AfroPHC
Building Effective Primary Health Care Teams for UHC in Africa

A CALL TO AFRICA
AfroPHC

A Call to Africa

Join AfroPHC and build effective primary health care teams for universal health coverage in Africa
Dear All,

I am delighted to introduce our policy document on building primary health care teams for Universal Health Coverage (UHC) in Africa. I believe this document will serve as a valuable resource for policymakers, healthcare professionals, and stakeholders committed to advancing healthcare delivery in Africa. It will serve especially as an advocacy tool for dedicated frontline health care workers across the region and AfroPHC members.

The document provides evidence-based recommendations and best practices for building strong primary healthcare teams that can provide high-quality, accessible, and affordable care to all Africans, especially those in underserved and remote areas. It outlines the key roles and responsibilities of different healthcare providers, including physicians, nurses, midwives, community health workers, and other allied health professionals. It emphasizes the importance of collaborative teamwork and interdisciplinary approaches to care delivery. It also provides guidance on key policy areas, including health financing, human resources for health, service delivery, medicines and health technologies, and health information systems. We believe that by focusing investment on these key areas, we can make significant progress towards achieving UHC in Africa.

However, achieving UHC will require a concerted effort from all stakeholders. We call on governments, development partners, civil society, and the private sector to work together to implement the policy recommendations outlined in this document. We also urge all stakeholders to prioritize investments in health systems strengthening as a critical component of efforts to achieve UHC in Africa. At a time when the world is facing unprecedented health challenges, including the COVID-19 pandemic, it is crucial that we prioritize investments in primary healthcare systems that can provide comprehensive and integrated care to all. By building strong primary healthcare teams, we can ensure that all Africans have access to essential health services, including preventive care, health promotion, and disease management.

I am confident that together, we can build stronger health systems and ensure that all Africans have access to the health services they need. I encourage all stakeholders to read and share this document widely and to work together to implement its recommendations. Let us join hands and build a healthier and more prosperous Africa for all.

Sincerely,

Dr. Mercy Wanjala
Executive Coordinator- AfroPHC
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EXECUTIVE SUMMARY

Primary health care is the cornerstone of achieving UHC. The Astana Declaration on Primary Health Care acknowledges that strengthening primary health care is the most equitable, effective and efficient approach to improving population health. Primary health care is a crucial foundation of UHC through its focus on the socioeconomic determinants of health and well-being, empowered individuals and communities, and integrated health services based on a person and family centred approach, with community involvement. Our vision for PHC and UHC in Africa is a PHC team with a skills mix appropriate to Africa, including family doctors, family nurse practitioners, medical officers, clinical officers, nurses, community health workers (CHWs) and other health cadres that are empowered to take care of an empanelled population providing high-quality person and family PHC.

Africa has the most severe health personnel shortages, with the need predicted to reach 6.1 million by 2030 out of the anticipated global health care worker need of 14.5 million required for UHC and to achieve the Sustainable Development Goals (SDGs). The continent had an average of 1.30 health workers per 1,000 people in 2015, significantly less than the 4.5 needed to achieve the SDGs.

Currently, the PHC system in Africa is facing several challenges AND opportunities. To date, human resources for health in PHC are grossly insufficient in number, often inefficient and inequitably distributed, and lack adequate training to deliver fully responsive and comprehensive first contact care. In addition, communities are treated inequitably within the health system. Projections for the African health workforce suggest this will worsen over the next five years. There has been a lack of solidarity among key stakeholders in health care to avail adequate PHC funding in Africa. Resources do not appropriately or adequately reach the frontline PHC service providers due to outdated service delivery and payment models. However, there are opportunities that leaders can capitalize on: global PHC milestones, increasing political will for investment in PHC, and proven mechanisms for achieving a stronger workforce such as the professionalization and scaling up of community health workers, clinical role-sharing, and more effective, increased integration of family doctors, advanced nurse practitioners and allied health professionals into PHC.
A CALL TO AFRICA

Join AfroPHC and build effective primary health care teams for universal health coverage in Africa

In opening, we call on Africa:

- To heed the call of its health professionals for PHC and universal health coverage (UHC) in Africa.
- To seize opportunities to overcome African challenges for PHC and UHC in Africa.
- To re-organise UHC around PHC service delivery, integrating public health with primary health care, and incorporating private PHC providers into a regulated system.

In terms of PHC Systems, we call on Africa:

- To embrace the disciplines of family medicine and generalist PHC, with its bio-psycho-social-spiritual approach to care, to achieve PHC and UHC in Africa by 2025 that is personalised, comprehensive, continuous and coordinated, in line with global standards.
- To embrace primary care, defined by WHO as an essential level of care that needs to be responsive, person-, family- and community-centred and covers the full spectrum of care within the paradigm of One Health for PHC and UHC in Africa by 2025.
- To integrate priority programmes (communicable diseases, non-communicable diseases, mother-woman-child health, violence-trauma, mental health, etc.) into PHC in a diagonal manner that both supports these vertical priorities as well as horizontal integration by PHC teams around patient and population for UHC in Africa by 2033.
- To strengthen rehabilitation and palliation in PHC by 2033 with decentralised and well-funded community rehabilitation and palliation services, where teams with an appropriate mix of skills and professional supervision are linked to multiple community practices to ensure accountable care.
• To integrate oral health into PHC by 2033 with team-based service delivery models that comprise appropriate role- and task-sharing with a range of oral health care practitioners and dentist support plus supervision, and that are linked to multiple community practices for accountable care.

• To strengthen access to medicines and investigations with closer links to pharmacy professionals and proper diagnosis at PHC level to achieve PHC for UHC in Africa by 2033.

• To strengthen coordination of PHC referrals to hospitals with the placement of postgraduate-trained family doctors and postgraduate trained family advanced practitioners in PHC teams by 2033 to achieve UHC in Africa.

• To prioritise PHC as the foundation for UHC: making “Health in All Policies” and integrating a developmental public health approach to decentralised government and strengthening PHC teams with local linkages to other sectors that affect the social determinants of health by 2025 to deliver PHC and UHC in Africa.

• To strengthen district health services to coordinate decentralised and empowered providers by 2033 and to ensure they deliver on agreed-upon results as they implement PHC and UHC in Africa.

• To embrace the strategy of empanelment of a defined population and link them to a defined, fully staffed and equipped PHC team and medical home by 2025 as a foundational step to achieving PHC and UHC in Africa.

• To embrace community-oriented primary care in community practices of 30,000 by 2033, and aspire to community practices of 10,000 to achieve PHC and UHC in Africa by 2043.

• To embrace the Blueprint for Rural Health and rural-proof all health policies by 2025 to support rural and marginalised urban primary health care comprehensively, especially by creating stepladder entry requirements for educational institutions and rural/marginalised urban student immersion for the full PHC team, to achieve PHC and UHC in Africa.

• To recognise the unique challenges of women in PHC and to explore innovative and sustainable interventions to overcome these for PHC and UHC in Africa.

• To recognise the unique opportunities of youth in PHC and to explore innovative and sustainable interventions to address these for PHC and UHC in Africa.

• To embrace the variety of e-Health solutions for PHC by ensuring that sustainable national e-Health strategies are supported by accessible infrastructure, interoperability and user-friendly designs that enable the PHC team and patients/populations to enhance quality and support new models of care in PHC and UHC in Africa.
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- To engage communities and ensure social participation in advancing team-based PHC across Africa.
- To embrace the culture of quality and patient safety with strong teamwork, and to measure and monitor performance to achieve quality PHC and UHC in Africa.
- To develop and support practice and population research sites focussed on PHC across Africa, and to expand the range of indicators that will assess the effectiveness of PHC teams empanelled to populations as a key service delivery reform.

In terms of the PHC Workforce, we call on Africa:

- To build a larger, better trained PHC workforce (integrating public and private providers) with more opportunities (educational, financial and clinical) and greater resources (starting by structurally defining PHC services) to facilitate PHC and UHC.
- To acknowledge the burden on all cadres in PHC and to embrace trans-professional collaboration with a mix of all health professionals using respectful, collaborative role-sharing and supportive supervision to achieve PHC and UHC in Africa.
- To embrace distributed leadership practices, and education for it, among all PHC workers and managers to achieve PHC and UHC in Africa.
- To embrace the important role of medical, dental, nursing and other professions with post-graduate training for decentralised primary care settings to support clinical governance, coordinated care and efficient referrals to achieve PHC and UHC in Africa.
- To standardise, professionalise and decently remunerate community health care workers (CHWs) that are strongly integrated into the PHC team, and furthermore to aspire to a target of one CHW per thousand persons by 2043 to achieve PHC and UHC in Africa.
- To clarify and harmonise PHC workforce nomenclature for the different categories and disciplines in PHC, and to then embark on labour market analyses in PHC (including public and private) and specific PHC human resource for health (HRH) policies and strategic plans to scale up the PHC health workforce by 2033 to achieve PHC and UHC in Africa.
- To implement robust educational and credentialing systems for developing a competent workforce dedicated to delivering comprehensive PHC services necessary to achieve UHC in Africa.
• To protect all PHC workers as a precious and vulnerable resource and to empower them to build quality and resilience as a team that works closely with communities to achieve PHC and UHC for Africa.

In terms of PHC Finances, we call on Africa:

• To regard health as an investment and to leverage political goodwill for action on PHC/UHC by defining PHC in budget terms, ring-fencing the financing of PHC and committing at least 2% of their GDP to PHC for UHC in Africa.

• To re-examine global social solidarity on PHC and strengthen contributions to PHC for UHC in Africa as a priority, starting with High-Income Countries increasing ‘donor aid’ to 2% of their health spend and ‘donor aid’ funds allocating 30% to an African Union funding pool for integrated PHC and UHC in Africa by 2033.

