DOCTORS WITH AFRICA CUAMM

SUPPORTING FAITH-BASED ORGANISATIONS DELIVERING HEALTHCARE IN AFRICA

FACILITIES ASSESSMENT REPORT

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FACILITIES ASSESSMENT REPORT

Faith-based organizations (FBOs) play a crucial role in the delivery of quality health services to the most vulnerable populations in africa. However, FBOs in Africa are often neglected in terms of supplies, human resources, funding and visibility, with the risk of going unnoticed by the international community and potential partners. Moreover, they are often not integrated into healthcare systems. Doctors with africa CUAMM believes that local FBOs must be recognized as essential contributors towards universal health access efforts.

LIST OF ACRONYMS

ANC	Antenatal Care
CAR	Central African Republic
CODAS	Diocesan Coordination Health Center
COE	Centro Orientamento Educativo
CMU	Couverture Maladie Universelle
CUAMM	Doctors with Africa-CUAMM
DRM	Disaster Risk Management Committee
ECD	Early Child Development
ENT	Ear, Nose, Throat diseases
EPI	Expanded program on Immunisation
EWS	Early Warning System
FBOs	Faith Based Organisations
GBV	Gender Based Violence
GDP	Gross Domestic Product
HP	Health Post
HVCA	Hazard Vulnerability and Capacity Assessment
ICU	Intensive Care Unit
MOH	Ministry of Health
MOHP	Ministry of Health and Population
MSF	Médecins Sans Frontières
MSP	Ministère de la Santé et de la Population
NA	Not applicable
NGOs	Non-Governmental Organisations
NICU	Neonatal intensive Care unit
OOP	Out of pocket
PoNC	Postnatal care
PPP	Public Private Partnerships
RDTs	Rapid Diagnostic Tests
SOPs	Standard Operating procedures
STI	Sexually Transmitted Infections
U5	Children under 5 years old
URSSCI	Union des Religieux dans la Santé et le Social en Ivory Coast

LIST OF CONGREGATIONS

Bethany Sisters
Camillian Sisters/Soeurs Camillien
Canossian Daughters of Charity
Capuchin Sisters
Capuchin Sisters of Mother Rubatto
Caritas
Change ONLUS ETS in collaboration with Sisters Disciples of the Sacred Heart
Claretian Sisters/Soeurs Clarettien
Communauté des Béatitudes
Communauté des Béatitudes au Monastère
Congrégation des Sœurs Petites Servantes du Sacré-Cœur de Jésus
Congregation of Teresian Sisters
Daughters of St Anne
Daughters of the Mercy and of the Cross
Daughters of Wisdom
Dioceses of Garoua and OCE (Centro Orientamento Educativo)
Dioceses of Ondjiva
Diocese of Shinyanga –Sisters of Our Lady of Kilimanjaro
Dorothean Sisters
Filles de Saint Joseph de Genoni
Franciscan Sisters
Franciscan Sisters Missionaries of Christ
Franciscan Missionaries of Our Lady
Franciscan Sisters of St Joseph
Little Missionary Sisters of Charity (Don Orione)/Petites Sœurs Missionnaires de la charité – Don Orione
Marie Immaculée Missionnaire Clarétaines
Misericordia Sisters of Verona
Missionary Sisters Of Our Lady of Apostles
Notre Dame des Apostoles
Obra da Divina Providencia
OLA Sisters
Hospitaller Order of St John of God
Petite-Œuvre de la Divine Providence - Don Orione
Petites Servantes du Sacré-Cœur de Jésus
San Francesco di Sales Congregation
Servants of the Blessed Virgin Mary
Servant Sisters of Marie Reparatrices
Sister of Providence/Soeurs de la Providence
Sisters of St Ann
Servants of the Blessed Virgin Mary
Sisters of the Blessed Virgin of Nairobi
Sisters of the Poor
Sisters of the Sacred Heart of Jesus
Soeurs de Saint Paul de Chartres
Soeurs Dominicaines Missionnaires d'Afrique
Sunyani Diocesan Health Services
The Daughters of St. Camillus
Work of Divine Providence

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This document was developed thanks to the work of many people. First of all, we wholeheartedly thank all the FBOs representatives, and all the health professionals met during the assessment missions. The time they have dedicated to this project and the information shared allowed us to develop an insightful view of such a complex topic. Secondly, a profound thanks is addressed to all the CUAMM professionals involved in the assessment missions, because their tireless work generated the contents of this document. Finally, we would like to sincerely thank the Colleagues from the University College London, because their contribution definitely represented an asset to the production of this document.

EXECUTIVE SUMMARY

BACKGROUND

Faith-based organisations (FBOs) are essential providers of healthcare in Africa, delivering 30-70% of services in LMICs. They often serve in **remote and under-resourced areas** to meet the needs of the continent's poorest populations. Despite their significance, FBOs face many challenges in adapting to evolving healthcare systems in low-resource settings. Recognising their importance and addressing their challenges are crucial for achieving universal health coverage and global health priorities.

OBJECTIVE

This document is aimed to report the findings emerged from the CUAMM assessment missions conducted on the field in sub-Saharan African countries **between November 2021 to February 2024**. The assessments activities were developed in the context of the project "*Supporting Faith-Based Organizations (FBOs) on the Frontline of Healthcare Service Delivery in Africa"* and were to identify primary strengths, challenges, and needs faced by FBO-managed facilities in sub-Saharan Africa.

METHODOLOGY

The assessment missions were conducted by CUAMM staff members qualified in **hospital management, project management, disaster management, and resource mobilisation**. These missions involved a visit to the healthcare facility, guided by the FBOs' representative, to obtain an overview of the services provided and gather details on their quality and overall conditions. Each visit was followed by an in-depth meeting with key staff members, during which two standardised assessment questionnaires were administered: the **Health Facility Assessment questionnaire** (distributed to all 63 health facilities across 11 countries) and the **Disaster Preparedness Assessment questionnaire** (administered to a subset of 33 health facilities in 7 countries). Moreover, in-depth interviews were conducted with key staff members to further understand the challenges, needs, and strengths of each health facility.

FINDINGS

The health facilities' assessment covered **63 health facilities across 11 countries in sub-Saharan Africa managed by 48 FBOs**. The disaster preparedness assessment involved a subset of 33 health facilities in 7 countries. These health facilities played a crucial role in serving vulnerable populations, and demonstrated remarkable resilience despite major gaps in infrastructure and services. The assessment revealed multifaceted challenges and needs related to various domains of interest. The majority of the health facilities reported a significant **shortage of healthcare professionals**, and complained of **difficulties in ensuring the provision of adequate health services**, also in terms of specialised care. Regarding infrastructure and **logistics issues**, many facilities suffered from extended periods without electricity or water. Most of them did not have the capacity to perform surgeries, and reported consistent **gaps in the supply chain of medicines and equipment**. A significant proportion of the health facilities reported issues related to patients' referral systems, mainly due to the lack of ambulances. Most of the facilities were located in hazard-prone areas but were ill-equipped to cope with emergencies or even warn local residents of impending hazards.

CONCLUSIONS

This report provides critical insights into the challenges faced by FBO-managed healthcare facilities in sub-Saharan Africa. Through CUAMM's comprehensive assessment missions, **the project has highlighted the vital role played by FBOs in delivering healthcare services to vulnerable populations**. Despite their significant contributions, challenges such as limited disaster preparedness, staffing shortages, infrastructure deficiencies, and financial constraints continue to persist for many of the facilities. Moving forward, **the importance of collaborative efforts to strengthen FBOs' capacity and resilience cannot be underestimated**. By prioritising the improvement of human resources, specialist services, financing, and infrastructure, stakeholders can work together to address these needs and ultimately improve healthcare in the region. The project underscores the need for sustained engagement and support for FBOs to achieve lasting impact and advance towards universal health coverage in sub-Saharan Africa.

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1. INTRODUCTION

1.1. BACKGROUND

Faith-based organisations (FBOs) are vital contributors to providing quality health services to Africa's most vulnerable populations. These organisations **deliver between 30-70% of health services in LMICs** at primary, secondary, and tertiary level to mostly poor populations and have a significant influence on the health outcomes of users (1).
Currently, a significant portion of health infrastructure in Africa is under the ownership of FBOs. These organisations, typically situated in remote areas, are at the forefront of service delivery and closely connected to local communities. They can identify and tackle the real needs of the poorest, extending their services to remote regions and often surpassing the capabilities of local and national governments. However, many faith-based health providers **struggle to adapt and provide sufficient support in challenging and under-resourced settings.** Recognising FBOs as essential partners and identifying the challenges and needs they face is crucial for advancing universal health coverage and addressing global health priorities.

1.2 PROJECT

Since 2019, Doctors with Africa CUAMM (CUAMM) has been implementing the programme ***"Supporting Faith-Based Organizations (FBOs) on the Frontline of Healthcare Service Delivery in Africa"*** with the aim of strengthening the capacity and resilience of FBOs managing health facilities in Sub-Saharan Africa. The project aims to reach health staff operating in health facilities located in the following countries: **Angola, Benin, Burkina Faso, Cameroon, Chad, Central African Republic, Congo DR, Ethiopia, Gabon, Ghana, Guinea-Bissau, Ivory Coast, Kenya, Madagascar, Malawi, Mozambique, Niger, Nigeria, Rwanda, Senegal, Sierra Leone, South Sudan, Tanzania, Togo, Uganda and Zambia** (Figure 1).

The project includes the following core activities:
1. **map** the existing health facilities managed by FBOs
2. **provide** tailored training packages to human resources for health
3. **conduct** need assessments and provide technical assistance to target facilities online or through field missions
4. **disseminate** the work done and advocate for the better integration of and support of FBOs facilities in healthcare systems.

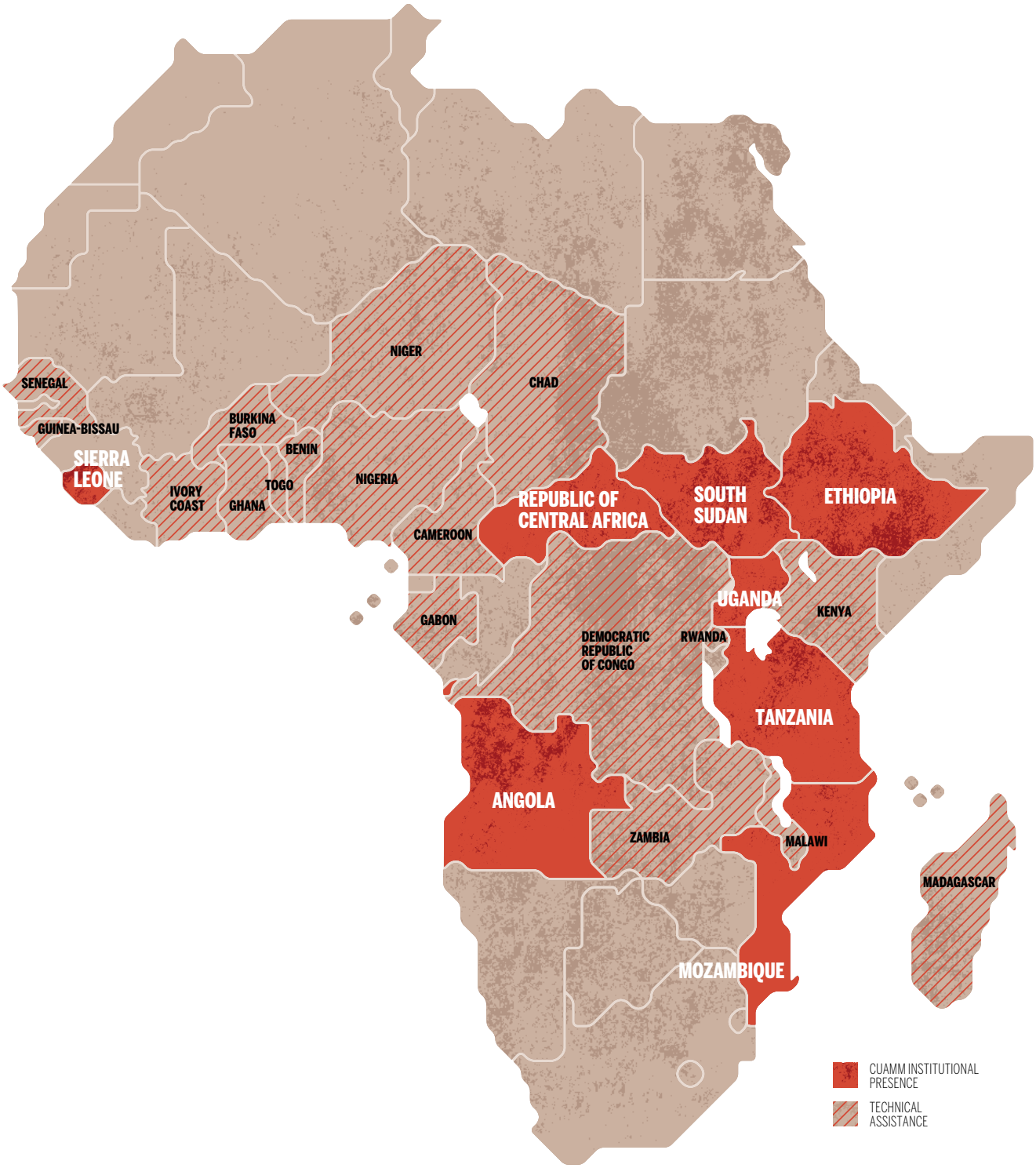


Figure 1. *Map of African countries involved in the CUAMM project "Supporting Faith-Based Organizations (FBOs) on the Frontline of Healthcare Service Delivery in Africa".*

2. HEALTH FACILITIES ASSESSMENT

A core activity of the programme *Supporting Faith-Based Organizations on the Frontline of Healthcare Service Delivery in Africa* is **technical assistance (TA)** provided by CUAMM to FBOs managing health facilities in Africa. By engaging its network of skilled health professionals, CUAMM conducts insightful assessments, identifying the key challenges, needs and best practices that the health facilities face. What sets this initiative apart is the **identification of issues and the provision of actionable recommendations for short- and long-term improvements** for these organisations working alongside the most vulnerable. FBOs embrace this initiative as it equips them with practical tools to improve their work and overcome hurdles while encouraging them to continue making a meaningful impact.

2.1 AIM OF THIS REPORT

This document is aimed to report the findings from the CUAMM assessment missions conducted in the field between November 2021 to February 2024. The assessment activities were developed in the context of the project "*Supporting Faith-Based Organizations (FBOs) on the Frontline of Healthcare Service Delivery in Africa"* and were implemented to **identify the main challenges and needs faced by health facilities managed by FBOs** in multiple sub-Saharan African countries.

Picture 1. *St Mary's Mission Hospital, Nairobi, Kenya.*

3. METHODOLOGY

Assessment missions were conducted by two qualified staff, who are experts in hospital management, project management, disaster management and resource mobilisation on a request basis.
The TA activity involved a visit to the facility guided by the FBOs representative in charge. The visit to the field allowed CUAMM experts to get an overview of the services provided, as well as details about their quality and about the overall conditions.
Each visit was followed by an **in-depth meeting** involving the key staff members and based on the **administration of two standardised assessment questionnaires**, named i) Health facility assessment (Appendix A) and ii) Disaster preparedness assessment (Appendix B). **The assessment tools were based on WHO recommendations.** The Health facility assessment questionnaire was administered to all the health facilities illustrated in this report (**63 health facilities, 11 countries**). The Disaster preparedness questionnaire was administered to a group of the health facilities described in this document (33 health facilities, 7 countries), due to the fact that this questionnaire was introduced in the assessment missions by 2022. After the questionnaires were administered, in-depth interviews with key staff members were performed in order to understand the challenges faced, the needs experienced and the best practices and strengths of each health facility.

Picture 2. *Toeram-Pitsaboana Olontsambatra Anne Michelotti, Moramanga District, Madagascar*

4. FINDINGS

4.1 HEALTH FACILITIES ASSESSMENT OVERVIEW

Since the beginning of the TA program, **13 assessment missions** have been conducted **in 11 countries**, for a total of **63 facilities assessed**, belonging to **48 FBOs**. The assessments were conducted between October 2021 and February 2024. The targeted countries were **Angola, Cameroon, Central African Republic, Ethiopia, Ghana, Ivory Coast, Kenya, Madagascar, Malawi, Tanzania, and Togo** (Figure 2).

Figure 2. *Map of African countries involved in CUAMM health facilities assessment missions.*

The facilities included were distributed across **urban (49.2%)** and **rural areas (50.8%)** (Figure 3) and presented heterogeneous characteristics in terms of type (i.e. dispensary, health centre, hospital), infrastructural properties and health services offered.

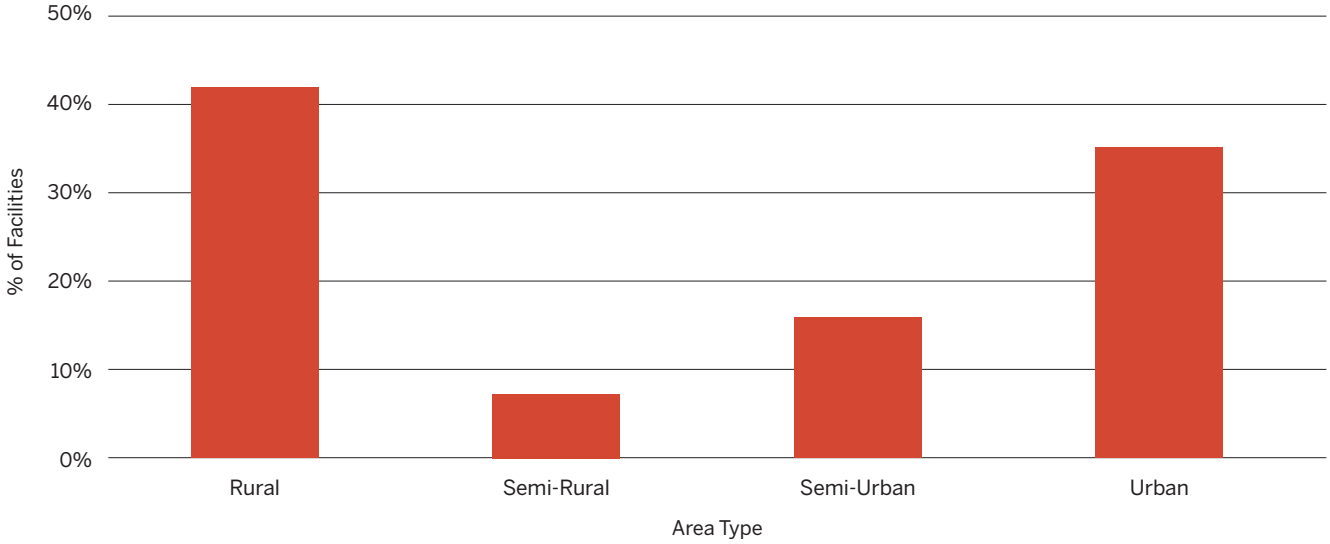


Figure 3. *Health facilities distribution across urban, semi-urban, rural and semi-rural areas.*

The assessment revealed multifaceted challenges and needs related to various domains of interest. The majority of the health facilities reported a significant **shortage of healthcare professionals**, and complained of **difficulties in ensuring the provision of adequate health services**, also in terms of specialised care. Regarding infrastructure and logistics issues, many facilities suffered from extended periods without electricity or water (Figure 4, Figure 5). Most of them did not have the capacity to perform surgeries, especially in need of emergent caesarean sections (Table 1). A significant proportion of the health facilities reported issues related to patients' referral systems, mainly due to the **lack of ambulances** (Figure 6). **Financial constraints** were reported as a major challenge significantly impacting the sustainability of the health services provided. Additionally, the **lack of support** from the Government and the **poor integration within the public health system** played a significant role in weakening the health facilities performance.

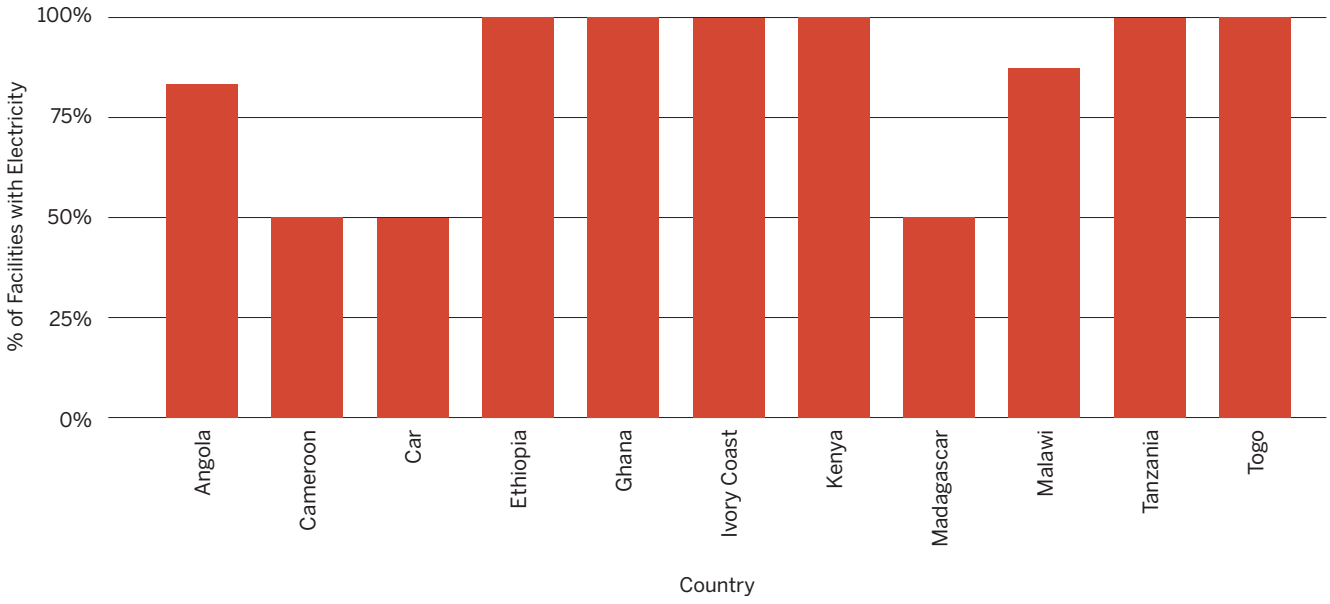


Figure 4. *Electricity provision in the health facilities assessed.*

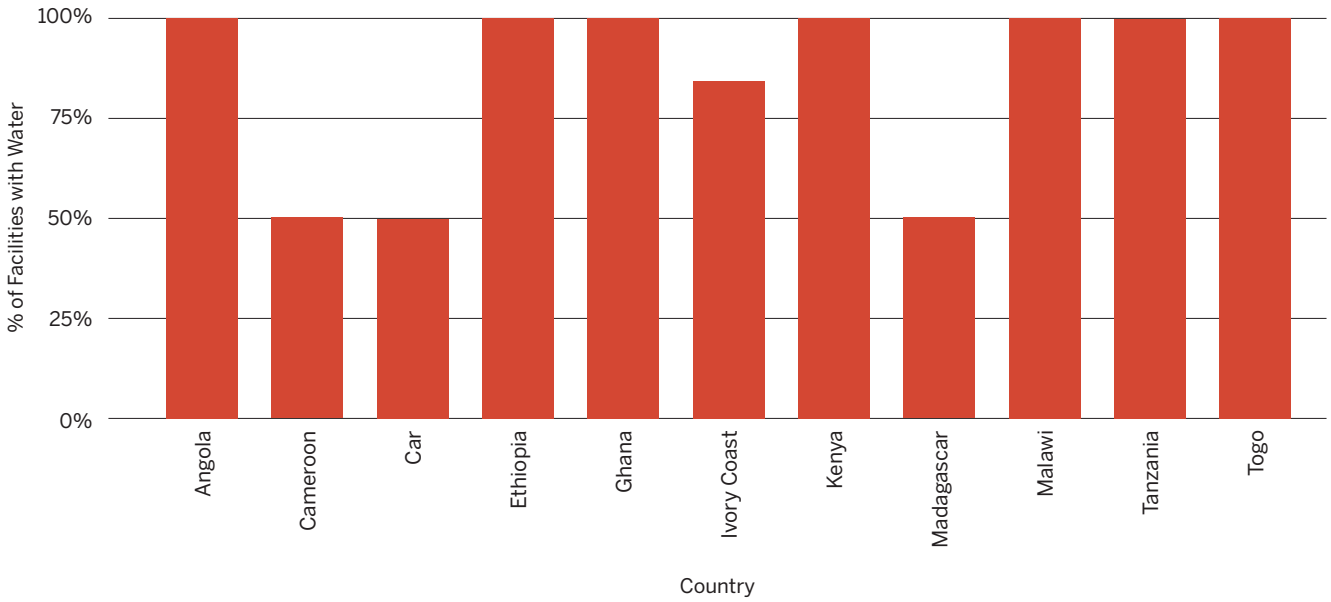


Figure 5. *Water provision in the health facilities assessed.*

Table 1. *Availability of maternal and obstetric services in the health facilities assessed.*

	Vaginal Deliveries	Operating Theatre	Antenatal Care	Postnatal Care	Ultrasound
Angola	67%	33%	100%	100%	100%
Camerun	50%	50%	100%	100%	100%
Central African Republic	50%	0%	100%	100%	0%
Ethiopia	75%	0%	100%	88%	38%
Ghana	100%	40%	100%	100%	60%
Ivory Coast	17%	0%	17%	17%	50%
Kenya	67%	50%	100%	100%	67%
Madagascar	50%	25%	75%	50%	75%
Malawi	100%	50%	100%	100%	50%
Tanzania	75%	50%	100%	100%	100%
Togo	100%	0%	100%	100%	100%
Total	**68%**	**27%**	**90%**	**87%**	**67%**

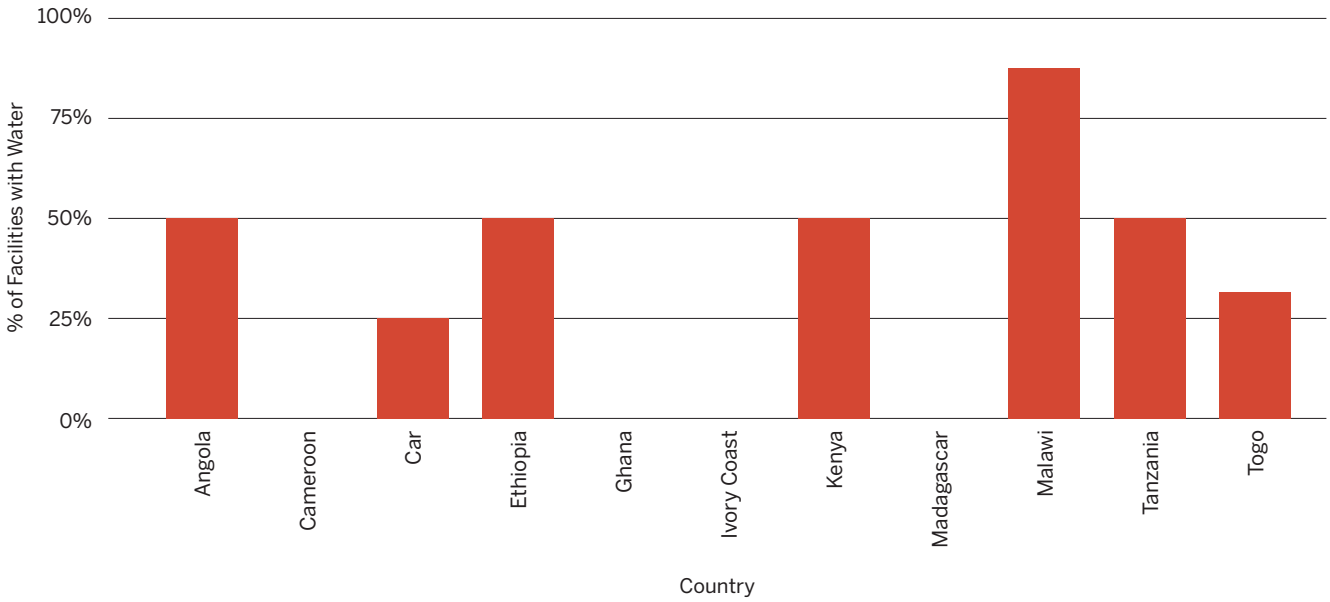


Figure 6. *Availability of ambulances in the health facilities assessed.*

4.2 DISASTER PREPAREDNESS OVERVIEW

The disaster preparedness assessment was conducted in **33 health facilities** located **in 7 African countries** (**Angola, Cameroon, Central African Republic, Ethiopia, Kenya, Madagascar, and Malawi**). The majority of these centres (75.7%) were situated in hazard prone areas, particularly subjected to floods, droughts, strong winds, and disease outbreaks (Figure 7). However, the assessment showed that the current capacity to cope with emergencies was limited. Despite the fact that many health facilities were based in high-risk regions, the assessments performed showed many weaknesses with regard to disaster preparedness (Figure 8).
Although an **Early Warning System** was in place in the majority of the regions visited (75.5%), the respondents reported a lack of trust from the population in this tool. The reasons were mainly related to the shortage of non-inclusive messages and to the fact that people cannot act on the warning when the system is activated. Many health centres were not part of functional epidemiological surveillance systems (45.5%), leading to gaps in monitoring and response. The majority of the interviewees (81.8%) reported the lack of essential components of disaster preparedness systems, such as functioning **Disaster Risk Management Committees and Civil Protection Committee.**
Regarding the health facilities' disaster preparedness, the findings showed that **only 12.1% of the centres had contingency plans in place.** Moreover, a large proportion of the facilities did not develop Standard Operating Procedures (SOPs) aimed to face massive emergencies and catastrophe. Finally, a general lack of training programs focused on disaster preparedness was reported.

