOs, supplies

Construct	Attribute
Standards and norms	Recent (under 5-year-old) norms that elaborate standards for all the categories of medical products are defined and being applied in practice
Policy and regulations	National and sub national policy and regulatory guidance is in place, and appropriate and comprehensive to guide planning and management for all categories of medical products
Planning	Short, and medium-term planning for all categories of medical products is functional, and able to guide stakeholder support and actions
Local production	There are functional processes to facilitate local production of medical products, based on value for money – including at facilities (e.g. oxygen)
Procurement	Procurement is need based, with input from facilities, and based on essential lists for all categories of medical products
Supply chain management	A functional and effective supply chain process exists that maintains integrity of all categories of medical products till use
Maintenance	The storage/warehousing needs are defined, and functionally maintain integrity of the different categories of medical products
Rational use	Processes to ensure rational use of all categories of medical products, including enforcement of prescribing practices are functional

Health infrastructure

Construct	Attributes
Standards and norms	Recent (under 5-year-old) norms that elaborate standards for all the categories of infrastructure are defined and being applied in practice
Policy and regulations	National and sub national policy and regulatory guidance is in place, and appropriate and comprehensive to guide planning and management for all categories of infrastructure
Planning	Medium term planning for all categories of health infrastructure is functional, and able to guide stakeholder support and actions
Maintenance	Maintenance (including preventive) processes for health infrastructure are defined and practiced, ensuring infrastructure functionality

Health governance

Construct	Attributes
Organizational structure	A recent (under 5 years) and comprehensive national and sub national government structure (organogram) that defines tasks, inter-relations, roles and responsibilities during management of delivery for essential services
Stewardship capacity	Functional and clearly defined process to identify, and tackle leadership and management capacity gaps – in terms of persons and/or skills – to ensure appropriate capacity to guide service provision
Authority and mandate	Availability of clear roles, and responsibilities of the national and sub national levels of management, including their level of decision making space and clear mechanisms for inter-linking their functions – with limited experience of frustrations/overlaps of functions
Accountability	Clear guidelines are available and in use for ensuring accountability to different stakeholders (government, the public, partners, etc.). These include: <ul style="list-style-type: none"> • Comprehensive and participatory planning processes • Openness in implementation with regular stakeholder dialogue • Performance monitoring processes
Policy and legal frameworks	The statutory instruments providing a legal basis for health actions are up to date, enforceable and appropriate for current health service delivery needs. These instruments include, but are not limited to: <ul style="list-style-type: none"> • National Health Policy defining long term aspirations for health • Health laws defining the scope of essential services, and the legal requirements for the health system to deliver these services • Health regulations operationalizing the health laws
Partnerships and engagement	The processes for ensuring different stakeholders are contributing to delivery of the defined health agenda are present, and functional. These processes include, but are not limited to: <ul style="list-style-type: none"> • State and non-state stakeholder engagement through PPPs • State, non-state and external stakeholder coordination mechanisms • State, and community engagement through dialogue events • Intra state stakeholder institutions
Corruption control	Systems to ensure integrity, and public confidence in the process of health and health-related service delivery. These include, amongst others: <ul style="list-style-type: none"> • Integrity building processes • Enforcement of ethical practices • Functional internal audit and control systems • Corruption perception assessments • Functional reward and sanction mechanisms