• To work towards better-resourced single pools for UHC funding, prioritising strategic purchasing for PHC with standard and transparent contracting of both public and private providers in empowered decentralised units of PHC for UHC in Africa by 2043.

• To embrace PHC teams paid by blended capitation models (including capitation, fee-for-service and performance payments) to achieve holistic and responsive PHC and UHC in Africa by 2043.

• To embark on simple nationally-defined PHC contracting to community practices for accountable care from both public and private service providers.
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<tr>
<td>AFRO</td>
<td>African Region</td>
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<tr>
<td>AfroPHC</td>
<td>The African Forum for Primary Health Care</td>
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<td>AHAIC</td>
<td>The Africa Health Agenda International Conference</td>
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<td>AU</td>
<td>African Union</td>
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<td>CA</td>
<td>Clinical Associates</td>
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<td>CHEW</td>
<td>Community Health Extension Worker</td>
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<td>CHP</td>
<td>Community Health Practitioner</td>
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<tr>
<td>CHW</td>
<td>Community Health Worker</td>
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<td>CO</td>
<td>Clinical Officer</td>
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<td>COPC</td>
<td>Community-Oriented Primary Care</td>
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<td>COVID</td>
<td>Coronavirus Disease</td>
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<td>CPD</td>
<td>Continuing Professional Development</td>
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<td>DHS</td>
<td>District Health System</td>
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<td>GDP</td>
<td>Gross Domestic Product</td>
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<tr>
<td>GOBI-FFF</td>
<td>Growth Monitoring Oral Rehydration Breast-feeding and Immunisation – Female Education Family Spacing and Food Supplementation</td>
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<td>GP</td>
<td>General Practitioner</td>
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<td>GTFCC</td>
<td>Global Task Force on Cholera Control</td>
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<td>HIAP</td>
<td>Health in all Policies</td>
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<td>HICs</td>
<td>High-Income Countries</td>
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<td>HIV-AIDS</td>
<td>Human Immunodeficiency Virus – Acquired Immune Deficiency Syndrome</td>
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<td>HRH</td>
<td>Human Resource for Health</td>
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<td>HSA</td>
<td>Health Surveillance Assistant</td>
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<td>Health Systems Strengthening</td>
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<td>ILO</td>
<td>International Labour Organisation</td>
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<td>Acronym</td>
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<td>ISCO</td>
<td>International Standard Classification of Occupations</td>
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<td>Leadership, Management and Governance</td>
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<td>PA</td>
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<td>PBRN</td>
<td>Practice-Based Research Network</td>
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<td>PC</td>
<td>Primary Care</td>
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<td>Primary Health Care Performance Initiatives</td>
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<td>PoC</td>
<td>Point of Care</td>
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<td>SDGs</td>
<td>Sustainable Development Goals</td>
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<td>TB</td>
<td>Tuberculosis</td>
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<td>TBA</td>
<td>Traditional Birth Attendant</td>
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<td>TPC</td>
<td>Trans Professional Collaboration</td>
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<td>UHC</td>
<td>Universal Health Coverage</td>
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<td>United Kingdom</td>
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<td>UNICEF</td>
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<td>United States of America</td>
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<td>WHO</td>
<td>World Health Organisation</td>
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<tr>
<td>WONCA</td>
<td>World Organisation of National Colleges, Academies and Academic Associations of General Practitioners/Family Physicians</td>
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1. BACKGROUND

Heed the call of African health professionals

*We call on Africa to heed the call of its health professionals for PHC and UHC in Africa.*

The African Forum for Primary Health Care (AfroPHC) brings together the leadership of ALL health workers and activists at the coalface of primary health care (PHC) in Africa to be a voice for change, sharing resources and providing support towards the PHC team for UHC in Africa.

**Box 1: More about AfroPHC**

AfroPHC has focused its energy since inception in 2021 on developing this policy framework with interactive policy workshops in partnership with its many members across the African continent and diverse leadership. It is now deepening the conversation in chapters at regional and country level and in a youth hub. AfroPHC is determined to be part of the solution with active clinical continuing professional development (CPD) being provided virtually involving 500-1,000 attendees weekly and in an online learning management system in partnership with the World Continuing Education Alliance to their 500,000 users. AfroPHC has partnered with Amref Health Africa to deliver a supported version of the online Leadership, Management and Governance for Health Systems Strengthening (eLMG HSS) course to more than 400 PHC health workers in 2022. AfroPHC is also developing a ten-module 18-month long online training curriculum framework and repository of learning content for clinicians. The objective is to train family doctors, family nurse practitioners, and clinical officers in a clinical post-graduate diploma on family medicine and primary health care. We hope to advocate this across the continent as a standard of training that can be embraced by accreditation authorities and learning institutions. It is a way to scale up online workplace-based training of the PHC team across Africa. We are open to funding to further develop the learning process/materials and scale up the delivery platform as a free offering to institutions across Africa. AfroPHC has also set up a research group to train and mentor researchers across Africa and PHC disciplines. We are using our network to respond to some important challenges in taking this policy framework forward as well as to describe daily practice and experiences of members of the PHC team in an AfroPHC Practice-Based Research Network (PBRN) in partnership with global PBRNs. We are actively exploring funding to test the concept of community practices across Africa as partners in developing the African Population Cohort Consortium.

Our PHC experience is of patients who are treated as numbers in a queue with poor comprehensiveness, continuity and coordination. Health workers are also treated like numbers in a bureaucracy that fragments and undermines integrated care around patient and population needs. The AfroPHC vision of African PHC service delivery under the universal health coverage (UHC) is that it should be comprehensive, accessible, of high quality, responsive to local needs, in partnership with communities and delivered by a strong team that has adequate training and supportive supervision.
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Box 2: Members of AfroPHC

AfroPHC represents an array of health care workforce stakeholders in Africa (family nurse practitioner, family doctor, public health, family physician, generalist nurse, pharmacist, manager, advocates, generalist specialist, student, activist, government sector representatives, community health worker, social worker, educationist, allied health, clinical officer, scientists, dental professionals, environmental health practitioners, researchers, lab technician, nutritionist, psychologist, lawyer, ambulance driver, optometrist and traditional healer). We had a membership of 1,582 from more than 40 of the 54 countries in Africa as of 1st October 2022.

We see ourselves working in community practices as a PHC team with a skills mix appropriate for Africa including family doctors, family nurse practitioners, clinical officers, community health workers and others that are empowered to take care of an empanelled population in high-quality people-centred PHC. Chiawelo Community Practice is an example.

Box 3: Chiawelo Community Practice

Chiawelo Community Practice is an experiment in developing community-oriented primary care (COPC) more specifically in South Africa, as a model for GP-led teams contracted to the National Health Insurance (NHI). It is part of the Chiawelo Community Health Centre in Soweto, a facility owned by the public health service in South Africa. It also functions as part of the Wits University teaching and research platform. The practice is led by a family physician, Prof. Shabir Moosa. The team includes a family physician, an occasionally rotating 1st-year family medicine registrar, one clinical associate, three medical interns rotating weekly, one professional nurse, three enrolled nurses (team leaders), and 30-42 CHWs. They provide care to 30,000+ residents from the community of Ward 11, 12, 15, 16, & 19 in strong teamwork. Local stakeholders are fully engaged, and support a growing targeted health promotion programme. This has resulted in low utilisation rates (less than one visit per person per year), easy access based on needs, high satisfaction and high clinical quality. This has been working despite the challenge of a reductionist PHC system, poor management support and poor public service culture. The results could be more impressive if panels were limited to 10,000, if there was a better team structure with a single family doctor leading a team of 3-4 nurse/clinical associates and 10-12 CHWs, and PHC provider units that were truly empowered to manage resources locally.[21]

Africa must prioritise human capital for growth, invest in health and education with a strong focus on cost-benefit. AfroPHC has put together this call to Africa and the world to build effective PHC for UHC in Africa.
Recognise African challenges AND opportunities

We call on Africa to seize opportunities to overcome African challenges for PHC and UHC in Africa.

The African population suffers from the challenges of a high disease burden and public and private health systems that are divided with poorly managed resources poor governance and lack of accountability. Almost one in ten people incur catastrophic health expenditure while 15 million are driven to poverty annually due to out-of-pocket expenditure.[1] We believe in Africa and see many opportunities in Africa to deliver on PHC/UHC with the economic growth trajectory in the continent the demographic dividend of a youthful Africa well-trained and competent health professionals the traditional health care network religious leaders a strong civil society a developed private sector the innovation ecosystem and health system strengthening efforts in response to the COVID-19 pandemic. [1] Investments in leadership education service delivery and employment for all health professions are needed to meet SDG 2030 and NCD 2030 targets.

Note Global PHC milestones

We call on Africa to embrace the World Health Report of 2008 Astana Declaration of 2018 and Global Competency and Outcomes Framework for Universal Health Coverage by prioritising integrated resilient person-centred and high quality PHC within UHC re-organising UHC around PHC service delivery integrating public health with primary care and bringing private PHC providers into a regulated PHC system for UHC in Africa.

