iAHO Integrated African Health Observatory

World Health Organization African Region

75 HEALTH FOR ALL

Analytical Fact Sheet
February 2024

DAK

Sub-National Unit (SNU) Functionality in Africa – Key findings from 18 countries

Rationale

The ability of the health system to provide needed essential services remains a crucial driver for attaining health goals in all countries of the African Region. Understanding the health system's performance entails exploring the nature, depth, and interactions among these complex and dynamic elements over time with each other and within a given context. There is no single correct way; rather, there are multiple approaches to mixing, matching, and interacting with these different elements of a system to produce the desired outcomes. Therefore, A different approach is needed to guide Countries on investing in their systems to attain the desired results. Identifying sub-national health systems priorities requires an assessment approach that allows specific recommendations at the sub-national level. Functionality is defined as the **capacities a system needs to have, irrespective of how it is configured and how this contributes to overall performance.**

Key messages

- **Health systems functionality assessment** has provided districts and countries with necessary tools and norms for regular real-time evaluations that are holistic and aligned to health goals, Universal health coverage, health security and health determinants using the Primary health care approach
- Districts have **statistically higher capacities** in oversight (78%) functions compared to management (69%) and health services (67%) capacities.
- Within **management**, there is a higher emphasis on strategic planning (81%) but significantly less on ensuring appropriate management culture and processes that enhance productivity and appropriate work environment (e.g. Leadership style stood at 65%, systems capacity at 60.0%, and service delivery structure at 66%). The existing structures in districts have inadequate capacity to coordinate the functions of the organogram, maximize synergies, minimize overlaps, and eliminate gaps in responsibility.
- **Oversight** components such as authority (81%), organizational structure (79%), and technical accountability (82%) are typically established, while integrity and public confidence (70%) and social accountability (72%) have not received sufficient emphasis. Despite the active involvement of stakeholders, districts reported lower ratings for integrity and public confidence, underscoring the imperative to address these aspects among the broader population systematically.

Health system functionality : What it entails

Currently, most effort is placed on global support towards strengthening national health systems. Universal Health Coverage (UHC) is a national target monitored regularly; health security (HSE) components have international health regulations and resilience targets, amongst others, as well as determinants of health (DoH) spanning economic, political, social, and environmental.

Figure 1: Constructs of Health systems

There is a need to focus on districts to guide actions to attain health results. This has been echoed in the Report of the Global Conference on Primary Health Care: from Alma-Ata towards universal health coverage and the Sustainable Development Goals. Geneva: World Health Organization; 2019 (WHO/UHC/SDS/2019.62) and the 69th RC resolution: "Framework for the provision of essential health services through strengthened district / local health systems to support universal health coverage" (AFR/RC69/8).

The current sub-national approach is a selective PHC approach (**focus on specific conditions**), not a comprehensive PHC approach (**focus on age cohort needs**). Systems are expected to deliver three interlinked but distinct results using a comprehensive PHC approach (UHC, HSE, and DoH). Population needs have evolved to meet dynamic health needs, which the health system needs to respond to.

Identifying sub-national health systems priorities requires an assessment approach that allows specific recommendations at the sub-national level. Functionality is defined as the **capacities a system needs to have, irrespective of how it is configured and how this contributes to overall performance.**

SNU Rationale

The assessment aims to systematically assess the functionality of sub-national health units in the WHO African Region. This is through developing an understanding of their levels of operationality. The output from the assessment will be specific areas that a sub-national unit. More specifically, the process aims to:

- Make available tools and processes to assess the functionality of health systems in the WHO African Region;
- Provide succinct information for participating sub-national units on areas they need to focus on to improve their functionality;
- Consolidate at a country level the priorities that are most impeding the attainment of health results at the sub-national level and
- Define regional priorities for investment in sub-national units to attain health results.

- The sub-national unit functionality assessment has three tools.
- **Tool 1** focuses on the distribution of health outcomes (Universal health coverage, health security, determinants of health and primary health care approach)
- **Tool 2** (the core) focuses on the system's functionality, looking at oversight, managerial and health services capacity.
- **Tool 3** (optional) is available for countries in case there is a need to assess the functionality of a specific facility. The contents are the same as Tool 3 but customized for hospitals (Tool 3A) and primary care facilities (Tool 3B)