Service delivery systems

Construct	Attributes
Standards and norms	Recent (under 5-year-old) care standards are available and in use, which elaborate the level and form of care to be adhered to during the delivery of different essential services, to ensure consistency in service provision
Essential package of services	Recent (under 5-year-old) definition, with roll out plan for services that are essential for the population, by: <ul style="list-style-type: none"> • Life cohort (maternal/newborn, childhood, adolescence, adulthood, elderly people) • Public health functions (promotion, prevention, curative, rehabilitative) • Payment source (Indirect taxes, social insurance, private insurance, OOP)
Supervision mechanisms	Functional mechanism in use that allows supportive supervision and mentorship during health service provision, including: <ul style="list-style-type: none"> • Peer to peer mentorship and support across same levels of the system • Supervisory support from higher to lower levels of the system
Services organization	Recent (under 5 years) succinct elaboration of the levels of care, from community, facility, sub national and national including their descriptions, roles, and mechanisms of interaction for administrative, management and technical service delivery functions
Services management	Available and in use guidance for the conduct of management functions for each type of health facility (hospital, health centre, etc) including but not limited to functions of HR, infrastructure and medicines management, plus planning and monitoring
Service quality and safety	Presence and use of guidelines for clinical governance in care delivery, focusing on: <ul style="list-style-type: none"> • Client relations and responsiveness/satisfaction monitoring • Patient safety mechanisms • Ensuring effectiveness of interventions being provided • Ensuring person centeredness during care provision by health workforce
Equity in service delivery	Functional mechanisms in use, to facilitate identification and targeting of most vulnerable populations for different essential services

Health information

Construct	Attributes
Data generation	Mechanisms and collaboratives to collect different forms of health and health-related data from the health sector, and other government institutions responsible for health related data.
Data validation	Systems to review available data, to ensure consistency, accuracy, and completeness
Data analysis	Approaches to ensure available data is analysed on and off collection site in the most effective and efficient manner, including through use of technology, to generate required information on health and well-being
Information dissemination	Mechanisms that are used to share emerging health information, such as through reports, or data repositories
Knowledge translation and use of evidence	Establishment of observatories to constantly link emerging health information, with different potential users in a manner most appropriate for them. Users include health managers, other sectors, researchers, etc.

Health financing

Construct	Attributes
Financing Policy, regulatory and legal systems	The statutory instruments providing a legal basis for health financing actions are up to date, enforceable and appropriate to guide revenue generation, management and purchasing of services.
Financial management and accountability systems	The capacity for management and accountability of health funds is appropriate in terms of numbers and skills, to facilitate efficient and effective management of health revenue
Institutional Arrangements	The mechanisms for management of health funds are functional, clear and comprehensively defined, ensuring generated funds are effectively used to purchase services (using input, process, output or outcome-based purchasing approaches). Such mechanisms include, amongst others, arrangements for management of: <ul style="list-style-type: none"> • Tax funds (unearmarked) • Public insurance funds – national and community based • Private insurance funds • Out of pocket funds
Evidence generation for health financing	Information processes and systems to generate, analyse and use information for health financing to guide decision making. They include conduct of health accounts, expenditure tracking and reviews, costing studies amongst others

Annex 3 Policy briefs format

See WHO Regional Office for Africa Toolkit for monitoring UHC and other SDGs for guidance on compiling policy briefs to complete this outline

GUIDANCE NOTE NUMBER	
SUBJECT	
DATE	
BACKGROUND	
SUMMARY OF GLOBALLY PUBLISHED LITERATURE RELATED TO SUBJECT	
SUMMARY OF COCHRANE REVIEWS ON SUBJECT	
SUMMARY OF COUNTRY-SPECIFIC LITERATURE ON SUBJECT	
REGIONAL OFFICE SUMMARY GUIDANCE	
REGIONAL OFFICE RECOMMENDATIONS FOR FURTHER RESEARCH	
LINKS TO INFORMATION ON SUBJECT	

Annex 4 Outline for documenting best practices

See *Guide for documenting best practices in health systems strengthening to attain universal health coverage and other SDG health targets* to assist in completing this outline

Purpose:

- ▶ Used by the person documenting the practice
- ▶ Covers the elements needed to bring out the information needed by other beneficiaries
- ▶ The completed tool is reviewed by the WHO Regional Office and the country for accuracy and completeness before sharing with any other persons

Qualifier:

- ▶ A practice is deemed a best practice if there is evidence (preferably documented, but could be anecdotal) that it has directly / indirectly led to improvement in health and/or wellbeing, and has ALL the 5 core attributes of a best practice