In addition to the Alma Ata Declaration of 1978 there have been other key milestones on the global journey to PHC/UHC.[2] The World Health Report (2008) on PHC speaks of (i) the need for PHC to be central to UHC; (ii) the need for service delivery reforms that re-organise health services around people’s needs; (iii) the need to integrate public health actions with primary care; and (iv) the need for leadership reforms (where governments act as custodians of the entire health system including the private sector and not just the public service).[3] The Astana Declaration (2018) set out several operational levers including models of care that prioritise primary care and public health functions as well as engagement with private sector providers in new purchasing and payment systems. [4] The World Bank Report (2021) “Walk the Talk: Reimagining Primary Health Care after COVID-19” suggests four structural shifts: from low to high quality PHC from fragmentation to person-centred integration from inequity to fairness and integration and from fragility to resilience.[5]

We call on African leaders and global stakeholders to develop and implement a regional
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forward-looking plan to build robust PHC systems; educate, recruit and maintain a sufficient frontline PHC workforce; and support PHC with finances:

1) **Build robust PHC SYSTEMS.** Improving PHC systems starts with innovative preventive models of care and integrated population health management including comprehensive person- family- and community-centred PHC; a bio-psycho-social-spiritual approach to PHC; integrated PHC priorities including mental health rehabilitation palliation and oral health; improved access to medicines and investigations; coordination of referrals; Health in All Policies; better quality PHC; a strong District Health System (DHS) to coordinate providers; empanelling of defined populations to a specific team using community-oriented primary care; and embracing interoperable e-Health that is person-centred and user-friendly.

2) **Educate, recruit and maintain a sufficient frontline PHC WORKFORCE.** This must include a complete workforce of locally trained family doctors, family nurse practitioners, advanced practitioners, pharmacists, professionalised CHWs and others to deliver high quality essential and routine health care services across the entire life course, without restriction based on age, gender, organ system or disease. This workforce must be supported by role-sharing with supportive supervision; distributed leadership; clinical governance by accountable clinicians; and an integrated human resource development and management plan suitable for PHC including protection of workers.

3) **Support PHC with FINANCES.** These must be political and sustained funding action that considers PHC an investment; a fight for global solidarity action on PHC funding pools; and better management of PHC across Africa with strategic purchasing and payment reforms using blended capitation.
2. PHC SYSTEMS

Embrace the bio-psycho-social-spiritual approach to PHC

We call on Africa to embrace the disciplines of family medicine and generalist PHC, with its bio-psycho-social-spiritual approach to care to achieve PHC and UHC in Africa by 2025 that is personalised, comprehensive, continuous and coordinated in line with global standards.

Many professional members of the PHC team are integrating principles of primary health care within their discipline, with many shared values across disciplines. Family medicine, the specialist discipline of generalist primary care, shares principles of the biopsychosocial spiritual model with other health professions and medical disciplines. Health care workers trained in these are expertly able to deliver person-, family- and community-centred care that addresses a patient’s problems using the bio-psycho-social-spiritual approach.

Box 4: Bio-psycho-social-spiritual model

AfroPHC embraces the bio-psycho-social-spiritual concepts shared by family medicine, nursing and other disciplines involved in PHC in managing personal care, with services being comprehensive (as defined by the team composition and available resources of medicines and investigations), the locus of control in communities and multisectoral collaboration as a strategy to create a truly healthy community.[68] Family medicine, especially in Africa, urges clinicians to go beyond the narrow biomedical model and patient encounter to centralise the ideas of community-orientation, managing resources and lifelong learning in everyday practice by the PHC team. A principle is managing a population at risk, preferably not a nebulous ‘community’, but a fixed panel of enrolled members of the community. This will support best practices in family medicine and good risk management at population level to emerge even with limited resources, especially human. The strategy to improve quality and safety in PHC is focused on communication, supportive teamwork, professional training and a learning organisation. However, the way PHC is organised in Africa – top-down fragmented approach which is “integrated” around managers’ needs rather than patients’ needs – makes it very difficult for PHC teams to deliver high quality care for patients that the majority are trained for. Family medicine considers interdisciplinary teamwork essential.

In Africa, PHC service delivery is expected to be personalised, comprehensive, continuous and coordinated just like the global standard.[6] Personalisation comes with several tools for patient- and family-centred care that matter to generalists across the world and that are still implemented by African family physicians, family nurse practitioners and others, even in difficult circumstances in some spaces. Knowledge and practice of good consultation skills is essential for the delivery of patient-centred care with shared decision-making in delivering services. Comprehensiveness can be achieved by ensuring that as many of a patient’s needs are met in any one of their encounters with first contact care. Continuity means that repeated episodes of care are perceived by patients as continuous, whether
personally, informationally or by continuity of management by a team. Coordination is about the PHC team as a unit ensuring that referrals within and especially beyond the team are coordinated around the patient’s bio-psycho-social-spiritual needs.[7]

**Envision comprehensive person-, family- and community-centred PHC**

*We call on Africa to embrace primary care, defined by WHO as an essential level of care that needs to be responsive, person-, family- and community-centred, and covers the full spectrum of care within the paradigm of One Health for PHC and UHC in Africa by 2025.*

Low- and middle-income countries risk over-simplifying primary care and primary health care.[3] Whilst PHC is a broader concept than primary care (PC), good quality primary care services need to be better understood and structured to achieve PHC. This must make use of PC as defined in the three levers of PHC from WHO/UNICEF’s Operational Framework for PHC.[8] It must also utilise PC services as the cornerstone of frontline PHC service delivery and serve as the principal tool of governments’ provision of first contact health care for their populations. PHC services include illness prevention, health promotion, treatment, rehabilitation and palliation. Common conditions are easily complicated by growing multimorbidity, unhealthy choices fuelled by the commercial determinants of health, psychosocial and spiritual issues. Such unique person-centred care with strong humanism is best delivered within a wider spectrum of care in the context of family, work, community, environment and information. While a systematic review has shown that most patients in Sub-Saharan Africa view PHC positively, our experience is that African patients are no longer happy to be treated as numbers in a large faceless PHC system where relationships are neither existent nor supported.[9] Unsafe and ineffective primary care increases morbidity and preventable mortality, leading to increased use of hospital and specialist resources, especially in private health care. Traditional health and self-care are important constructs for engagement by PHC in Africa. [3,10] There is a growing interest in One Health with climate change, where human health (especially PHC) is seen as intertwined with the health of other living things and the environment as a whole.[11] Africans are struggling with the effects of climate change and air pollution which have affected their health and safety in a variety of ways. The WONCA Course on Planetary Health is an important free resource for PHC workers for community care and advocacy, starting at local level.
Integrate PHC priorities

We call on Africa to integrate priority programmes (communicable diseases, non-communicable diseases, mother-woman-child health, violence-trauma, mental health, etc.) into PHC in a diagonal manner that both supports these vertical priorities as well as the horizontal integration by PHC teams around patients and populations for UHC in Africa by 2033.

Strong person-, family- and community-oriented PHC must have priority health programmes that are integrated within the care that is provided to each individual in a personalised manner. This can work very well in PHC teams that are themselves integrated to work on that premise, embrace task sharing and support each other in a range of skills suitable for the country’s full human resources, both public and private, and designed to cater to empanelled populations universally across the country. Important priorities in the burden of disease across Africa must be part of both the training and service by integrated PHC teams: communicable diseases, non-communicable diseases, mother-child and women’s health, violence and trauma, mental health plus a range of national/regional priorities. Ultimately, the PHC team should understand the demographics and epidemiology of their local empanelled populations and incorporate these priorities into strong community-oriented primary care.

Strengthen rehabilitation and palliation in PHC

We call on Africa to strengthen rehabilitation and palliation in PHC by 2033 with decentralised and well-funded community rehabilitation and palliation services, where teams with an appropriate mix of skills and professional supervision are linked to multiple community practices for accountable care.

Most communities in Africa lack access to rehabilitation and palliation services. In addition, there is poor understanding of disability issues as well as death and dying, centralised services, skills shortages, spending largely out-of-pocket and poor policies. Populations that require these services are largely invisible and experience more significant barriers to care, e.g., lack of transport. This population is also more vulnerable to the social determinants of health. Cost-effective community-based rehabilitation and palliation services require service delivery reform with strong emphasis on accountability and performance management. Decentralising services to community level (including role- and task-sharing with mid-level rehabilitation and palliation workers in team-based care supervised by rehabilitation and palliation professionals, peer-parent facilitators – home-based care, innovative assistive device management and social empowerment by CHWs, as an add-on to a set of community practices) can strengthen rehabilitation and palliative service coverage in PHC for UHC.
Integrate oral health into PHC

*We call on Africa to integrate oral health into PHC by 2033 with team-based service delivery models that include appropriate role- and task-sharing with a range of oral health care practitioners, plus dentist support and supervision. These should be linked to multiple community practices for accountable care.*

In Africa, there are independently functioning dental and medical care systems with inequity and missed opportunities to provide services. The integration of oral health into PHC systems can reduce the burden of oral disease and improve access to oral health care, especially for the disadvantaged and under-served communities. It should include risk assessment, oral health evaluation, preventive interventions, communication and oral health education. This is important as there is a strong biological relationship between what occurs in the mouth and the rest of the body. Many vulnerable population groups with untreated oral diseases often obtain medical care but not oral health care, especially in emergency settings. Integration can also reduce the cost of oral health care. This can be achieved through integrated team-based service delivery models that include appropriate task-shifting to a range of PHC team members and oral health care practitioners using population-based models of care. This must include dentist supervision. Whilst the population for oral health care teams may have to be larger than those for the medical/clinical core team, the prerogative of oral health care needs to be embedded into all community practices, especially with CHW work on environmental and societal factors that have an impact on oral health as practised in Brazil.[12,13]

Improve access to medicines and investigations in PHC

*We call on Africa to strengthen access to medicines and investigations with a greater embrace of pharmacy professionals and point-of-care technology at PHC level to achieve PHC for UHC in Africa by 2033.*

Medicines and investigations are an important component and cost of PHC, besides the workforce. It is of vital importance that pharmacists are incorporated into PHC. They could supervise and support teams that cover multiple PHC facilities and mid-level pharmacy staff who can then improve the quality of management of medicines, as well as reduce the burden of pharmacy management on the non-pharmacy workforce. Laboratory technicians are quite prevalent across Africa. This cadre can be enhanced with the use of more point-of-care testing devices, better training and stronger quality assurance at PHC level to ensure patient safety. The increasing technological advances, the value of simple tests in local settings and important clinical decision-making, e.g., antibiotic prescription, plus the increasing value of such interventions make this a compelling proposition for
PHC in Africa. This includes a range of investigations that technology has made more accessible and amenable to be placed in PHC settings, e.g., point-of-care ultrasound and digital radiology.