Figure 2: Health systems functionality assessment tools structure

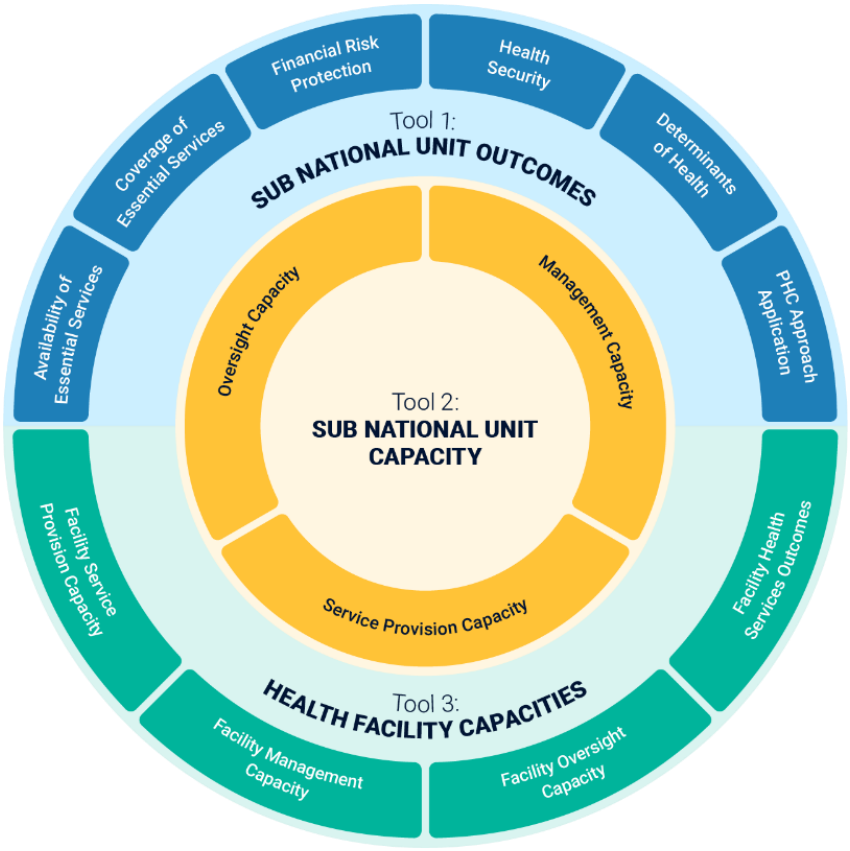


Figure 3. Countries with Sub-national unit assessed countries

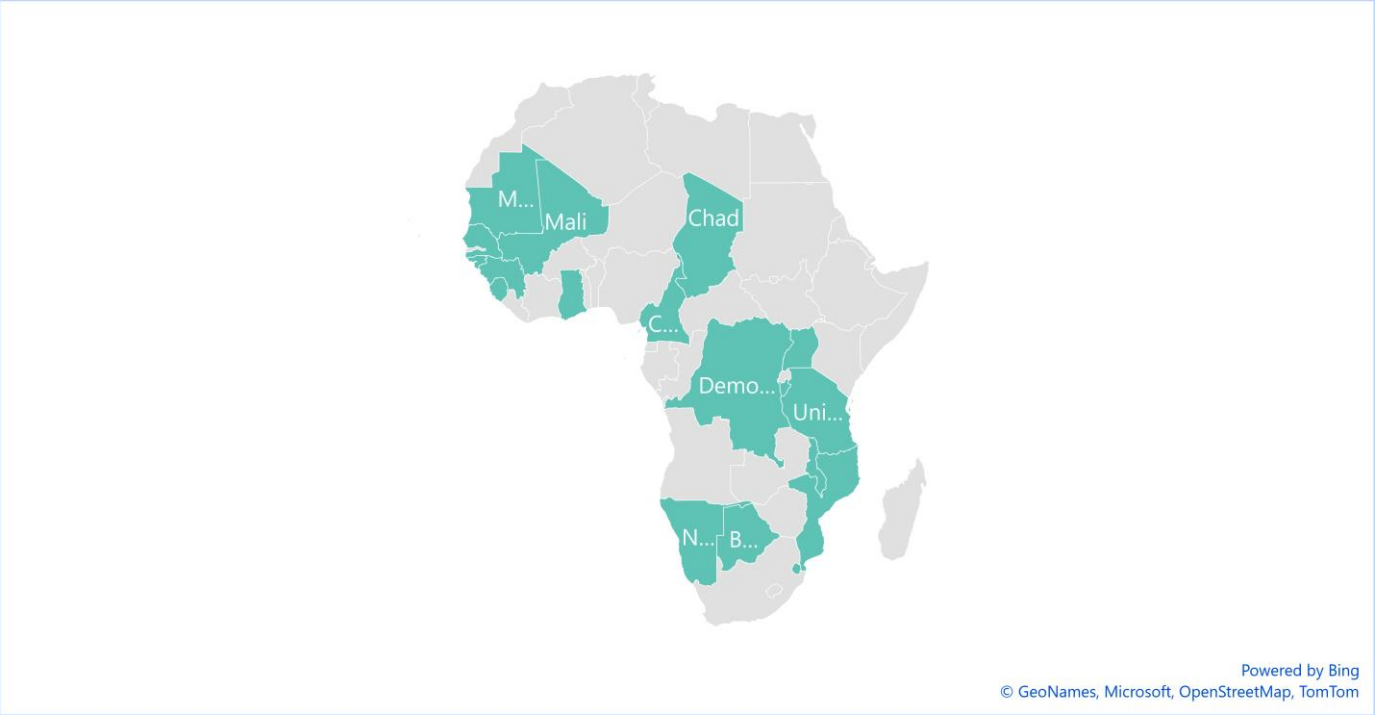


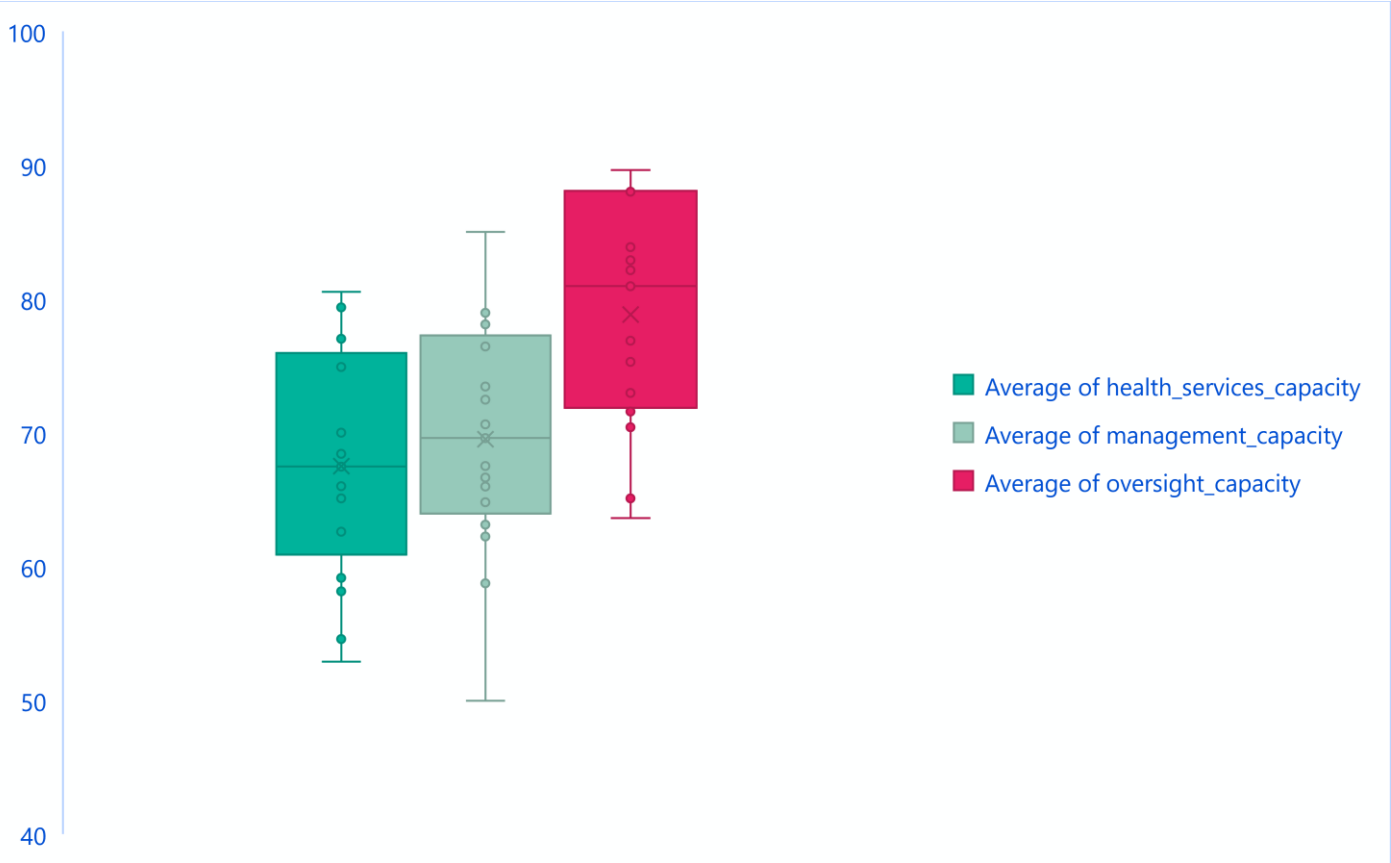
***Table 1**: Summary of Countries and districts assessed vs Total Number of districts (as of dec 2023)*

Countries	Total Districts assessed (Tool 2)	Total number of districts	% of total
Botswana	18	18	100
Burundi	24	114	21.1
Cameroon	30	203	14.8
Chad	38	150	25.3
DRC	150	518	29.0
Eswatini	1	4	25.0
Ghana	34	261	13.0
Guinea	16	38	42.1
Guinea-Bissau	21	140	15.0
Malawi	9	28	32.1
Mali	11	11	100.0
Mauritania	30	63	47.6
Mozambique	43	162	26.5
Namibia	14	14	100.0
Senegal	79	79	100.0
Sierra Leone	15	15	100.0
Uganda	47	146	32.2
United Republic of Tanzania	159	196	81.1
Total	**739**	**2160**	**34.2**

Findings

Emerging evidence shows that districts have invested **relatively more in oversight and stewardship functions (78%) relative to their management (69%) and health service provision capacities (67%)**. It was observed that the functionality of sub-national systems is NOT correlated with national health system performance. However, the consolidated national functionality correlates strongly with the UHC service coverage index [6]. Specific variations in priorities exist per capacity of functionality.

Figure 4: Health systems functionality by component



- Districts have statistically higher capacities in oversight **(78%)** functions compared to management **(69%)** and health services **(67%)** capacities.
- With regards to **management**, there is a higher emphasis on strategic planning (81%) but significantly less on ensuring appropriate management culture and processes that enhance productivity and appropriate work environment (e.g. Leadership style stood at 65%, systems capacity at 60.0%, and service delivery structure at 66%). The existing structures in districts have inadequate capacity to coordinate the functions of the organogram, maximize synergies, minimize overlaps, and eliminate gaps in responsibility.
- Within **oversight**, authority (81%), organizational structure (79%), and technical accountability (82%) are generally in place, whereas integrity and public confidence (70%) and social accountability (72%) have not been prioritized. Despite the high engagement of stakeholders, integrity and public confidence were rated low by districts, indicating the need to reach the wider population systematically.
- The **health services capacity** is the weakest link among the 3 for almost all countries. The analysis noted there is high perceived demand (71%), which may be hindered by the substandard quality of care (67%) and systems resilience (69%) to maintain the delivery of essential health services. Access is the dimension with the lowest score (62%), with financial access at 54%, physical access at 62%, and socio-cultural access at 72%.