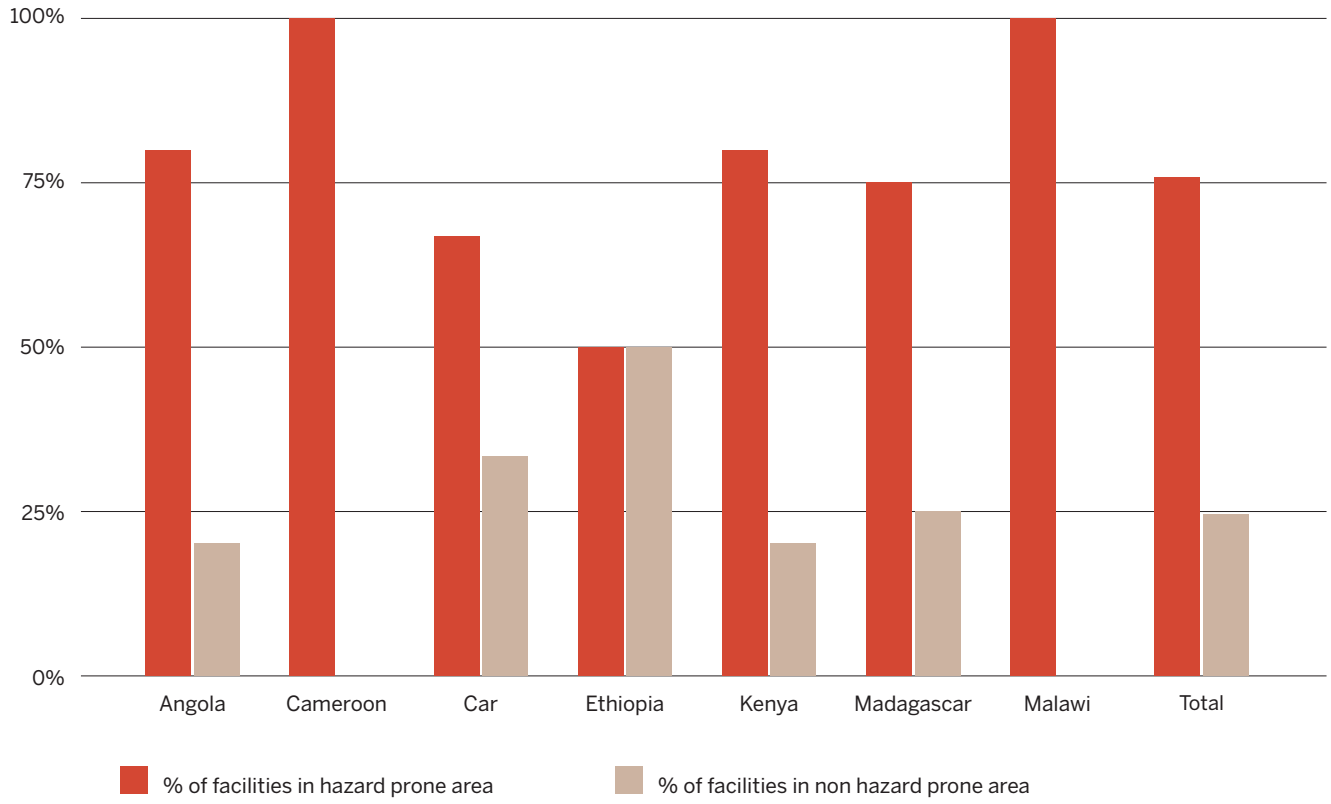


Figure 7. *Health facilities situated in hazard prone areas.*

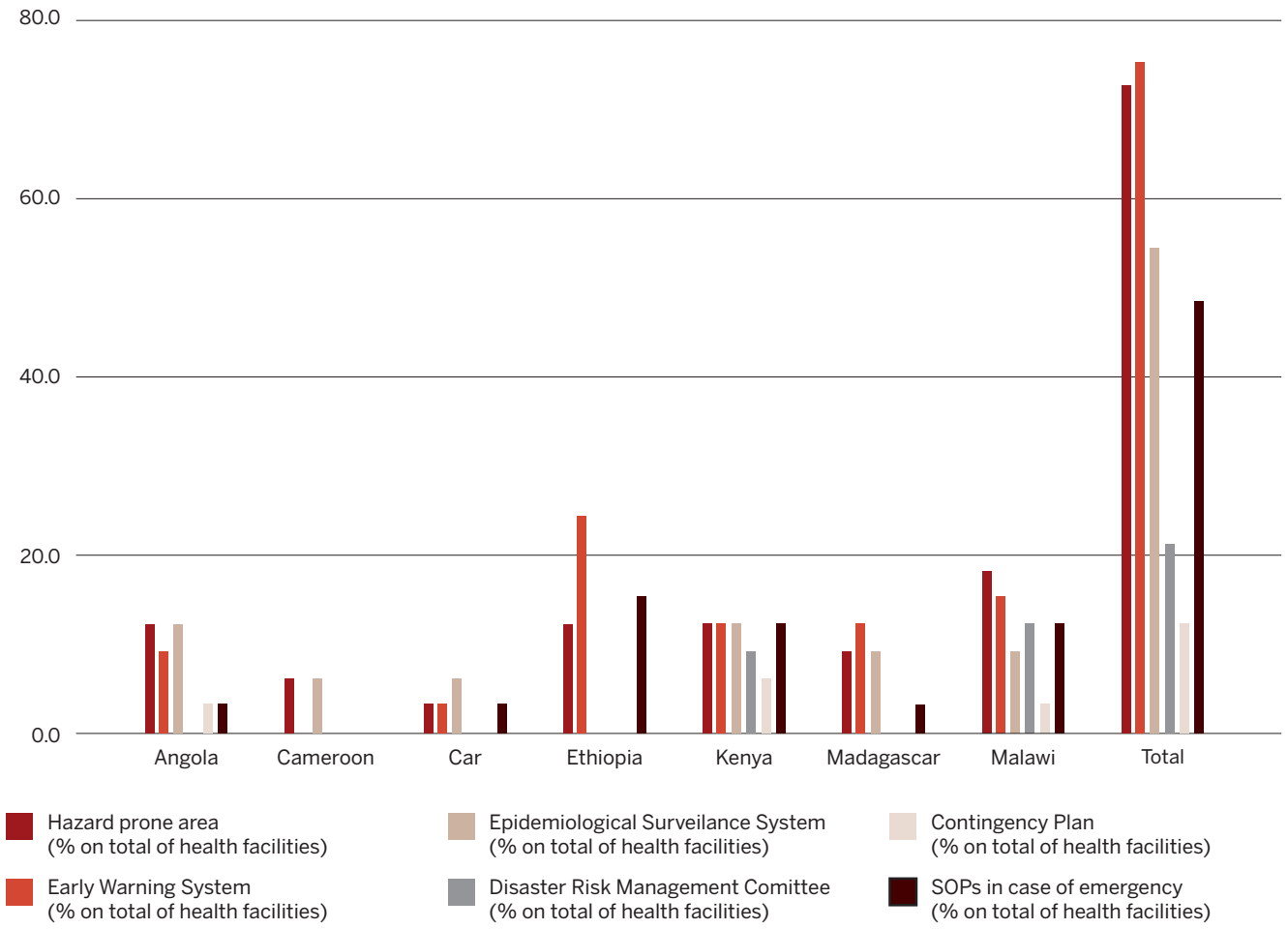
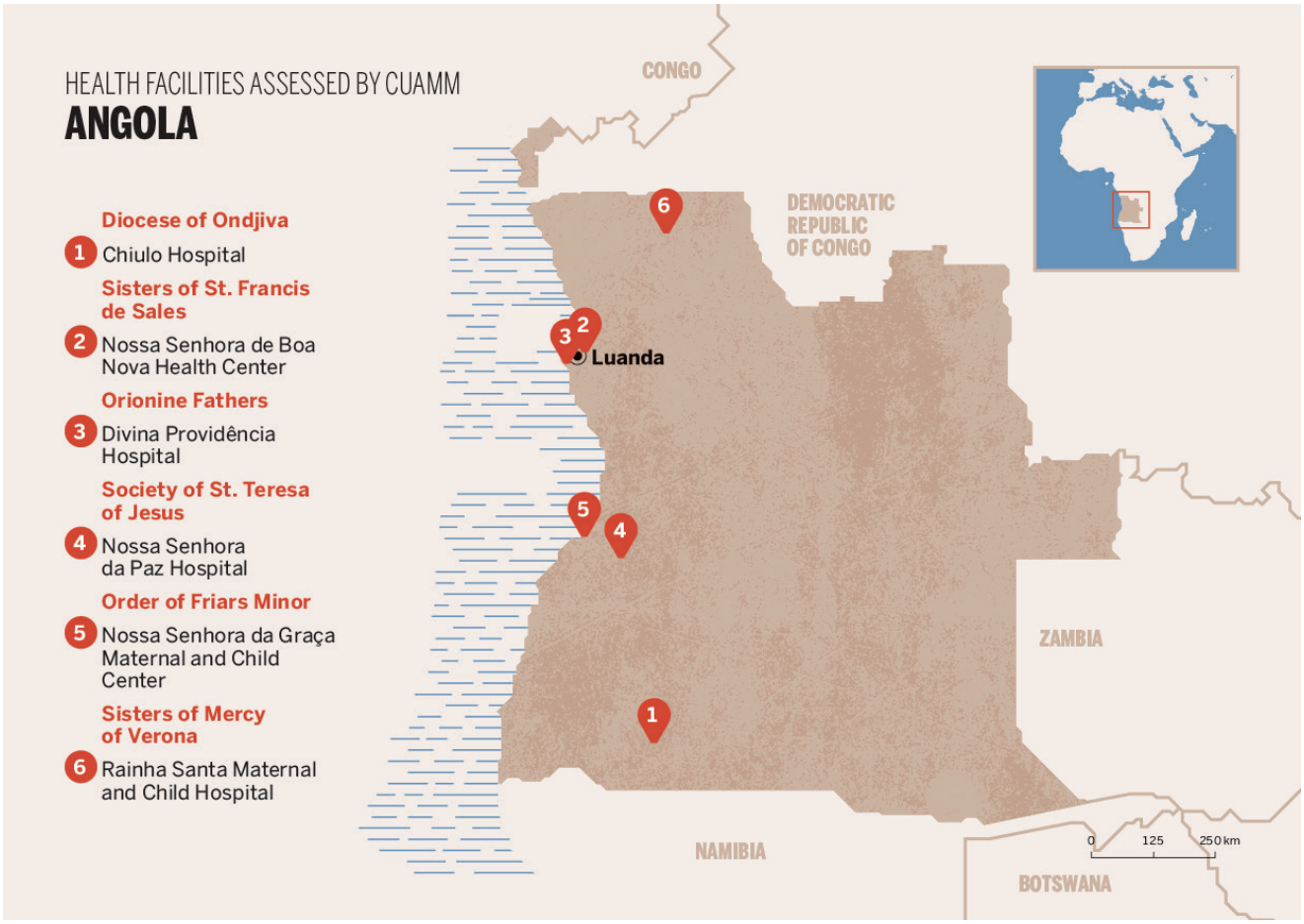


Figure 8. *Main disaster preparedness components showed per each one of the countries assessed.*

4.3 ANGOLA

COUNTRY CONTEXT

Angola, situated in southwest Africa, spans 1,247 million square kilometres and comprises 18 provinces, 164 municipalities, and 559 communes. The country's landscape encompasses diverse regions, including arid coastal lowlands, inland hills and mountains, vast plains, and rainforests. However, Angola faces significant **environmental challenges** exacerbated by climate change, resulting in frequent **droughts, floods, coastal erosion, and temperature increases.** These environmental crises have severely impacted agriculture, leading to **food and water scarcity**, perpetuating poverty cycles, and **affecting over 3.81 million people** with insufficient food consumption in various provinces. These prolonged droughts have left **over two million children in need of humanitarian assistance**, exacerbated acute food insecurity, and led to severe malnutrition (Table 2).
The social fabric of Angola is characterised by a young population, with over 63% residing in urban areas, and significant gender disparities persisting despite a current period of relative political stability. Women, particularly those in rural areas with poor education and socio-economic backgrounds, face inequality in resource access, land rights, and decision-making processes. **Gender-based violence** remains a significant



issue, with intimate partner violence affecting a quarter of women. The economic landscape, heavily reliant on oil and vulnerable to international market fluctuations, struggles with **high poverty rates and inflation**. Basic service provision, including water, electricity, education, and healthcare, faces challenges due to **poor infrastructure and resource scarcity**, especially in drought-affected regions. Despite political stability and efforts to enhance women's participation, Angola grapples with deep-seated socio-economic and environmental issues that necessitate comprehensive strategies for sustainable development and improved public health (Table 2).

Table 2. *General information about Angola.*

Capital	Luanda
Population	35,588,987
Official language	Portuguese
Geography	Angola is a large country that stretches across Southern Africa, bordering Namibia, Botswana, Zambia, and the Democratic Republic of the Congo.
Environment	Angola has abundant arable land and favourable climatic conditions, but unsustainable agricultural practices and oil exploration have resulted in severe environmental challenges such as deforestation, soil erosion, and water contamination. The country's rich biodiversity is threatened by habitat destruction and the overexploitation of natural resources. Natural disasters like flooding, erosion, droughts, and epidemics also pose significant challenges.
Political situation	Angola has been ruled by the same party since its independence, and the nation continues to struggle with establishing stable governance structures and combating corruption - especially with ongoing human rights abuses by state security forces.
Socio-economic situation	Angola's human rights record remains appalling. Decades of conflict have resulted in a significant portion of Angola's population grappling with inadequate access to fundamental necessities such as food, clean water, sanitation, healthcare, and electricity. Much of this is linked to a lack of high-quality jobs. Angola's economic landscape is dominated by the oil sector, which contributes to over a third of the nation's gross domestic product (GDP) and accounting for more than 90% of exports. Approximately 85% of Angolans are primarily engaged in subsidence farming in the agricultural sector. Extreme food shortages, exacerbated by the war in Ukraine, have led to severe malnourishment, where some adults and children have resorted to eating grass to survive.

THE NATIONAL HEALTH CARE SYSTEM

The Ministry of Health, abbreviated by MoH or MINSA, is the central government agency that executes, supervises and oversees the national health policy.
The National Health System is managed by MINSA; Provincial Governments with their Provincial Health Directions and Provincial Hospitals; and the Municipal Administrations which run the Municipal Health Directions, Municipal Hospitals and Health Care Units and Posts.
The MOH is responsible for the development of health policies, the preparation, evaluation and monitoring of annual strategic plans, as well as the promulgation of regulations.
The provincial governments have the responsibility of managing the provinces' network of health services, and of ensuring that all units operate within their allocated provincial budgets.

Municipal governments are increasingly managing the primary health care network and all basic health care activities. However, the **limited administrative and technical capacity at the local level remains a constraint** to tackle the challenges imposed by the decentralisation process.
The health services provided by the National Health System are **free of charge** and delivered through a **three-level pyramidal system that suffers from disrepair and overloading.**

The health system comprises three levels of care:
- the first made up of health posts and centres, nursing posts and medical practices, as well as municipal hospitals
- the second of general or provincial hospitals
- the third is composed of single or polyvalent hospitals, which are differentiated and specialised

The health network encompasses **3,164 public facilities in operation**, including 13 national hospitals, 32 specialised hospitals, 18 provincial hospitals, 166 municipal hospitals, 10 not-for-profit private hospitals, 105 mother and child centres, 640 health facilities and 2,180 health posts.
The main health indicators are illustrated in Table 3.

Table 3. *Main economic and health indicators of Angola, United Kingdom of Great Britain and Northern Ireland (UK) and Italy (2-5).*

	Angola	United Kingdom	Italy
Population**	35,588,987	66,971,395	58,940,425
Human Development Index*	0.59	0.93	0.89
GDP per capita (US$)**	3000,4	46,125	34,776
Current Health Expenditure (% of GDP)*	2.91§§	11.94*	9.45*
OOP expenditure (% of current health expenditure)§§**	37.4	13.6	21.3
Density of physicians (per 10,000 population)*	2.1ˆ	32	41
Life expectancy at birth (years)§**	61.6*	81.4§	83§
Fertility rate (birth per woman)*	5.3	1.6	1.3
Maternal Mortality rate/100,000 live births	222§§	4.2*	2.6*
Neonatal mortality rate/1,000 live births§§**	26.6*	9.8	4.59
Under Five mortality rate /1,000 live births*	69.4	2.8	1.47

*ˆData related to 2018. §Data related to 2019. §§Data related to 2020. *Data related to 2021. ** Data related to 2022.*

ANGOLA ASSESSMENT

OVERVIEW

The assessment highlighted that in Angola **there are many religious congregations that provide healthcare services at all levels of the National Health System**. However, it is worth emphasising that, apart from receiving authorizations to operate as recognized health providers, FBOs do not receive sufficient technical and financial resources from the government.
The five facilities visited have the same institutional setting: private not-for-profit, managed by FBOs or charitable organisations with the same missions and visions rooted in the Christian faith. They are located in **three different provinces of the country**, in urban, semi-rural or urban areas. The main characteristics of the health facilities assessed are illustrated in Table 4, Table 5 and Table 6.

The assessment activity reveals that all the facilities face some common challenges related to **clinical governance and management**. The main challenges are:

- To improve collaboration between state and religious authorities creating an agreement between the facilities and the government so that they will be able to receive government funds. That will improve drugs, pharmaceutical and equipment supplies
- Recruitment of more qualified health staff and presence of specialists particularly of generalist and specialist medical doctors
- Recruitment of more qualified administrative staff and accountants
- To improve risk awareness by creating a management network for environmental disasters that impact public health

Across these health facilities in Angola, a common theme emerges: a resilient commitment to delivering essential healthcare services despite significant challenges. These facilities operate in resource-constrained environments, marked by **infrastructure limitations**, **staffing shortages**, and **supply chain issues**. Yet, they exhibit a remarkable dedication to their communities, providing a diverse range of services, including **laboratory tests, pharmacy services, and specialist consultations**. Staff members, although facing difficulties such as delayed payments and recruitment bans, remain loyal and motivated, striving to deliver quality care with limited resources. Basic infrastructure elements like functional laboratories and electronic information systems reflect efforts to maintain essential healthcare delivery. However, persistent weaknesses, such as the lack of emergency services and inadequate infrastructure, pose significant barriers to effective care. Shortages of specialised medical staff and supply chain disruptions further strain healthcare services.
The main challenges and needs reported are illustrated in Table 7.

DISASTER PREPAREDNESS

The health centres in Angola face notable challenges in disaster preparedness. A significant proportion of these centres are situated in **high-risk areas**, particularly prone to floods, strong winds, and disease outbreaks, which can have severe impacts on public health. However, the current capacity to cope with emergencies is limited. There is a **lack of communication of early warnings**, with events seldom communicated in advance, and when they are, the messages are not inclusive or actionable. Additionally, while some health centres are part of functional epidemiological surveillance systems, many are not, leading to **gaps in monitoring and response**. There is also a **lack of regular risk assessments, inadequate training in disaster response, and deficiencies in infrastructure**, including buildings not constructed according to national standards.

Picture 3. *Nossa Senhora da Graça Maternal and Child Medical Centre, Benguela.*

Picture 4. *Maternal and Child Hospital Diocesano of Rainha Santa, Damba.*

Table 4. *Health facilities assessed in Angola.*

Facilities' Name	FBO managing the facility	Location	Area	Type
Health center of Nossa Senora de Boa Nova	San Francesco di Sales Congregation	Viana	Urban	Health centre
Hospital Da Davina Providencia	Work of Divine Providence	Kilamba Kiaxi (Luanda)	Urban	Hospital
Missionary Municipal Hospital Our Lady of Peace	Congregation of Teresian Sisters	Cubal	Urban	Hospital
Nossa Senhora da Graça Maternal and Child Medical Center	Caritas	Benguela	Semi-Urban	Health centre
Maternal and child Hospital Diocesano of Rainha Santa	Misericordia Sisters of Verona	Damba	Semi-Urban	Hospital
Missionary Hospital of Chiulo	Dioceses of Ondjiva	Cunene	Rural	Hospital

Table 5. *Main services provided and main operational data regarding the health facilities assessed in Angola.*

Health services		Health center of Nossa Senora de Boa Nova	Hospital Da Davina Providencia	Missionary Municipal Hospital Our Lady of Peace	Nossa Senhora da Graça Maternal and Child Medical Center	Maternal and child Hospital Diocesano of Rainha Santa
Outpatient services	Number of outpatients visits	67,882	88,872	Data not available	Data not available	Data not available
	Number of U5 outpatient visits	16,851	6,812	Data not available	148	3,885
	Specialist consultations availability (Cardiology, Ophthalmology, etc.)	No	Yes	No	No	No
Inpatient services	Wards for admissions	No	Yes	Yes	Yes	Yes
	Number of inpatient beds	NA	147	233	10	46
	Number of admissions	NA	3,626	Data not available	33	1,933
	Number of U5 admissions	NA	277	Data not available	46	947
Mother and Child health	Number of deliveries	NA	Not applicable	Data not available	180	637
	Free consultation for U5 and ANC	Data not available	Yes	Yes	No	Yes

(data related to 2022)

Picture 5. *Nossa Senora de Boa Nova Health Centre, Viana.*

Picture 6. *Nossa Senora de Boa Nova Health Centre, Viana.*

Table 6. *Main services provided and main operational data regarding the Missionary Hospital of Chiulo, Angola.*

Health services		Missionary Hospital of Chiulo
Outpatient services	Services available	Outpatient clinic, PNC, PoNC, immunisation, TB treatment, HIV/AIDS diagnosis and treatment, STI diagnosis and treatment, ophthalmology
Inpatient services	Wards for admissions/ inpatients services	Medicine ward, maternal ward, paediatric ward
	Number of beds	288
Consultations	Consultations (outpatients + inpatients)	18,860
Mother health	Number of deliveries	1,647
	Operating theatre	Not available

(data related to 2020)

Table 7. *Challenges, needs and strengths concerning the health facilities assessed in Angola.*

CHALLENGES	
Human resources	Insufficient local specialised doctors and nurses place limitations on the range of medical services provided
Health services delivered	Lack of family planning, a dedicated under-5 clinic, physiotherapy, and an emergency ward are notable gaps in healthcare services across Angola
Logistics	Most of the healthcare centres experienced issues in maintaining critical hospital infrastructure, including malfunctioning solar panels and non-functional X-ray rooms
Management	Challenges in planning and managing the delivery of drugs have led to stock-outs of crucial medicines within the last three months; Administrative difficulties frequently contributed to delays in supply chains, affecting the availability of essential resources in many of the centres
NEEDS	
Human resources	Recruiting local specialised doctors and nurses will enhance the healthcare centres' capacity to provide comprehensive medical care
Health services delivered	Introducing family planning, a dedicated under-5 clinic, and physiotherapy services will broaden the range of healthcare offerings in Angola; Establishing an emergency ward and addressing specific issues, like low availability of blood in blood banks, will improve emergency healthcare services
Logistics	Qualified technicians for general maintenance are required to address issues with solar panels and other essential pieces of equipment; Providing a phone at the facility will enhance communication capabilities
Management	Improved planning and management systems for drugs are essential to prevent stock-outs and ensure the availability of necessary medications
STRENGTHS	
Human resources	Many of the healthcare centres across the country boasted trained and committed staff members. This is especially significant given reports of delayed payments and recruitment bans in resource-constrained environments
Health services delivered	Many health centres offer a wide range of services, including laboratory tests, pharmacy services, and specialist consultations
Logistics	Plans for extensive renovations, including electricity and water upgrades, demonstrate a commitment to enhancing facility infrastructure in healthcare centres across Angola; Although resources are limited, quality care was still provided by centres using elements such as functional laboratories for clinical tests, working refrigerators for medicines, and electronic information systems

Picture 7. *Nossa Senhora da Graça Maternal and Child Medical Centre, Benguela.*

Picture 8. *Missionary Municipal Hospital Our Lady of Peace, Cubal.*

Picture 9. *Nossa Senhora da Graça Maternal and Child Medical Centre, Benguela.*

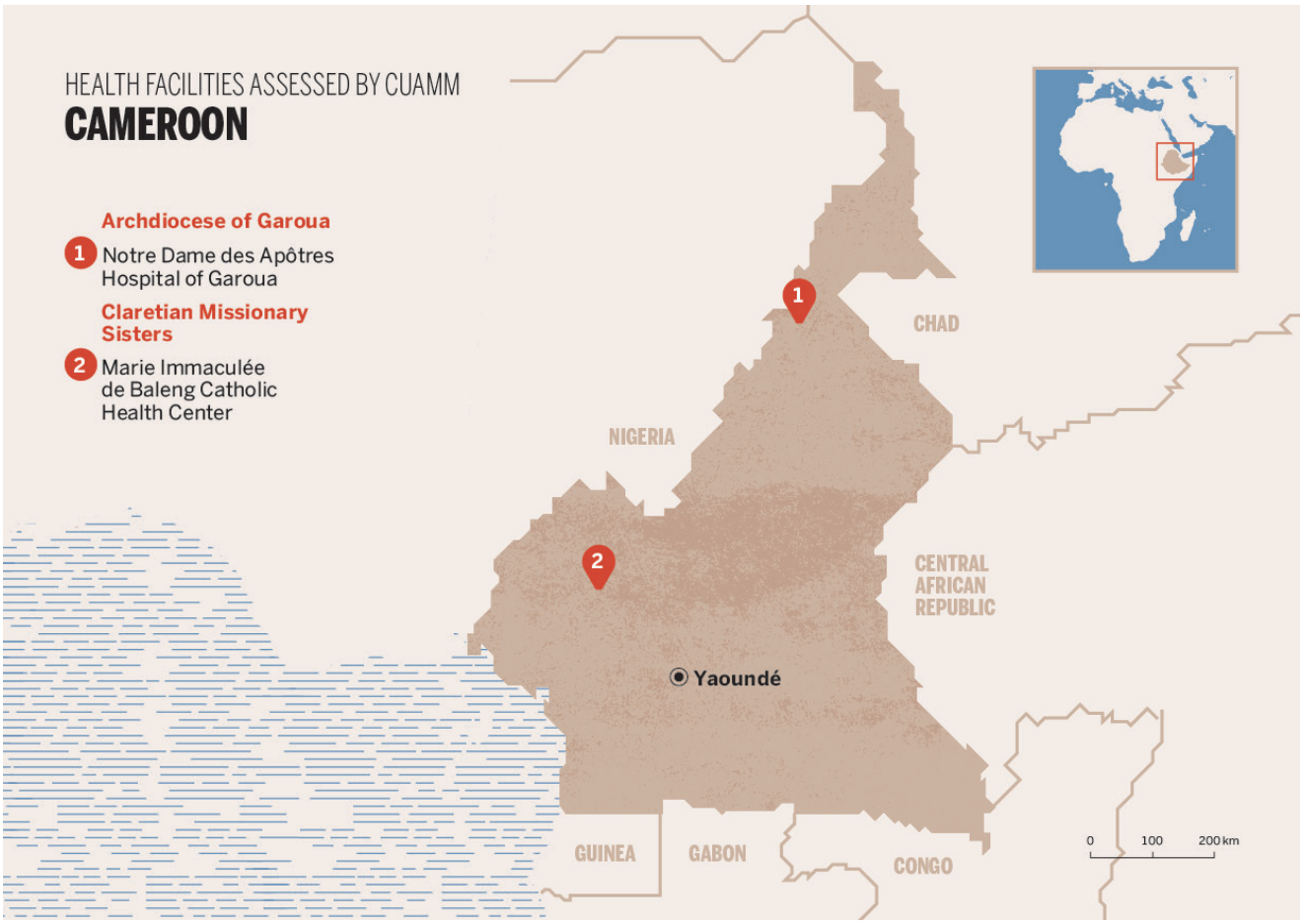
Picture 10. *Maternal and child Hospital Diocesano of Rainha Santa, Damba.*

4.4 CAMEROON

COUNTRY CONTEXT

Cameroon is a lower-middle-income country with a population of over 27 million. Two of its border regions with Nigeria (northwest and southwest) are Anglophone, while the rest of the country is Francophone. Cameroon is endowed with rich natural resources, including oil and gas, mineral ores, and high-value species of timber, and agricultural products, such as coffee, cotton, cocoa, maize, and cassava (6). Cameroon's economy is mainly based on agriculture, which produces cassava, plantains, maize, oil palm fruit, taro, sugar cane, sorghum, tomatoes, bananas, vegetables. The principal industrial activities are petroleum production and refining, aluminium production, food processing, light consumer goods, textiles, lumber, ship repair. The main political, socio and economic characteristics are illustrated in Table 8.

