SPARC AND AFROPHC JOINT WEBINAR ON "EXPLORING UHC FUNDING AND PAYMENT REFORMS FOR PHC IN AFRICA." HELD ON 27TH OF JULY

Session Questions and Answers

QUESTION	ANSWER
Rael Mutai: @Dr Nkechi, the estimated $200b required per annum to attain primary health care (PHC), is it worldwide or only for Africa? Are there country-specific estimates?	The estimates are globally obtained from the 2019 GLOBAL MONITORING REPORT EXECUTIVE SUMMARY (Primary Health Care on the Road to Universal Health Coverage). The report is available here: https://www.who.int/docs/default-source/documents/2019-uhc-report-executive-summary
Farhan Ahmed: @Dr Nkechi, how can a Civil Society Organization (CSO) partner with SPARC, Amref and AfroPHC?	To partner with SPARC, please reach out to us via our email – communications@sparc.africa or through any of our social media sites.
Zachary Ngare: @Dr Nkechi, indeed, it's a good gesture on the topical issues under PHC; my concerns on this discussion are how we tackle the rampant corruption in most African countries and how SPARC and Africa can help in addressing this huge giant issue mostly in Africa?	Accountability is a great concern, indeed. A typical entry point for SPARC into country processes is bringing together multiple stakeholders and supporting them to align behind a common vision of progress towards universal health coverage (UHC). This process provides an opportunity to define and hold one another accountable for specific measures that speak to progress and others that define transparency and accountability. Defining clear institutional arrangements that allocate responsibilities and governance structures that provide oversight, accountability, and reporting lines and ensure effective stakeholder participation are steps along the governance/accountability continuum that can support other efforts to address corruption and can be leveraged to keep the corruption discourse on the front burner.
Rael Mutai: @Dr Nkechi, please share some references on countries that have made significant transition from passive to strategic purchasing of services, especially at the PHC level.	Some good examples can be found in the following: **Burkina Faso** Tax-financed subsidies cover user fees for free primary and hospital care for these priority population groups at public health and some accredited private facilities.

	Nigeria The National Health Insurance Scheme (NHIS) and Tate health insurance schemes (SHISs pay providers capitation for primary care and fee-for-service for hospital care. **Uganda** PHC grants with allocation formulas based on catchment population attributes and administrative roles. **Kenya** The Ministry of Health (MoH) and County Departments of Health are testing new primary care networks as contracting units, in which the county hospital acts as the clinical and administrative hub for a geographically defined set of primary care providers, regardless of ownership type. The primary care networks aim to increase the focus on primary care and more integrated care. **Rwanda** Pyramid-shaped health system with Community Health Workers, Health Centres and Health Posts providing PHC. MoH's mandate to locate Health Posts in every cell without a health centre (so that people do not have to walk more than 1hr or 5km to access care). A virtual clinic complements these (on Community Based Health Insurance (CBHI's) provider network). Plan for capitation to increase PHC funding. For more details, access strategic purchasing policy briefs here: https://sparc.africa/changing-the-conversation/a-theory-of-change-and-practical-steps/policy-briefs/
Joseph Ana: @Dr Ama, I have always wondered why the exclusions in Health insurance schemes in Africa are those disease conditions for which an insurance scheme is most needed, e.g., organ failures, cancer, etc. Why?	**Ghana** The NHIS in Ghana covers the treatment of cervical and breast cancer. The scheme does not cover the other types of cancer. Some stakeholders have advocated that the treatment of non-communicable diseases which are not covered and other preventive health

	measures should be covered by the scheme. However, with the scheme financially overstretched, there have to be innovative mechanisms to draw in more resources to cover these expensive treatments.
Muthoni Mate: @Dr Ama, in Ghana, how do you balance between providing coverage/financial protection of the population with the increase in no-communicable diseases that are not included I your benefits package?	There are calls for the NHIS to cover services rendered by the community health workers who support preventive and health promotion activities to curb the huge bills from these lifestyle-induced diseases. If we can prevent these non-communicable diseases, we can cut down the huge cost of care.
Rachel Ambalu: Thanks, Dr Ama, for sharing the Ghana experience. How are the indigents identified as part of the group that is exempted from paying insurance premiums?	Criteria stipulated in the National Health Insurance Regulations 2004, LI 1809:58 for identifying the core poor: A person shall not be classified as an indigent under a district scheme unless that person: • is unemployed and has no visible source of income; does not have a fixed place of residence according to standards determined by the DHIS; • does not live with a person who is employed and who has a fixed place of residence; • does not have any identifiable consistent support from another person.
Zachary Ngare: Thanks Ama for sharing. Are the grassroots organizations involved in advocating for the scheme by the Ghana Government?	Grass root organizations and other stakeholders advocate for the benefits package, including conditions like cancers and clinical family planning methods. Family planning services were excluded as a covered benefit in the initial NHIS law, passed in 2003, but this law was revised in 2012 to include these services through advocacy. The NHIS is currently piloting its implementation in some districts to ascertain the scheme's cost and the optimum payment mechanism to be used.
Dr Mercy Wanjala-Kenya: Thank you, Dr Ama, for that very enlightening presentation! You have raised the million-dollar question that developed and developing countries alike are grappling with- how do we get skilled healthcare workers to work in PHC facilities, especially in rural areas?	I think healthcare workers are demotivated by the lack of resources and availability of essential drugs, and these sentiments have been expressed in various publications. The issue of amenities comes to bear – lack of power, water, and bad road networks worsen the case.

Mujtaba: @Dr Ama, Is the number of health facilities numbers in Ghana is adequate?	Most health professionals and highly recommended health facilities are located in the south and urban areas. The government intends to provide more health facilities under the Agenda 111 initiative to provide district and regional hospitals.
DieudonnÃ© Mpunga: Apart from the accreditation of health facilities in Ghana, how do you ensure that health workers (including community workers) maintain their performance? Are there periodic evaluations of their performance? What are the challenges?	CHPS service delivery is based on the deployment of Community Health Officers (CHOs) throughout the country in CHPS zones. They are expected to receive supervisory interactions from the district level based on Ghana's decentralized health system. There have been recommendations to improve the supervision system and formally train the CHOs and define their roles and responsibilities.