Figure 5: Health systems functionality by country

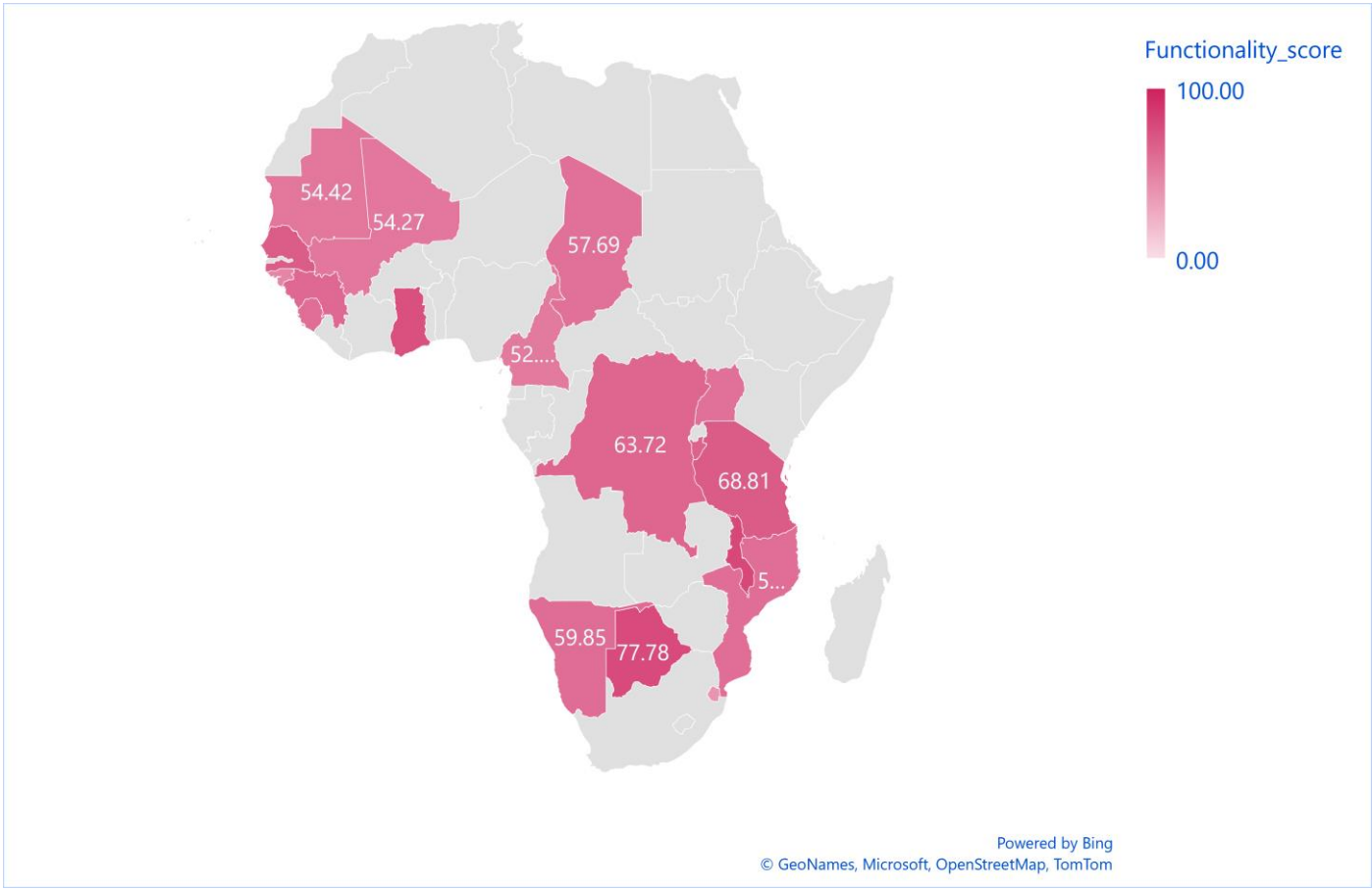


Figure 6: Oversight capacity by country

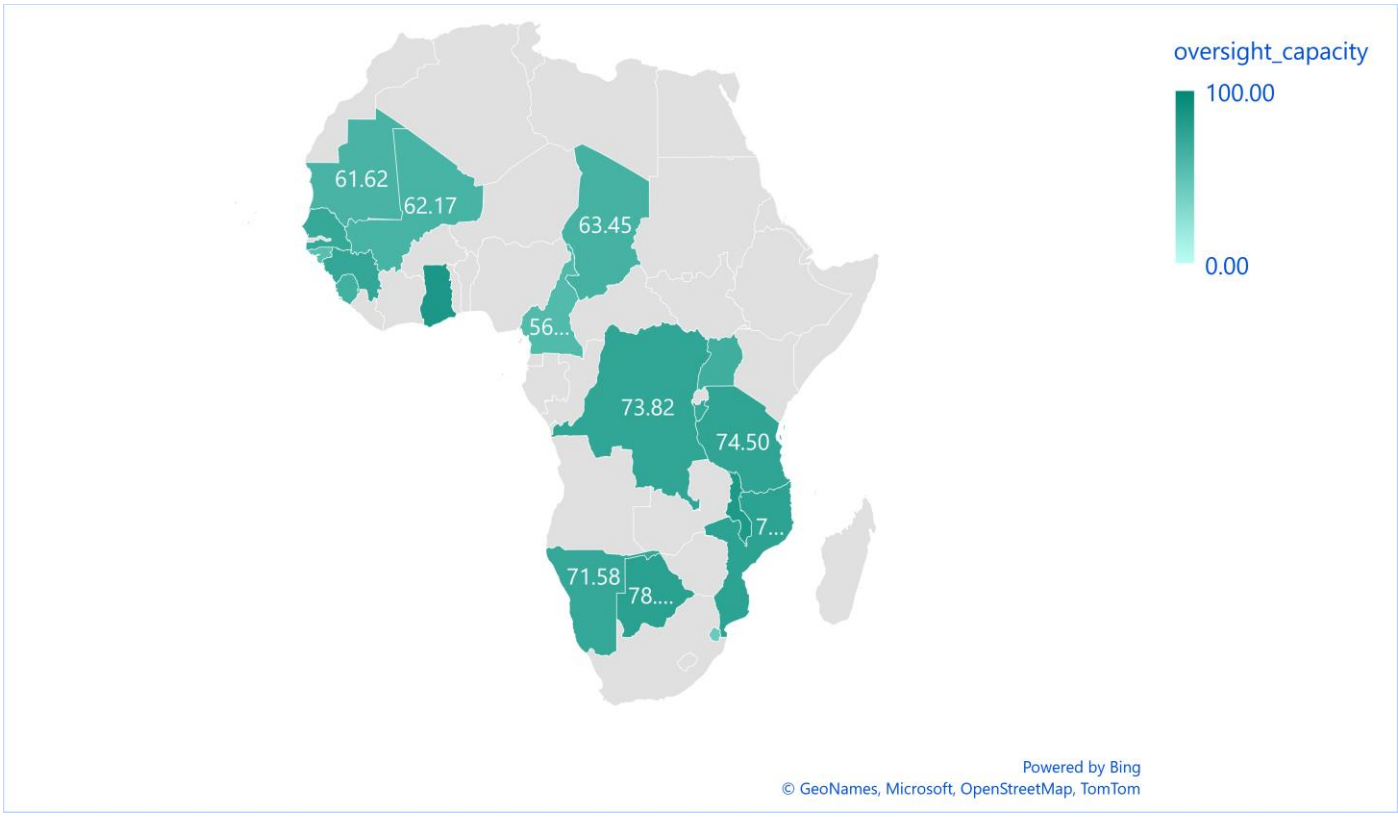


Figure 7: Oversight capacity by country

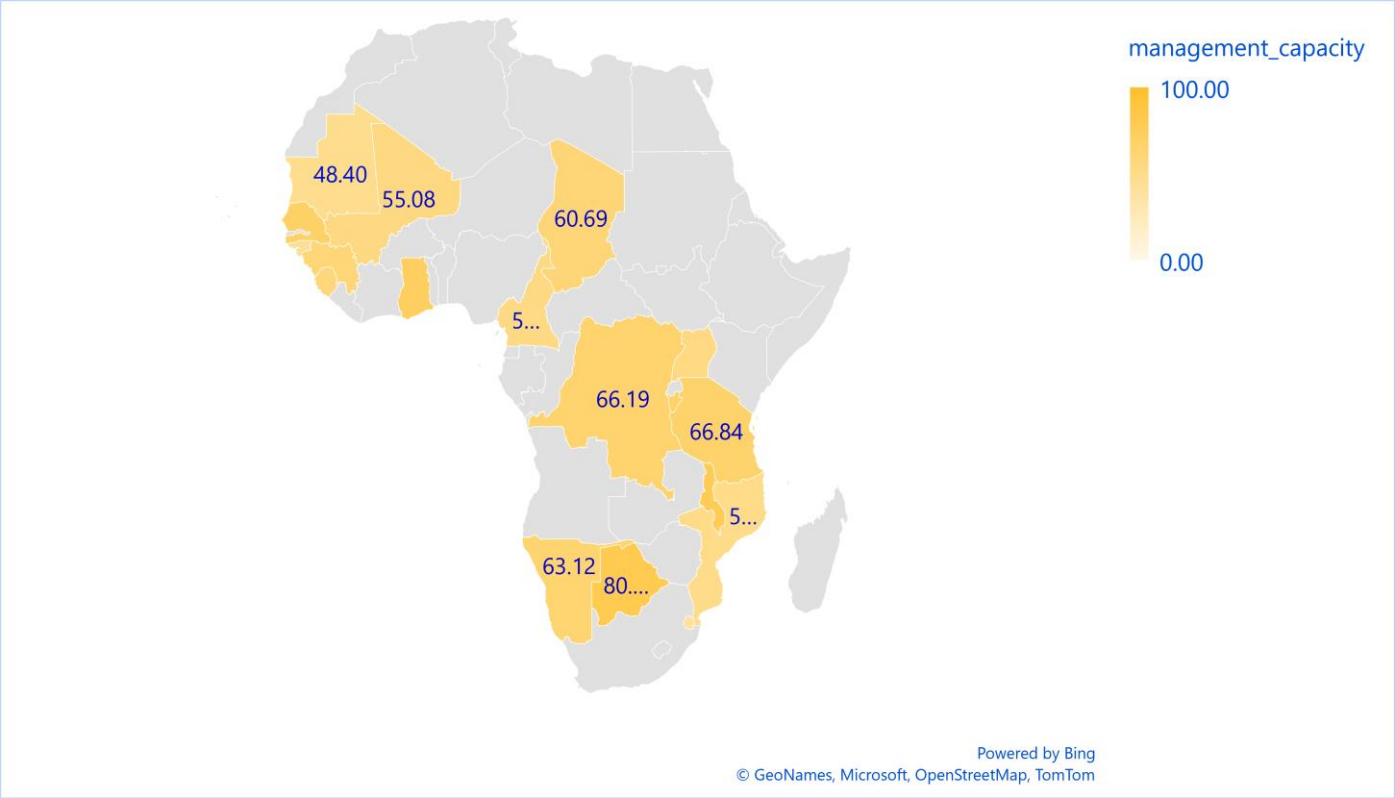
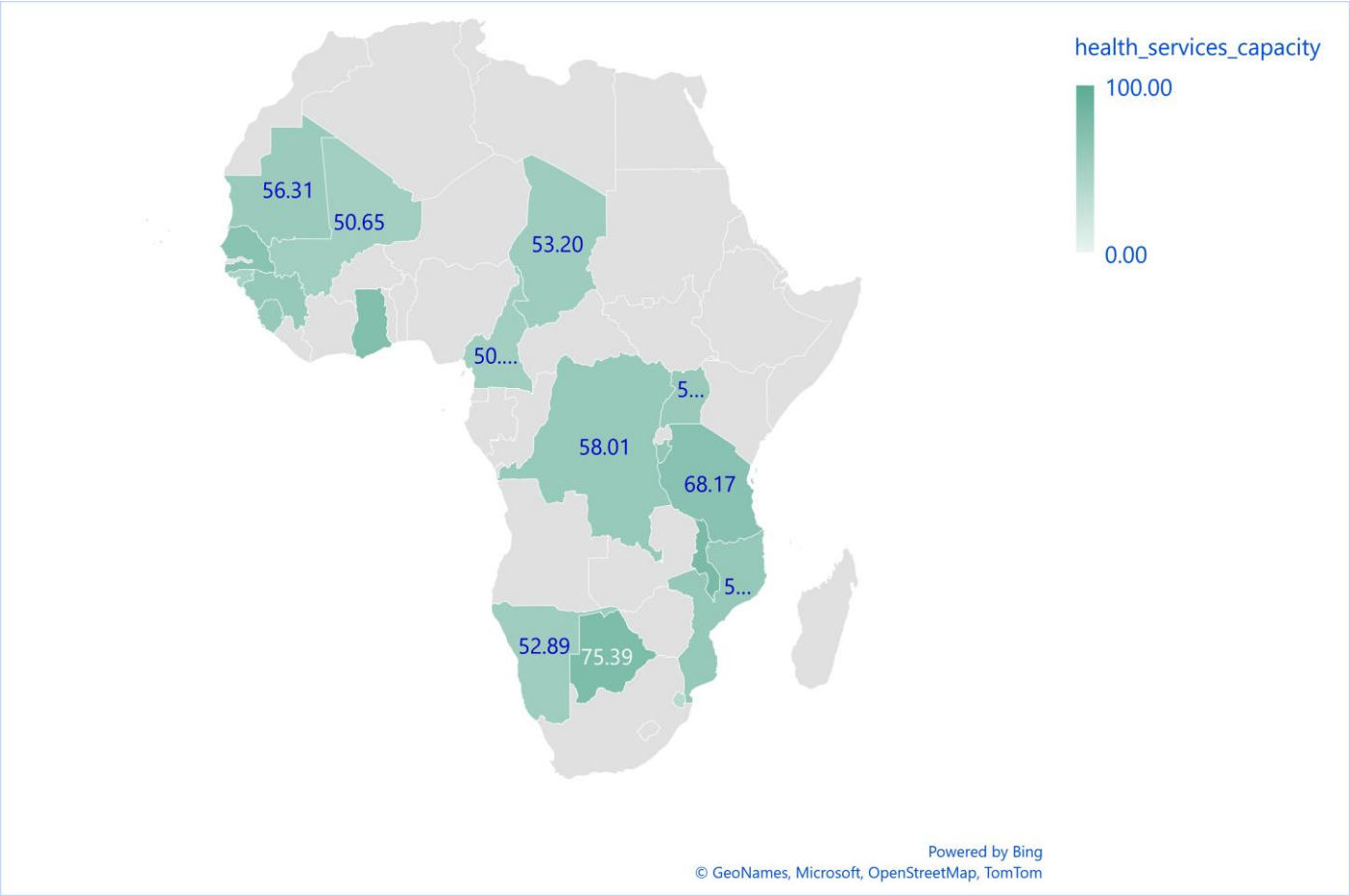


Figure 8: Health services capacity by country



Sub-national unit functionality: data use and institutionalization

Several countries have moved forward to translate the data into knowledge products (e.g. Burundi) and publications (e.g. Ghana). Others have institutionalized the tool within their routine systems (e.g. Malawi has incorporated it in the ISS; Ghana is adapting it for a regular operational review of districts). Tanzania is using the tool to establish a baseline by assessing all districts that have received high priority. DRC has used the opportunity to deep dive into the status of districts and identify areas for targeted support.