Cameroon is facing multiple **humanitarian challenges**, driven by violence, climate shocks, and disease outbreaks. These are compounded by structural development weaknesses and other vulnerabilities. The Far North region of Cameroon is affected by the Lake Chad basin conflict, with **1.6 million people in need of humanitarian assistance and protection services in 2023** (7). The region suffers from one of the



highest rates of chronic food deficits and acute malnutrition in the country. Protection, access to food, education, and drinking water are some of the most acute needs in these regions. In the Eastern regions, the impact of the **influx of refugees** from the Central African Republic has driven the humanitarian needs of both the host and the refugee populations. The refugees face protection risks, such as gender-based violence, exploitation, and abuse, as well as limited access to basic services and livelihood opportunities. The host communities suffer from high food insecurity, malnutrition, and poverty rates. In addition to these crises, Cameroon is also affected by **climate-related disasters**, such as floods and droughts, which affect the livelihoods and resilience of the people (7).

Table 8. *General information about the republic of Cameroon (6-7).*

Capital	Yaoundé
Population	27,198,628
Official language	French
Geography	The Republic of Cameroon is a country in Central-West Africa facing the Gulf of Guinea, in the Atlantic Ocean. It borders Nigeria to the West, Chad and Central Africa Republic to the East, Gabon, Democratic Republic of Congo and Guinea Equatorial to the South
Environment	The climate varies with terrain, from tropical along the coast to semiarid and hot in the north. The country has all Africa principal geographic and climatic areas: the coast, the desert, the mountains, the rainforest and the savannah
Socio-economic situation	Since November 2021, Cameroon is experiencing high inflation, driven mainly by shortage and increase of the price of staple goods (bread, wheat and related products, vegetable oil, and meat), which can be explained by the disruption of the global value chain due to Covid-19 pandemic and Ukraine's invasion by Russia. Cameroon's real GDP growth is projected to reach 4.2%, on average, over 2023-25, supported by sustained activity in the secondary and tertiary sectors.

THE NATIONAL HEALTH CARE SYSTEM

Health services in Cameroon are delivered through a **decentralised system**.

The system is structured according to three functionally levels:
- Central level: government authorities
- Intermediate level: regional authorities
- Peripheral level: local government authorities (districts)

Due to the progressive decentralisation, both district and regional levels are fully responsible for delivering health services within their area of jurisdiction. In Cameroon, there are currently 10 regions, 189 health districts, which are, in turn, composed of health areas (aires de santé), with an average population of 10,000 people. Healthcare services provided are distinguished in Primary Health Care (PHC), secondary and tertiary health care. The structures delivering health care are classified into **seven categories**: (i) general hospitals, (ii) central hospitals, (iii) regional hospitals, (iv) district hospitals, (v) district medical centres, (vi) integrated health centres and (vii) dispensaries. **Primary and secondary care is offered at dispensaries** (*Cabinet de soins*), health centres (centre de santé) and hospitals, which are spread within the reference territory and intended to provide mainly outpatient services such as prevention, health promotion, maternity and some inpatient curative services. **Tertiary care is provided by regional hospitals**, which

offer more specialised services, including emergency, blood bank and specialised surgical services (gynaecology, urology, cardiology). These hospitals serve as referral hospitals for the districts. The public sector represents half of the health care delivery system, complemented by private not-for-profit (FBOs and NGOs) services and private for-profit. The distribution of facilities across levels of care reflects the healthcare needs of the population, with **most cases treated at district level** and more complex cases referred to regional hospitals. In Cameroon there are about **5,661 health facilities**, of which 60% are owned by the public sector.
The main health indicators of the country are illustrated in Table 9.

FINANCING SCHEME

Households contributed more than 70% of the health financing (direct payment). Nearly one third of this expenditure is spent on drugs. Household financing in Cameroon is the third largest contribution in sub-Saharan Africa after Sudan and Nigeria.
The State implemented a **free care policy for some common diseases** (malaria, HIV/AIDS, tuberculosis), **immunisation and support services for certain targets** (children under 5, pregnant women, etc.). However, this free health care policy is not systematically applied due to a **lack of formal compensation mechanisms**. The level of spending is still insufficient to ensure equitable access to basic and essential health services and interventions, so the major concern is to ensure adequate mobilisation and equitable resource allocation for health.

Table 9. *Main economic and health indicators of Cameroon, United Kingdom of Great Britain and Northern Ireland (UK) and Italy (3-6).*

	Cameroon	United Kingdom	Italy
Population**	27,198,628	66,971,395	58,940,425
Human Development Index*	0.58	0.93	0.89
GDP per capita (US$)**	1441.79	46,125	34,776
Current Health Expenditure (% of GDP)*	3.77§§	11.9*	9.5*
OOP expenditure (% of current health expenditure)§§**	68.6	13.6	21.3
Density of physicians (per 10,000 population)*	3.65	32	41
Life expectancy at birth (years)§**	1.2	81.4	83
Fertility rate (birth per woman)*	54.5	1.6	1.3
MaternalMortality rate/100,000 live births*	4.4	4.2	2.6
Neonatal mortality rate/1,000 live births§§**	438	9.8	4.6
Under Five mortality rate /1,000 live births*	25.6	2.8	1.5

*§Data related to 2019. §§Data related to 2020. *Data related to 2021. **Data related to 2022.*

CAMEROON ASSESSMENT

OVERVIEW

The assessment involved **two private-not-for-profit health facilities** both based in urban areas (Marie Immaculée de Baleng in Bafoussam and Notre Dame des Apostolique in Garoua) (Table 10 and Table 11). They varied in type and level of services provided within the Cameroon national health system: one was a health centre (Centre Médicalisé Catholique Marie Immaculée de Baleng) and the other a district hospital (Notre Dame des Apostolique).

The assessment activity revealed that the two facilities face common challenges concerning human resources, logistics, and financing issues (Table 12). From a general perspective, the challenges reported can be summarised as follows:

- lack of qualified health staff according to the services provided and patient needs, particularly of specialised medical doctors in Garoua hospital and midwives in the Bafoussam health centre
- lack of diagnostic medical equipment or their proper and timely maintenance due to financial constraints
- general financial constraints due to the progressive reduction of the main sources of income and the parallel increase of expenses, mainly for drugs. Drugs and running materials are purchased in the public market (40%) or diocesan stores (70%) using patients' fees income. These financial difficulties can be associated with:
  - the absence of government financial or personnel support
  - the absence of other sources of funds (projects, donors, insurance companies)
  - the increase in price of drugs due to difficulties of the National Drugs Purchasing Centre and absence of a National Drug Authority to monitor and control prices and quality of products
  - the concurrence of other private and public health units in the same area.
- the two facilities apply fees for service schemes which impairs the accessibility of institutions by the low-income part of the population (children and pregnant women)

A substantial difference between the two visited facilities concerned governance issues: while in Garoua Hospital the governance was sound with documents, procedures and meetings carried out regularly and timely, roles and responsibilities between governors and managers are well separated, in Bafoussam Health Centre this process had not started yet.

DISASTER PREPAREDNESS

The health facilities assessed were in **non-hazard prone areas**. The interviewees reported that an Early Warning System (EWS) and a Disaster Risk Management Committee (DRM) were not in place in the regions where they were operating, while an epidemiological surveillance system was functioning. The health facilities did not have a contingency plan and Standard Operating Procedures (SOPs) in place in case of emergencies.

Table 10. *Health facilities assessed in Cameroon.*

Facilities' Name	FBO managing the facility	Location	Area	Type
Centre Médicalisé Catholique Marie Immaculée de Baleng	Marie Immaculée Missionnaire Clarétaines	Bafoussam, (District of Mifi, West Region)	Urban	Health Centre
Hôpital Notre Dame des Apostolique	Archdioceses of Garoua and COE (Centro Orientamento Educativo, an Italian NGO)	Garoua, (District of Garoua I, North Region)	Urban	District Hospital

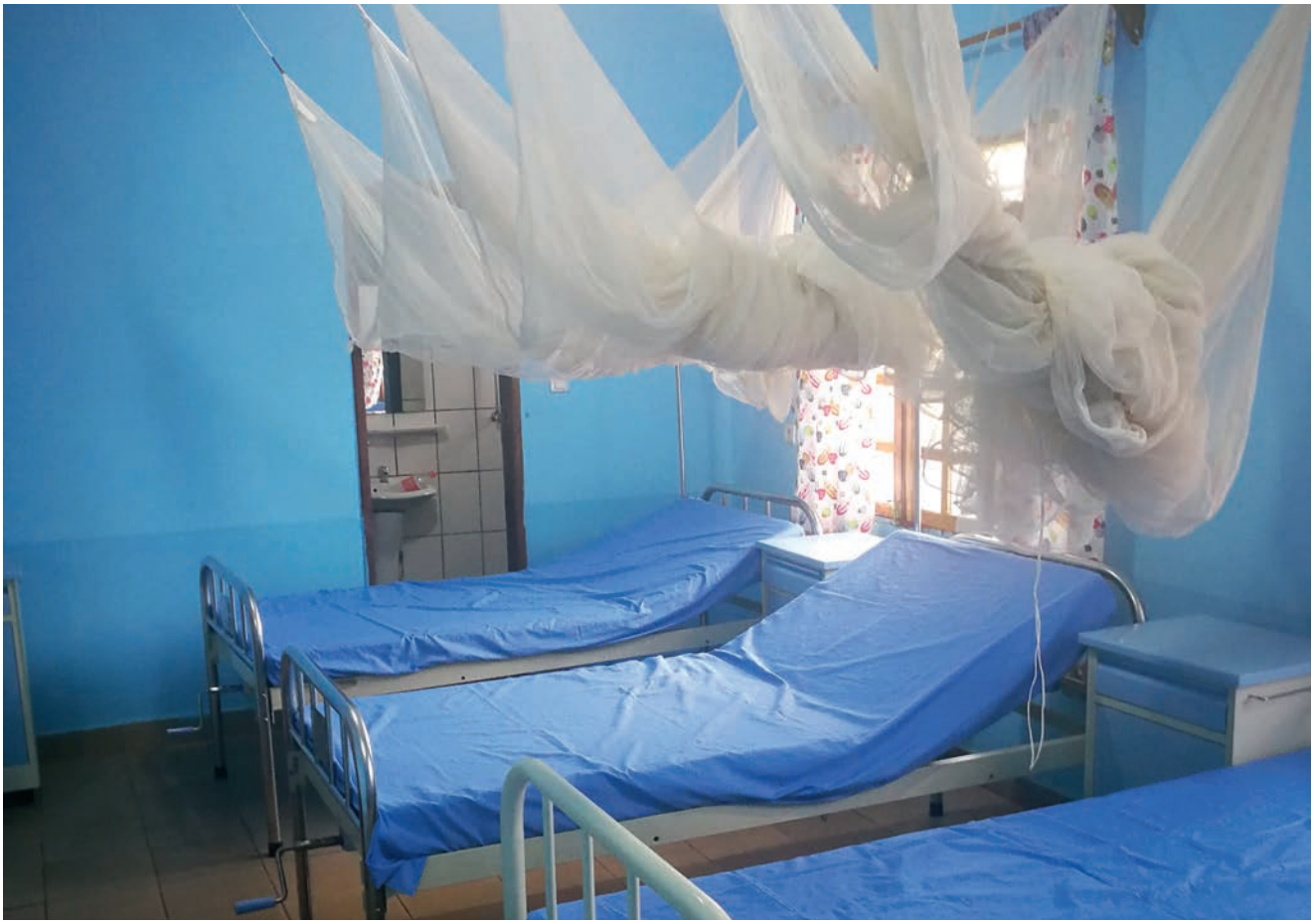
Table 11. *Main services provided and main operational data regarding the health facilities assessed in Cameroon.*

Health services		Centre Médicalisé Catholique Marie Immaculée de Baleng	Hôpital Notre Dame des Apostolique
Outpatient services	Number of outpatients visits	1,027	18,721
	Number of U5 outpatient visits	113	5,457
	Specialist consultations availability (Cardiology, Ophthalmology, etc.)	No	No
Inpatient services	Wards for admissions	Maternal, Children, Surgical, Medical	Emergency, Maternal, Children (with Malnutrition Unit), Surgical
	Number of inpatient beds	17	58
	Number of admissions	234	2,389
	Number of U5 admissions	27	368
Mother and Child health	Number of deliveries	77	525
	Number of caesarean sections	1	42
	Free consultation for U5 and ANC	Data not available	Data not available

(data related to 2022)

Picture 11. *Centre Médicalisé Catholique Marie Immaculée de Baleng, Mifi District.*

Picture 12. *Hôpital Notre Dame des Apostolique, Garoua District.*



Picture 13 and 14. *Centre Médicalisé Catholique Marie Immaculée de Baleng, Mifi District.*

Table 12. *Challenges, needs and strengths concerning the health facilities assessed in Cameroon.*

CHALLENGES	
Human resources	Lack of specialised health personnel (midwives, surgeons, gynaecologist, radiologist technician, senior medical officer with competence in internal medicine)
Health services delivered	Absence of services for chronic diseases (diabetes, hypertension), and lack of specialised services (dental clinic, ophthalmologic clinic)
Logistics	Lack of equipment concerning the following main areas: operating theatre and delivery room: anaesthesia machine, oxygen cylinders, autoclave, surgical light, trolleys; pharmacy: refrigerator; electricity: a generator or a solar supply system in case of interruption of electricity from town; data collection: lack of devices equipment for data collection and analysis management (personal computer)
Referral system	Absence of vehicles (motorcycle, motor vehicle, ambulance)
Data collection	Weakness of the data collections system and procedures
Management	Lack of guidelines concerning governance, and resources management (equipment, supplies, human resources, funds)
Financing	Financial constraints mainly due to the following issues: low utilisation of the services by the population; elevated price of drugs/running material; absence of support from the government both in terms of financing and in terms of posting personnel; lack of diversification of income sources (the funds come only from patients' fees); Fees for services scheme applied to the most vulnerable groups (under 5 and pregnant women); Low certainty in the upcoming years due to the concurrence of other health units in the same area
Integration and coordination	Lack of support from the Diocesan Health Centre *(Centre Médicalisé Catholique Marie Immaculée de Baleng)*
NEEDS	
Human resources	Specialised health personnel (midwives, surgeons, gynaecologist, senior medical officer with competence in internal medicine), radiologist technician; Training and education: need to plan continuous medical education programmes for health professionals
Health services delivered	Need to implement both inpatients and outpatient services. In particular, the health facilities reported the need to implement the following services/units: operating theatre; delivery room; postoperative care unit; sterilisation unit; maternal and children wards; radiology unit; trauma patient care; chronic diseases care; outreach consultation activities (for instance including cardiologist and surgeon)
Logistics	Need of equipment in operating theatre (surgical light, autoclave, oxygen cylinders, anaesthesia machine), in the wards/units (trolleys, x-ray machine), in administration (personal computers, printer) and in pharmacy (refrigerator); need of generator or solar system panels to supply electricity in case of emergency
Referral system	Mean of transport for patients' referral and for logistic purposes
Data collection	Implement the functioning of the Health Management Information System (HMIS); Carry out a cost analysis survey in order to know the current/real cost of each service and better planning the activities, review the fees scheme, make proposal for donors
Management	Develop a document to regulate the composition, functions, roles and responsibilities in order to have a functioning Management Team; Create a committee to define hospital protocols for diagnosis and treatment and a list of essential drug; Support in the development and implementation of procedures for managing resources (material, finances and human resources); Elaborate an annual financial report; Define a list of essential drugs
Financing	Review the payment scheme for vulnerable groups, need to raise funds from other national/international partners or contracting services with local insurance companies

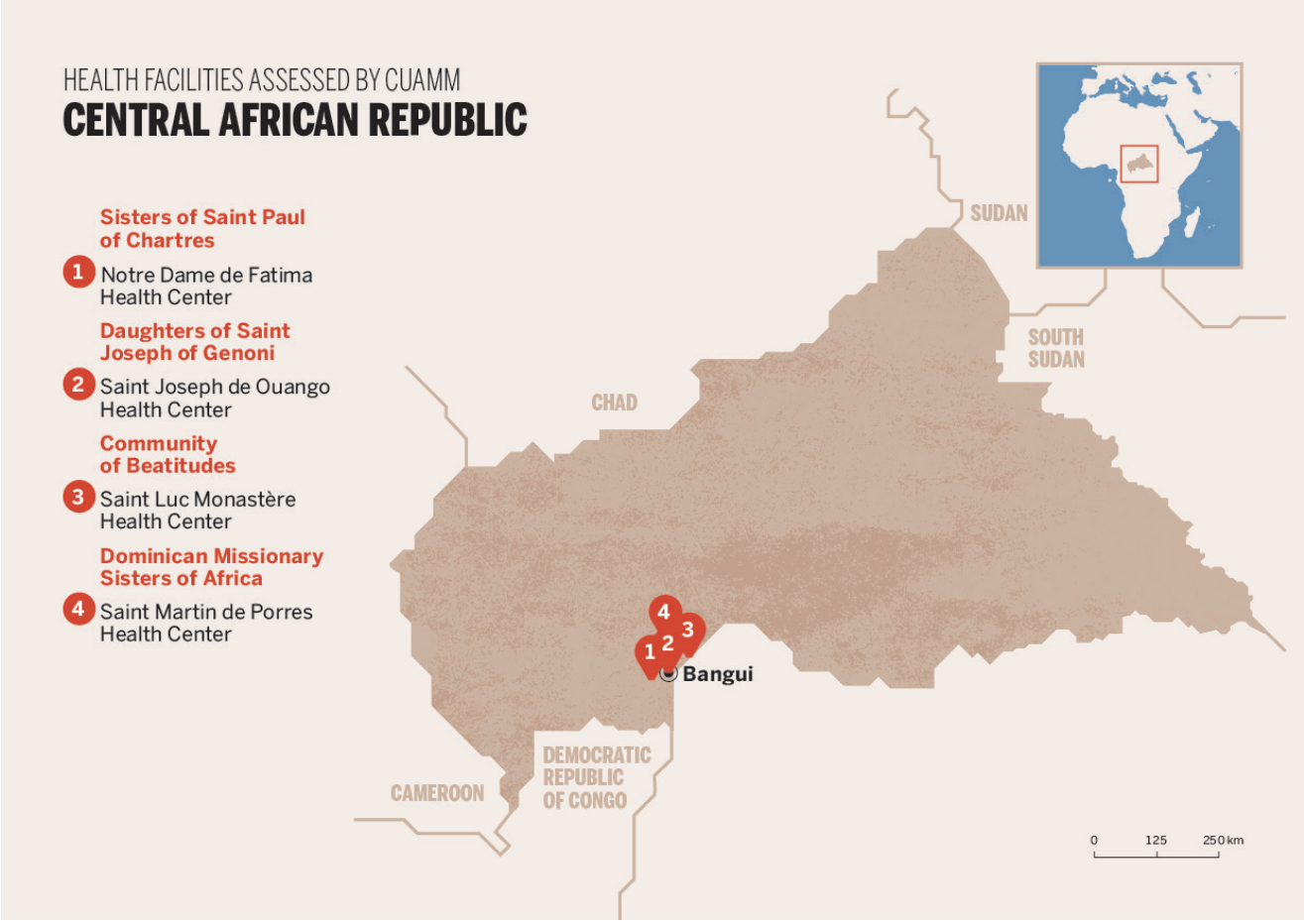
Integration and coordination	Advocacy for better support/coordination from Diocesan Health Centre *(Centre Médicalisé Catholique Marie Immaculée de Baleng)*
STRENGTHS	
Human resources	Good interprofessional relations between healthcare workers that allow team working practices; Good organisations of hospital shifts; Presence of healthcare workers with extensive professional experience; Presence of community health workers for sensitisation of the population on hospital services;
Health services delivered	Well-functioning outpatients and inpatients services, including children, maternal, surgical and medical services
Logistics	Cleanliness of premises, well-organised and equipped laboratory
Data collection	Availability of the Health Management Information System (HMIS), that includes health services reports monthly developed by the Hospital Director and disseminated to local/nation health authorities through an electronic platform called Rapport Mensuel des Activities *(only with regard to Notre Dame des Apostolique);* Availability of patients registers, availability of essential documents (Organigram, Manual of administrative, financiers, accountability and logistic procedures, audited budgets and annual work-plans)
Management	*(only with regard to Notre Dame des Apostolique):* good relations with local authorities (District and Regional Officers) and with the Bishop and Diocesan Coordination Health Centre (CODAS)

Picture 15 and 16. *Centre Médicalisé Catholique Marie Immaculée de Baleng, Mifi District.*

4.5 CENTRAL AFRICAN REPUBLIC

COUNTRY CONTEXT

The Central African Republic is one of the poorest and most fragile countries in the world, despite its abundant natural resources and its significant agricultural potential. The drivers of fragility include a **lack of social cohesion**, the **concentration of political power**, **social and regional disparities**, the **capture and mismanagement of natural resources by the elite** and **persistent insecurity** fuelled by a regional system of conflicts. For over two decades now, the Central African Republic has been afflicted by crises (8). With a population of about 6,100,000 the Central African Republic ranks at the bottom of the human capital and development indices (188th out of 191). Its institutions are weak, its citizens have limited access to basic services, infrastructure is inadequate, gender-based violence (GBV) is widespread (9).
Despite a peace agreement signed between the Government and 14 armed groups (February 2019), the security situation in the country remains precarious (10). Due to the security, humanitarian, human rights and political crisis in the Central African Republic, the Security Council authorised on 10 April 2014 the deployment of a multidimensional United Nations peacekeeping operation, named MINUSCA (United



Nations multidimensional integrated Stabilisation Mission in the Central African Republic) (10). The country has also been receiving bilateral military support from Russia and Rwanda. The main characteristics of the country are illustrated in Table 13.

Table 13. *General information about the Central African Republic (CAR) (8).*

Capital	Bangui
Population	6,091,090
Official language	French, Sango
Geography	Landlocked country that shares borders to the north with Chad, to the northeast with Sudan, to the east with South Sudan, in the south by the Congo and Democratic Republic of Congo, and to the west with Cameroon.
Environment	The country's terrain consists of a vast peneplain dominated by two mountain ranges at the eastern and western ends. These are joined by a central 'spine', which separates the two principal drainage sources for the country: the Chari-Longue Basin in the north, and Congo Basin in the south. Due to the country's location, CAR has relatively favourable climate conditions, that are primarily hot and humid, characterised by a dry and rainy season. Over the last thirty years, annual rainfall has shown a slight upward trend, estimated at 8%. The number of consecutive days with 1 mm of precipitation has decreased and the number of days with precipitation of 10 mm has increased, reflecting an increase in extreme weather events. The most marked climatic hazards in recent years have been storms, flooding (in the South-West) and droughts (in the North).
Political situation	CAR has suffered decades of conflicts (1997, 2003, 2013 and 2020), and its people are trapped in a cycle of indiscriminate and endemic violence.
Socio-economic situation	Due to the multiple challenges outlined above and the compounding effect of one crisis after another, 71.4% of Central Africans live in poverty. The UN Humanitarian Coordinator estimated that 56% of the population were in need of humanitarian assistance and protection in 2023. The Central African Republic has some of the lowest education indicators. The expected length of schooling is 5.3 years for boys compared to 3.8 years for girls. The quality of primary education is low, and few girls have access to secondary education. The country has some of the largest gender gaps in the world, ranking 188th out of 191 countries in terms of gender equality. These gender gaps contribute to high rates of GBV that are a major obstacle to the full participation of women in social and economic life. Their empowerment is key to the country's development

THE NATIONAL HEALTH CARE SYSTEM

The Ministry of Health and Population (MoHP) is responsible for overseeing public health and health service delivery. It consists of four technical units: (a) the General Directorate of Population and Primary Health Care; (b) the General Directorate of Epidemiology and Disease Control; (c) the General Directorate of Research, Studies, and Planning; and (d) the General Directorate of Pharmacy and Health Care Organization. The health system is organised in a pyramid structure with **three levels**: central, intermediate, and peripheral. Each level has **three types of structure**: institutional management structures, health facilities and population representation structures. The central level is represented by the Cabinet and the various Directorates General with their respective directorates and central departments. The hospitals at this level serve as a reference for peripheral hospitals. The intermediate level corresponds to seven Health Regions, each of which follows the boundaries of the Administrative Regions. The peripheral or operational level is constituted by the

health district facilities. The Central African Republic is subdivided into **35 health districts**.
There are a total of **1,011 health facilities**, of which 862 are operational. The functional structures are made up of 5 central hospitals, 5 regional hospitals, 27 district hospitals, 18 secondary district hospitals, 365 health centres and 442 health posts. Between 2020 and the first half of 2021, 85 (32.95%) of the facilities have been rehabilitated/constructed, while 173 (67.05%) remain to be rehabilitated/constructed.

HEALTH SITUATION

The state of health of the population is still characterised by very high mortality and morbidity rates, with a predominance of **communicable diseases** and an increase in **noncommunicable diseases**. In particular, the Central African Republic has **one of the highest maternal mortality (832/100,000 live births) and fertility (5.98 children per woman) rates in the world** (Table 14). High maternal mortality and fertility, including adolescent pregnancies and short birth spacing, are linked to the country's poor underlying social determinants of health and limited access to and quality of health services.
Child mortality and chronic malnutrition levels are extremely high (Table 14). The three main causes of child mortality include diarrhoea, respiratory infection, and malaria. They have not changed since 1990 and constitute more than half of child deaths. The main neonatal death causes are perinatal complications, preterm births, and septicemia.
In 2019 CAR's MoHP has adopted the targeted **Free Healthcare Policy** for all pregnant women, postpartum women, children under five, and survivors of GBV in order to provide better financial protection to these most vulnerable groups.

Table 14. *Main economic and health indicators of the Central African Republic, the United Kingdom of Great Britain and Northern Ireland (UK) and Italy (3-5, 8).*

	Central African Republic (CAR)	United Kingdom	Italy
Population**	6,091,097	66,971,395	58,940,425
Human Development Index*	0.404**	0.93	0.89
GDP per capita (US$)**	480	46,125	34,776
Current Health Expenditure (% of GDP)*	8	11.94	9.45
OOP expenditure (% of current health expenditure)§§**	43.7	13.6	21.3
Density of physicians (per 10,000 population)*	0.66§	32	41
Life expectancy at birth (years)§**	53.1	81.4	83
Fertility rate (birth per woman)*	5.98	1.6	1.3
Maternal Mortality rate/100,000 live births*	835	4.2	2.6
Neonatal mortality rate/1,000 live births§§**	31.9	9.8	4.59
Under Five mortality rate /1,000 live births*	99.9	2.8	1.47

*§Data related to 2019. §§Data related to 2020. *Data related to 2021. **Data related to 2022.*

CENTRAL AFRICAN REPUBLIC ASSESSMENT

OVERVIEW

During the assessment, **four FBOs facilities** belonging to different congregations were visited (Table 15 and Table 16). All the facilities were private-not-for-profit primary care facilities, and they were located within the borders of CAR's capital, Bangui, in slums (banlieues) areas.
Although the health facilities assessed were classified as primary care facilities, the range of services provided showed a variability in terms of challenges, needs and strengths (Table 17). For instance, only one of them (St Joseph de Ouango) had inpatient capacity for the general population, while just two out of four provided maternity service and basic delivery care (St Luc and St Martin de Porres). **All the facilities offered services for child health and vaccination needs.**
With the exception of the Centre de Santé de Notre Dame de Fatima, none of the other centres reported offering free care but asked patients to pay for care out of pocket. This has the dual effect of increasing inequity, and of reducing the demand for health care from these catholic facilities as they asked patients to pay out of pocket. These effects are particularly felt in Bangui due to the high concentration of both public and private health facilities, and ease of access compared to other areas of the country (the vast majority of the territory out of Bangui), where Missionary or faith-based facilities may represent the only option available for the local population.

DISASTER PREPAREDNESS

Two of the four health facilities assessed were located in **hazard prone areas**. However, only one of them reported the presence of an EWS aimed to disseminate warning information to the population in case of hazard. All the interviewees reported that a **Disaster Risk Management Committee (DRM)** were not in place in the regions where they were operating, while an epidemiological surveillance system was functioning. A contingency plan was not in place in any of the facilities assessed, and **Standard Operating Procedures (SOPs)** for emergency situations were established in only one case.