**Improve coordination of referrals**

*We call on Africa to strengthen coordination of PHC referrals to hospitals with the placement of postgraduate-trained family doctors and other advanced practitioners in PHC teams by 2033 to achieve UHC in Africa.*

Coordination of care, specifically managing referrals from primary to other levels of care, is a vital component of high quality PHC and is best done by postgraduate-trained family doctors placed in PHC. They will be able to manage referrals as gatekeepers, doing what is possible in the PHC setting and then referring appropriately to other specialists and services. This coordination function operates with other key elements of first-contact PHC – management continuity and service comprehensiveness to achieve higher quality care. Global work done on postgraduate-trained family doctors placed in PHC indicates that this type of care is able to achieve fewer and more appropriate referrals and fewer re-admissions, thus lowering the overall cost of care. This placement can also allow well-trained generalist expertise to negotiate the engagement of various other specialties into PHC based on medical needs, and in a targeted manner to achieve better results at a lower cost.[6,14,15]

**Health in All Policies (HiAP) for robust PHC**

*We call on Africa to prioritise PHC as the foundation for UHC: making “Health in All Policies” an integrating and developmental public health approach to , decentralised government, and strengthening PHC teams with local linkages to other sectors affecting social determinants of health by 2025 to deliver PHC and UHC in Africa.*

The Africa Health Agenda International Conference (AHAIC) Commission makes important recommendations to re-orient African health systems and prioritise and strengthen PHC as the foundation for UHC.
Box 5: AHAIC recommendations

AHAIC recommendations to re-orient health systems to prioritise and strengthen PHC as the foundation for UHC:

1. Prioritise PHC and a Health in All Policies approach at the highest level of government as an integrating concept for a developmental approach to decentralised government.

2. Reallocate existing health system resources and increase investments to prioritise the strengthening of PHC systems.

3. Strengthen the role of PHC facilities as the first point of contact for health care needs. This includes increasing physical access to PHC facilities, employing mechanisms to explicitly assign population groups to PHC units, and implementing robust referral systems.

4. Strengthen PHC delivery by implementing flexible models of non-hierarchical multidisciplinary teams of clinical and non-clinical staff to provide integrated care to defined empanelled populations.

5. Implement integrated care models of service delivery, contracting and reimbursement. This will entail developing primary care networks that integrate horizontally across several health care providers at the same level and across services to span promotive, preventive, curative, rehabilitative, and palliative care and community health systems, including traditional medicine providers; diagonally with various priority programmes; and vertically with secondary health care facilities.

It recommends a “Health in All Policies” approach by national governments as an integrating and developmental public health approach to decentralised government. The “Health in All Policies” approach brings together various stakeholders whose contributions are critical to ensuring a functional, effective and efficient PHC, including providers of utilities (potable water, electricity, waste, information and security management). AHAIC suggested PHC delivery be implemented by using flexible models of non-hierarchical multidisciplinary teams of clinical and non-clinical staff to provide integrated care to defined empanelled populations.[1] This is in line with the Primary Health Care Model put forward by WHO.[16]

Box 6: Primary Health Care Model

AfroPHC supports a model of primary health care (WHO, 2018) which incorporates “a whole-of-society approach to health that aims to ensure the highest possible level of health and wellbeing and their equitable distribution by focusing on people’s needs and preferences (as individuals, families, and communities) as early as possible along the continuum from health promotion and disease prevention to treatment, rehabilitation and palliative care, and as close as feasible to people’s everyday environment. Furthermore PHC incorporates care that 1) Meets people’s health needs through comprehensive promotive, protective, preventive, curative, rehabilitative and palliative care throughout the life course, strategically prioritising key health care services aimed at individuals and families through primary care and the population through public health functions as the central elements of integrated health services; 2) Systematically addresses the broader determinants of health (including social, economic and environmental factors, as well as individual characteristics and behaviour) through evidence-informed policies and actions across all sectors; and 3) Empowers individuals, families, and communities to optimise their health, as advocates for policies that promote and protect health and well-being, as co-developers of health and social services, and as self-carers and caregivers.”[16]
Build the District Health System

We call on Africa to strengthen district health services to coordinate decentralised and empowered providers by 2033 and to ensure they deliver on agreed-upon results as they implement PHC and UHC in Africa.

The district health system has been promoted across Africa. However, planning of health service delivery in some African countries is conducted at ministerial level, in most cases with local managers, health workers and communities just receiving what was concluded without their involvement. Most district managers utilise the top-down approach rather than focusing on the patient in what must be a bottom-up approach led by the PHC team in their daily encounters. Complexity is a way of thinking, in which system structures are interconnected with non-linear multi-directional interactions that the system evolves with. Complexity theory supports “emergent” behaviour from the ground up, which cannot be predicted using deterministic models. PHC should be seen as a complex adaptive system and supported with a clear purpose, values and simple operating principles to drive it in the right direction.[17] Policy proposals for UHC contracting for PHC, indicate that health care workers can be agents of change with a few principled operational drivers set out by policymakers for action at district level to drive appropriate and responsive PHC.[18] Some governments in Africa, e.g., Rwanda, Kenya, Sierra Leone and Nigeria, are already embracing this bottom-up approach where policymakers are able to step back and give PHC providers space to do what they are trained to do. We see the role of DHS as coordinating empowered PHC providers working as PHC teams at both facility and community levels.[19]

Empanel defined populations to a defined team

We call on Africa to embrace the strategy of empanelment of a defined population and link them to a defined, fully staffed and equipped PHC team and medical home by 2025 as a foundational step to achieving PHC and UHC in Africa.

The World Health Organisation (WHO) considers empanelment a foundational component of PHC. It is about assigning populations to facilities/PHC teams with a responsibility of understanding their assigned population and to deliver coordinated care. Empanelment allows PHC to move from reactive care, oriented around facility visits by patients, to proactive care that leverages the PHC team’s potential to improve population health. It allows a relationship to be built between the population and their providers.[20] Small defined populations cared for by a team with an appropriate mix of health care workers and delivered in a comprehensive, continuous, coordinated manner can be the complex adaptive system that could deliver better PHC and health for all in Africa.[7] While global
panels average 1,500, there are some countries where it is larger, e.g., in Brazil where 3,500 are cared for by a family doctor, family nurse practitioner and a group of CHWs. Africa has the experience to explore larger panels for a PHC team, e.g., the Chiawelo Community Practice with 10,000 to 30,000 people (see Box 3: The Chiawelo Community Practice).

There is need to define and standardise PHC facilities and human resource nomenclature across Africa as teamwork should involve all health care workers. From here, appropriate population panels to PHC team mixes can be defined in ratios appropriate to each country’s human resources (including private sector providers). However, this must be built in layers, starting with the clinical core of CHWs, family nurse practitioners, clinical officers and a family doctor.

Develop community-oriented primary care for Africa

*We call on Africa to embrace community-oriented primary care in community practices of 30,000 by 2033 and aspire to community practices of 10,000 to achieve PHC and UHC in Africa by 2043.*

A culture of distributed leadership and clinical accountability can be created to improve PHC team cohesion and thereby ensure quality care for populations in Africa. This can be realised in a decentralised model of PHC team practice, dubbed “community practice”. It is based on experiences with PHC teams in Africa, e.g., the Chiawelo Community Practice. In this model, CHWs serve defined sections of an enrolled population of 30,000 strongly linked to clinicians at a local clinic where care is provided in a patient- and family-centred manner by a PHC team with a mix of skills including a family doctor, clinical associate, family nurse practitioners and CHWs. This link involving individual, facility, community and self-care is strengthened by stakeholder engagement and targeted health promotion based on data collected from the enrolled population. Panel sizes of enrolled populations can be larger than the global averages. The Chiawelo Community Practice reveals that 30,000 per core clinical PHC team of a family doctor, family nurse practitioners, clinical officers and CHWs, can work as a point of departure. However, we propose 10,000 per core PHC team across Africa as an aspirational target for 2050.[21] PHC team configurations for various ancillary disciplines can also vary across Africa, taking pathophysiological processes, social determinants of health, available human resources and the skills mix (including ancillary health professions) needed into account.
Box 7: Strategy for defining PHC teams per panel

We need to establish the total PHC human resources in each country per population and then work out the ratios per 10,000. It then becomes possible to explore a combined team composition appropriate to the country (whether 10,000 or 30,000), that will ensure equitable access and quality. Different configurations of PHC teams (and the many additional layers of PHC team members) need to be progressively explored across Africa based on and optimised with clear and defined human resource and population data, available resources and understanding of community needs in each country. This approach can be adapted for all members of the PHC team, including oral health and rehabilitation professionals and various other cadres (including CHWs) that can extend their reach through task-sharing. Ensuring an appropriate mix of skills in community practices at first contact primary care will not work without appropriate funding and payment reform for PHC teams in Africa.

“Rural-proof” rural and marginalised urban health

We call on Africa to embrace the Blueprint for Rural Health and rural-proof all health policies by 2025 to support rural and marginalised urban primary health care comprehensively, especially by creating stepladder entry requirements for educational institutions and rural/marginalised urban student immersion for the full PHC team, to achieve PHC and UHC in Africa.