At the regional level, the information generated is being used to shape strategic directions. More specifically, the implications of the findings are being used in the emerging conceptualization of the 'future of health services for attainment of UHC', forming the basis for RD's technical inputs to the Future of Health and Economic Resilience in Africa (FHERA) commission. One of the critical outputs will also include the redefined concept of district health management for AFRO in the 21st century. The process and deliverables from the SNU assessment can also be used for resource mobilization, such that the priorities are streamed using a bottom-up approach at national and regional levels.

Reflections and recommendations

The process and information generated from the functionality assessment have significantly benefited member states. These can be viewed from 3 perspectives:

a. The sub-national unit management teams (e.g. DHMTs) - The process has facilitated a strategic dialogue, with critical information (such as gaps, opportunities and lessons learnt) sieved for practical implementation and re-alignment to health goals (UHC, Health Security, Determinants of Health, PHC).

b. Sub-national unit/district functions - The information collated is synthesized and presented in a disaggregated manner, which allows countries to view where 1) introduction of new interventions may be needed, 2) scale-up is required, and 3) sustaining and sharing lessons within and across countries.

c. National level - The information generated has aided policymakers, partners, and other stakeholders to make evidence-driven decisions that is specific to the context (cognizant of the need for provision of services across the continuum of care and public health function (from preventive to palliative).

Capacity	Scope	Status / issues	Recommendations moving forward
Oversight capacity The ability to effect the decisions needed for efficient, equitable and effective provision of services	**Authority & Mandate** *The leadership has the needed implicit and explicit ability to make decisions relating to health resources in the unit's area of responsibility.*	The decision space of a district is significantly influenced by the level of top-down restrictions imposed by National political and/or technical institutions. District managers in countries with broadly similar forms of decentralization (e.g. DRC, Ethiopia, Kenya, Nigeria, South Africa and South Sudan) have varying levels of decision space. Decision space varies depending on the area where decisions are needed. Decision space in different decision areas, in descending order: (1) Health information, (2) governance, (3) health products management, (4) service delivery systems, (5) health workforce management, (6) financial management, (7) health infrastructure management.	Unpacking incremental decentralization to allow wider decision space for districts
	Organizational structure *The existing structure is an appropriate translation of the existing authority to facilitate the implementation of oversight functions, expectations, and information.*	Although explicit organograms exist, many have misaligned the current status. Current posts and job descriptions tend to be outdated, with responsibilities needing to be explicitly articulated. There are inadequate functional mechanisms (e.g. committees) to coordinate the functions of the organogram, maximizing synergies, minimizing overlaps and eliminating gaps in responsibility.	The expected health functions of the sub-national unit need to be accurately mapped with the approved organogram – with minimal redundant positions.
	Policy & strategic guidance *A clear long- and medium-term direction exists, aligned with the overall government and health sector directions.*	Most countries have strategic plans at the national level, which are not as strong at the district/sub-national level. Depending on the decentralization status and decision space, districts focus on immediate to short-term plans.	Alignment of the strategic direction of the sub-national unit (in time and content) with that of the political and administrative unit it works within