Table 15. *Health facilities assessed in the Central African Republic.*

Facilities' Name	FBO managing the health facility	Location	Area	Type
Centre de Santé Saint Joseph de Ouango	Filles de Saint Joseph de Genoni	Bangui, Health District 1	Urban	Health centre
Centre de Santé Saint Luc Monastère	Communauté des Béatitudes	Bangui, Health District 3	Urban	Health centre
Centre de Santé St Martin de Porres	Soeurs Dominicaines Missionnaires d'Afrique	Bangui, Health District 3	Urban	Health centre
Centre de Santé de Notre Dame de Fatima	Soeurs de Saint Paul de Chartres	Bangui, Health District 2	Urban	Health centre

Picture 17. *Centre de Santé Saint Luc Monastère, Bangui.*

Table 16. *Main services provided and main operational data regarding the health facilities assessed in Central Africa Republic.*

Health services		Centre de Santé Saint Joseph de Ouango	Centre de Santé Saint Luc Monastère	Centre de Santé St Martin de Porres	Centre de Santé de Notre Dame de Fatima
Outpatient services	Services available	Outpatient department, ANC and PoNC, immunisation, U5 care, tuberculosis diagnosis and treatment, HIV/AIDS diagnosis and treatment, sexually transmitted diseases	Outpatient department, ANC and PoNC, immunisation, U5 care, sexually transmitted diseases, health education	Outpatient department, ANC and PoNC, immunisation, U5 care, STI, health education	Outpatient department, ANC and PoNC, immunisation, U5 care, STI, HIV/AIDS diagnosis and treatment, prevention of mother-to-child transmission of HIV
Inpatient services	Wards for admissions	Emergency unit, maternal ward (delivery room)	NA	Emergency unit, maternal ward (delivery room)	Observation room
	Number of inpatient beds	28	NA	20	8
	Number of admissions	976	NA	Not reported	NA
Mother and Child health	Number of deliveries	25	NA	208	NA
	Number of caesarean sections	Operating theatre not available	NA	Operating theatre not available	NA

(data related to 2022)

Table 17. *Challenges, needs and strengths concerning the health facilities assessed in the Central African Republic.*

CHALLENGES	
Safety and security	Conflicts and tensions that afflict the country since a long time, produce safety and security issues for patients and health professionals
Human resources	Shortage of health professionals, especially with regard to maternal and neonatal care
Health services delivered	The health facilities assessed offered only basic health services (outpatient services, vaccination services, TB program, HIV programs)
Logistics	Difficulties in drug procurement and medical equipment supply. All the facilities visited in Bangui had only very basic laboratory diagnostics and rapid diagnostic tests (RDTs)
Referral system	There is not a well-established/functioning referral system in place. All the facilities referred emergency/complicated cases to higher-level facilities using transport via motorcycle or cars hired from the local communities. Only the Centre de Santé St Martin de Porres had an ambulance. The patients have to cover all the transport fees by themselves
Data collection	None of the facilities assessed, had a systematic approach to data collection, nor did they produce systematic and comprehensive monthly/annual reporting
Financing	All the facilities assessed reported major financial issues. CAR does not have provisions for the establishment of PPP with private not for profit providers; There is no institutionalised mechanism/procedure whereby FBOs engaged in healthcare provision can sign a service agreement with the MoHP for the provision of targeted free care and be compensated for the costs incurred
Integration and coordination	Lack of integration and coordination with governmental health facilities
NEEDS	
Human resources	Need to improve the amount of health professional, mainly for maternal and neonatal health services (i.e. gynaecologists, midwives)
Health services delivered	Need to improve and expand the health services offered, especially with regard to maternal and neonatal care services, nutrition services and mental health services
Logistics	Need of infrastructure's construction and renovation, medical equipment (steriliser, refrigerator, ultrasound machine, microscope, laboratory reagents), other materials (computer, photocopier, printer)
Referral system	Need to implement a well-structured referral systems
Data collection	Need to implement data collection systems
Financing	Need to implement financial strategies
Integration and coordination	Due to the lack of support for the government, some of the health facilities requested the support from NGOs in order to deal with the major challenges reported
STRENGTHS	
Safety and security	The facilities assessed provided assistance in very tense areas, ensuring not only health services but also protection to the population. During the 2013-2014 conflict, the Centre de Santé Saint Luc Monastère hosted many refugees (40,000) offering protection from the combatants. In the same period, the dispensary was transformed into a MSF field hospital
Human resources	All of the health centres employed highly motivated staff
Health services delivered	The health services offered (outpatient services, vaccination services, TB program, HIV programs) presented a good level of functioning
Logistics	The facilities presented a good state of maintenance and had reliable electric and water supply

Picture 18. *St. Joseph Health Centre, Bangui.*

Picture 19. *Centre de Santé Saint Luc Monastère, Bangui.*

4.7 ETHIOPIA

COUNTRY CONTEXT

Ethiopia, situated in the Horn of Africa, shares borders with Sudan, South Sudan, Eritrea, Djibouti, Somalia, and Kenya. With a population exceeding 120 million, it ranks as **the second most populous country in Africa** and the 12th globally. Characterised by diverse ethnicities and languages, Ethiopia experiences rapid **population growth at 2.6%,** leading to a predominantly young demographic and a notable rural-urban divide. Despite its considerable population, the country remains economically challenged, albeit experiencing impressive economic growth averaging 9.7% annually from 2011 to 2021, driven by agriculture, industry, and service sectors. Despite this growth, Ethiopia grapples with persistent poverty, remaining among the world's poorest nations (Table 18).

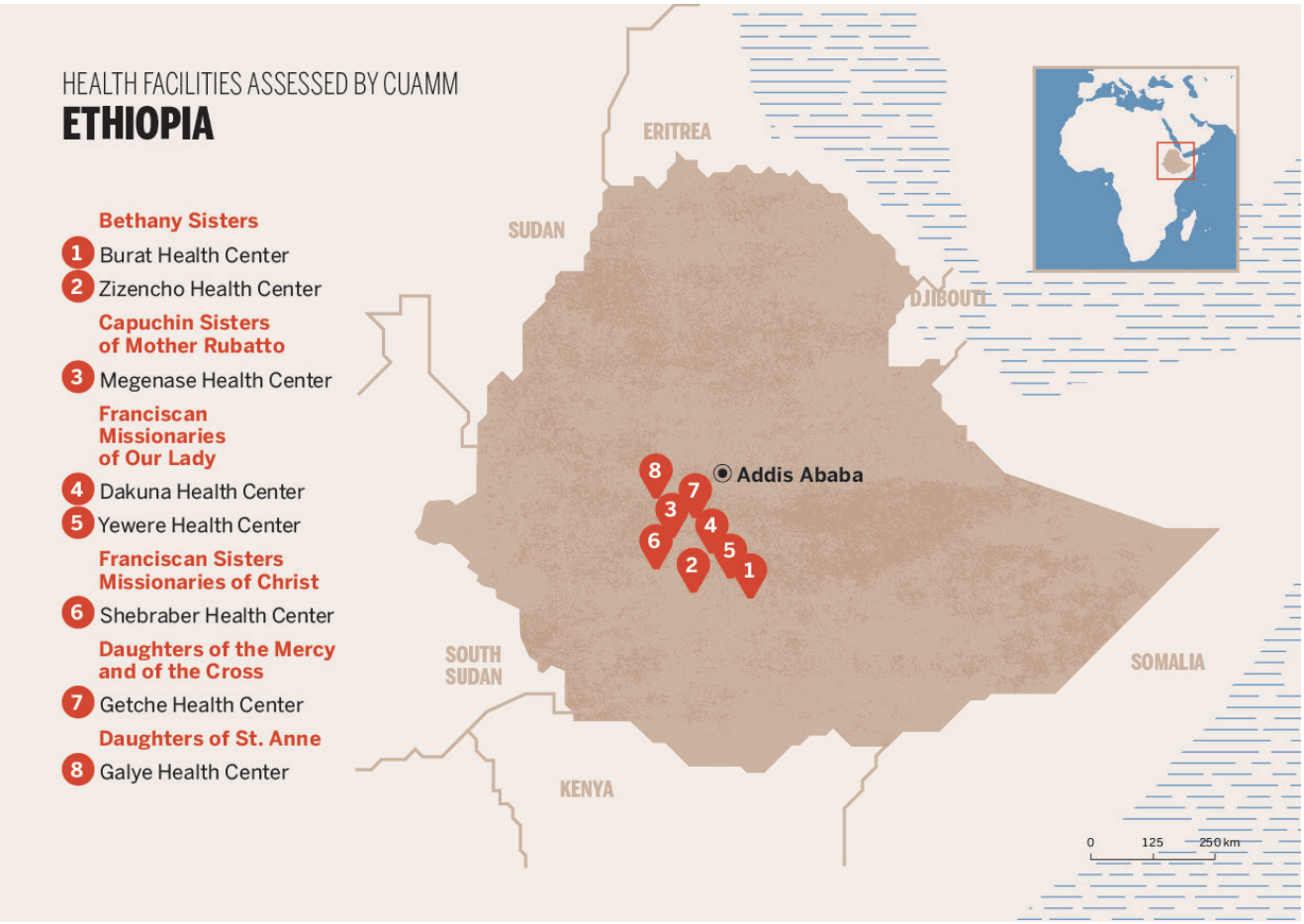


Table 18. *General information about Ethiopia (11).*

Capital	Addis Ababa
Population	123,379,924
Official language	Oromo (English is the most widely spoken foreign language which is also taught in many schools)
Geography	Ethiopia is located in the Horn of Africa. It is bordered by Eritrea to the north, Djibouti and Somalia to the east, Sudan and South Sudan to the west, and Kenya to the south.
Environment	Severe drought has spread to much of the country, while other areas have experienced extreme flooding. This has caused extensive damage to infrastructure and livelihoods.
Political situation	Although a cessation of hostilities agreement between the Federal Government and the Tigray Defence Force technically ended civil war in November 2022, the country remains in a state of emergency with severe human rights abuses. The aftermath of the conflict is characterised by civilian deaths, atrocity crimes, and the displacement of millions fleeing violence.
Socio-economic situation	The situation in drought-affected areas is deteriorating due to a convergence of food insecurity, severe malnutrition rates, and outbreaks of diseases such as malaria, measles, and cholera. Many children remain out of education due to the conflict. Although Ethiopia has one of the fastest growing economies in Africa, it remains one of the poorest. Its economic situation remains precarious, with rising inflation and the continual devaluation of the local currency.

THE NATIONAL HEALTH CARE SYSTEM

The Ethiopian health service delivery is structured into **three tiers** providing primary-, secondary- and tertiary-level health care. The primary health care unit consists of health posts, health centres and primary hospitals. One health centre is attached to five satellite health posts to provide services to approximately 25,000 people altogether. **Health posts (HP)** can be either comprehensive or basic. The comprehensive health posts are staffed by health extension workers, nurses, midwives and other health professionals to provide more comprehensive services, while the basic health posts are staffed by health extension workers and provide various preventive and health promotion services, in addition to treating cases such as malaria, pneumonia, scabies, trachoma and other mild illnesses. Both HPs types also refer clients to health centres for services requiring higher-level care. The health extension workers are supported by volunteer community workers to reach every household and execute their package of interventions.
Health centres provide both preventive and curative services, and also serve as referral centres and practical training sites for health extension workers. **Primary hospitals** offer inpatient and ambulatory services to about 100.000 people and also provide emergency surgery (including caesarean sections and blood transfusions). General hospitals are categorised under the second tier of health care. These hospitals provide similar services to those of primary hospitals, and serve on average 1 million people. They are referral centres for primary hospitals and training centres for health officers, nurses, and emergency surgeons. The third tier in the Ethiopian health care system, tertiary health care, consists of specialised hospitals that cover a population of approximately 5 million. These also serve as referral centres for general hospitals.
The main health indicators of the country are illustrated in Table 19.

Table 19. *Main economic and health indicators of Ethiopia, the United Kingdom of Great Britain and Northern Ireland (UK) and Italy (3-5, 11).*

	Ethiopia	United Kingdom	Italy
Population**	123,379,924**	66,971,395	58,940,425
Human Development Index*	0.498*	0.93	0.89
GDP per capita (US$)**	1027.6**	46,125	34,776
Current Health Expenditure (% of GDP)	3.48§§	11.94*	9.45*
OOP expenditure (% of current health expenditure)§§	33.8	13.6	21.3
Density of physicians (per 10,000 population)	1§§	32*	41*
Life expectancy at birth (years)	65*	81.4§	83§
Fertility rate (birth per woman)*	4.2*	1.6	1.3
MaternalMortality rate/100,000 live births	267§§	4.2*	2.6*
Neonatal mortality rate/1,000 live births	26.2*	9.8§§	4.59§§
Under Five mortality rate /1,000 live births*	46.8	2.8	1.47

*§Data related to 2019. §§Data related to 2020. *Data related to 2021. **Data related to 2022.*

ETHIOPIA ASSESSMENT

OVERVIEW

The health facilities assessed were not-for-profit health centres. Seven of them are located in SNNPR while one of them is located in the Oromia Region. All of them have governance bodies. Six of them are located in rural areas while 2 of them are located in semi-rural areas. The health centres located in SNNPR are part of five different districts, namely: Geto, Gumer, Edjia, Enemor and Cheha. **None of the facilities have inpatient services.** The total number of beds reported are mainly used for maternity and emergency services.
In addition, the main challenges, strengths and needs of each of the health facilities were assessed. Concerning the challenges, **inconsistent electric power supply**, **lack of capacity building activities**, **shortage of human resources** and **lack of financial resources** were the main difficulties expressed. The good working relation with the health authorities and the efforts they made to help disabled and poor people were mentioned as their strengths. Financial support, training, medical equipment and supplies support, back-up electric source and human resource support were mentioned as their immediate needs.
The main characteristics of the facilities assessed are illustrated in Table 20 and Table 21.
The main challenges and needs reported are illustrated in Table 22.

DISASTER PREPAREDNESS

The health centres in Ethiopia predominantly operate in **areas not deemed as high-risk for disasters**, with Burat HC, Dakuna HC, Getche HC, Meganase HC, Shebraber HC, Yewere HC, and Zizencho HC all located in non-risk areas. Galye Rogda is the only centre that faces **seasonal risks of disease outbreaks**. Despite limited impact on

public health, communication of events is infrequent but effective through telephone warnings, with inclusive messages. Galye Rogda lacks an epidemiological surveillance system, early warning training, risk assessments, and standard operating procedures for emergencies. Buildings comply with national standards.

Table 20. *Health facilities assessed in Ethiopia.*

Facilities' Name	FBO managing the health facility	Location	Area	Type
Burat Health Centre	Bethany Sisters	Geta Woreda	Rural	Health centre
Dakuna Health Centre	Franciscan Missionaries of Our Lady	Chena Woreda	Rural	Health centre
Galye Rogda Health Centre	Daughters of St. Anne	Goro Woreda	Rural	Health centre
Getche Health Centre	Daughters of the Mercy and of the Cross	Cheha Woreda	Rural	Health centre
Megenase Health Centre	Capuchin Sisters of Mother Rubatto	Cheha Woreda	Rural	Health centre
Zizencho Health Centre	Bethany Sisters	Gumer Woreda	Semi-rural	Health centre
Shebraber Health Centre	Franciscan Sisters Missionaries ofChrist	Enemor Woreda	Semi-rural	Health Health centre
Yewere Health Centre	Franciscan Missionaries of Our Lady	Gumer Woreda	Rural	Health centre

Picture 20. *Megenase Health Centre, Cheha Woreda.*

Table 21a. *Main services provided and main operational data regarding the health facilities assessed in Ethiopia.*

Health services		Galye Rogda Health Centre	Megenase Health Centre	Getche Health Centre	Shebraber Health Centre
Outpatient services	Number of outpatients visits	5,589	21,385	3,420	18,195
	Number of U5 outpatients visits	930	675	0	773
	Specialist consultations availability (Cardiology, Ophthalmology, etc.)	No	No	No	No
Inpatient services (for daily observation)	Wards for admissions	NA	NA	NA	NA
	Number of inpatient beds (daily observation)	10	10	13	8
Mother and Child health	Number of deliveries	51	253	398	208
	Number of caesarean sections	NA	NA	NA	NA
	Free consultation for U5 and ANC	Yes	Yes	Yes	Yes

(data related to 2022)

Picture 21. *Yewere Health Centre, Gumer Woreda.*

Table 21b. *Main services provided and main operational data regarding the health facilities assessed in Ethiopia.*

Health services		Burat Health Centre	Zizencho Health Centre	Dakuna Health Centre	Yewere Health Centre
Outpatient services	Number of outpatients visits	19,660	31,096	4,933	2,830
	Number of U5 outpatients visits	1148	807	0	153
	Specialist consultations availability (Cardiology, Ophthalmology, etc.)	No	No	No	No
Inpatient services (for daily observation)	Wards for admissions	NA	NA	NA	NA
	Number of inpatient beds (daily observation)	5	21	7	27
Mother and Child health	Number of deliveries	495	415	48	NA
	Number of caesarean sections	NA	NA	NA	NA
	Free consultation for U5 and ANC	Yes	Yes	Yes	Yes

(data related to 2022)

Table 22. *Challenges, needs and strengths concerning the health facilities assessed in Ethiopia.*

CHALLENGES	
Human resources	Shortage of medical staff and challenges in attracting and retaining doctors are consistent weaknesses
Health services delivered	Absence of family planning, HIV/AIDS clinics, physiotherapy, emergency wards, and specialist services is a recurring theme across the healthcare centres in Ethiopia; Blood bank, caesarean sections, operating theatres, and inpatient admission services were common limitations throughout the centres
Logistics	Lack of equipment (e.g. X-ray, ultrasound); Limited access to reliable transportation, road problems, and inconsistent electricity supply are shared weaknesses. Many health centres spent the majority of 2022 without electricity
Management	Problems related to stock-outs, often due to financial constraints and issues at the central store, are common challenges
Financing	Many centres identify financial problems as a key challenge, necessitating financial support for improved services in the country
NEEDS	
Human resources	Address shortage in medical staff Ensure proper training
Logistics	Requests for medical equipment such as ultrasound machines, X-ray facilities, and sterilisers are prevalent; Many health centres express the need for improved infrastructure, including more robust buildings and reliable utilities
Financing	Many centres identify financial problems as a key challenge, necessitating financial support for improved services in the country

STRENGTHS	
Health services delivered	Availability of 24/7 pharmacies with regular drug supplies is a consistent positive aspect
Referral system	Quick access to referral health facilities within 20-30 minutes is a common positive feature. This is especially important for surgical procedures, which many of the more rural healthcare centres lack the capacity to perform
Logistics	Reliability in utilities such as water, functioning incinerators, and good general conditions of buildings are shared strengths across the centres assessed in Ethiopia
Data collection and information system	Both electronic and paper-based information systems, monthly reports, and unique patient numbers are prevalent across the centres

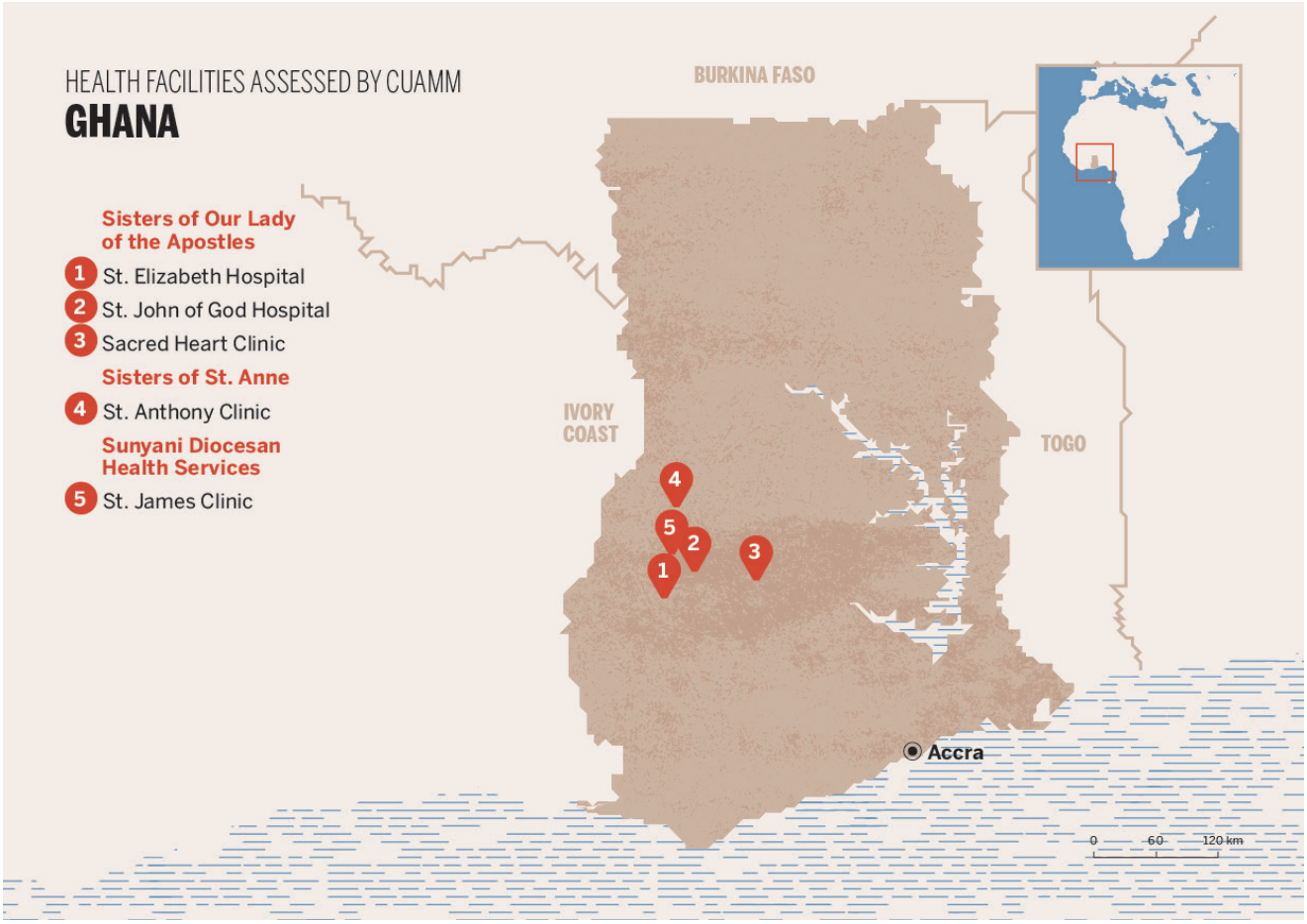
Picture 22. *Zizenco Health Centre, Gumer Woreda.*

4.8 GHANA

COUNTRY CONTEXT

Ghana is a West African country, located on the Guinea Gulf. It is **one of the leading countries of Africa**, partly because of its considerable natural wealth and partly because it was the first sub-Saharan African country to achieve independence from colonial rule. In the past two decades, it has taken major strides towards democracy under a multi-party system, with its independent judiciary winning public trust. Ghana consistently ranks in the top three African countries for freedom of speech and press (12).

In 2010, mainly thanks to the discovery and commercialization of oil, Ghana became a middle income country with a per capita gross national income growing from USD 400 in 1990 to USD 2,176 in 2022. However, Ghana's economy entered a **full-blown macroeconomic crisis in 2022** on the back of pre-existing imbalances and external shocks. Large financing needs and tightening financing conditions exacerbated debt sustainability concerns, shutting-off Ghana from the international market. To help restore macroeconomic stability, Ghana has secured a three-year IMF Extended Credit Facility (ECF) program of about $3 billion and has embarked on a comprehensive debt restructuring. The government has completed a Domestic Debt



Exchange Programme (DDEP) and implemented an external debt repayments standstill. Poverty has worsened. The "international poverty" rate is estimated at 27% in 2022, an increase of 2.2% points since 2021. Ghanaian households have been under pressure from **high inflation and slowing economic growth** (12).
The main characteristics of the country are illustrated in Table 23.

Table 23. *General information about Ghana (12).*

Capital	Accra
Population	33,797,235
Official language	English
Geography	Ghana is a country in West Africa, located on the Guinea Gulf, between Cote d'Ivoire on the West, Togo on the East and Burkina Faso on the northwest.
Environment	The southwest, northwest, and extreme northern parts of the country consist of a land surface. Most of the remaining area is occupied by the so-called Voltaian Basin, dominated by Lake Volta, an artificial lake extending far into the country's central area. Ghana has a tropical climate, with high humidity and hot temperatures throughout the year.
Political situation	Ghana is a presidential republic. In the past two decades, it has taken major strides towards democracy under a multi-party system, with its independent judiciary winning public trust. Ghana consistently ranks in the top three African countries for freedom of speech and press.
Socio-economic situation	In 2010, mainly thanks to the discovery and commercialization of oil, Ghana became a middle-income country with a per capita gross national income growing from USD 400 in 1990 to USD 2,176 in 2022. Poverty was reduced from 50% to 23,4%, and extreme poverty from 37% to 8,2% between 1990 and 2017, with some regions experiencing worsening poverty. There are social and economic inequalities between the South and the North of Ghana due to geography (lower rainfall, savannah vegetation and remote and inaccessible locations in the North) and history. However, Ghana's economy entered a full-blown macroeconomic crisis in 2022 on the back of pre-existing imbalances and external shocks. Poverty has worsened. The "international poverty" rate is estimated at 27% in 2022, an increase of 2.2% points since 2021. Ghanaian households have been under pressure from high inflation and slowing economic growth.

THE NATIONAL HEALTH CARE SYSTEM

Ghana's health system has a **well-established and detailed structure**, among the most advanced in sub-Saharan Africa. In 1996, the Government of Ghana created "Vision 2020", a long-term project aimed to implement growth and development. In this context, the Ministry of Health (MoH) developed several subsequent Medium-Term Health Strategy documents defining a five-year programme and roadmap.

Health Services in Ghana are organised on a three tiers level:
1. **district level**: the District Hospitals (many mission-based) deliver curative services, and the District Health Management team deliver public health services
2. **regional level**: curative services are delivered by the Regional Hospitals and preventive services are under the responsibility of Regional Health Management Teams
3. **central level**: Tertiary Hospitals and Teaching Hospital

Health Service Delivery in Ghana is ensured through the **contribution of different providers:** governmental facilities, non-governmental facilities (mainly FBOs), and private facilities. The contribution of private and non-governmental facilities is significant, representing about 50% of the health facilities. The majority of the FBOs operate within the district level (health centres and district hospitals), while private facilities cover 17% of the tertiary care.

FINANCING SCHEME

Ghana is one of the first countries in Africa to introduce **nationwide health insurance**, substituting the previously applied 'cash and carry system'. The scheme is supposed to pay the full cost of treatment of subscribers, including medical bills and referrals for over 90% of the diseases afflicting the Ghanaians.
There are exempted categories included in the scheme by national law without payment of the premium: **people aged > 70 years**; **pregnant women** (antenatal, delivery and post-natal care); **children** (< 18 years of age); **children in orphanages**; **disabled people**; **people with mental health conditions**; and **indigents**. The government strongly supports membership, which is actually mandatory by law, but there is no penalty for those who decide not to join the scheme. In 2021, the enrollment of citizens reached 45% of the population. Uninsured patients pay the full cost of the care.
The main health indicators of the country are illustrated in Table 24.

Table 24. *Main economic and health indicators of Ghana, United Kingdom of Great Britain and Northern Ireland (UK) and Italy in 2023 (3-5, 12).*

	Ghana	United Kingdom	Italy
Population**	33,797,235	66,971,395	58,940,425
Human Development Index*	0.63	0.93	0.89
GDP per capita (US$)**	2,203	46,125	34,776
Current Health Expenditure (% of GDP)-	3.99§§	11.94*	9.45*
OOP expenditure (% of current health expenditure)§§	30.8	13.6	21.3
Density of physicians (per 10,000 population)	1.6§§	32*	41*
Life expectancy at birth (years)§	64	81.4	83
Fertility rate (birth per woman)*	3.7	1.6	1.3
MaternalMortality rate/100,000 live births§§	263	4.2	2.6
Neonatal mortality rate/1,000 live births§§	23.4	9.8	4.59
Under Five mortality rate /1,000 live births*	44	2.8	1.47

*§Data related to 2019. §§Data related to 2020. *Data related to 2021. **Data related to 2022.*

FBOs ASSESSMENT

OVERVIEW

The health facilities assessment revealed the presence of a well organised health system, providing a **solid framework for the service delivery** at each level. The framework is defined by the government (MoH) and implemented by Ghana Health Service with intensive cooperation with private, especially private non for profit FBOs, which are managing a high number of health facilities at different levels (health Centres, district Hospitals, regional referral hospitals) in the country.
Catholic institutions managing health services represent a significant proportion of the health services in the country. They are organised in a well-defined network helping each facility to reach and maintain the required quality and, therefore, fit in the national policies.
The assessment included five health facilities, based in urban and rural areas (Table 25 and Table 26).