Africa is still largely rural, but is rapidly urbanising. The Blueprint for Rural Health urges governments to act on several fronts. The ideas are applicable in both rural areas and marginalised urban settings in an Africa that is grappling with rapid and poorly managed urbanisation. Governments should ensure that resources are available and conveniently accessible to all sections of the population irrespective of their socio-economic status. PHC in marginalised areas should be predicated on fit-for-purpose community infrastructure. Education, employment, housing, clean water, sanitation, good roads and sustainable energy are essential to this. Communities should be empowered – in all spheres of life – to identify and solve their local health care challenges. Policies should be assessed in terms of their impact on vulnerable communities to mitigate any adverse effects of these in marginalised areas. Governments should strengthen intersectoral collaboration and coordination among various departments and work towards developing a unified policy to promote health and resilience among vulnerable groups. The Blueprint for Rural Health also informs human resource development. It advises that the health workforce be systematically supported and planned with a stepladder progression of skills attainment and certification of the PHC team. Students undertaking health science courses should also have marginalised immersion that reflects the significance and importance of practice in hard-to-reach areas. Educational institutions must orient their training, research and service provision to prioritise the underserved and vulnerable populations.
During the last two decades, increasing evidence has emerged on not only what should be done, but how to do it. These have been encapsulated in the “Blueprint for Rural Health” from the 17th International Rural Health Conference. The blueprint was designed to inform rural communities, academics, and policy makers about how to reach the goal of delivering high quality health care in rural and remote areas most effectively. It outlines several important principles that should underline rural and remote health including the importance of advocacy, PHC, UHC, public health, community infrastructure, access and the workforce. Some important concepts and themes include end-to-end planning and integrity, clinical courage, rural health education, immersive community engaged education, rural exposure, stepladder education, engaging young doctors, the right health worker, rural policy and localizing economic benefits. This provides a framework for further developments in rural and remote health for the benefit of rural people and communities.

Decentralised training platforms and distance-based training can cater to all members of the PHC team. Nigeria and Ethiopia offer examples of such training schemes.[23–25]

Women deserve extra consideration in PHC

We call on Africa to recognise the unique challenges of women in PHC and to explore innovative and sustainable interventions to overcome these for PHC and UHC in Africa.

It is important to consider women in PHC for UHC, both as users and providers. Many women interact with PHC as users, while many more find themselves suited to provide care in PHC. There are serious limitations to women’s participation in PHC, both as users and providers, especially with gender-based violence and sexual harassment, plus the lack of safe avenues for reporting these. Female users are also forced to contend with inaccessible facilities, lack of financial and cultural independence, greater health burdens, home obligations, cultural-community norms, and a reluctance to be attended to by male health care workers. Female providers must also contend with salary gaps in some countries, and male-dominated leadership.[26, 27]

Youth deserve extra consideration in PHC

We call on Africa to recognise the unique opportunities for youth in PHC and to explore innovative and sustainable interventions to address these for PHC and UHC in Africa.

It is important to consider youth in PHC for UHC, both as users and providers. With a youthful Africa it is important to address their needs. The WHO vision for PHC in the 21st century includes the importance of managing youth.[16] Youthful professional students and providers are an important source of inspiration for AfroPHC. The organisation is actively developing youth activities to support PHC and UHC by involving youthful leaders.
in the governance of AfroPHC so that they can drive its agenda far into the future. The youth can build a strong community of practice in creating the foundations of PHC and UHC in Africa.[28]

**Make e-Health accessible, interoperable, and patient- and user-friendly**

*We call on Africa to embrace the variety of e-Health solutions for PHC by ensuring that sustainable national e-Health strategies are supported by accessible infrastructure, interoperability and user-friendly designs that enable the PHC team and patients/populations to enhance quality and support new models of care in PHC and UHC in Africa.*

COVID-19 brought e-Health to the fore for all of us, especially in PHC. E-Health is a vital part of the solution to bring quality PHC and UHC to scale across Africa. However, solutions are not well-contextualised both for provider and user. Solutions need to be always focused on patients and the population, and must therefore take into consideration end-user capacity. This is both in terms of skills and ability to integrate e-Health into poorly capacitated and busy African PHC settings. There is a great opportunity to utilise e-Health with growing internet connectivity and mobile phone usage, growing use of digital tools and the evolution of electronic medical records in high disease burden African settings. A combination of innovative and tech-enabled solutions could, over time, help to re-imagine an African PHC that is tailored to patient pathways. These would ideally seamlessly integrate brick-and-mortar and remote point-of-care (PoC) solutions to provide continuous, integrated, and preventive care, especially for long-term conditions, among team members and at different levels of care. E-Health can increase efficiency by reducing unnecessary in-person visits, optimise facility workflow processes and reduce access barriers for clients. It can also streamline and coordinate supply chains, workforce and facility costs, thus increasing availability and quality of PHC services. E-Health can also be integrated into professional education to build the capacity of the health workforce. AfroPHC does not endorse single national digital health systems, but rather advocates for strong nationally regulated systems that integrate multiple solutions with interoperability and make for seamless PHC service provision across Africa.[29-31] This can help the continent to leapfrog the world.

**Build community engagement and social participation**

*We call on Africa to engage communities and ensure social participation in advancing team-based PHC across Africa.*

AfroPHC strongly supports community engagement and social participation for UHC
and recognises the role of CHWs in the African PHC team, as set out in WHO’s Handbook on social participation for UHC. [32] UHC may not translate into adequate PHC if social participation is not addressed. Participation by communities, as an empowered voice with agency, is vital to get behind this call. There needs to be an enabling environment for participation where power dynamics are addressed to create equal conditions for engagement. Representatives need to be considered legitimate and able to represent.

The engagement between government, communities and civil society needs to be recalibrated to create a level playing field for frank discussions and policy influence. Legal frameworks should be created for participation, especially through decentralisation. Long-term sustainability of participatory spaces can only happen if these are adequately funded so that people remain engaged, results are visible and a culture of participation is created. [32] We intend to engage communities using these principles whenever we can, from building AfroPHC Chapters in our countries to building best practice community-oriented primary care around our own practices.

**Build quality into PHC**

*We call on Africa to embrace the culture of quality and patient safety with strong teamwork, and to measure and monitor performance to achieve quality PHC and UHC in Africa.*

Improving access has come at the cost of quality. There is need for major reform to achieve quality and UHC offers the opportunity. Quality PHC can best be provided by a suitable trained workforce with the multiprofessional perspectives of family doctors, family nurse practitioners, midwives, clinical officers, CHWs, oral health care workers, pharmacists, laboratory technicians, physiotherapists, occupational therapists, social workers and administrative staff. However, the priority for quality improvement is empowering health care providers and the enhancement of teamwork by the array of professionals available. Africa should avoid a siloed training and practice medical model of PHC service delivery in UHC initiatives, especially among clinicians. There is a culture of territoriality in health care with entrenched silos that could derail a renewed focus on the patient, teamwork and interprofessionalism. There is need to develop and understand professional identity and to then articulate the role, space and contribution of each cadre in a PHC team as colleagues.

Multidisciplinary teamwork in PHC goes beyond care providers – the PHC team needs to liaise with other disciplines and various networks, e.g., education, civil works, water, power supply, security, environment, trade and community-based institutions, in line with the Health in All Policies approach described earlier. [33,34]
Manage effectiveness

**We call on Africa to develop and support practice and population research sites focussed on PHC across Africa and to expand the range of indicators that will assess the effectiveness of PHC teams empanelled to populations as a key service delivery reform.**

What gets measured gets done. It is unfortunate that a 2022 scoping review on Strengthening the Health System as a Strategy to Achieving Universal Health Coverage in Underprivileged Communities in Africa showed little evidence of PHC teams empanelled to populations to be able to achieve UHC.[35] This is despite a consensus amongst PHC workers that this concept does deliver better health care and outcomes in line with UHC. The Primary Health Care Performance Initiatives (PHCPI) 38 Core Indicators and resulting Vital Signs Profile, inspired by the PHCPI Conceptual Framework (2017) have further inspired various indicators in the WHO's PHC Measurement Framework (2022). These tools, based on the 14 Levers of the Astana Operational framework, can support the improvement of service coverage, financial risk protection and ultimately the health of patients and populations in Africa. These are particularly pertinent to the PHC workforce, models of care, engagement with private providers and purchasing and payment systems. Whilst Tier 1 indicators (including Global Indicators) are more feasible to collect, Tier 2 indicators, deemed desirable and needing testing, speak more compellingly to issues that could test the value of PHC teams empanelled to populations. These are specifically processes and outputs of PHC. There are useful examples in both. On the process, examples of useful indicators include experience of an empanelment system in models of care; multidisciplinary team-based service delivery in organisation and facility management; and collaboration between facility-based and community-based service providers. In the case of outputs, access indicators are available. However, more work needs to be done on useful indicators on quality of care. Examples include people's perception of health systems and services; admissions for ambulatory care sensitive conditions; prescribing patterns for antibiotics; and provider caseload.[36,37]

These can be expanded with testing of revalidated tools that can be more widely scaled across Africa. The indicators can be incorporated into the WHO measures of UHC across Africa. We need to focus on key indicators such as out-of-pocket expenditure and catastrophic expenditure to provide a much more sensitive measure of service coverage, as opposed to the current narrow programmatic-type measures available. This would truly underpin WHO’s strategic goals in Africa of rethinking and repivoting health service delivery with a focus on service integration, community involvement, private sector engagement and enhancing resilience.[38]

AfroPHC is working with various partners to develop and strengthen practice- and
population-based research networks across Africa. We are committed to mobilising PHC workers across Africa to create teams around empanelled populations as sentinel sites across Africa, to share best practices and to show evidence of how effective we can be at both practice and population level once empowered to deliver quality PHC as a team. We also consider the PHCPI's PHC Progression Model as a way to develop country AfroPHC Chapters and engage with stakeholders around these objectives.[39]
3. **PHC WORKFORCE**

**Strengthen human resources for PHC**

*We call on Africa to build a larger, better trained PHC workforce (integrating public and private providers) with more opportunities (educational, financial and clinical) and greater resources (starting by structurally defining PHC services) to enable PHC and UHC.*

Africa has the most severe health personnel shortages, with the need predicted to reach 6.1 million by 2030 out of the anticipated global health care worker need of 14.5 million required for UHC and to achieve the Sustainable Development Goals (SDGs). Africa had an average of 1.30 health workers per 1,000 people in 2015, significantly less than the 4.5 needed to attain the SDGs.\[1\] With this shortfall, the focus of the health system becomes more curative, with professionals working in curative spaces like hospitals (often serving the elite) and primary care (usually for marginalised communities) regarded simplistically.\[3\] This distortion in distribution of human resource compounds the problem of poor quality primary care with the growth in both hospitals and a private sector that perversely neglect PHC needs.