Country best practice in health systems strengthening to attain universal health coverage and other SDG health targets

Good practice

Best practice

SECTION 1. IDENTIFICATION INFORMATION

Title of the practice	
Country	
Date (MM/YYYY) of documentation	

Domain, and dimension relating to the practice (circle the appropriate one(s))

Population benefit from health and/or related service (OUTCOME DOMAIN)						Health system functionality (OUTPUT DOMAIN)				Health system investments (INPUT / PROCESS DOMAIN)						
Service availability	SDG 3 coverage	Financial risk protection	Health security	Service responsiveness	Non-SDG 3 coverage	Access	Quality of care	Effective demand	Resilience	Health Workforce	Infrastructure	Medical Products	Governance	Delivery systems	Information systems	Financing systems

SECTION 2. DESCRIPTION OF THE INTERVENTION

Background and justification for introducing the intervention (under 200 words)

Aim and objectives of the intervention (under 50 words)

Process of introduction of the intervention (under 200 words)

Population targeted by the intervention (whole population / specific geographical or age cohort population)

What was done / activities carried out (under 300 words)

Key implementers and collaborators (under 100 words)

Financial, HR, infrastructure, and/or medical product resource implications (under 100 words)

SECTION 3. IMPLICATION OF THE PRACTICE

Implications on the sector: Changes it influenced in the sector (under 100 words)

Implications on the beneficiaries: If any, the political, social and/or cultural changes it influenced (under 100 words)

Implications on the stakeholders: If any, changes in actions of donors, or non state actors it influenced (under 100 words)

SECTION 4. DESCRIPTION OF ATTRIBUTES OF BEST PRACTICES

EFFECTIVENESS: Evidence the practice produced the desired results for the related dimension (<100 words)

EFFICIENCY: Evidence the practice produces the result with low resources / is value for money (<100 words)

SUSTAINABILITY: Evidence the practice can be maintained with available DOMESTIC resources (<100 words)

REPLICABILITY: Evidence there is political / technical willingness and ability to continue and scale up the practice (<100 words)

EQUITY: Evidence the practice can be applied in hard to reach populations – urban unplanned settlements; geographically inaccessible populations, gender disadvantaged persons, etc (<100 words)

SECTION 5. LESSONS AND GUIDANCE IN ADOPTING THE PRACTICE

Internal / design features that made the practice work (<100 words)

External / environmental features that made the practice work (<100 words)

Internal / design features that hindered the practice (<100 words)

External / environmental features that hindered the practice (<100 words)

KEY GUIDANCE FOR CONSIDERATION BY OTHERS (< 100 words)

- 1.
- 2.
- 3.

FURTHER READING / REFERENCES

The 2030 Agenda for Sustainable Development represents an unprecedented undertaking of the global community to eradicate poverty and achieve sustainable development worldwide by 2030. Its 17 goals and 169 associated targets represent a commitment to improving by 2030 the livelihood of people in a sustainable manner. The single health goal SDG 3 relates to direct actions that influence health within the SDGs. However, achieving health and well-being is also closely intertwined with other SDGs: including the 13 targets of SDG 3, nearly 50 of the 169 targets of the 17 SDGs have a direct impact on health and wellbeing.

As the Agenda is meant to be implemented in the context of countries' existing commitments, a translation process is required to adapt the SDGs to national development plans. The WHO Regional Committee for Africa adopted a strategy for health systems development towards UHC in the context of the SDGs in August 2017. This 'Framework of actions' provides guidance to countries on the realignment of system investments needed to attain a comprehensive set of health and health-related outcomes critical to achieving SDG 3.

Implementation of the actions needed to attain UHC and other health targets in the SDGs calls for countries to adopt new, and in many instances innovative, approaches to addressing their health needs. To support accelerated actions, the Regional Office is developing a series of toolkits to guide countries in their work and support knowledge sharing across the Region.