The main challenges identified concerned the following domains (Table 27):
1. **financing**:
   - the insurance system has currently accumulated a long delay in refunding the facilities
   - the list of drugs included in the insurance refund system is quite narrow
2. **human resources:**
   - high turnover and low retention rate in rural facilities
   - the national level covers the basic salary of the staff. Meanwhile, allowances, when applicable, remain to be paid by the facility, causing a not requested financial burden

Table 25. *Health facilities assessed in Ghana.*

Facilities' Name	FBO managing the health facility	Location	Area	Type
Sacred Heart Clinic	OLA Sisters	Bepoase, Ashanti region	Urban	Health centre
St John of God Hospital	OLA Sisters	Duayaw Nkwanta, Ahafo region	Urban	District hospital
St Elizabeth Hospital	OLA Sisters	Hwidiem, Ahafo region	Urban	District hospital
St. Anthony Clinic	Sisters of St Ann	Badu, Bono region	Rural	Health centre
St. James Clinic	Sunyani Diocesan Health Services	Sunyani, Bono region	Rural	Health centre

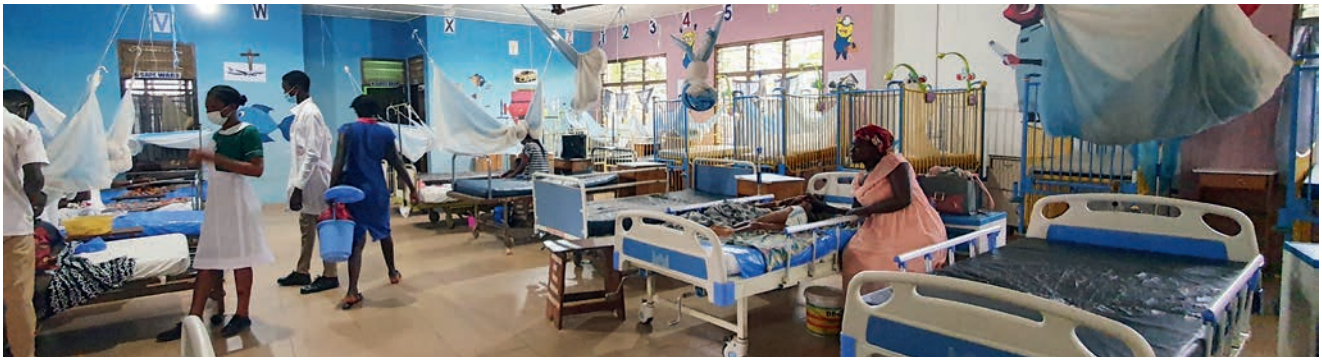
Picture 23. *Sacred Heart Clinic, Ashanti Region.*

Picture 24. *St, James Clinic, Bono Region.*

Table 26. *Main services provided and main operational data regarding the health facilities assessed in Ghana.*

Health services		Sacred Heart Clinic health centre	St John of God Hospital	St Elizabeth Hospital	St. Anthony Clinic	St. James Clinic
Outpatient services	Services available	Outpatient department, ANC and PoNC, vaccination, U5 care	Outpatient department, ANC and PoNC, immunisation, U5 care,family planning, tuberculosis diagnosis and treatment, HIV/AIDS diagnosis and treatment, STI diagnosis and treatment	Outpatient department, ANC and PoNC, immunisation, U5 care,family planning, tuberculosis diagnosis and treatment, HIV/AIDS diagnosis and treatment, STI diagnosis and treatment, mental health services	Outpatient department, ANC and PoNC, U5 care, tuberculosis diagnosis and treatment, HIV/AIDS diagnosis and treatment, STI diagnosis and treatment	Outpatient department, ANC and PoNC, immunisation, U5 care,family planning, HIV/AIDS diagnosis and treatment, STI diagnosis and treatment
Inpatient services	Wards for admissions	Maternal unit	Emergency unit, Maternal and Children unit, operating theatre, blood bank, orthopaedic unit, physiotherapy, nutrition unit, adiology	Emergency unit, Maternal and Children unit, operating theatre, blood bank, maxillofacial unit, nutrition unit, radiology	Emergency ward, Maternal unit	Maternal unit
	Number of beds	29	167	130	7	10
Consultations	Consultations (outpatients + inpatients)	6,812	91,291 (outpatients: 85,213 Inpatients: 6,078)	94,187	4,913	7,108
Mother and Child health	Number of deliveries	161	1,507	2,075	25	13
	Operating theatre for caesarean section	NA	Available	Available	NA	NA

(data related to 2021)



Picture 25. *St. John of God Hospital, Ahafo Region.*

Table 27. *Challenges, needs and strengths concerning the health facilities assessed in Ghana.*

CHALLENGES	
Human resources	Shortage of qualified health professionals in rural areas (high turnover and low retention)
Health services delivered	Weakness of some of the current health services
Logistics	Lack of generator (St Anthony health centre); Lack of ultrasound machine (St James health centre)
Referral system	Lack of a functional ambulance (Sacred Heart Clinic, St James health centre), then patients have to rely on private taxis for transport and referral of emergency cases since also the National Ambulance Service is most of the time unavailable
Financing	Lack of funds for major renovation of the buildings; Long delay in the refund of claims by the national insurance body; Injectable medicines are not covered under the national insurance system; Extraordinary expenses during the COVID-19 pandemic (oxygen, mechanical ventilators)
Integration and coordination	Although many health facilities offer specialised services, they cannot be recognised as specialised hospital integrated in the national health system due to the government policy (a facility can only be recognized as a specialised hospital when it can provide the full range of specialised services required by national regulation)
NEEDS	
Human resources	Need to increase the amount of qualified professionals in rural/peripheral areas (for instance offering attractive' conditions (i.e. staff houses, financial reimbursement)
Health services delivered	Need to expand the health services currently available: maternal unit (St James clinic); paediatric ward (St John hospital); histopathology and endoscopy (St Elizabeth hospital)
Logistics	Need of structural changes to expand some services/units: maternal unit; isolation unit, to reduce the risk of in-hospital contamination in case of epidemic/ pandemic
Referral system	Need to implement the referral system
Financing	Need of financial investment to expand the services offered (to upgrade the level from health centre to district hospital); Need of support from NGOs
Integration and coordination	Need to optimise the integration within the National Health System
STRENGTHS	
Human resources	Availability of qualified staff, mainly in urban areas; Availability of training and teaching programs
Health services delivered	Provision of a huge range of services, adequate to the level of the facility (health centre or district hospital); Specialised services of high level (St. John of God Hospital): - orthopaedic unit - occupational unit - dental unit - ear, nose and throat (ENT) unit - nutrition unit - mental health services - COVID-19 unit (St. Elizabeth Hospital)
Logistics	The equipment is usually adequate to the level of health facilities; The infrastructures are in good conditions and kept clean
Data collection	Internal electronic records system (St Elizabeth hospital)

Integration and coordination	The high quality of the services provided is widely recognised by the community and by the government, making some of these facilities referral points even for patients from far outside the geographical catchment area of the hospital
Management	Good health facility management, provided by well-structured management teams; Good planning for future development (many projects covering the expansion of health services offered are in place)

Picture 26. *St. James Clinic, Bono Region.*

Picture 27. *St Anthony Clinic, Bono Region.*

4.9 IVORY COAST

COUNTRY CONTEXT

Ivory Coast is located in West Africa, sub-Saharan Africa. After the political and humanitarian crisis experienced in 2011, the country has been stable until now, enabling **satisfactory social and economic development**. The main characteristics of the country are illustrated in Table 28.

Table 28. *General information about Ivory Coast (13).*

Capital	Yamoussoukro
Population	28,160,540
Official language	French
Geography	Ivory Coast borders to the West with Liberia and Guinea, to the North with Mali and Burkina Faso, to East Ghana, to the South with the Gulf of Guinea.
Environment	It is mainly characterised by forests in the South, savanna in the middle-north of the country. The only mountains are in the West area. The average temperature is about 30°C with a high humidity level.
Political situation	Ivory Coast is a Presidential Republic. Since the resolution of tensions linked to the 2020 presidential election, at the end of which President Ouattara was re-elected for a third consecutive term, Côte d'Ivoire has enjoyed notable political and social stability. However, the country is facing a humanitarian challenge in its northern part, bordering Burkina Faso, due to the influx of refugees mainly fleeing jihadist violence in the neighbouring country.
Socio-economic situation	Ivory Coast, the world's leading cocoa and cashew producer, is experiencing one of the fastest sustained economic growth rates in Sub-Saharan Africa in over a decade. With real GDP growth averaging 8.2% between 2012-2019, Côte d'Ivoire successfully contained the COVID-19 pandemic and maintained a 2% rate in 2020. In 2022, Ivorian economic activity remained robust, despite facing challenges arising from Russia's invasion of Ukraine, global monetary tightening, and growing political instability in the West African Economic and Monetary Union (WAEMU). Continued investment in network infrastructure, particularly in the digital and transport sectors, and the exploitation of recent oil discoveries, support a fast economic growth

THE NATIONAL HEALTH CARE SYSTEM

The national health system in Ivory Coast has a **pyramidal structure organised in two branches**, each one constituted of three levels. The two branches are the Governance and Administration branch and the Service Delivery branch. The Governance branch includes a central level, a regional level and a peripheral level.

The service delivery includes the public government services, private services, traditional medicine, organised under the supervision of the dedicated national program. It is organised in three levels:

- **primary care level**: it represents the entry point of the patients in the health system. It includes rural health centres, urban health centres, specialised health centres offering both curative and health promotion and preventive services
- **secondary level:** it represents the referral point for the primary level, including general hospitals, regional referral hospitals and two specialised psychiatric hospitals
- **tertiary level:** it includes government centres serving as higher referral level for the clinical cases who cannot be managed from the diagnostic and therapeutic point of view at secondary level

The service delivery branch of the health system also includes private facilities (more than 2000 in the country) belonging to different categories. The faith-based facilities also contribute to the service delivery with a total number of **49 centres**, mainly offering primary care level services. Traditional Medicine, with more than 8,500 health practitioners, is also part of the national health system, following specific policies established as law in 2015-2016.
Global performance of the health system is still low and **several indicators still lie below the required national and international standards**; moreover, the quality of the services is unevenly distributed in the country with the majority of the resources concentrated in the city of Abidjan, the largest economic centre of the country. In October 2019, the country established a national health insurance system called **Couverture Maladie Universelle (CMU)** aiming to ensure adequate care to all the population lining the country. The CMU includes 2 regimens: i) contributive regimen (General Basic Regimen), financed by the ensured contributors. ii) non-contributive regimen, aiming to offer free of charge medical assistance to the poor and vulnerable, otherwise unable to cover for their medical costs.
The main health indicators are illustrated in Table 29.

FINANCING

According to the most recent MoH reports, **6% of the national budget** is allocated to the health system. Looking at the source of the budget for health, the main income still comes from the patients and their families (51%) through the payment of the user fees; 24% from Government, 14,4% from private entrepreneurships, about 10% from international institutions and NGOs.

Table 29. *Main economic and health indicators of Ivory Coast, United Kingdom of Great Britain and Northern Ireland (UK) and Italy (3-5, 13).*

	Ivory Coast	**United Kingdom**	**Italy**
Population**	28,160,540	66,971,395	58,940,425
Human Development Index*	0.4§§	0.93*	0.89*
GDP per capita (US$)**	2,486	46,125	34,776
Current Health Expenditure (% of GDP)*	3.7§	11.94*	9.45*
OOP expenditure (% of current health expenditure)§§	32.0	13.6	21.3
Density of physicians (per 10,000 population)	1.6§	32*	41*
Life expectancy at birth (years)§	62.9	81.4	83
Fertility rate (birth per woman)*	4.4	1.6	1.3
Maternal Mortality rate/100,000 live births*	480§§	4.2*	2.6*
Neonatal mortality rate/1,000 live births§§	32.9	9.8	4.59
Under Five mortality rate /1,000 live births*	74.8	2.8	1.47

*§Data related to 2019. §§Data related to 2020. *Data related to 2021. **Data related to 2022.*

FBOs ASSESSMENT

Overview

The assessment of **12 health facilities** led to identifying common challenges and needs, mainly concerning drugs procurement, human resources, governance and integration and coordination within the National Health System. The main challenges can be summarised as follow:

1. **Drugs procurement**: the majority of the facilities complained about difficulties in the procurement of drugs. All of them have an internal pharmacy/drug store, where they use to sell to the patients the drugs prescribed during consultations trying to keep them at affordable price (ideally lower than the private drug stores in the market).
2. **High turnover and difficult retention of the staff**, especially of the qualified cadres. Difficulties are higher in rural areas, but also in urban areas, where qualified staff (doctors, midwives etc.) are available through national and private universities and courses, but they often raise salary issues. In fact, there is interconfessional agreement to keep the basic salary at the same government level, but extra benefit paid by faith based facilities are usually lower than government, though the workload and the quality target requested are high/higher, leading to high turnover.
3. **Integration and coordination** within the National health System: the participation and integration of the facilities within national programs is variable from very high to scars. None of them is currently participating in the national health insurance program (CMU).
4. **Governance and management**: there is a lack of organised management teams. For the majority of the facilities (maybe excluding Don Orione Medical Centre), the governance mainly relies on the managerial skills of the current Director, who often is also the founder of the facility.

The main characteristics of the health facilities assessed are illustrated in Table 30, Table 31a and Table 31b. The main challenges and needs reported are illustrated in Table 32.

Table 30. *Health facilities assessed in Ivory Coast.*

Facilities' Name	FBO managing the facility	Location	Area	Type
Dispensaire of Kongouanou	Sister of Providence	Kongouanou (Belier Region)	Rural	Dispensary (specialised hospital)
Dispensary 'Luigi Tezza' of Kokoumbo	The Daughters of St. Camillus	Kokoumbo (Belier Region)	Rural	Health centre
Formation Sanitaire à base communautaire Anonkoua-Kouté	Sister of Providence	Abobo (Abidjan)	Urban	Health centre
Medical Centre don Orione (Hospital)	Little Missionary Sisters of Charity (Don Orione)	Anyama (Abidjan)	Urban	Hospital
Centre d'Education Sanitaire des Soeurs Dorothee d'Alepe (CESDA)	Dorothean Sisters	Alepe (Agneby-TiassaMe Region)	Urban	Health centre
Centre Medical Mere Maria Elisa Andreoli	Servant Sisters of Marie Reparatrices	Riviera Palmieraie (Abidjan)	Urban	Health centre
Private Faith-Based Health Center Mere Franziska	Franciscan Sisters	Gbagbam (Gbokle Region)	Rural	Health centre
Private Urban Health Center "Notre Dame des Apostoles"of Divo	Notre Dame des Apostoles	Divo (Loh Djiboua Region)	Urban	Health centre
Notre Dame Dispensary of Gagnoa	Notre Dame des Apostoles	Gagnoa (De Goh Region)	Urban	Dispensary
Faith Based Health Center Notre Dame de Bouaké	Notre Dame des Apostoles	Bouaké (Gbeke Region)	Urban	Health centre
Urban Private Faith-Based Dispensary Mother Leonia of Prikro	Claretian Sisters	Prikro (Dulffou Region)	Rural	Health centre
Rehabilitation Center of Mother Teresa Verze	Sisters of the Sacred Heart of Jesus	Agnibilekrou (Indenie Djuablin Region)	Rural	Health centre

Picture 28. *Faith Based Health Centre "Notre Dame de Bouaké", Bouaké, Gbeke Region.*

Table 31a. *Main services provided and main operational data regarding the health facilities assessed in Ivory Coast.*

Health services		Dispensaire of Kongouano	Dispensary 'Luigi Tezza' of Kokoumbo	Formation Sanitaire à base communautaire Anonkoua-Kouté	Medical Centre don Orione (Hospital)	Centre d'Education Sanitaire des Soeurs Dorothée d'Alepe (CESDA)	Centre Medical Mere Maria Elisa Andreoli
Outpatient services	Services available	Outpatient department, U5 clinic, HIV/AIDS treatment, immunisation, STI diagnosis and treatment, physiotherapy	Outpatient department, ANC and PoNC, U5 clinic, HIV/AIDS treatment, STI diagnosis and treatment, Buruli ulcer unit, nutrition unit	Outpatient department, ANC and PoNC, U5 clinic, immunisation, TB treatment, HIV/AIDS treatment, STI diagnosis and treatment, nutrition services, cardiology,-dermatology, rheumatology, ENT	Outpatient department, ANC and PoNC, U5 clinic,immunisation, HIV/AIDS treatment, STI diagnosis and treatment, nutrition services, cardiology,ophthalmology, cardiology, ENT, physiotherapy	Outpatient department, ANC and PoNC, U5 clinic, cardiology, dental service, ophthalmology, malnutrition unit, ozone therapy for chronic osteoarticular pain	Outpatient department, ANC, U5 clinic, immunisation, HIV/AIDS diagnosis and treatment, dental care, ENT, dermatology, cardiology, diabetes, gastroenterology, neurology, rheumatology, ophthalmology
Inpatient services	Wards for admissions/inpatients services	Buruli ulcer unit, observation unit for other patients, operating theatre, blood bank	Observation unit (only daily hours), maternal unit, blood bank	Maternal unit	Maternal unit, NICU, blood bank	Observation unit (only daily hours)	Observation unit (only daily hours)
	Number of beds	52	18 (overnight admission only for delivering mothers)	25 (overnight admission only for delivering mothers)	55	24 (only daily care)	14 (only daily care)
Consultations	Consultations (outpatients + inpatients)	3,423	5,028	69,927	7,042	15,856	25,478
Mother health	Number of deliveries	Service not available	116	2,936	1,200	Service not available	Service not available
	Operating theatre	Available (but not used for caesarean section)	Not available	Available	Available	Not available	Not available

(data related to 2021)

Picture 29. *Urban Private Faith-Based Dispensary "Mother Leonia of Prikro", Prikro, Dulffou Region.*

Table 31b. *Main services provided and main operational data regarding the health facilities assessed in Ivory Coast.*

Health services		Private Faith-Based Health Center Mere Franziska	Private Urban Health Center "Notre Dame des Apostoles"of Divo	Notre Dame Dispensary of Gagnoa	Faith Based Health Center Notre Dame de Bouaké	Urban Private Faith-Based Dispensary Mother Leonia of Prikro	Rehabilitation Center of Mother Teresa Verze
Outpatient services	Services available	Outpatient department, U5 clinic, immunisation, HIV/AIDS diagnosis and treatment, STI diagnosis and treatment, ophthalmologist, radiology	Outpatient department, ANT, PoNC, immunisation, HIV/AIDS diagnosis and treatment, STI diagnosis and treatment, radiology	Outpatient department, (adults and children), HIV/AIDS diagnosis and treatment, STI diagnosis and treatment	Outpatient department, (adults and children), U5 clinic, HIV/AIDS diagnosis and treatment, radiology, dermatology, diabetes care	Outpatient department, (adults and children), U5 clinic, HIV/AIDS diagnosis and treatment, radiology,	Outpatient department (adults and children), U5 clinic, physiotherapy
Inpatient services	Wards for admissions/inpatients services	Observation and treatment unit	Observation and treatment unit	Observation and treatment unit	Observation and treatment unit	Observation and treatment unit	NA
	Number of beds	13	8	3	4	10	NA
Consultations	Consultations (outpatients + inpatients)	2,914	5,130	943	8,055	1,500	615
Mother health	Number of deliveries	NA	212	NA	NA	NA	NA
	Operating theatre	NA	NA	NA	NA	NA	NA

(data related to 2021)

Picture 30. *Centre d'Education Sanitaire des Soeurs Dorothee d'Alepe (CESDA), Alepe, Agneby-TiassaMe Region.*

Picture 31. *Urban Private Faith-Based Dispensary "Mother Leonia of Prikro", Prikro, Dulffou Region.*

Table 32. *Challenges, needs and strengths concerning the health facilities assessed in Ivory Coast.*

CHALLENGES	
Human resources	Shortage of specialised health professionals, mainly in rural areas; Lack of adequate training, mainly concerning obstetric emergencies and neonatal stabilisation
Health services delivered	Weakness or lack of the following services: maternal healthcare; operating theatre; blood bank; nutrition unit
Logistics	Lack of equipment (sterilising, laboratory and maternal-neonatal equipment, such as infant warmer); Difficult maintenance of the equipment
Referral system	Lack of ambulances to refer critical patients; Lack of an organised referral system
Data collection	Absence of structured data collection procedures/systems
Financing	Financial issues, mainly related to: drugs procurement; electricity
Integration and coordination	Lack of collaboration with the Government and lack of integration within the National Health System
NEEDS	
Human resources	Need to implement specialised health staff; Need to implement training programs on specific clinical topics (maternal care, neonatal care); Need to implement salaries of health professionals
Health services delivered	Need to implement the following services maternal health; operating theatre; blood bank; health education on chronic non communicable diseases; nutrition unit
Logistics	Need of: generator; sterilising machine; ultrasound machine; laboratory equipment
Referral system	Need to strengthen the referral system
Data collection	Need to utilise the data from the activities to prepare a brief description of the centre including the perceived challenges and opportunities in order to facilitate the background for projects which may help to meet the needs
Financing	Need to involve more donors/NGOs; Consider joining national program for free of charge under-five consultations and antenatal care consultations in order to receive refund from the government and possibly posted qualified staff, and be aligned with national and international standards; Consider creating a network among the catholic facilities in order to coordinate the procurement of drugs and have a stronger negotiation power; Educate the donors to take care of the running costs, in order to help the centre leaving the fees low enough to ensure accessibility
Integration and coordination	Need to strengthen the cooperation with the Government (e.g. in order to join the main national programs, including free maternal and child care) and with other Governmental facilities in the surrounding; Need to join more national government program (like under-five care); Need to join more research programs (i.e. in partnership with national institutions), which may help to mobilise resources for the development of the health facilities

STRENGTHS	
Health services delivered	Good quality of the health services provided. In some case, high quality services (NICU) that make the facility a referral centre both for governmental facilities and for other FBOs; A high level of patient trust and attendance due to the low consultation fees and the quality of services received
Financing	Low consultation fees
Integration and coordination	Union des Religieux dans la Santé et le Social en Ivory Coast (URSSCI): network of catholic congregations with the aim of share experiences and concerns related to their activities

Picture 32. *Private Faith-Based Health Center Mere Franziska, Gbokle Region.*

Picture 33. *Dispensary 'Luigi Tezza' of Kokoumbo, Belier Region.*

4.10 KENYA

COUNTRY CONTEXT

The Republic of Kenya (Kenya) is a country located in East Africa. The country borders in the North with Ethiopia and South Sudan, in the East with Uganda, in the West with Somalia, and in the South with Tanzania.
Kenya achieved the status of **lower middle-income economy** in 2014 and currently it is the ninth largest economy in Africa, and the fourth largest in sub-Saharan Africa. The country has made significant political and economic reforms that have contributed to sustained economic growth, social development, and political stability gains over the past decade. However, its **key development challenges** still include poverty, inequality, youth unemployment, transparency and accountability, climate change, continued weak private sector investment, and the vulnerability of the economy to internal and external shocks.
The main characteristics of the country are illustrated in Table 33.

Table 33. *General information about Kenya (14).*

Capital	Nairobi
Population	54,027,487
Official language	English and Swahili
Geography	The country borders in the North with Ethiopia and South Sudan, in the East with Uganda, in the West with Somalia, and in the South with Tanzania. The Indian Ocean coastline which forms the Eastern border stretches some 480 kilometres from the Somali border to the Tanzania border.
Environment	Kenya's climate varies from tropical along the coast to temperate inland to arid in the north and northeast parts of the country. The most significant environmental issues are water pollution from urban and industrial wastes; degradation of water quality from increased use of pesticides and fertilisers; water hyacinth infestation in Lake Victoria; deforestation; soil erosion; desertification; and poaching.
Political situation	Kenya is a presidential representative democratic republic. The president is both the head of state and head of government. Executive power is exercised by the government. The president is elected by direct popular vote.
Socio-economic situation	Kenya has made significant political and economic reforms that have contributed to sustained economic growth and social development. COVID-19 pandemic shock hit the economy hard, disrupting international trade and transport, tourism, and urban services activity. Although the economic outlook is broadly positive, it is subject to elevated uncertainty, including through Kenya's exposure to the global price impacts of the Ukrainian crisis.

THE NATIONAL HEALTH CARE SYSTEM

The healthcare system in Kenya operates on **two levels**: national and county, with the former handling overarching stewardship and the latter focusing on implementation and service delivery. Kenya has a mix of **public (48%), private (40 %), faith based and NGOs (12%) health service providers**. Most public health facilities are managed by county governments. All healthcare providers are organised in levels or tiers of health service provision.

A majority of Kenya's population receives healthcare services from the public sector. The range of services include preventive, promotive, curative and rehabilitative. **Preventive services** include routine childhood immunizations and environmental activities to control mosquito breeding which in turn reduce malaria transmission. **Promotive services** are mostly educational services provided to the general population on healthy lifestyles and available interventions. **Curative and rehabilitative** services include all treatment activities available at hospitals and other healthcare facilities.

To achieve these functions, the Kenya government has traditionally run a network of healthcare facilities staffed by government employees and run directly by the budgets allocated by the government from public resources.

Under the centralised system, all healthcare facilities were organised into **six levels**:
1. community health units;
2. dispensaries and private clinics;
3. health centres;
4. sub-county hospitals and nursing homes;
5. county referral hospitals, teaching and referral hospitals and private hospitals;
6. National Referral hospital.

The main health indicators of the country are illustrated in Table 34.

FINANCING SCHEME

According to the Government of Kenya, the primary sources of funding for healthcare are:
- **Public funds**: these are government allocations from the national budget comprising about 30% of the total yearly expenditure in healthcare in the country. This is also the main source of funding for about 80% of the population that receives services from the public sector
- **Private** (consumers): this is the largest contributor of total healthcare funds spent in the country at 35.9% of the total expenses. These funds serve about 20% of the population that is able to access private healthcare services. These are mostly funded through company or employee insurance schemes. These funds are thus not available for the newly decentralised units
- **Donors**: these include funds to fight high burden diseases such as HIV, malaria and tuberculosis. These funds directly supplement public sector funds and contribute about 30% of the total healthcare expenditure in the country.

Table 34. *Main economic and health indicators of Kenya, United Kingdom of Great Britain and Northern Ireland (UK) and Italy (3-5, 14).*

	Kenya	United Kingdom	Italy
Population**	54,027,487	66,971,395	58,940,425
Human Development Index*	0.58	0.93	0.89
GDP per capita (US$)**	2,099	46,125	34,776
Current Health Expenditure (% of GDP)*	4.29	11.9	9.5
OOP expenditure (% of health expenditure)§§**	24.6	13.6	21.3
Density of physicians (per 10,000 population)*	2.3	32	41
Life expectancy at birth (years)§**	66.1	81.4	83
Fertility rate (birth per woman)*	3,2	1.6	1.3
MaternalMortality rate/100,000 live births§§**	530	9.8	4.6
Neonatal mortality rate/1,000 live births*	18.4	2.8	1.5
Under Five mortality rate /1,000 live births*	37.2	4.2	2.6

*§Data related to 2019. §§Data related to 2020.*Data related to 2021. **Data related to 2022.*

KENYA ASSESSMENT

OVERVIEW

The assessment focused mainly on the equatorial area of the country, where most of the population is concentrated, and on health centres located mainly in semi-urban areas. It involved **seven health facilities**. These health facilities cover areas that are not reached by the public health system or give alternative access to good quality services with affordable rates for most of the patients, although fees charged for consultations and diagnostic procedure, as well as admission fees remain an issue. Almost all the facilities assessed do not receive any financial help from the government, and **consultation and admission fees** remain the first source of income together with private funding.
All the health centres and hospital visited during the assessment showed a **good level of organisation**; **very good standard of care** when compared to other health system in other African countries; **availability of diagnostic test** and **partial access to specialist consultations** – in some case outsourced; **adherence to national health programmes for HIV and TB screening**, **counselling and treatment**; **maternal and child health services**, with busy pre- and post-natal clinics and excellent immunisation schemes in place. Most of the centres have a delivery room with newborn care units, even if the quality of care provided of mothers and babies vary among the centres. Nonetheless, the mortality rate and the complications reported in both mothers and children are very low in all the facilities assessed.

The assessment activity reveals that all the facilities face some common challenges related to clinical governance and management. These challenges are:

- **lack of technical and financial support** by the government. The only programmes supported by the government are TB and HIV care, and the immunisation campaigns
- **general financial constraints** due to the inability to cope with the increase in expenses through the utilisation of the main sources of income, e.g. fees from patients, funds from external partners/reference congregation, and revenues from alternative business activities. However, all the health facilities assessed generate revenues from insurances, even if the different administrations report that refund requests are often denied with patients unable to pay for the services provided. Despite these financial issues all the facilities refer to have fees lower than the ones charged by the public health services, in order to guarantee the equity of access to healthcare for the poorest and most vulnerable groups of the reference population
- **lack of qualified health staff** according to the services provided and patient needs, particularly of generalist and specialist physicians
- **request for more advanced diagnostic medical equipment**, although most of the centres have radiology services with digital x-rays and ultrasound machines. None of the facilities consider the lack of supply of consumables an issue, and power supply is considered reasonably reliable

The assessment also emphasised the facilities' strengths, showing that their activities represent best practices that can be shared among healthcare providers. The assessment highlighted a very **high level of commitment** of the staff employed, a **good quality of healthcare** across the country, relatively **good structures and premises**, with reliable supply of energy and water. The level of infrastructure was excellent compared to other African countries. All the facilities assessed were connected to the Internet and most of them adopted an electronic medical record for data management.
The main characteristics of the health facilities assessed are illustrated in Table 35 and Table 36. The main challenges and needs reported are illustrated in Table 37.

DISASTER PREPAREDNESS

The majority of the health facilities assessed were located in **hazard prone areas**. An EWS was in place in the majority of the areas visited, but it frequently presented **difficulties in reaching out the population**. The main reasons were the following: people think that the messages provided are not relevant, people cannot act on the warning and the messages provided are not inclusive. The majority of the interviewees reported that a **Disaster Risk Management Committee (DRM)** and an epidemiological surveillance system were in place in the regions assessed. Only two health facilities had a contingency plan available, while the majority of them developed SOPs for emergencies.