As AfroPHC came together, we realised that the definition of the PHC workforce is lacking, with non-standardised nomenclature, training, qualifications, pay and career prospects across the continent. Primary care providers in many low-middle income countries (LMICs), struggle with the poor definition of PHC services resulting in difficulty measuring the financial and human resource allocations to PHC. Many countries do not have statutory standards of care to be expected at the different levels of care, including the PHC level. Health services, especially the primary care service delivery platform, lacks definition and ring-fenced resources. The number of family doctors, family nurse practitioners, clinical officers, CHWs and other members of the PHC team available in the country is often not easily or reliably available. This is further exacerbated because governments do not take their stewardship role over the private sector very seriously and have not created systems to measure the total number of professionals across the country, with planning based on just public health service ‘shortages’. There is need to clearly define the spaces of primary health care, including the human resources required to service it in a standardised way across Africa. This will lay the basis for strengthening human resources for PHC and UHC in Africa.\[40\]
Build the team with role-sharing and collaborative supportive supervision

We call on Africa to acknowledge the burden on all cadres in PHC and to embrace trans-professional collaboration with a mix of all health professionals using respectful, collaborative role-sharing and supportive supervision to achieve PHC and UHC in Africa.

We acknowledge various cadres – family nurse practitioners, midwives, dental therapists, pharmacy assistants, laboratory technicians and community health practitioners – as the backbone of PHC service delivery across the continent. We bemoan their neglect with a growing service burden without the required competence, resources and support. Rather than looking for some ubiquitous “mid-level” worker to “solve all” problems, we propose the adoption of the language of interdisciplinary and interprofessional teams, as mentioned in Astana, for enhanced health outcomes. There will always be professions, but trans-professional collaboration (TPC) can enhance a deliberate exchange of knowledge and skills aimed at meeting complex health care needs. Role-sharing is important in the current PHC service delivery with the shortage of all health professional cadres. However, siloed task-sharing is not the same as teamwork, where everyone should be focused as a team on holistic person-centred care. Role-sharing should not be about “replacing” or “substituting” any health professional. It is about extending the reach of the PHC team considering the limited resources. PHC teamwork is best achieved in an integrated and flexible mix of skills with supportive supervision. Role-sharing can be achieved through PHC teamwork and collaboration among many disciplines and should not be resisted by professional turfs. Instead, there should be cooperation to extend the range of services/tasks possible by the PHC team in an accountable manner, e.g., allowing advanced nurse practitioners and clinical officers to prescribe based on their education, training and scope of practice so that the team becomes fit-for-purpose in an efficient manner. The skills mix will create resilience with flexibility.

Service packages are not usually defined by a written document, but rather by the mix of professionals and resources available at practice level. Whilst nurses, midwives, clinical officers, family nurse practitioners, family doctors and CHWs are all core to integrated PHC service delivery in Africa, all other health care professionals (including pharmacy, laboratory, mental, rehabilitation, oral health etc.) and other stakeholders (patients, administrative staff, community, traditional services, local leaders, etc.) need to be part of the PHC team in an interprofessional team-based approach that balances curative and preventive care. This can only be achieved through adequate human resource planning and integration, upscaled workforce training and education, appropriate credentialing and regulations, plus
by incorporating aspects of support and supervision. For the protection of patients and to ensure quality care outcomes, role-sharing should be subject to appropriate education and training in new skills. It should also be backed up with supportive supervision, mentoring, monitoring and evaluation.

**Build distributed leadership**

*We call on Africa to embrace distributed leadership practices, and ensure that education and training is made available to all PHC workers and managers to achieve PHC and UHC in Africa.*

Professional turf wars continue globally, and in Africa. The sources of conflict include role boundary issues, scope of practice and accountability.[41] The increasingly globalised and digital nature of work in the future is not in fixed roles, teams and spaces, and would require practical changes in PHC.[42-44] A critical role in this regard is leadership. It is crucial to train PHC teams on the need to embrace such roles at the undergraduate level. Leadership is often portrayed as an entitled position, usually of authority and power. However, all PHC members must be trained to understand that occupation of a formal leadership role is not a requirement to be a leader.[41,45] True leadership for teamwork should support various team roles in relation to tasks. Team members, as “leaders”, should look and listen to the team dynamic, reinforce the value of each role, help set boundaries and attempt to fill gaps in the team where needed skills are not available. This “leadership” role should assiduously seek to understand unique ideas and motivations, both in relation to the initial team objectives, and then weave each of these into an overall bigger vision for the team. [45] True leadership should also actively seek to empower others to be leaders, building on strengths, helping overcome weaknesses and seeing in teammates the things that the teammates themselves may not see – possibilities.[44] This enhances team motivation and cohesion, thus reflecting the wise words of Aristotle that “the whole is greater than the sum of its parts”.
We call on Africa to embrace the important role of medical, dental, nursing and other professions with post-graduate training for decentralised primary care settings to support clinical governance, coordinated care and efficient referrals to achieve PHC and UHC in Africa.

True leadership should recognise and defer to clinical knowledge and the need for clinical governance in the PHC team.[46] Clinical governance practised in Africa, with low income and resource constraints, needs to be more contextually relevant, with managers and professional members of the facility working synergistically to address the many quality-hampering gaps, such as lack of an enabling health law, financing-mix, lack of infrastructure – water, sanitation, electricity, etc. An example is the 12-Pillar Clinical Governance Programme in Nigeria.[47] The hierarchy of clinical knowledge, especially with medical training, needs to be acknowledged and respected.

PHC teamwork and distributed leadership will not work if the team is not held clinically accountable. Postgraduate-trained family doctors, dentists and other professionals can ensure broad clinical accountability and specifically prevent inappropriate referrals. They need to be acknowledged for their ability to improve clinical quality across the spectrum.
of care from clinic to community, and not just in hospitals.[44] In addition, an enhanced role in more decentralised primary care settings to support clinical governance could strengthen the competencies of family nurse practitioners and other health care providers, and create effective and efficient PHC teams. We advocate that mechanisms be put in place to ensure that all cadres respect and keep to their clinical competence levels for the safety of patients under their care, and referring to the next higher cadre as appropriate, in a timely manner.

Professionalise community health workers

*We call on Africa to standardise, professionalise and decently remunerate community health care workers who are strongly integrated into the PHC team, and furthermore to aspire to a target of one CHW per thousand persons by 2043 to achieve PHC and UHC in Africa.*

CHWs and the many equivalent cadres across Africa are an essential part of the PHC team and need to be respected, as UHC may not translate into adequate PHC. Participation by communities, as an empowered voice with agency, is vital.[32]

**Box 9: Nomenclature for CHWs, including TBAs**

Community Health care Workers (CHWs) as lay persons with basic education, trained in short courses lasting weeks or months, and then working in the community as mostly preventive/promotive caregivers, whether paid or voluntary, are common in Africa. However, the nomenclature may vary across the continent. In most cases they are known as CHWs or Community Care Givers. However, there are some variations; in Ethiopia they are known as Community Health Extension Workers (CHEWs), while in Malawi they are known as Health Surveillance Assistants (HSAs). In Nigeria, their status and position are enhanced as they are called Community Health Practitioners comprising: Junior Community Health Extension Workers (JCHEWs), Community Health Extension Workers (CHEWs) and Community Health Practitioners (CHPs).

CHWs need to be professionalised by defining their training, employment and fair remuneration, among other issues. They perform important educational and support tasks for rural and marginalised communities in Africa. They embed a whole of society approach that embraces meaningful engagement across sectors (education, agriculture, environment, financial, etc.) to identify innovative and sustainable solutions. They tackle preventive, promotive, predictive and curative health areas. However, CHWs should not be seen to substitute professionals, but rather extend their reach as part of the PHC team.
Box 10: Two sides of the same coin

Professionalised CHWs and trained family doctors are two sides of the same coin. You need a professionalised CHW workforce to go into homes and maximise the value of community outreach and community-based care. At the same time, they need to be integrated into and backed up by a PHC team operating out of a facility anchored by a family doctor – typically the only advanced health workforce provider specifically trained in competencies of all the core primary care functions (first contact access, comprehensiveness, continuity, coordination, patient-centredness) AND complex diagnosis and management of undifferentiated problems at the frontlines of care AND community-oriented primary care (COPC).[70] They are a crucial component to filling out the full scope of services of the PHC team. The other essential roles of the team (family nurse practitioners, midwives, pharmacists, behavioural health providers, rehab, etc.) are then supported on both the frontline lines reaching into the home and with expert resources for managing complexity to the maximum degree that community-based services are capable, and making efficient and appropriate referrals to elevated levels of care.