Capacity	Scope	Status / issues	Recommendations moving forward
		Alignment of district plans to national levels and/or cascading national strategic plans in the lower levels needs to be strengthened. Although efforts have been made, there are still misalignments in health sector planning, monitoring, and evaluation. For instance, many health sector reviews have indicated no data and information outlined in the 5-year strategies. In cases where the information is available, it tends to sit in parallel systems, only used during the mid or end-term reviews.	Focus on district policies and strategies, guiding its long-term health goals.
	Technical accountability *Mechanisms to ensure answerability of health leadership to the health agenda*	Most districts have sound technical accountability systems, with regular reports generated, M&E reviews conducted, and health sector reviews that have gained momentum across the region.	Emphasis on M&E for lower levels (e.g. districts annual review) Emphasis on real-time information and timely action, Vis-à-vis the regular annual reviews
	Social accountability *Mechanisms to ensure answerability of health leadership to the public*	Social accountability is **significantly lower than technical accountability across the region.** Information on all sources, reports, and progress summits are not readily shared/held with all health actors. There is also minimal engagement of the public in the decision-making process (eg. Open budgeting)	Promote the involvement of the public, partners, civil society, private actors and other stakeholders in planning, decision making and progress-tracking initiatives.
	Legal & regulatory mechanisms *Required formal and informal instruments that give a mandate to act*	Health acts, laws and regulations exist in most countries, covering management of the health workforce, infrastructure deployment, and medical product use However, the appropriateness of enforcement capacity for adherence to the regulatory and legal instruments is not as strong. Districts reported that the health leadership is aware of and has oriented all the health management on the informal societal norms that affect health service provision – e.g. on values of the placenta, gender roles in health, etc.	Multi-sectorial coordination should be strengthened and expanded to address advocacy, development and implementation of legislative tools for health issues beyond the MOH's mandate.
	Stakeholder engagement *The mandate and responsibilities of stakeholders in health are clear and monitored.*	There are many initiatives across districts for stakeholder engagement, with districts scoring an average of 79% (according to the 501 districts assessed). However, the roles of public, private, and external partners in the health agenda are not elaborated in many instances. Public-private relationships exist in some settings, which need strengthening to ensure functional public-private partnership relations for complementary actions. The public health confidence is estimated to be moderate across the region (78%), needing heightened efforts and further evaluations from the eyes of the beneficiaries.	Partnership instrument that consolidates responsibilities, defining how they are enforced and actions when they are highly recommended
	Integrity & public confidence *Active processes are in place to build public trust and respect in the sector.*	Aligned with the social accountability principle, district teams need functional processes to capture public views, engage regularly, and institutionalize a culture of corrective actions when reputation and integrity are compromised.	Develop/mainstream approaches that allow public engagement and feedback, accountability, dialogues, and transparency.
Management capacity The ability to maximize the use of existing resources in the provision of services	**Structure** Definition of roles, responsibilities, and accountability relationships	The structure of primary care was reported as better than hospital organization in some districts. This could be shortcomings related to categories of hospital services, centres of excellence for specialized and specific complementary services, and in-service and pre-service training.	Define the roles and responsibilities of hospitals and primary care facilities succinctly.
	Strategy A process to guide the team from current to desired position subject to capacities	Strategy is one of the strong suits in many districts. Defined areas of responsibility, population, and coverage targets are regularly deployed by programs at districts, although this may be limited to vertical programs.	Emphasis is needed for the sub-national unit to elaborate essential health interventions across public health functions by level of care and age cohort; The sub-national unit should advocate and articulate explicit targets for improving capacities relating to better system access, quality, demand and resilience.
	Systems The tools and processes staff use daily to accomplish their goals.	Systems have one of the lowest scores across the districts, indicative of the interlinked nature. Some of the key challenges include models of service delivery to take services into the community, effective referral (patient, sample, information, specialist movement)	Establishment of service delivery systems with clearly articulated platforms and modalities mix-and-match for efficiency, equity and effectiveness
	Style Behavioral elements that leaders use and the culture of interaction	The appropriate leadership styles (Strategic leadership, Transactional, democratic and transformational) is rarely practiced as a necessity in districts. As one of the core soft	Design a coherent guide/handbook on leadership styles, as part of the management umbrella, on how DHMTs can utilize different approaches and mechanisms for optimal results.

Capacity	Scope	Status / issues	Recommendations moving forward
		S's, minimal focus has been given to it, with most countries scoring <75% (68.2% average).	
	Skills Ability to do the teams work	Technical and managerial skill sets remain pivotal for the growth of districts. Although many initiatives are undertaken for various trainings, there is less focus on the managerial skill sets required and systematic mechanisms for incremental professional growth.	Mandate regular, systematic managerial capacity-building initiatives for DHMT heads.
	Staff The employee base, staffing plans and talent management	Poor status of staffing – a critical gap in almost all districts	Optimise performance, quality and impact of the health workforce Align investment in human resources for health with the current and future needs of the population and health systems, taking account of labour market dynamics and education policies; Build the capacity of institutions at sub-national, national, and regional levels for effective public policy stewardship, leadership and governance of HRH
	Shared values Traits, behaviors and characteristics the team believes in	Although not implemented intentionally, most districts reported good scores for shared values (82%). This indicates the pre-existing arrangements in countries that tend to be based in the culture, practices, beliefs, values and norms, inherently practiced as society.	Semi-formalization and institutionalization of principles and working cultures
Service provision capacity The ability of the system to provide the necessary health services	**Access to essential services** The physical, financial and social infrastructure needed for service provision	Physical and socio-cultural access is a key barrier in most regional districts.	**Physical access** - Use of emerging technologies; mechanism for referral; targeted outreaches/sustainable systems that enhance access **Financial** – Appropriate schemes for OOP minimization and eventually eradication ; **Socio-cultural** - engagement of males/partners in healthcare; sensitization, community empowerment in decision-making
	Quality of care The process by which care is provided	User safety, care effectiveness, and user experience vary widely across and within countries.	Focus on enhancing health workers' performance; regularizing quality control systems across all levels of care; enhancing sanitation and water coverage; defining and implementing standards of care incrementally, institutionalization.
	Demand for essential services Alignment of beneficiaries' expectations with provided services	Low/moderate health-seeking behavior and individual health actions related to • individual healthy actions & • health-seeking behaviors	Identification of local barriers; enhanced quality of care; elevated levels of social accountability and public trust; Engagement of service users and caregivers is a proven strategy to enhance district demand.
	Resilience in the provision of essential services Continuity in the availability of essential services, even during shock events	The analysis from districts indicates that inherent resilience is stronger in districts that targeted resilience (representing resilience targeted at potentially known shocks)	Surveillance, preparedness, early detection and response Enhanced capacity for governance, preparedness, laboratory systems, coordination and communication Focus on system awareness (mapping the health system assets health risks); Diversity (system's ability to maintain delivery of essential services); Versatility and self-regulating; Deployment and mobilization (drawing on existing capacities across teams) and Transformation (incorporating lessons learnt and

References

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Sources

Data on Sub-national unit functionality (SNU) come from World Health Organization: integrated African Health Observatory

Production of the infographic was supported by the Integrated African Health Observatory.

Photography: https://photos.hq.who.int/, https://photos.afro.who.int/

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