Table 35. *Health facilities assessed in Kenya.*

Facilities' Name	FBO	Location	Area	Type
St Mary's Mission Hospital	Sisters of the Blessed Virgin Mary of Nairobi	Lang'ata, Nairobi, Nairobi County	Urban	Hospital
Olmalaika Health Centre	Sisters of the Blessed Virgin Mary of Nairobi	Olooloitikosh, Kajiado County	Semi-urban	Health centre
Embulbul Catholic Dispensary	Capuchin Sisters of Mother Rubatto	Oloolua, Kadjado County	Semi-urban	Dispensary
St. Paul's Mission Hospital	Franciscan Sisters of St. Joseph	Homa Bay, Homa Bay County	Semi-urban	Hospital
Saint Claire Dispensary Rongo	Franciscan Sisters of St. Joseph	Homa Bay, Homa Bay County	Semi-rural	Dispensary
Mother Francesca Rubatto Medical Center	Capuchin Sisters of Mother Rubatto	Nakuru, Nakuru County	Semi-urban	Dispensary
St. John Of God Tigania Hospital	Hospitaller Order of St. John of God	Muthara, Meru County	Semi-rural	Hospital

Picture 34. *Mother Francesca Rubatto Medical Center Nakuru, Nakuru County.*

Picture 35. *Olmalaika Health Centre, Kadjado County.*

Table 36a. *Main services provided and main operational data regarding the health facilities assessed in Kenya.*

Health services		St Mary's Mission Hospital	Olmalaika Health Centre	Embulbul Catholic Dispensary	St. Paul's Mission Hospital
Outpatient services	Number of outpatients visits	132,445	4,400	12,286	15,656
	Number of U5 outpatients visits	14083	813	2095	2525
	Specialist consultations availability (Cardiology, Ophthalmology, etc.)	Yes	No	Yes	Yes
Inpatient services	Wards for admissions	Medical, surgical, paediatrics, obstetrics and gynaecology	Medical, Pre- and post-natal	No	Medical, surgical, paediatrics, obstetrics and gynaecology
	Number of inpatient beds	320	12	NA	40
	Number of admissions	7,883	87	NA	2,105
	Number of U5 admissions	92	52	NA	123
Mother and Child health	Number of deliveries	2,138	95	NA	436
	Free consultation for U5 and ANC	Partially	Partially	Partially	Partially

(data related to 2022)

Table 36b. *Main services provided and main operational data regarding the health facilities assessed in Kenya.*

Health services		Saint Claire Dispensary Rongo	Mother Francesca Rubatto Medical Center	St. John Of God Tigania Hospital
Outpatient services	Number of outpatients visits	Data not available	1,763	17,444
	Number of U5 outpatient visits	Data not available	350	2,446
	Specialist consultations availability (Cardiology, Ophthalmology, etc.)	No	No	Yes
Inpatient services	Wards for admissions	No	No	Medical, Surgical, paediatrics, obstetrics and gynaecology
	Number of inpatient beds	NA	NA	110
	Number of admissions	NA	NA	1,819
	Number of U5 admissions	NA	NA	174
Mother and Child health	Number of deliveries	NA	NA	1,057
	Free consultation for U5 and ANC	Partially	Partially	Partially

(data related to 2022)

Picture 36. *St. Mary Mission Hospital, Nairobi County.*

Picture 37. *Embulbul Catholic Dispensary Kadjado, Kadjado County.*

Table 37. *Challenges, needs and strengths concerning the health facilities assessed in Kenya.*

CHALLENGES	
Human resources	Shortage of specialised health professionals
Health services delivered	Weakness of the emergency department (triage and assistance of patients admitted in critical conditions); Weakness of obstetric services; Weakness of paediatric services; Weakness of surgical services; Absence of specialised services (ophthalmological services, dental services)
Logistics	Equipment renovation (mainly for maternal and neonatal services); Equipment maintenance; Water supply
Referral system	Lack of ambulances
Data collection	Weakness of data collection procedures
Financing	Inability to cope with the increase in expenses through the utilisation of the main sources of income (fees from patients, funds from external partners, and revenues from alternative business activities); Lack of financial support from the government
Integration and coordination	Lack of technical and financial support from the Government
NEEDS	
Human resources	Need to increase specialised medical staff
Health services delivered	Need to implement/strengthen the following services: emergency services; basic and advanced surgical services; obstetric services; (inpatient) maternal services; neonatal care services (proper pre and post-natal area, neonatal critical care services); (inpatient) paediatric services; dental unit; ophthalmologic unit

Logistics	Surgical equipment (laparoscopic tower); Neonatal critical care equipment; Maternal services equipment (mainly for delivery rooms); Radiology equipment (x-ray machine, ultrasound machine); Computers and software to improve the gathering of data and the general administration of the health centre
Referral system	Need of ambulances to refer patients in case of more advanced care
Data collection	Need implement electronic data collection procedures
Financing	Need to implement funds from external partners
Integration and coordination	Need to improve integration within the National Health System
STRENGTHS	
Human resources	Highly motivated staff; Continuous medical education (Embulbul Catholic Dispensary)
Health services provided	Ability to provide quality services; Ability to ensure equity of access through affordable fees; Proper follow-up services (Embulbul Catholic Dispensary)
Logistics	Good condition of infrastructures; Well-equipped testing laboratory; Good surgical equipment; Good equipment for neonatal care, also for critical newborn (St Mary's mission hospital)
Data collection	Availability of electronic medical record system for data management (St Mary's mission hospital)
Integration and coordination	Very good engagement with the local community

Picture 38. *Mother Francesca Rubatto Medical Center Nakuru, Nakuru County.*

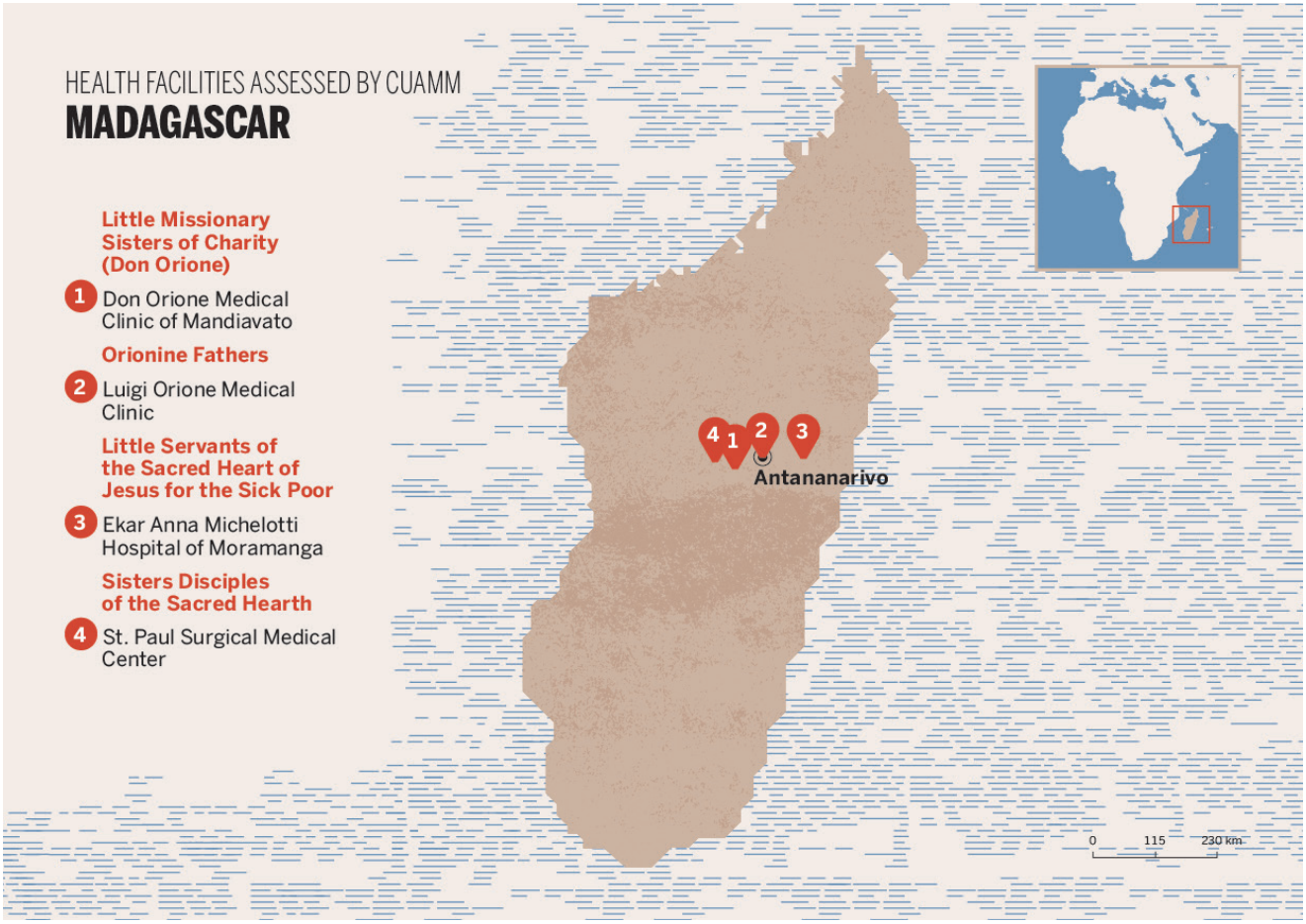
Picture 39. *Saint Claire Dispensary, Homa Bay County.*

Picture 40. *St. John of God Tigania Hospital, Meru County.*

4.11 MADAGASCAR

COUNTRY CONTEXT

The Republic of Madagascar, positioned in the Indian Ocean off the East African coast, encompasses approximately 587,000 square kilometres and is inhabited by around 28 million people. Renowned for its exceptional biodiversity, Madagascar boasts diverse geographical features ranging from lush rainforests to arid deserts. The island's climate varies, with humid tropical conditions along the eastern coast and more arid climates along the western coast. Madagascar's political system is a semi-presidential representative democratic republic, with a President and Prime Minister overseeing executive functions and legislative powers vested in both the government and the Senate and National Assembly. Despite experiencing **notable economic growth**, Madagascar faces **persistent challenges of poverty and social inequalities**, exacerbated by factors like the COVID-19 pandemic and climate-related disruptions. Madagascar's economy, driven by sectors like tourism, textiles, mining, and agriculture, has demonstrated resilience despite setbacks caused by natural disasters and global economic challenges. However, urban poverty is on the rise due to **rural-urban migration** and **limited urban employment opportunities**. The economy rebounded with a 5.7% growth rate in 2021, but projected growth for 2022 is 3.8%,



influenced by climate-related disasters and global uncertainties. Despite progress in areas such as education and healthcare, Madagascar continues to confront **obstacles in healthcare infrastructure, life expectancy, and disease prevalence.** The country's journey toward comprehensive socio-economic development is ongoing, with efforts focused on addressing disparities and shaping a more equitable and prosperous future.
The main characteristics of the country are illustrated in Table 38.

Table 38. *General information about Madagascar (15).*

Capital	Antananarivo
Population	29,611,714
Official language	Malagasy, French
Geography	Madagascar is the world's fifth largest island, situated in the Indian Ocean off the coast of southern Africa.
Environment	Despite rich resources and agricultural potential, droughts and cyclones continue to intensify famine in Madagascar. This is a significant concern, given that 80% of the population depend on agriculture for their livelihoods.
Political situation	Politics of Madagascar takes place in a framework of a semi-presidential representative democratic republic, with a pluralist multi-party system. The President of Madagascar is head of state and the Prime Minister of Madagascar is head of government. Executive power is exercised by the government. Legislative power is vested in both the government and the bicameral parliament, which is composed of the Senate and the National Assembly. The Judiciary is independent of the executive and the legislature. The country has a long history of political instability and politics continue to be controlled by a small group of elites. Lawlessness, poverty, and corruption persist amid widespread human rights violations.
Socio-economic situation	For decades, Madagascar has struggled with sluggish growth and persistent poverty, largely due to weak governance, inadequate human and physical capital development, and slow structural transformation. The situation is exacerbated by increasing climate crises and heightened vulnerability to external shocks. Moreover, weak economic growth combined with rapid population growth has resulted in Madagascar having one of the highest poverty rates in the world, reaching 75% in 2022 using the national poverty line. Educational, health, and social assistance spending in Madagascar is among the lowest worldwide. Only a quarter of Madagascar's population has access to electricity, and the country has the world's fourth-highest chronic malnutrition rate.

THE NATIONAL HEALTH CARE SYSTEM

Madagascar's healthcare system, comprising **114 health districts**, operates with a decentralised approach to better cater to community needs, yet access to medical care remains limited, especially in rural areas where most facilities are located. Quantitative and qualitative inadequacies persist, with low ratios of healthcare personnel and disparities between urban and rural regions. Despite efforts over the past two decades, Madagascar continues to face health challenges, including **epidemics, high maternal and infant mortality rates, malnutrition, and non-communicable diseases** exacerbated by natural disasters. The healthcare system encompasses public, private, and traditional medicine sectors. Financing heavily relies on external aid and lacks a clear strategy, with households bearing a significant portion of expenses and prepayment systems remaining inadequate despite efforts towards universal health coverage and performance-based financing implementation.

Healthcare services in Madagascar operate within a decentralised framework, ensuring that medical assistance reaches communities effectively:
1. Community-based services
2. Local Government Authorities (districts)
3. Regional Health Authorities
4. Central Government

The provision of healthcare services is organised into **three tiers**. **The first tier**, at health district level, comprises: (i) provision of services in the community, through community workers and health staff using an outreach approach; (ii) primary health care facilities, which serve as the user's entry point into the health care system or Level 1 and 2 of Dispensaries and Health Centers (CHDs) and offer the minimum package of activities. **The second tier** comprises the district referral hospitals (CHRDs) without surgery, which provide a complementary package of activities, and the CHRDs with surgery representing frontline or first-level referral hospitals. **The third tier** comprises the regional referral hospitals (CHRRs) and university hospitals (CHRUs); these are the second-level referral hospitals.

The main health indicators of the country are illustrated in Table 39.

Table 39. *Main economic and health indicators of Madagascar, United Kingdom of Great Britain and Northern Ireland (UK) and Italy in 2023 (3-5, 15).*

	Madagascar	**United Kingdom**	**Italy**
Population**	29,611,714	66,971,395	58,940,425
Human Development Index*	0.501	0.93	0.89
GDP per capita (US$)**	516.6	46,125	34,776
Current Health Expenditure (% of GDP)	3.88§§	11.94*	9.45*
OOP expenditure (% of health expenditure)§	34.4	13.6	21.3
Density of physicians (per 10,000 population)	0.2ˆ	32*	41*
Life expectancy at birth (years)	64.5*	81.4§	83§
Fertility rate (birth per woman)*	3.9	1.6	1.3
MaternalMortality rate/100,000 live births	392§§	4.2*	2.6*
Neonatal mortality rate/1,000 live births	24.1*	9.8§§	4.59§§
Under Five mortality rate /1,000 live births*	66	2.8	1.47

*ˆData related to 2018. §Data related to 2019. §§Data related to 2020. *Data related to 2021. **Data related to 2022.*

FBOs ASSESSMENT

OVERVIEW

The assessment highlighted that in Madagascar there are many religious congregations that provide healthcare services at all levels of the National Health System, especially in the most remote areas. However, it is worth emphasising that, apart from receiving authorizations to operate as recognized health providers, **FBOs do not receive any technical and financial resources** from the government. According to all the FBOs' representatives interviewed, this issue affects all religious congregations in Madagascar, regardless of the level of care, area of intervention, and geographical location. This scenario makes it even more relevant to provide technical and financial assistance to the FBOs and private not-for-profit organisations which struggle with many challenges without any support and guidance from the government. The assessment identified common challenges across these healthcare facilities, including **limited government support**, **financial constraints**, **reliance on external funding sources**, and **lack of revenue from insurances**. Despite these financial issues, facilities prioritise affordability to ensure equitable access to healthcare for vulnerable populations. Additionally, there are **delays in drug procurement**, **shortages of specific medications**, **inadequate staffing levels**, and **insufficient diagnostic equipment maintenance**. Staff also lack awareness of the importance of data collection for decision-making, with limited access to digital platforms for data management, which has hindered evaluation and service improvement efforts.
The main characteristics of the health facilities assessed are illustrated in Table 40 and Table 41. The main challenges and needs reported are illustrated in Table 42.

DISASTER PREPAREDNESS

Disaster preparedness among health centres in Madagascar varies significantly, revealing a mixture of strengths and weaknesses across different facilities. While **Koche HC** operates in a high-risk area, facing annual floods, disease outbreaks, and strong winds, it lacks functional early warning systems, inclusive messaging, and emergency preparedness measures. In contrast, facilities like **Mlambe and Mwanga HC** have implemented certain preparedness measures such as early warning communication and standard operating procedures, yet still face challenges such as inadequate infrastructure and lack of functional epidemiological surveillance systems. **Holy Family Mission Hospital and St. Joseph** demonstrate more comprehensive approaches, with active civil protection committees and recent early warning training, but still lack risk assessments and hazard maps.

Picture 41. *Clinique Medical Don Orione Mandiavato, Miarinarivo District.*

Table 40. *Health facilities assessed in Madagascar.*

Facilities' Name	FBO managing the health facility	Location	Area	Type
EKAR Toeram-Pitsaboana Olontsambatra Anne Michelotti (EKAR TPOAM)	Congrégation des Sœurs Petites Servantes du Sacré-Cœur de Jésus	District of Moramanga, Region of Alaotra Mangoro	Urban	Specialised Health care centre
Centre Médico Chirurgical Saint Paul	Change ONLUS ETS in collaboration with Sisters Disciples of the Sacred Heart	District of Soavinandriana, Region of Itasy	Semi-urban	Specialised Health care centre
Clinique Medical Don Orione Mandiavato (C.D.O.M.)	Petites Sœurs Missionnaires de la charité – Don Orione	District of Miarinarivo, Region of Itasy	Rural	Dispensary
Centre Medical Luigi Orione	Petite-Œuvre de la Divine Providence - Don Orione	District of Antananarivo-Renivohitra, Region of Analamanga	Urban	Health care centre

Picture 42. *Toeram-Pitsaboana Olontsambatra Anne Michelotti, District of Moramanga.*

Table 41. *Main services provided and main operational data regarding the health facilities assessed in Madagascar.*

Health services		EKAR TPOAM	Centre Médico Chirurgical Saint Paul	Clinique Medical Don Orione Mandiavato (C.D.O.M.)	Centre Medical Luigi Orione
Outpatient services	Number of Outpatients Visits	1,897	9,136	2,395	Data not available
	Number of U5 Outpatients Visits	Not applicable	1,824	750	
	Specialist Consultations (Cardiology, Ophthalmology, etc.) availability	No	Yes	No	No
Inpatient services	Wards for Admission	Tuberculosis, Hospice for end-life cancer, patients Leprosarium	Internal Medicine Maternity Children Ward	Maternity	NA
	Number of Inpatient Beds	48	23	8	NA
	Number of Admissions	89	192	15	NA
	Number of U5 Admissions	11	NA	NA	NA
Mother and Child health	Number of Deliveries	NA	108	28	NA
	Free Consultation for U5 and ANC	NA	Yes	No	No

(data related to 2022)

Picture 43. *Toeram-Pitsaboana Olontsambatra Anne Michelotti, Moramanga District.*

Table 42. *Challenges, needs and strengths concerning the health facilities assessed in Madagascar.*

CHALLENGES	
Human resources	Many facilities lack specialised doctors, impacting the range of medical services available
Health services delivered	Missing services such as family planning, under-five clinics, vaccination clinics, and emergency units were notable in most of the centres in Madagascar
Logistics and infrastructures	Issues like inconsistent electricity, malfunctioning equipment, and infrastructure limitations are prevalent
Financing	Financial issues
Management	Administrative errors and stock-outs at central stores frequently contributed to supply chain delays across the centres
NEEDS	
Human resources	Recruiting specialised doctors and nurses is critical for comprehensive healthcare
Logistics	Adequate technicians are needed for maintaining essential infrastructure like solar panels and medical equipment; Additional resources such as solar panels, diagnostic equipment
Management	Improved planning systems - ideally electronic - are necessary to prevent multiple issues, such as medication stock-outs
Financing	Adopt strategies to implement financial support
Integration	Involving communities for outreach activities could be an empowering way to boost capacity.
STRENGTHS	
Human resources	Despite challenges, the presence of committed volunteers and medical professionals is a common strength across the centres assessed
Health services delivered	Several healthcare facilities offer a wide range of services, including physiotherapy, dental care, and clinical tests; Certain facilities are strategically positioned, ensuring accessibility and timely referrals to larger clinics with the capacity to provide emergency and specialist services
Logistics	Facilities generally maintained good conditions, cleanliness, and well-maintained buildings

Picture 44. *Toeram-Pitsaboana Olontsambatra Anne Michelotti, Moramanga District.*

4.11 MALAWI

COUNTRY CONTEXT

Malawi, a landlocked country in East Africa with three regions and 28 district councils, grapples with socio-economic challenges despite progress in health indicators. The population of over 20 million people predominantly resides in rural areas, with poverty incidence at 51.5% and income inequality high. Malawi's economy heavily relies on agriculture, with health contributing 5.4% to GDP. However, severe macroeconomic challenges, including currency depreciation and high debt, constrain public spending and essential service delivery. The country's vulnerability to extreme weather events exacerbates **food insecurity**, with recurring **floods and droughts** affecting livelihoods and food access, worsened by the recent devastation caused by Cyclone Freddy. The health sector, though improving, faces hurdles such as **underinvestment and disruptions** due to public health emergencies like COVID-19, polio, and cholera outbreaks, hindering the delivery of essential health services and threatening previous gains in health outcomes. Despite progress in reducing stunting and improving maternal and child health, challenges persist in addressing **non-communicable diseases and adolescent health**, while **nutrition and food security** remain critical concerns, exacerbated by high food prices.
The main characteristics of the country are illustrated in Table 43.

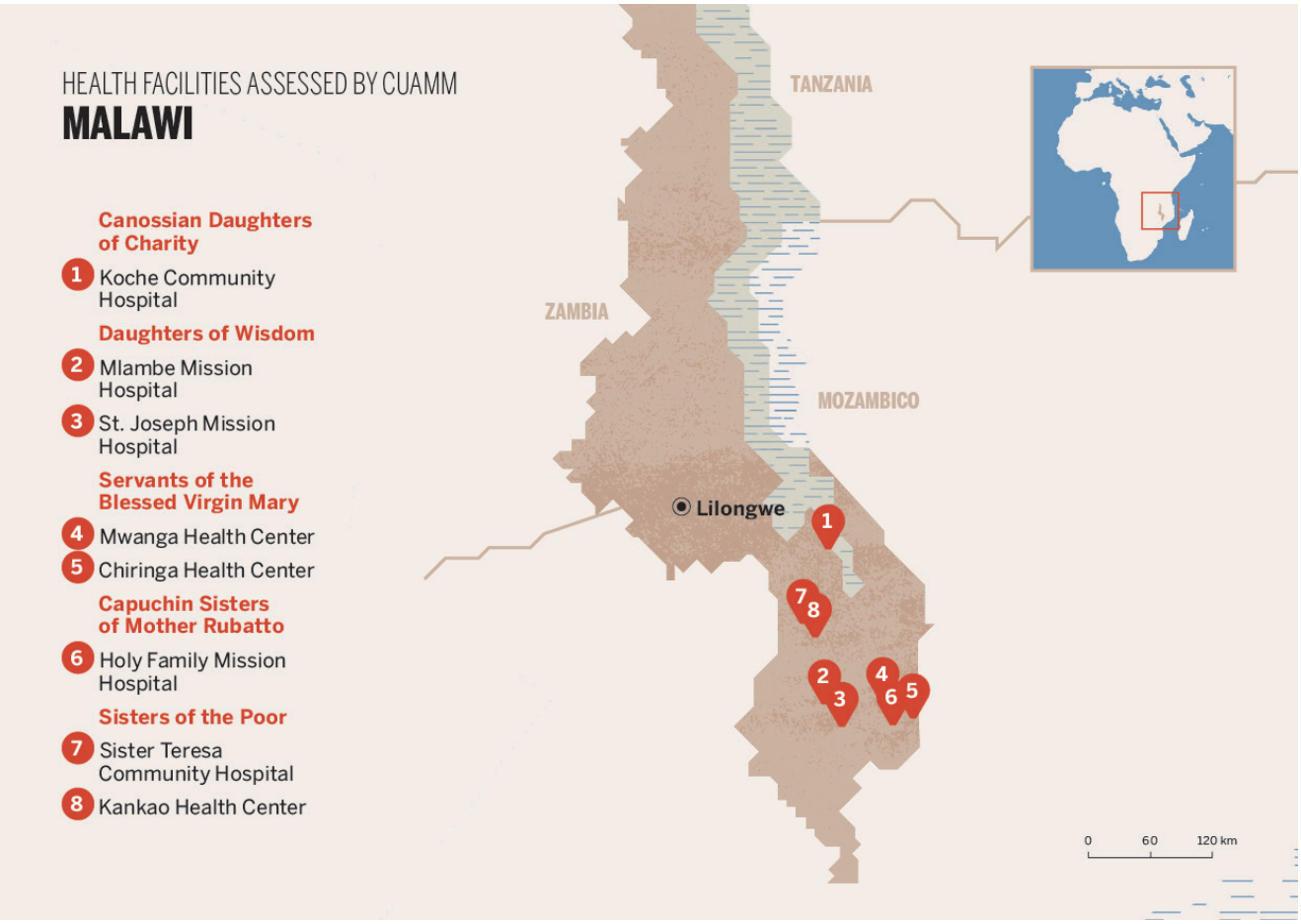


Table 43. *General information about Malawi (16).*

Capital	Lilongwe
Population	20,405,317
Official language	English
Geography	The country occupies a thin strip of land between Zambia and Mozambique, extending southwards into Mozambique along the valley of the Shire River. In the north and northeast it also shares a border with Tanzania.
Environment	Malawi has a sub-tropical climate. One of the biggest challenges facing the country is deforestation, along with constrained water resources, soil erosion, and erratic rainfall. Tropical cyclones, such as Cyclone Freddy in February 2023, have triggered widespread humanitarian crises.
Political situation	Malawi has enjoyed sustained peace and stable governments since independence in 1964. One-party rule ended in 1993. Since then, multi-party presidential and parliamentary elections have been held every five years. Although political rights and civil liberties are largely respected by the state, problems like corruption, police brutality, and discrimination remain common.
Socio-economic situation	Malawi remains one of the poorest countries in the world despite making significant economic and structural reforms to sustain economic growth. The economy is heavily dependent on agriculture, which employs over 80% of the population, and it is vulnerable to external shocks, particularly climatic shocks. Malawi's population is growing rapidly and poverty is severe, with over 70% of the population living below the international poverty line. The economy is expected to grow at 2.8% in 2024, supported by further anticipated macroeconomic reforms. However, such growth remains insufficient to substantially mitigate the prevailing high levels of poverty.

THE NATIONAL HEALTH CARE SYSTEM

Malawi's health service delivery system is organised into **three levels** (primary, secondary, and tertiary) linked by a referral system. The services are delivered through a network of public, Non-Governmental Organisations (NGOs), Private-not-for-Profit, and Private-for-Profit providers. Health services in the public sector are free of charge at the point of use.
In 2019, Malawi had a total of **1,098 health facilities**, with 52% government-owned, 23% Private-for-Profit, and 25% Private-not-for-Profit/NGO/institutional clinics. Public facilities delivered 60% of services and employed 70% of the health workforce, while the Christian Health Association of Malawi (CHAM) managed 15% of facilities, providing 35% of services. Malawi's health sector operates under a **decentralised system**, with governance extending from central ministries to district assemblies. However, despite increased health expenditure, per capita spending remains below required levels, resulting in limited health worker capacity and inadequate supplies. The financing structure heavily depends on donors. Challenges include **inefficient budget execution, misaligned resource allocation, and a chronic shortage of critical health workers**, exacerbated by fiscal constraints. Human resource expenditure consumes over half of the health budget, leading to **shortages in medicines and supplies**. Despite these challenges, investment in health workers remains crucial, especially amidst public health emergencies like COVID-19.
The main health indicators of the country are illustrated in Table 44.

Table 44. *Main economic and health indicators of Malawi, the United Kingdom of Great Britain and Northern Ireland (UK) and Italy (3-5, 16).*

	Malawi	United Kingdom	Italy
Population**	20,405,317	66,971,395	58,940,425
Human Development Index*	0.512	0.93	0.89
GDP per capita (US$)**	645.2	46,125	34,776
Current Health Expenditure (% of GDP)	5.43§§	11.94*	9.45*
OOP expenditure (% of health expenditure)§	19.53	13.6	21.3
Density of physicians (per 10,000 population)	0.49§§	32*	41*
Life expectancy at birth (years)§	62.9*	81.4§	83§
Fertility rate (birth per woman)	3.9*	1.6	1.3
MaternalMortality rate/100,000 live births	381§§	4.2*	2.6*
Neonatal mortality rate/1,000 live births	19.3*	9.8§§	4.59§§
Under Five mortality rate /1,000 live births*	41.9	2.8	1.47

*§Data related to 2019. §§Data related to 2020. *Data related to 2021. **Data related to 2022.*

FBOs ASSESSMENT

During the assessment, **seven Private-not-for-Profit health facilities** managed by different religious congregations in Malawi were visited, each falling under different dioceses. These facilities varied in the services provided and faced challenges related to **clinical governance, financial constraints, procurement delays, human resource shortages, lack of diagnostic equipment, vandalism, and theft**. Despite these challenges, the facilities maintained low fees to ensure affordability for patients, although these fees still posed a significant financial barrier. Procurement of drugs and consumables faced delays due to financial constraints and fuel issues, while the government's recruitment halt worsened the shortage of qualified health staff. Additionally, **inadequate disaster preparedness** and response measures left the facilities vulnerable to the impact of epidemic outbreaks and natural disasters.
The assessment highlighted the need for immediate and **long-term interventions** to address these challenges, including securing financial support, improving procurement processes, addressing human resource shortages, enhancing security measures, and strengthening disaster preparedness. The reports also identified strengths and best practices within the facilities that could be shared among healthcare providers to promote quality improvement initiatives and ultimately enhance the delivery of healthcare services in Malawi.
The main characteristics of the health facilities assessed are illustrated in Table 45 and Table 46. The main challenges and needs reported are illustrated in Table 47.