They are essential in the balancing of the bio-medical focus of health professionals and to engender community engagement by the PHC team. CHWs, as part of the holistic interdisciplinary team, can improve reach, reduce inequity and provide a good return on investment, not only through their impact on community health, but as a job creation mechanism across a country. It is recommended that CHWs be professionalised and remunerated in all countries in Africa as they form an integral part of the health ecosystem. [48]

The effective use of CHWs is evident in case studies from Nigeria, Ethiopia and Rwanda. [49] Career progression of CHWs, including prioritising them as recruits for higher levels of professional training, can promote professional retention in rural and marginalised communities.[50]

Manage human resources better

We call on Africa to clarify and harmonise PHC workforce nomenclature for the different categories and disciplines in PHC, and to then embark on labour market analyses in PHC (including public and private) and specific PHC human resource for health (HRH) policies and strategic plans to scale up the PHC health workforce by 2033 to achieve PHC and UHC in Africa.

Human resource management for PHC is critical. The shortage of human resources in Africa compared to the rest of the world is compounded in African PHC, with professional resources drawn into hospitals located in urban centres and often linked to private practice. Weak human resource for health (HRH) leadership and governance compounds the challenges of PHC workers, resulting in poor remuneration, poor working conditions, heavy workload and burnout, which all contribute to poor quality of care. Other challenges include development of curricula that have ignored the reality of the African context, poor harnessing of the multidisciplinary team, lack of supportive supervision and mentoring,
migration, inefficient use of the available workforce and staff demotivation from lack of appreciation.[51,52] Documents such as the Kampala Declaration and Agenda for Global Action mention, inter alia, the retention of an effective, responsive and equitably distributed health workforce and scaling up health worker education and training using a needs-based skills mix. Critical success factors for scaling up include political commitment and good governance, workforce planning (with relevant skills mix) and creation of an enabling environment.

A useful framework on how to manage human resources better is depicted in the working lifespan framework from WHO: Entry (Preparing the workforce with planning, education and recruitment), Workforce (Enhancing worker performance with supervision, compensation, systems support and lifelong learning) and Exit (Managing attrition with migration, career choice, health and safety and retirement). All this is expected to lead to Workforce Performance (availability, competence, responsiveness and productivity). [51, 53, 54] The WHO AFRO Regional Road Map for Scaling Up the Health Workforce by 2025 offers useful insights into scaling up with proposals for investments in harmonised health systems, with national registries and HRH information systems, to support and track the development and efficiency of the PHC workforce.[55] Each PHC team member should be working within the full scope of their capability in versatile, resilient teams, and supported further by a wider regional team through collaboration. The Blueprint for Rural Health provides useful insights for PHC workforce management. Successful recruitment requires intersectoral investment in training and career progression in PHC, thus creating a desirable workplace, and thereby putting in place and incentivizing a pool of workers who can make a longer-term commitment to a rural area. These initiatives can be successful in attracting and retaining young health professionals to remote and marginalised areas.[22]

**Develop human resources better**

*We call on Africa to implement robust educational and credentialing systems in order to develop a competent workforce dedicated to delivering comprehensive PHC services necessary to achieve UHC in Africa.*

All team members must be educated in the core competencies to deliver UHC. Focused education of all health care professionals for PHC service delivery should be intensified. In addition, all professionals should be trained interprofessionally together in different levels of comprehensive family and community care, rather than just in narrow fragmented task-shifting or in the artificial environment of central academic institutions. This will enable the entire PHC team, well-trained in the principles of family medicine and generalist PHC, to deliver high quality bio-psycho-social-spiritual personal health care. This must be practised to a scope that is most efficient for each country.[57]
Box 11: Definition and practice scope of an Advanced Practice Nurse Practitioner

A family nurse practitioner is an Advanced Practice Nurse who integrates clinical and biopsychosocial skills associated with nursing and medicine to assess, diagnose, and manage patients in PHC settings and acute care populations as well as ongoing care for populations with chronic illness. The Nurse Practitioner possesses advanced health assessment, diagnostic and clinical management skills that include pharmacology management based on additional postgraduate education (recommended minimum standard Master of Science degree) and clinical education that includes specific clinical practicum to provide a range of health care services. The focus of NP practice is expert direct clinical care, managing health care needs of populations, individuals and families in PHC or acute care settings with additional expertise in health promotion and disease prevention. As a licensed and credentialed clinician, the NP practices with a broader level of autonomy beyond that of a generalist nurse, advanced in-depth critical decision-making and works in collaboration with other health care professionals. NP practice may include, but is not limited to, the direct referral of patients to other services and professionals. NP practice includes integration of education, research and leadership, in conjunction with emphasis on direct advanced clinical care.[69]

Curricula used to educate the health workforce should be reviewed to integrate key competency areas such as clinical prevention, disease management, soft skills (e.g., emotional intelligence), entrepreneurship, digital literacy, population health, research, leadership and management. This approach must be integrated into the basic training, undergraduate, and postgraduate training and continuing professional development (CPD). Africa needs to upscale and train more PHC workers to a higher level to ensure a more capable and competent workforce able to provide the needed level of care. Some mid-level professional cadres need to be created to work in partnership with the professionals, not to serve as substitutes but rather to extend their reach.

Collaboration among all cadres of the PHC team in Africa (including CHWs) with lifelong learning will offer better options at scaled up training than offering training en-masse as a one-off exercise. In many AfroPHC workshops, PHC clinicians from Africa shared lessons from the training of family doctors, family nurse practitioners and clinical officers. Some useful lessons learnt were the alignment of training (programmatic learning outcomes informing curriculum content, assessment and educational approach) with resources, and roles and responsibilities in the health system. An experiential and co-constructivist adult learning approach was considered central to decentralised training centres, work-based learning and online support. Liaising with specialists in regional hospitals to create decentralised training platforms can enhance gatekeeping for secondary care and related costs. This onsite training can be further enhanced by online and/or blended learning approaches. The Family Medicine Diploma in Nigeria supported by the Postgraduate Medical College of Nigeria offers a useful template.[24] AfroPHC is building a core curriculum for online modular clinical family medicine and PHC training of family doctors, family nurse practitioners and clinical officers.
PHC Workforce

Box 12: AfroPHC Diploma in Family Medicine

AfroPHC is not only advocating for this policy framework, but is also doing its bit in building PHC teams for UHC across Africa. AfroPHC is developing a curriculum framework for post-graduate training of clinicians – family doctors, family nurse practitioners, clinical officers, etc. to work in a team in first contact primary care. They are expected to go beyond being a competent clinician to being a change agent, a capability builder, a critical thinker, a community advocate and a collaborator/mentor. Clinicians are expected to work with PHC teams to care for defined populations, and to build long term relationships. The plan is to develop ten modules for online work-based training over a period of 18 months. This is all based on work on the National Postgraduate Diploma in Family Medicine in South Africa.[70]

A key challenge is the commonality within Africa around nomenclature of PHC cadres as well as their training. Professional credentialing authorities need to come together across Africa to work on this. Training of clinical trainers and national (even regional) licensing examinations are useful opportunities. We advocate for educational frameworks for PHC in Africa. Governments should invest in research and innovation including creating dedicated domestic funds for building research capacity, offering grants and fellowships, together with the dissemination and utilisation of research findings to inform PHC training, practice and policy.

Protect PHC workers

We call on Africa to protect all PHC workers as a precious and vulnerable resource and to empower them to build quality and resilience as a team that works closely with communities to achieve PHC and UHC for Africa.

Health is one of the most hazardous sectors for workers, with daily exposure to dangerous diseases, chronic low back pain and poor mental health. Workers in PHC are more at risk due to high patient load, wider exposure, isolated work dynamics, and poor access to occupational health services. The PHC workforce in Africa is struggling with urban-rural inequities, fragmented and poor organisation, poor resourcing, disempowerment, poor working conditions and challenging community contexts. COVID-19 exposed the vulnerability of PHC workers – poor health workforce management, hazardous working conditions, occupationally-acquired COVID-19 and mental health challenges. Policies for healthier and safer workplaces are part of global commitments to UHC. Such policies will improve quality of care, build resilience and stimulate retention of the health care workforce. All this starts with political commitment, and WHO provides excellent resources. Governments need to adopt a bottom-up approach to organisation of PHC by empowering the PHC team and communities being served to protect PHC workers. PHC workers working as a multi-disciplinary team can protect each other better.[56]
View political and funding action for PHC as an investment

We call on African countries to consider health as an investment and to leverage political goodwill for action on PHC/UHC by defining PHC in budget terms, ring-fencing the financing of PHC and committing at least 2% of their GDP to PHC for UHC in Africa.

The progress on PHC/UHC in Africa is variable. The African Union should be congratulated on its efforts with Agenda 2063, the New Public Health Order and various UHC policies in Africa, with some focus on PHC.[58] However, the implementation of PHC/UHC is challenged, not only by factors outside our control, but more importantly by factors within our control. Health should not just be viewed as an expense, but an investment and an opportunity for job creation, with resulting economic growth from improvements in both the quantity and quality of human capital.[59,60] Government (and AU) commitments on PHC often seem like rhetoric.

The Abuja Declaration of 2001, committing AU countries to dedicate at least 15% of their annual budget to enhance sustainable financing for health, has been poorly implemented with only two of the 54 countries in Africa achieving this.[61] The Lancet Report on Financing for PHC (2022) reveals that low-income countries (LICs) allocate an average of just $3 (0.4%) of GDP per capita on PHC, with out-of-pocket expenditure at $8. The report identified key challenges such as lack of a clear definition of PHC and financing of PHC across Low-Middle Income Countries (LMICs).[62] LMICs spend less than 1% of their GDP on PHC compared to the 2% allocation in HICs. Ultimately, the decision to prioritise and invest in PHC is political. However, there are other diverse and creative ways of mobilising funds.