DISASTER PREPAREDNESS

The health centres in Malawi exhibit varying degrees of preparedness for disasters. While some centres have implemented measures such as early warning systems, training, and active civil protection committees, others lack these essential components. Common challenges include **ineffective communication of early warnings, limited inclusivity in communicating** these early warnings, an **absence of functional epidemiological surveillance systems**, **inadequate training**, and **deficiencies in emergency equipment and standard operating procedures.**

Table 45. *Health facilities assessed in Malawi.*

Facilities Name	FBO managing the facility	Location	Area	Type
Koche Community Hospital	Canossian Daughters of Charity	Michesi Village, Mangochi District, Southern Region	Semi-rural	Community hospital
Sister Teresa Community Hospital	Sisters of the Poor	Sauzana Village, Ntcheu District, Southern Region	Rural	Community hospital
Kankao Health Center	Sisters of the Poor	Kankao, Balaka District, Southern Region	Rural	Health centre
Mlambe Mission Hospital	Daughters of Wisdom	Blantyre, Southern Region	Rural	District hospital
Mwanga Health Center	Servants of the Blessed Virgin Mary	Phalombe, Southern Region	Rural	Health centre
Chiringa Health Center	Servants of the Blessed Virgin Mary	Phalombe, Southern Region	Rural	Health centre
Holy Family Mission Hospital	Capuchin Sisters	Phalombe, Southern Region	Rural	District hospital
St. Joseph Mission Hospital	Daughters of Wisdom	Chiradzulu, Southern Region	Semi-rural	District hospital

Picture 45. *Chiringa Health Centre, Phalombe.*

Table 46a. *Main services provided and main operational data regarding the health facilities assessed in Malawi.*

Health services		Koche Community Hospital	Sister Teresa Community Hospital	Kankao Health Center	Mlambe Mission Hospital
Outpatient services	Number of Outpatients Visits	27,074	17,684	8,230	34,736
	Number of U5 Outpatients Visits	23,848	7,829	112	2,482
	Specialist Consultations availability (Cardiology, Ophthalmology, etc.) availability	NA	NA	NA	Yes
Inpatient services	Wards for Admission	Maternit y, children, surgical, Internal medicine	Maternit y, children, surgical, Internal medicine	Maternit y, children, surgical, Internal medicine	Maternit y, children, surgical, Internal medicine
	Number of Inpatient Beds	103	56	55	254
	Number of Admissions	4,246	1,067	656	6,693
	Number of U5 Admissions	NA	433	112	933
Mother and Child health	Number of Deliveries	1,941	250	NA	3,444
	Number of Caesare an Sections	219	NA	NA	801
	Free Consultation for U5 and ANC	Yes	Yes	Yes	Yes

(data related to 2022)

Picture 46. *Koche Community Hospital, Mangochi District.*

Table 46b. *Main services provided and main operational data regarding the health facilities assessed in Malawi.*

Health services		Mwanga Health Center	Chiringa Health Center	Holy Family Mission Hospital	St. Joseph Mission Hospital
Outpatient services	Number of Outpatients Visits	6,891	NA	7,192	11,980
	Number of U5 Outpatients Visits	3,484	NA	4,956	6,467
	Specialist Consultations availability (Cardiology, Ophthalmology, etc.) availability	NA	NA	Yes	Yes
Inpatient services	Wards for Admission	NA	NA	Maternit y, children, surgical, Internal medicine	Maternit y, children, surgical, Internal medicine
	Number of Inpatient Beds	17	NA	153	200
	Number of Admissions	NA	NA	8,353	3,331
	Number of U5 Admissions	NA	NA	1,016	594
Mother and Child health	Number of Deliveries	342	720	2,239	1,975
	Number of Caesare an Sections	NA	NA	937	498
	Free Consultation for U5 and ANC	Yes	Yes	Yes	Yes

(data related to 2022)

Picture 47. *Koche Community Hospital, Mangochi District.*

Table 47. *Challenges, needs and strengths concerning the health facilities assessed in Malawi.*

CHALLENGES	
Human resources	A common challenge across Malawi's healthcare facilities is the shortage of qualified medical staff, impacting service provision. This leads to an increased workload and potential compromises in patient care
Logistics	Most of the centres across Malawi rely on inconsistent power and water supplies, which makes it incredibly challenging to maintain essential medical services
Financing	Financial limitations adversely impact operations and supply chains across the centres, hindering the procurement of essential equipment and services
Management	Numerous facilities face difficulties related to stock-outs and delayed payments affecting the consistent availability of essential drugs and medical supplies
NEEDS	
Human resources	Increasing the number of skilled healthcare staff, especially in remote areas, is crucial to address shortages and enhance healthcare services. This is crucial to maintain quality service provision and alleviate workload burdens
Logistics	Across the board, healthcare facilities require improvements in infrastructure, including staff housing, x-ray machines, pharmacies, and operating theatres
Management	Enhanced supply chain management is crucial to mitigate stock-outs of essential drugs and supplies
STRENGTHS	
Human resources	Despite challenges, several facilities boast dedicated staff, including midwives and administrative personnel, contributing to quality service delivery. There is clear commitment amongst staff to provide quality healthcare to patients
Health services delivered	Many health centres actively engage in outreach activities, including immunisation and growth monitoring, fostering community wellbeing; Proximity to referral facilities within reasonable distances ensures that patients can access specialised care when needed
Data collection	Most centres practised monthly data reporting, which facilitates evidence-based decision-making and enables healthcare providers to track trends and outcomes for better service provision

Picture 48. *St. Joseph Mission Hospital, Kiradzulu.*

4.13 TANZANIA

COUNTRY CONTEXT

Tanzania is a country in transition. Following two decades of sustained economic growth, Tanzania graduated from low-income to **lower-middle-income status** in May 2020 based on income thresholds established by the World Bank. Much of the country's development success over the decade was predicated on its strategic maritime location, rich and diverse natural resources, socio-political stability and rapidly growing tourism while the national poverty rate declined from 34 percent of the population in 2007 to 26 percent in 2018, rapid population growth caused the absolute number of people living in poverty to increase. The economic shock generated by **COVID-19** triggered an increase in the poverty rate to 27 percent in 2021 (17-19). Despite the progressive economic and population growth, Tanzania remains a country with the poorest scores for most of the socio-economic indicators in the world (Table 48).

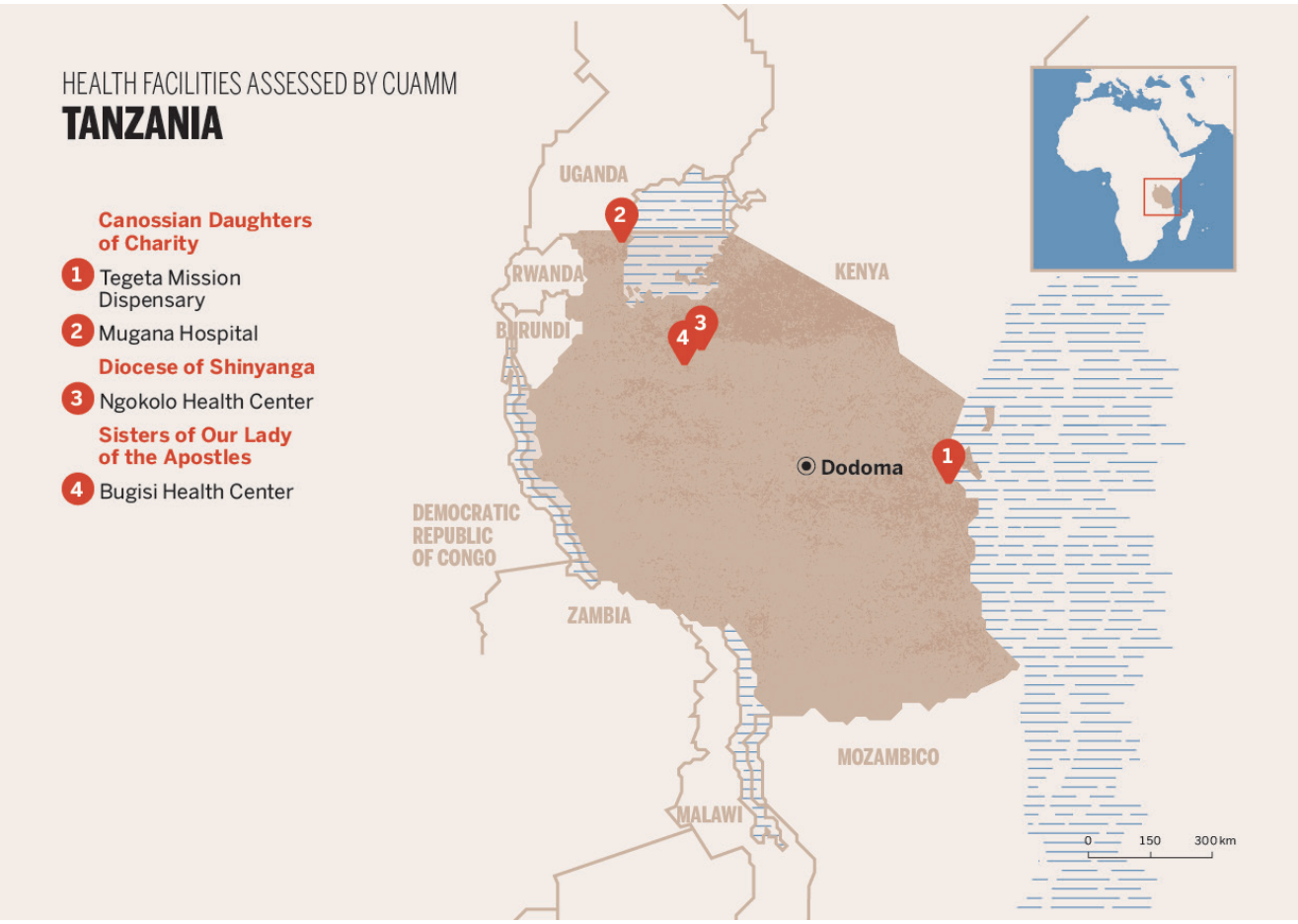


Table 48. *General information about Tanzania (17).*

Capital	Dodoma
Population	65,497,748
Official language	English and Swahili
Geography	The United Republic of Tanzania (Tanzania) is a country in East Africa within the African Great Lakes region. It borders Uganda to the north; Kenya to the northeast; the Indian Ocean to the east; Mozambique and Malawi to the south; Zambia to the southwest; and Rwanda, Burundi, and the Democratic Republic of the Congo to the west.
Environment	Tanzania is mountainous and densely forested in the northeast, where Mount Kilimanjaro is located. Three of Africa's Great Lakes are partly within Tanzania. To the north and west lie Lake Victoria, Africa's largest lake, and Lake Tanganyika, the continent's deepest lake, known for its unique species of fish. To the southwest lies Lake Nyasa. Central Tanzania is a large plateau with plains and arable land. The eastern shore is hot and humid, with the Zanzibar Archipelago just offshore.
Political situation	Tanzania is a stable unitary republic with both a national government and the revolutionary government of Zanzibar, which has autonomy for non-union matters. The Country's political system is organised in a unitary presidential republic framework, whereby the President of Tanzania is both head of state and head of government.
Socio-economic situation	Tanzania has achieved relatively strong economic growth and declining poverty rates. Much of the country's development success over the decade was predicated on its strategic maritime location, rich and diverse natural resources, socio-political stability and rapidly growing tourism. Despite the progressive economic and population growth, Tanzania remains a country with the poorest scores for most of the socio-economic indicators in the world.

THE NATIONAL HEALTH CARE SYSTEM

Health services in Tanzania are delivered through a **decentralised system**. It is structured according to **three territorial levels**: i) local government authorities (districts); ii) regional authorities; iii) national government.
Healthcare services in the public sector are provided through a decentralised health system across an extensive and interacting network of services at the community, primary, secondary, tertiary, and quaternary care levels (Figure 2). **Primary and secondary care** is offered at dispensaries and health centres, which are spread within the reference territory and intended to provide mainly outpatient services such as prevention, health promotion, maternity and some inpatient curative services. **Tertiary care** is provided by regional hospitals, which offer more specialised services, including consultation, emergency, and surgical services.

FINANCING SCHEME

The level of spending is still insufficient to ensure equitable access to basic and essential health services and interventions, so the major concern is to ensure **adequate mobilisation and equitable resource allocation** for health. External sources, such as international agencies and NGOs, have recently substantially increased resources for selected health interventions, leading to increased attention to sustaining such expenditure over time. At the same time, health costs have been rising rapidly, and a dominant concern is to select the priorities, thus reducing the

growth rate of health expenditure while maintaining the quality of the services offered.
The financing scheme is characterised by a mixed financing model, which includes multiple financing sources:
- government budget financed by general taxation
- external funding by international and national agencies and NGOs
- private funding, such as OOP payments or social insurance companies

Access to health services is limited by financial barriers. The most vulnerable people can easily cross into poverty with high out-of-pocket health expenditures. According to WHO OOP expenditures amounted to 22% of the total health expenditure in 2019 (21). To address this, the country has a long-term goal to attain universal health coverage through major health financing reform introducing mandatory **single national health insurance** with a standard minimum benefit package entitlement for all citizens. This, in effect, has the potential to provide financial protection against **catastrophic health costs** and **out-of-pocket expenses**, enhance access to and increase the availability of medication and services, and lead to improved health outcomes for adolescents, vulnerable men and women and marginalised communities (22).The main health indicators are illustrated in Table 49.

Table 49. *Main economic and health indicators of Tanzania, United Kingdom of Great Britain and Northern Ireland (UK) and Italy (2-3, 19).*

	Tanzania	United Kingdom	Italy
Population**	65,497,748	66,971,395	58,940,425
Human Development Index*	0.549	0.93	0.89
GDP per capita (US$)**	1,193	46,125	34,776
Current Health Expenditure (% of GDP)*	3.8	11.94	9.45
OOP expenditure (% of health expenditure)§§**	23.1	13.6	21.3
Density of physicians (per 10,000 population)*	0.5$	32	41
Life expectancy at birth (years)§**	67.3	81.4	83
Fertility rate (birth per woman)*	4.8	1.6	1.3
MaternalMortality Rate/100,000 live births*	238	4.2	2.6
Neonatal mortality rate/1,000 live births§§**	20	9.8	4.59
Under Five mortality rate /1,000 live births*	47.1	2.8	1.47

*§Data related to 2019. §§Data related to 2020.*Data related to 2021. **Data related to 2022.*

TANZANIA ASSESSMENT

OVERVIEW

The **four facilities** visited in Tanzania were private not-for-profit facilities located in three different regions of the country, in **rural or semi-urban areas**. They varied in type and level of services provided: district designated hospital, health centre, and dispensary (Table 50 and Table 51).
The assessment activity revealed that all the facilities face some common challenges, mainly related to **clinical governance and management.** The main challenges reported are summarised as follows:

- **general financial constraints** due to the progressive reduction of the main sources of income and the parallel increase of expenses. This financial unsustainability can be associated with:
  - the huge reduction and delay of government financial support, such as basket funds for recurring expenses
  - the delay of reimbursements from insurance companies for the services provided
  - the increase in the number of exemptions for patients who cannot afford the services, informal payments to health personnel and lost payments due to some patients' opportunistic behaviours.
- Although more than 95% of drugs and consumables are purchased from private pharmacies in the reference territory, there is a **delay from the government** in procuring some drugs.
- **Lack of qualified health staff** according for the services provided and patient needs, particularly of specialised medical doctors.
- **Lack of diagnostic medical equipment** or their proper and timely maintenance due to the lack of financial capabilities.
- **Staff unaware** of the importance of effective and continuous data collection through new digitised health information systems to support data-driven decision making, allocation of resources and accountability.

Despite major challenges and needs, all the facilities presented multiple strengths. All of them decided to maintain **fees low and affordable**, thus continuing to guarantee the equity of access to healthcare services. The health services delivered presented a high-quality level, both for outpatient and inpatient management. The healthcare workers employed were highly qualified and strongly motivated. Finally, all the facilities assessed reported **good collaboration with government authorities**. The main challenges and needs reported are illustrated in Table 52.

Table 50. Health facilities assessed in Tanzania.

Facilities' Name	FBO managing the health facility	Location	Area	Type
Mugana Hospital	Canossian Daughters of Charity	Rwamashong (Missenyi District – Kagera Region)	Rural	District hospital
Bugisi Health Center	Missionary Sisters Of Our Lady of Apostles	Didia (Shinyanga District Council – Shinyanga Region)	Rural	Health centre
Ngokolo Health Center	Diocese of Shinyanga – Sisters of Our Lady of Kilimanjaro	Shinyanga (Shinyanga District Council – Shinyanga Region)	Rural	Health centre
Tegeta Mission Dispensary	Canossian Daughters of Charity	Tegeta (Dar es Salaam – Dar es Salaam Region)	Semiurban	Dispensary

Picture 49. *Mugana Hospital, Missenyi District.*

Picture 50. *Ngokolo Health Center, Shinyanga District.*

Table 51. *Main services provided and main operational data regarding the health facilities assessed in Tanzania.*

Health services		Mugana Hospital	Bugisi Health Center	Ngokolo Health Center	Tegeta Mission Dispensary
Outpatient services	Number of outpatients visits	13,299	15,168	6,712	24,309
	Number of U5 outpatients visits	803	4,632	1,646	8,604
	Specialist consultations availability (Cardiology, Ophthalmology, etc.)	No	No	No	No
Inpatient services	Wards for admissions	Emergency, Maternity and NICU, Children, Surgical, Medical	Emergency, Maternity, Children (With Malnutrition Unit), Surgical	Maternity, Medical	NA
	Number of inpatient beds	140	70	25	NA
	Number of admissions	3,302	4,237	353	NA
	Number of U5 admissions	372	737	109	NA
Mother and Child health	Number of deliveries	962	1,037	87	NA
	Number of caesarean sections	301	150	NA	NA
	Free consultation for U5 and ANC	Yes	Yes	Yes	Yes

(data related to 2022)

Picture 51. *Mugana Hospital, Missenyi District.*

Picture 52. *Bugisi Health Centre, Shinyanga District.*

Table 52. *Challenges, needs and strengths concerning the health facilities assessed in Tanzania.*

CHALLENGES	
Human resources	Shortage of specialised healthcare workers, mainly physicians and nurses; Limited number of human resources seconded by the government; Lack of health personnel to conduct health education on reproductive and child health; Lack of adequate training, especially with regard to Intensive Care unit (ICU) and Neonatal intensive Care Unit (NICU)
Health services delivered	Lack of public health education services; Lack of malnutrition units; Lack of Early Child Development (ECD) service
Logistics	Shortage of medical equipment, mainly concerning maternal wards and ICU, NICU; Inadequate water supply system (Mugana hospital); Poor Internet connection
Data collection	Lack of staff awareness of effective data collection and analysis; Very poor digitisation despite the presence of good-quality hardware equipment
Financing	Lack of timely payments from insurance, thus generating recurrent cash imbalance; Constant delays of government financial support for running expenses; Lack of diversification of the hospital's sources of income
Integration and coordination	Low certainty regarding government support in the upcoming years due to the construction of a new public District Designated Hospital, which raises questions on the future positioning of the hospital within the National Health System
NEEDS	
Human resources	Need of specialised healthcare workers, mainly regarding the following are of expertise: ICU; NICU; surgery; Need of training activities on: data analysis; obstetric emergencies and neonatal resuscitation; surgery procedures
Health services delivered	Need of support to implement of the following services/units: operating theatre; malnutrition services; ECD service; X-ray diagnostic services
Logistics	Need to invest in equipment for the following units/services: ICU and NICU (vital signs monitors); maternal wards (ultrasound machine, fridge for oxytocin, delivery beds); rehabilitation unit; radiology (X-ray machine); laundry; Improvement of the water system (Mugana hospital)
Data collection	Support in the development and implementation of a comprehensive and integrated hospital information system for both clinical and administrative records
STRENGTHS	
Human resources	High professional motivation; High staff commitment; Strong leadership of the management team; Promotion of continuous medical education among health care staff (Bugisi health centre)
Health services provided	Provision of a high-quality level of in patients and outpatient services (including a completely renovated operating theatre and blood bank in Bugisi health centre)
Integration and coordination	Good relationship with health authorities

Picture 53. *Tegeta Mission Dispensary, Dar es Salaam Region.*

Picture 54. *Mugana Hospital, Missenyi District.*

4.14 TOGO

COUNTRY CONTEXT

Located on Africa's west coast, Togo has more than 8 million inhabitants. The poverty level is twice as high in rural areas (58.8%) as in urban areas (26.5%). This is due in large measure to **concentrated economic growth in the modern sectors** and **limited access to quality services.** Poverty is higher in female-headed households (45.7%) than in male-headed households (45.2%). Women remain more vulnerable, as they have less access to economic opportunities, education, health, and other basic socio-economic facilities.
Since the COVID-19 pandemic in 2020, Togo has faced significant headwinds ranging from the fallout from Russia's invasion of Ukraine on energy and food prices, to slowing external demand, tighter financing conditions and regional instability. A sharp increase in public spending helped stabilise growth in the face of these shocks but vulnerable populations have been adversely impacted by the rising cost of living and fiscal space has been depleted (23). The main characteristics of the country are illustrated in Table 53.

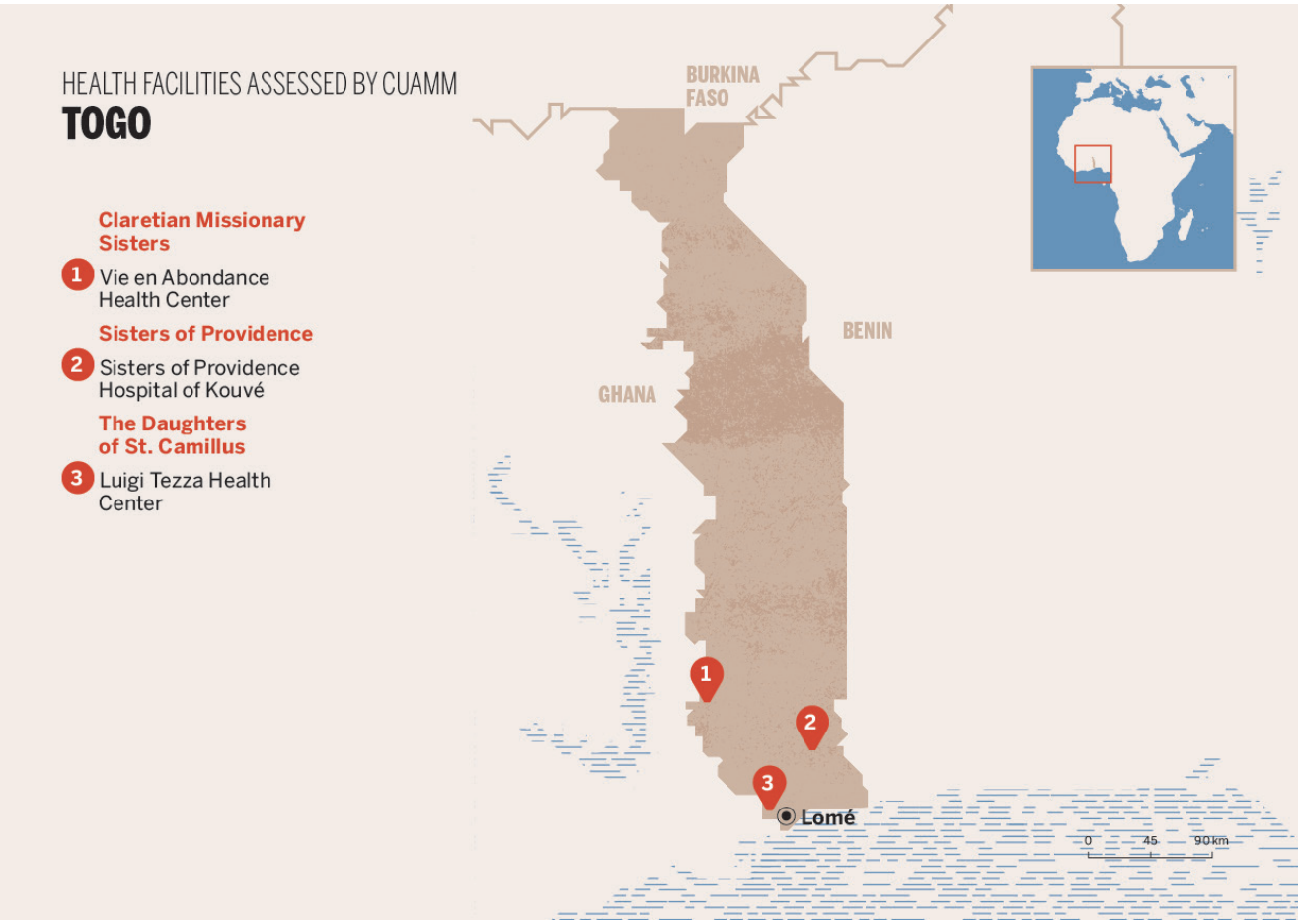


Table 53. *General information about Togo (20).*

Capital	Lomè
Population	8,848,699
Geography	Togo is bordered by Ghana, Benin and Burkina Faso.
Environment	The climate is tropical, with a dry season in winter and a rainy season due to the African monsoon, which runs from April to October in the centre and from May to October in the north, while along the coast, there is a marked decrease in rainfall from July to September.
Political situation	Togo is a presidential republic. On September 28, 2020, Victoire Tomégah-Dogbé was appointed prime minister, the first woman to hold this office in Togo.
Socio-economic situation	Since the COVID-19 pandemic in 2020, Togo has faced significant headwinds ranging from the fallout from Russia's invasion of Ukraine on energy and food prices, to slowing external demand, tighter financing conditions and regional instability. A sharp increase in public spending helped stabilise growth in the face of these shocks but vulnerable populations have been adversely impacted by the rising cost of living. The population living in extreme conditions accounts for 46% of the total

THE NATIONAL HEALTH CARE SYSTEM

The Health System organisation includes **three different levels**: national level (tertiary referral hospital), regional level (district hospitals) and local level (health centres, dispensaries). In May 2018, the MoH implemented the use of a digital platform aimed to collect data from the health facilities throughout the country. However, many issues still remain not only with regard to the data collection procedures but also to data analysis for planning, monitoring and evaluation of health services.
With regard to health needs, 59% of them are covered by public and 41% by private (for profit and not for profit) facilities, which appear poorly integrated into a structured development plan aimed to address the needs of the population. In this context the traditional sector survives, still very especially in rural areas. The country has health facilities that allow access to services to more than 65% of the population, but with high social and geographical inequalities. For instance, access to assisted childbirth moved from 92% in urban areas to 41% in rural areas.
The main insurance systems in Togo, promoted by the Government with a special law in 2011, are the follows:

- **Institut National D'assurance Maladie Du Togo** for civil servants (4.4% national coverage). Private health facilities, including not-for-profit organisations, can be accredited to deliver the package of services covered by the insurance and they can receive the reimbursement form the Government.
- **Les Mutuelles de Santé**: this system is still very little developed (0.04%).
- **Les assurances de Santé privées**: private insurances at an early development stage

The main health indicators of the country are illustrated in Table 54.

FINANCING SCHEME

The government expenditure on health corresponds to **5%** of total government expenditure. Almost 50% of the total health costs of the country, including ambulance transport, are sustained directly by patients and their families, generating a high amount of catastrophic health expenditures.

Table 54. *Main economic and health indicators of Togo, United Kingdom of Great Britain and Northern Ireland (UK) and Italy (3-5, 20).*

	Togo	United Kingdom	Italy
Population**	8,848,699	66,971,395	58,940,425
Human Development Index*	0.54	0.93	0.89
GDP per capita (US$)**	942.6	46,125	34,776
OOP expenditure (% of health expenditure)§	61.5	13.6	21.3
Current Health Expenditure (% of GDP)*	5.96§	11.94	9.45
Density of physicians (per 10,000 population)*	0.58	32	41
Life expectancy at birth (years)§	64.3	81.4	83
Fertility rate (birth per woman)*	4.3	1.6	1.3
MaternalMortality rate/100,000 live births§§	399	9.84	4.59
Neonatal mortality rate/1,000 live births*	24	2.8	1.47
Under Five mortality rate /1,000 live births*	62.6	4.2	2.6

*§Data related to 2019. §§Data related to 2020. *Data related to 2021. **Data related to 2022.*

Picture 55. *Centre Médical Social "Luigi Tezza", Sanguera.*

TOGO ASSESSMENT

OVERVIEW

The assessment involved **three health facilities** located in rural and urban areas. Although each facilities presented specific needs, the assessment highlighted the presence of common challenges, summarised as follows:

- **low activity** and the low number of patients attending the facility
- **financial issues**, due to the fact that financial revenue depends on more than 50% of the fees paid by patients
- **absence of insurance** and patient support programmes
- **high staff turnover** and low staff retention
- **absence of incentives** for health staff

Despite many challenges and needs, the facilities included presented some points of strengths. They employed **highly qualified and motivated health professionals**. The services provided were well organised and they presented **adequate standards of care**. The services ensured continuous assistance to the population (24 hours/7 days).
The main characteristics of the health facilities assessed are illustrated in table 55 and Table 56. The main challenges and needs reported are illustrated in Table 57.