Fight for global solidarity action on PHC funding pools

We call on the world to re-examine global social solidarity on PHC and strengthen contributions to PHC for UHC in Africa as a priority, starting with High-Income Countries increasing ‘donor aid’ to 2% of their health spend and ‘donor aid’ funds allocating 30% to an African Union funding pool for integrated PHC and UHC in Africa by 2033.

The reflection on global inequity by Anyangwe (2007) has shown that while sub-Saharan Africa only accounts for 11% of the world’s population it bears over 24% of the global disease
burden. The region is home to only 3% of the global health workforce and spends less than 1% of the world’s financial resources on health. This has worsened materially in the last 15 years.[63] The Lancet Global Health Commission (2022) on financing primary health care found that government PHC spending by HICs was $840 compared to $3 per capita in LICs, mostly in Africa and on human resources. This means that HICs spend 280 times more than LICs on PHC.[62] As of 2019, global health spending stood at about $7.5 trillion per year. Furthermore, to achieve PHC targets globally, $200 billion (2.6% of $7.5T) will be required. To achieve more comprehensive UHC targets requires an additional $170 billion (2.3% of $7.5T). Global social solidarity contributions of just 4.9% of international health expenditure can take the world forward dramatically and bring the wealth of health to the poorest, especially in Africa.[64] Global ‘aid donors’ spend $6 per capita in LICs, (twice that of governments) but are invariably fragmenting and distorting the local health system.[62] Selective PHC, viz. the GOBI FFF and HIV-AIDS programmes, driven by international agencies seeking low-cost results, has resulted in poor social solidarity, greater fragmentation of PHC and the growing power of hospitals/specialism with poor quality PHC, especially in Africa.[65] The 30by2030 campaign advocates for donors to allocate 30% of their funds to integrated PHC.[66]

Manage pooled funds with strategic purchasing

We call on Africa to work towards better funded single pools for UHC funding and prioritise strategic purchasing for PHC with standard and transparent contracting of both public and private providers in empowered decentralised units of PHC for UHC in Africa by 2043.

As mentioned previously, the Lancet Global Health Commission (2022) on financing primary health care shows out-of-pocket expenditure at $8 per capita, that is mostly spent on medicines. It advocates for stronger social solidarity using single funding pools with innovative and progressive taxation strategies and mandatory social/community insurance.[62] Rwanda, Ghana and Kenya are cited as examples of growing social solidarity. Countries like Nigeria have also expanded this pool through innovative policies, like ring-fencing for health ‘sin-taxes’ (Sugar Tax 2022) and allocating specific proportions of the consolidated federation accounts.[67] Contributions to this pool from donors can address not only inequities, but also reduce fragmentation of funding and integrate service delivery. Line-item budget systems make services unresponsive to the populations served, as accountability rests with the budget holder. WHO asserts that strategic purchasing must prioritise PHC as the engine for UHC, as it reflects the right priorities and remains the most cost-effective way to address comprehensive needs close to people’s homes and communities. Strategic purchasing, in line with global PHC thinking, is about separating public providers from the Ministry of Health and empowering them. In addition, it is about
introducing private providers into the equation, where possible, and enabling government to play a strong leadership and coordinating role across a regulated and integrated health provider system.[40] The Lancet Global Health Commission (2022) advocates for strategic purchasing to improve efficiency in the management of funds. Private health services are a threat to public facilities in many LMICs as they grow exponentially with populations disaffected with public services. In addition, they contribute to the drawing out of human resources from the public sector, an environment of weak regulatory and enforcement culture. Reversing this can be extremely difficult. Nevertheless, strategic purchasing offers a great opportunity if governments could get ahead of the curve to draw the private sector into this more regulated environment, provided governments embrace a systems approach with less bureaucracy and a greater focus on outcomes.[40]

Reform PHC payment with blended capitation

Capitation has been documented as a more effective system of PHC payment. We call on Africa to embrace PHC teams paid by blended capitation models (including capitation, fee-for-service and performance payments) to achieve holistic and responsive PHC and UHC in Africa by 2043.

Strategic purchasing with the global best practice payment reforms of blended capitation not only empowers decentralised units of care, but also allows the private sector to enter regulated UHC systems. Blended capitation, that is mostly risk-adjusted capitation with some fee-for-service and performance payment, is a global best practice.[40] Current line-item budgetary systems are unresponsive to users. Whilst fee-for-service is more responsive, it can be easily abused by providers. Mixed or blended capitation payment allows empanelment of populations. A dominantly per capita payment system is better suited to the complex nature of PHC that involves addressing socioeconomic determinants of health and integrating a holistic bio-psycho-socio-spiritual approach to health problems and interventions. [40] Important elements of service are difficult to reimburse in a fee-for-service system, e.g., teamwork, community work, group work or health promotion. Adjustments in capitation rates can target equity, e.g., risk groups, multi-morbidity, rurality or socio-economic status better over time with enrollee data. Nationally-defined mixed or blended capitation contracts offer great opportunity for PHC where enrollees can regularly vote with their feet and change providers.[40]
Build this with simple national contracting

We call on Africa to embark on simple nationally-defined PHC contracting to community practices for accountable care from both public and private service providers.

Many critics will consider this framework a long and incoherent wish list. This can all be put together into a simple and practical national PHC contracting system. An example is the National Health Insurance as developed for the National Treasury of South Africa. Community practices defined by population and an appropriate mix of skills, including family doctors, using numbers that are in line with the country’s human resources. A nationally-defined PHC contract using risk-adjusted blended capitation can be easily administered at national or sub-national level for both public and private providers. They should be coordinated by the DHS to provide services to the population, especially marginalised communities, in a manner that is regulated and respectful of the abilities of PHC teams (which include professionals) to be able to manage resources from appropriate payment systems, be resilient to emergencies and progressively adjust the care to the needs of the populations served [https://profmoosa.com/summary-of-proposed-nhi-capitation-contract-design/].
5. CONCLUSION

Primary health care has been considered the most equitable effective, efficient and cost-effective approach to achieving UHC. We call on Africa to empower and build an effective PHC team to achieve PHC and UHC in Africa:

1) **Build robust PHC SYSTEMS.** This must be based on a high-quality bio-psycho-social-spiritual approach for PHC that is comprehensive, coordinated and integrated person- family- and community-centred. It must integrate PHC priorities and Health in All Policies. It must be based on empanelling of defined populations to a specific PHC team using community-oriented primary care. It must be supported by interoperable e-Health and a strong DHS to coordinate public and private providers.

2) **Educate, recruit and maintain a sufficient frontline PHC WORKFORCE.** This must include a complete workforce of locally-trained family doctors, family nurse practitioners, medical officers, clinical officers, nurses, professionalised CHWs and other cadres and allied health care professionals, to ensure delivery of high quality PHC. This workforce must involve role-sharing with supportive supervision; distributed leadership; clinical governance by accountable clinicians; and an integrated human resource development and management plan suitable for PHC.

3) **Support PHC with FINANCES.** There must be political and sustained funding action that considers PHC an investment; a fight for global solidarity action on PHC funding pools; and better management of PHC across Africa with strategic purchasing and payment reforms using blended capitation.

We, as the African Forum for Primary Health Care (AfroPHC), commit to educating and empowering providers and their communities at the frontline to support this goal in any way we can including building AfroPHC Chapters at country level as a forum for PHC and UHC in Africa.

As the African Forum for Primary Health Care, we call on Africa to commit to making this plan a reality and building effective PHC teams for UHC in Africa. We commit to mobilising PHC workers across Africa to create teams around empanelled populations as sentinel sites across Africa to share best practices and to show evidence of how effective we can be at both practice and population level, if we are empowered to deliver quality PHC as a team.
REFERENCES


52. *Global Health Observatory [Internet]. [cited 7 April 2022]. Available from: https://www.who.int/data/gho*


APPENDIX

Physician Assistant/Physician Associate/ Clinical Officer/ Clinical Associate comparables

A global health care workforce crisis exists. Physician Assistant/Physician Assistant Comparable (PA/PA-comparable) professions can help fill this gap especially in areas such as obstetrics/gynaecology surgery and infectious diseases. These professions recognised by the WHO include: Physician Assistants/Physician Associates (PA), Clinical Officers/ Clinical, Associates and Assistant Medical Officers. They exist in over 50 countries under numerous different names as there is no unifying international title for this cadre. See the table below.

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Classification

The International Labour Organisation (ILO) classifies these providers as Paramedical Practitioners in the International Standard Classification of Occupations (ISCO) document. However, the ILO classification has resulted in some confusion around the name as being confused with Ambulance Workers which is a separate ISCO classification (https://socialinnovationsjournal.com/index.php/sij/article/view/1019).

Treatment of PA/PA Comparables in ISCO: PA/PA comparables are included in ISCO-08 in unit group 2240 Paramedical Practitioners

- Major Group 2 Professionals
- Sub Major Group 22 Health Professionals
- Minor Group 224 Paramedical Practitioners
- Unit Group 2240 Paramedical Practitioners (PAs are included here in ISCO-08)

The WHO Competency Framework recognises this profession and their ability to task share across disciplines (https://www.who.int/publications/i/item/9789240034662).

More information about the professions can be found here: https://socialinnovationsjournal.com/index.php/sij/issue/view/78
African PHC service delivery under Universal Health Coverage (UHC) should be comprehensive, accessible, high quality, responsive to local needs, in partnership with communities and delivered by strong teamwork, training and supportive supervision.