Table 55. *Health facilities assessed in Togo.*

Facilities' Name	FBO	Location	Area	Type
Centre Médical Social "Luigi Tezza"	Soeurs Camillien	Sanguera	Urban	Health centre
Centre Médical Social "Vie en Abondance"	Soeurs Clarettien	Kpalimè	Rural	Health centre
Kouvè hospital	Soeurs de la Providence	Kouvè	Rural	Hospital

Picture 56. *Kouvè hospital, Kouvè.*

Table 56. *Main services provided and main operational data regarding the health facilities assessed in Togo.*

Health services		Centre Medical Social "Luigi Tezza"	Centre Médical Social "Vie en Abondance"	Kouvè hospital
Outpatient services	Services available	Outpatient department, ANC, PoNC, U5 clinic, immunisation, HIV/ AIDS diagnosis and treatment, STI	Outpatient department, ANC, PoNC, U5 clinic, immunisation	Outpatient department, ANC, PoNC, U5 clinic, immunisation, HIV/ AIDS diagnosis and treatment, STI, physiotherapy
Inpatient services	Wards for admissions/ inpatients services	Maternal unit, internal medicine	Maternal unit, observation unit (daily hours)	Maternal unit, paediatric unit, internal medicine
	Number of beds	12	5	123
Consultations	Consultations (outpatients + inpatients)	2,352	2,264	9905 outpatient consultations/ 1677 admissions
Mother health	Number of deliveries	95	62	496
	Operating theatre	Not available	Not available	Not available

(data related to 2020)

Picture 57. *Centre Médical Social "Vie en Abondance", Kpalimè.*

Picture 58. *Kouvè hospital, Kouvè.*

Table 57. *Challenges, needs and strengths concerning the health facilities assessed in Togo.*

CHALLENGES	
Human resources	Shortage of specialised health professionals, mainly in rural areas; High turnover and low retention of health professionals
Health services delivered	Low patients' attendance of the health services provided; Lack of some health services: operating theatre; radiology unit; blood bank
Logistics	Lack of equipment for the operating theatre; Lack of equipment for the radiology unit; Lack of equipment of maternal and neonatal unit
Referral system	Lack of ambulances to refer patients; Lack of an organised referral system
Data collection	Weakness of data collection system (lack of digitization)
Financing	Financial issues because income depending on the fees paid by patients
Management and governance	Lack of an organised management team that coordinate and supervise the health facilities activities
NEEDS	
Human resources	Need to recruit more health professionals. Possible strategies: training programs implementation (both on-line and in presence); support international exchange with residents/specialised professionals; support research programs; financial incentives; establish agreement with the MoH to recruit health professionals
Health services delivered	Need to implement the access to health service, mainly for pregnant women and vulnerable people. Possible strategies: fees reduction; involvement in international projects; development of specific projects, tailored to support the access to health services for specific group of patients
Logistics	Need to procure equipment for the operating theatre; Need to procure the equipment for the radiology unit; Lack of equipment of maternal and neonatal unit
Data collection	Need to strengthen the data collection system, focusing not only on administrative topics but also on clinical data collection
Financing	Need to implement support from international donors; Need to implement support from NGOs
Management and governance	Need to have a organised management team, in order to build development plans
Integration and coordination	Need to strengthen collaboration with the MoH; Need to strengthen coordination between FBOs
STRENGTHS	
Human resources	High qualified health staff; High motivated health staff
Health services provided	The existing service are well organised; Adequate standards of care
Integration and coordination	OCDI (Organisation de la Charitè pour un Developpement Integral) aimed to: implement technical assistance and training programs; create network and collaboration between FBOs and MoH

Picture 59. *Centre Médical Social "Luigi Tezza", Sanguera.*

Picture 60 and 61. *Centre Médical Social "Vie en Abondance", Kpalimè.*

5. DISCUSSION

The CUAMM assessment missions performed in the context of the project **"Supporting Faith-Based Organisations Delivering Healthcare in Africa"** showed interesting findings, contributing to a better understanding of the quality of health facilities managed by FBOs in African countries.
The report revealed that the health facilities assessed played a **crucial role in delivering healthcare services**, especially to the most vulnerable populations. This finding is aligned with previous scientific papers that have highlighted the impact of FBOs in **supporting health care systems** and in **contributing to the achievements of Sustainable Development Goals** (1, 21).
The strength of health facilities managed by FBOs was based on multiple components. They delivered assistance in areas not usually reached by public health systems, providing care to the most vulnerable populations. Moreover, they employed **highly motivated staff**, offering services of **good quality with affordable rates** for most of the patients. All these elements generated a deep integration with the local communities, making the health facilities assess key players in the provision of health care.
Despite these valuable characteristics, the assessment missions revealed a multifaceted spectrum of challenges that can negatively impact the provision of health care services. The assessment provided an insightful view on the **difficulties experienced** by FBOs managing health facilities, expanding in depth previous findings reported in scientific literature (1, 22-23).

From a general perspective, the challenges reported complained the following areas of interest:

- ***Financing****:* the majority of health facilities reported financial issues. They didn't receive any financial help from the government, so the first source of income was represented by consultation and admission fees along with private funding. Despite this financial insecurity, the majority of them offered services with affordable ratings for most of the population. However, consultation and admission fees should be reduced in order to maximise the number of vulnerable patients that can afford the services delivered.
- ***Human resources****:* the majority of health facilities reported a shortage of qualified health professionals, mainly with regard to neonatal and maternal care, surgery, anaesthesia, and radiology. This issue was particularly pronounced in rural health facilities, where the shortage of health professionals was related both to low staff retention and to high staff turnover
- ***Health services****:* difficulties regarding the renovation of the existing health services or the implementation of new ones was reported mainly by rural facilities. These challenges concerned mainly the improvement of maternal and neonatal wards, and the implementation of an operating theatre to perform caesarean sections. Many facilities also reported the lack of services targeted to address chronic non communicable diseases. In urban areas, the health facilities assessed reported weaknesses concerning the emergency departments aimed to perform triage procedures and to treat patients in need of urgent treatments
- ***Referral system:*** lack of a well-structured and coordinated referral system. Many facilities, mainly in rural areas, reported a lack of ambulances to refer critically ill patients to facilities providing advanced health care

- ***Logistics:*** the range of challenges reported presented a certain degree of variability in relation to the health facilities location (rural *vs* urban areas). For instance, rural health facilities reported issues related to the regular provision of electricity and to the necessity of renovating the existing buildings. Urban facilities reported the need of purchasing medical devices to ensure more advanced diagnosis procedures and treatments (i.e. mechanical ventilators for intensive care units, laboratory machines for second level diagnosis, radiology machines, etc.)
- ***Data collection:*** difficulties in performing continuous and standardised data collection were frequently reported, both in rural and urban areas
- ***Governance and management:*** rural facilities reported the lack of well-structured management committees aimed to coordinate and manage the healthcare facilities
- ***Coordination and integration:*** many facilities, both in urban and rural areas, reported the lack of coordination between the healthcare facilities providing assistance in the same area of competence. Moreover, a lack of integration and collaboration with governmental health facilities was often a complaint
- ***Disaster preparedness and response:*** the majority of health facilities reported the absence of disaster preparedness and response plans, despite the fact the many of them are located in disaster prone regions.

Each challenge reported was associated with **specific needs** waiting to be solved to strengthen the capacity and the resilience of the health care facilities assessed.
The needs reported can be distinguished in accordance with the following domains of interest:

- ***Financing****:* implement the funds available, in order to ensure salaries payment, to guarantee proper health services delivery, and to establish fees affordable for vulnerable people
- ***Human resources:*** increase the number of health professionals employed, mainly with regard to qualified physicians
- ***Health services:*** expand the existent health services or to implement new ones in order to provide better assistance to the population served
- ***Referral system:*** develop a well-integrated and coordinated referral system for critically ill patients in need of advanced medical care. Moreover, a urgent need to ameliorate the patients' referral system was reported, in order to refer critically ill patients in adequate facilities
- ***Logistics:*** adopt strategies to allow better electricity provision, to improve the facilities' infrastructure, to improve the logistic chain for equipment, medicines and supplies
- ***Data collection:*** implement procedures and systems to allow standardised data collection
- *Governance and management:* implement well-structured management committee to properly administer health facilities
- ***Coordination and integration:*** establish partnerships and networks with other FBOs and with governmental health facilities in order to implement collaborations, share common goals and define strategic measures aimed to address the challenges and needs encountered
- ***Disaster preparedness and response:*** implementation of health facilities' disaster preparedness and development of disaster response plans.

6. RECOMMENDATIONS

The recommendations listed below are based on the main findings emerging from CUAMM assessment missions conducted across **11 African countries** (Angola, Cameroon, Central African Republic, Ethiopia, Ghana, Ivory Coast, Kenya, Madagascar, Malawi, Tanzania, and Togo) and involving **63 health facilities**. The challenges and short/medium-long term needs identified during the assessments guided the formulation of these recommendations. They are aimed at **strengthening the capacity and resilience of FBOs** managing the health care facilities assessed. These recommendations are addressed to health facilities' governing bodies (managers, administrators and health departments directors), FBOs representatives, policymakers and all the other stakeholders involved in developing plans, allocating budgets and designing projects to improve the quality of healthcare for the population assisted in these countries.

Main recommendations are:

HUMAN RESOURCES

- Promote measures aimed at **ensuring staff retention**, especially in rural areas. The possible mixed strategies to be adopted should include better salaries, continuous training and career development, regular shifts and balanced rosters in order to avoid workload.
- Review human resources **recruitment criteria**, also taking into account the competencies and technical skills required to provide specialised care and to better address population needs.
- Provide **training programmes** focused on specific health topics contextualised to local needs with the aim of increasing health professionals' technical skills and job motivation and improve quality of services provided. Mentoring and clinical supervision should be considered in promoting successful training strategies.

HEALTH SERVICES

- Facilitate the access of the most vulnerable patients through a **reasonable user fees system** (i.e flat rates and lower fees), exploring the potential of the national health insurance where applicable.
- Participate in **national and international programs** on Continuous Quality Improvement based on agreed standards of care.
- Establish shared **roles and protocols** with district and regional health facilities for referring patients with special needs in order to assure continuity of care.

INFRASTRUCTURE, ENERGY AND WATER

- Improve **energy access** developing **back-up systems**, sustainable energy systems (e.g. solar power) and balance between energy consumption and level of care/equipment needed.
- Ensure **access to safe water**, and improve **water management**, connection to the national water services and facility water infrastructures, especially in rural areas.

- Ensure adequate **maintenance of the equipment**, training local personnel, standardising procurement and ensure the **adequate level of technology** to respond properly to local needs.

MANAGEMENT AND DATA SYSTEMS

- Ensure **regular and standardised data collection procedures** regarding medical records, medicines and consumables.
- Encourage the use of **digitalisation** of health records and its integration into the national health management **information system**.
- Establish **management committees** aimed at coordinating the governance of each of the healthcare facilities, addressing the specific challenges and needs and negotiating with local, regional and national authorities, also addressing disaster preparedness schemes and plans.
- Improve the management of **logistic chains for equipment**, supplies and medicines establishing well-structured plans for procurement to avoid running out of medicines.

RESOURCE MOBILISATION AND FINANCING

- Provide basic skills to promote **donor's relations**, **project development** and **donor engagement** mobilising new and additional resources locally or internationally.
- Strengthen the **relationships with local governments** to advocate for co-participation in running costs, supply of medicines and consumables, allocation of staff, and other means to ensure adequate service provision to local population.

FBOs REPRESENTATION

- **Strengthen FBOs networks** aimed at implementing collaborations, sharing common goals and adopting strategic measures, as well as standardising and aligning practice to national and international standards to provide quality care to local population.
- **Disseminate results and best practices** in order to improve the dialogue with governmental authorities at all levels, policymakers and other stakeholders (e.g. NGOs and international donors) to promote investments on FBOs healthcare facilities.

7. LIMITATIONS AND STRENGTHS

Although the assessment missions involved multiple healthcare facilities situated in different sub-Saharan African countries, it must be noticed that they represent a portion of the centres managed by FBOs. Therefore, the findings cannot be generalised, but further studies are needed to develop a deep understanding of the topic. Despite these limitations, the results provided critical insights into the challenges faced by the healthcare facilities included in this project. The comprehensive assessment missions allowed us to better understand the key elements to act on in order to strengthen the capacity and resilience of FBO-managed healthcare facilities in sub-Saharan Africa.

Picture 62. *Mother Francesca Rubatto Medical Center, Nakuru, Kenya.*

8. CONCLUSION

This report provides critical insights into the challenges faced by FBO-managed healthcare facilities in sub-Saharan Africa. The project underscores the need for sustained engagement and support for FBOs to achieve **lasting impact in the provision of healthcare** to the Sub-Saharan African population. Through CUAMM's comprehensive assessment missions, the project has highlighted the vital role played by FBOs in delivering healthcare services to vulnerable populations. Despite their significant contributions, challenges such as **limited disaster preparedness**, **staffing shortages**, **infrastructure deficiencies**, and **financial constraints** continue to persist for many of the facilities. Moving forward, the importance of collaborative efforts to strengthen FBOs' capacity and resilience cannot be underestimated. By prioritising the improvement of human resources, health services provided, infrastructures, and financing, stakeholders can work together to address these needs and ultimately improve healthcare.

Picture 63. *Mugana Hospital, Missenyi District, Tanzania.*

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10. APPENDIX

Table 58. *Data related to 2020 and concerning the facilities assessed (HC: Health Centra; N/A: not applicable).*

Country	Health Facility Name	Beds	Outpatient visits	Deliveries	Physicians	Midwives + Nurses
ANGOLA	Missionary Hospital Of Chiulo	288	1,886	1.647	10	86
	Centro Médico Materno-Infantil De Nossa Senhora Da Graça	14	532	150	7	8
	Hospital Municipal Missionário Nossa Senhora Da Paz	233	3,500	28	10	91
	Maternal And Child Hospital Diocesano Of Rainha Santa	46	11,563	446	3	27
	Hospital Divina Providência	147	N/A	0	0	0
	San Francesco Di Sales Congregation	4	56,755	N/A	1	15
CAMEROON	Hospital Notre Dame Des Apôtres	61	27	684	5	3
	Centre De Santé Maria Immaculé	15	473	76	1	4
CENTRAL AFRICAN REPUBLIC	C. S. St Martin De Porres	20	10,792	N/A	3	4
	C. S. Our Lady Of Fatima	N/A	N/A	N/A	1	3
	C. S. St Luc Monastère	N/A	N/A	N/A	1	5
	C. S. Saint Joseph	28	N/A	23	1	4
ETHIOPIA	Getche HC	13	4,668	408	0	7
	Dakuna HC	7	6,752	81	0	4
	Burat HC	5	18,412	412	0	4
	Megenasse HC	10	20,999	284	1	8
	Zizencho HC	21	32,508	392	0	9
	Galye Rogda HC	10	N/A	46	0	5
	Shebraber HC	8	N/A	217	0	7
	Yewere HC	27	N/A	N/A	0	3
GHANA	St. Anthony HC	7	2,817	7	0	18
	Sacred Heart HC	29	5,851	160	0	48
	St. James Clinic	10	5,082	40	1	26
	St. John Of God Hospital	167	85,623	1,567	13	271
	St.Elizabeth Catholic Hospital	130	85,103	2,064	9	247

IVORY COAST	Rehabilitation Center Of Mother Theresa Verzeri	23	430	N/A	0	0
	Notre Dame Dispensary Of Gagnoa	3	865	0	0	1
	Urban Private Faith Based Dispensary Mother Leonia Prikro	10	949	N/A	0	2
	Private Urban Health Center "Notre Dame Des Apostoles"Of Divo	8	3,899	305	1	4
	Notre Dames Of Bouake HC	4	5,515	0	2	2
	Private Faith-Based Health Center Mere Franziska	13	N/A	0	1	2
KENYA	Kaijado Hospital	12	1,317	77		2
	Embulbul Catholic Dispensary	N/A	11,062	N/A	0	2
	St. Paul Hospital	40	18,303	324	1	17
	St. John Hospital	100	18,194	1,165	2	51
	St. Mary'S Mission Hospital	320	135,623	N/A	10	103
	Mother Francesca Rubatto Medical Centre	1	N/A	N/A	0	2
MADAGASCAR	Ekar Toeram-Pitsaboana Olontsambatra Anne Michelotti	N/A	N/A	100	1	4
	Centre Medical Luigi Orione	N/A	N/A	N/A	1	2
	Centre Médico Chirurgical Saint Paul	23	6,656	86	3	6
	Clinique Medical Don Orione Mandiavato	8	3,054	N/A	0	0
MALAWI	Mwanga HC	17	3,493	430	0	11
	Chiringa HC	30	5,750	500	0	8
	Kankao HC	55	9,365	608	0	6
	Sister Teresa Community Hospital	56	15,983	262	0	9
	St Joseph Mission Hospital	200	19,453	2,136	0	47
	Holy Family Mission Hospital	153	18,777	3,167	1	47
	Koche Community Hospital	103	26,656	2,559	0	43
	Mlambe Mission Hospital	254	43,733	3,624	3	143
TANZANIA	Ngokolo	25	9,745	252	6	6
	Bugisi Health Centre	70	20,627	733	6	15
	Mugana Council District Hospital	140	14,722	1,032	11	15
	Tegeta Mission Dispensary	4	25,105	N/A	6	10
TOGO	Social Medical Center "Life In Abundance"	5	62	2,264	1	2
	Center Medical Social "Luigi Tezza"	12	2,352	95	2	6
	Soeurs De La Providence	123	11,582	496	3	35
TOTAL		**3,112**	**786,615**	**28,947**	**128**	**1,510**

11. ANNEXES

ANNEX A. *Health facility assessment questionnaire.*

PART 1: GENERAL INFORMATION			
1	Faith-based organisation name *(In original language):*		
2	Reference person for the facility:	Name: Email: WhatsApp:	
3	Name and role of the people interviewed:		
4	Health facility name *(In original language)*:		
5	Type of health facility:		Dispensary
			Health centre
			Hospital
7	Level of urbanisation:		Urban
			Semi-urban
			Semi-rural
			Rural
8	Reference health district:		
9	Reference health facility at higher level:		
10	Ownership:		Public
			Private
			For profit
			Not-for-profit
11	Does the health facility have its own legal personality?		Yes
			No
12	Year of establishment:		
13	Catchment population of the health facility:		

PART 2: SERVICES PROVIDED AT THE FACILITY				
	Does the facility provide/has:	**YES**	**NO**	**Notes**
14	Outpatient department (OPD)			
15	Antenatal care			
16	Postnatal care			
17	Family planning			
18	Under five clinic			
19	Immunisation			
20	Grow monitoring			
21	Other specialist services *(Ex. dental, eye, ear-nose-throat) (Please specify)*			
22	Diagnosis and treatment for sexually transmitted infections			
23	TB treatment			
24	HIV/AIDS clinic and ARV treatment			
25	Prevention of mother-to-child transmission of HIV			
26	Physiotherapy			
27	Emergency ward			
28	Outreach activities			
29	X-ray			
30	Ultrasound			
31	Blood bank			
32	Vaginal deliveries			
33	Caesarean sections			
34	Operating theatre			
35	Inpatient admission			

36	Other services *(Please specify)*			
37	Other services *(Please specify)*			
38	Other services *(Please specify)*			

PART 3: OBSTETRIC CARE				
39	How many hours do women generally stay at the facility following a normal delivery?			
40	How many days do you usually keep a preterm baby without complications?			
41	Does the facility carry out maternal death audits or case reviews on a routine basis? *(Routine means: After every maternal death, or on a systematic, regular basis. Ex. Every month or every six months)*	Yes	No	Never had a maternal death
42	With who do you carry out maternal death audits? *(Ex. District health authorities, etc.)*			

PART 4: MAIN DISEASES			
43	What are the 5 main diseases you have in the outpatient department?		
	Male	**Female**	**Children <5**
	1. 2. 3. 4. 5.	1. 2. 3. 4. 5.	1. 2. 3. 4. 5.
44	What are the 5 main diseases you have in the inpatient department?		
	Male	**Female**	**Children <5**
	1. 2. 3. 4. 5.	1. 2. 3. 4. 5.	1. 2. 3. 4. 5.

PART 5: OPERATIONAL DATA					
		2019	**2020**	**2021**	**2022**
45	How many beds are available for patients in this facility? *(Total in all departments)*				
46	How many beds are dedicated exclusively to obstetric patients?				
47	How many delivery beds/couches are available in the delivery room?				
48	Number of outpatient visits				
49	Number of outpatient visits of children under 5				
50	Number of inpatients				
51	Number of inpatients – children under five				
52	Number of deaths				
53	Number of deaths – children under five				
54	Number of total deliveries				
55	Number of caesarean sections *(If any)*				
56	Number of maternal deaths				
57	Number of macerated stillbirth				
58	Number of fresh stillbirth				
59	Number of perinatal deaths *(Within 1 week from the delivery)*				

PART 6: REFERRAL SYSTEM			
60	What is the health facility to which patients are usually referred to?		
61	What is the type of referral facility?		Public
			Private
			Private not-for-profit
62	How long does it take to get to the referral health facility? *(Minutes)*	Minutes	
63	Does this facility provide surgical care?		Yes
			No
64	If not, to which health facility patients in need of surgical care are referred?		
65	How long does it take to get to the referral health facility with surgical care? *(Minutes)*	Minutes	
66	Which kind of patients do you usually refer?		

PART 7: INFRASTRUCTURE				
	Item	**Response**		**Observation**
67	Does this facility have electricity?		Yes	
			No	
68	What is the primary source of electricity?		Power lines (Grid)	
			Generator	
			Solar	
			Other *(Please specify)*	
69	What is the type of generator used? (*If any)*		Automatic	
			Manual	
70	Is the electricity functioning at the moment of this interview?		Yes	
			No	
71	Does this facility have water?		Yes	
			No	

72	What is the primary source of water?		Piped water	
			Hand pump	
			Well	
			Other *(Specify)*:	
73	In the last year, how many days were without water?	Days		
74	In the last year, how many days were without electricity?	Days		
75	How are the general condition of the buildings?			
76	Does the facility have a functioning incinerator?		Yes	
			No	
77	Where are the placentas disposed after deliveries?			

PART 8: TRANSPORTATION AND COMMUNICATION TO FACILITATE REFERRALS

	Item	**Is there at least one available and functional?**		**If yes, do the people on duty use it for referral 24/7?**	
78	Cell phone or land line owned by facility	Yes	No	Yes	No
79	Cell phone owned by the staff	Yes	No	Yes	No
	Item	**Response**		**Observation**	
80	Do you get a cell phone signal at this facility?	Yes	No		

	Item	**Is there at least one available?**		
		Available and functional	**Available but not functional**	**Not available**
81	Motor vehicle ambulance from the health facility			
82	Motor vehicle ambulance from the district hospital			
83	Other motor vehicle ambulance			

84	Other kind of vehicle *(Please specify):*			

PART 9: HUMAN RESOURCES									
		Doctors	**Midwives**	**Nurses**	**Assistant medical/ clinical officer**	**Laboratory/ Pharmacy technician**	**Specialist Medical Doctor**	**Pharmacist**	**Administrative staff**
85	Is this type of staff member currently working in this facility?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
		No	No	No	No	No	No	No	No
86	How many are currently working in this facility? *(Number)*								
87	How many are currently paid by the health facility? *(Number)*								
88	How many are currently paid by the government? *(Number)*								
89	How many are currently paid by external stakeholders? *(Number)*								
90	How many left this facility in the last 12 months? *(Number)*								

91	How many were posted at this facility in the last 12 months? *(Number)*								

PART 10: ESSENTIAL DRUGS, EQUIPMENT AND SUPPLIES				
PHARMACY				
	Item	**Response**		**Note**
92	Does this facility have a pharmacy/ drugstore?		Yes	
			No	
93	Is the pharmacy accessible 24 hours a day?		Yes	
			No	
94	Does the facility have a regular supply of medicines?		Yes	
			No	
95	What are the major sources of medicine supplies for this health facility? *(Please specify the percentages for each type of provider)*	%	Government supplier	
		%	Private pharmacy	
		%	NGO	
		%	Other *(Please specify)*	
96	What are the most common causes of delay in the delivery of supplies? *(Choose up to 3 responses and rank them form 1 to 3, where 1 is the most frequent)*		Inadequate transport	
			Administrative difficulties	
			Financial problems	
			Insufficient fuel	
			Insufficient Staff	
			Stock-out at central store	
			Other *(Please specify)*	
97	Are drugs that require refrigeration stored in a functioning refrigerator?		Yes	
			No	
98	Have you had a stock out of some important drugs in the last 3 months?		Yes	
			No	

STERILISATION			
	Item	**At least 1 available and functional?**	
99	Autoclave with temperature and pressure gauges	Yes	No
100	Hot air steriliser (Dry oven)	Yes	No
101	Steam steriliser	Yes	No
102	Steam instrument steriliser / Pressure cooker (Electric)	Yes	No
103	Sterilizer / Pressure cooker (Kerosene heated)	Yes	No
104	Other *(Please specify)*	Yes	No
DIAGNOSTIC CAPACITY			
105	Does this facility have a laboratory?	Yes	No
106	Which kind of clinical tests do you perform at the moment? *(Please list)*		
107	Does this facility have a functioning ultrasound?	Yes	No
108	If yes, how many?	1	2	3
109	If yes, where are they used?	1. 2. 3.	
110	Does this facility have a functioning X-Ray?	Yes	No
111	If yes, when was it installed?		

PART 11: HEALTH INFORMATION SYSTEM			
112	Is there an information system in the health facility?	Yes	No
113	If yes, in which form is it?		Electronic
			Paper
			Both
			Other *(Please specify)*
114	Is there an annual report on the health facility' volume of activity data?	Yes	No
115	Is there a monthly report of the health facility activity data?	Yes	No
116	Does each patient have a unique medical record number?	Yes	No

PART 12: CHALLENGES, STRENGTHS AND NEEDS	
117	**In your opinion, what are the main problems/challenges the health facility faces at the moment?**
118	**In your opinion, what are the main strengths/best practices of the health facility at the moment?**
119	**In your opinion, what are the main needs of the health facility at the moment?**

Name of the interviewer: **Date** (d/m/y):

ANNEX B. *Disaster preparedness questionnaire.*

Health Facility Name:			
1	Is the facility in a hazard-prone area?		Yes
			No
2	If yes, what are the main hazards?		Disease outbreaks
			Floods
			Droughts
			Heavy winds
			Other(s) *(Please specify)*
3	How frequently do disasters occur in the area?		
4	According to your judgement, do hazards impact public health in this area? *(If any)*		Yes
			No
5	If yes, how do they impact public health?		
6	According to your judgement, what level of impact do they have? *(If any)*		Low
			Medium
			High
7	Do you receive early warnings about these events? *(If applicable)*		Yes
			No
8	If yes, how much in advance?		
9	How do you receive the information? *(If applicable)*		Radio
			Phone
			Internet
			Other *(Please specify)*
10	What type of systems for monitoring risks and hazards exist in the area? *(If any)*		
11	Are early warning messages transmitted in a way that people can access and understand? *(If any)*		Yes
			No
12	Do people pay attention to early warning messages? *(If any)*		Yes
			No
13	If not, what do you think are the main reasons? *(If applicable)*		People feel it is not relevant to them
			There have been many false alarms
			People cannot act on the warning
			Other(s) *(Please specify)*

14	Are early warning messages inclusive? I.e. Do they reach women, children, the elderly and disabled people? *(If any)*		Yes
			No
15	Who issues the early warning information? *(If any)*		
16	Is there an epidemiological surveillance system in the area?		Yes
			No
17	If yes, how does this system work?		
18	If yes, is this facility part of the system?		Yes
			No
19	Is the epidemiological surveillance system functional? *(If any)*		Yes
			No
20	What kind of early action by the authorities is undertaken in your area? *(If any)*		
21	Do you remember any early warning awareness-raising campaigns or training in your area?		Yes
			No
22	If yes, how long ago?		
23	If yes, who conducted the campaigns?		
24	Is a Civil Protection Committee established in your area?		Yes
			No
25	If yes, are they active?		Yes
			No
26	If the Civil Protection Committee is not active/functioning, what do you think are the obstacles?		
27	If there is an active Civil Protection Committee, do you see any capacity gaps among its members?		Yes
			No
28	If yes, which ones?		
29	Does the facility have a Disaster Risk Management (DRM) Committee?		Yes
			No

30	If yes, who are the members?		
31	Does the DRM Committee meet regularly? *(If applicable)*		Yes
			No
32	If yes, how often does the DRM Committee meet?		
33	If the DRM Committee does not meet regularly, why is it? *(If applicable)*		
34	Is there a DRM focal person in the facility?		Yes
			No
35	If yes, who are they and what is their contact info?	Name and surname: Telephone number: Email:	
36	Has a Hazard Vulnerability and Capacity Assessment (HVCA) ever been conducted in the area?		Yes
			No
37	If yes, when was it conducted and by who?	Date: Responsible person/organisation:	
38	What were the main issues identified? *(If applicable)*	1. 2. 3.	
39	Were hazard/risk maps developed? *(If applicable)*		Yes
			No
40	If yes, are these maps available?		Yes
			No
41	Was a Disaster Risk Reduction (DRR) plan developed?		Yes
			No
42	Were mitigation measures identified and implemented? *(If applicable)*		Yes
			No
43	To what extent were mitigation measures identified and implemented? *(If any)*		

44	If no mitigation measures were identified and implemented, why is it so? *(If applicable)*		
45	When was the last time a contingency plan was developed for your area? *(If any)*		
46	Were the health authorities involved in the contingency plan development? *(If applicable)*		Yes
			No
47	Was this facility involved in the contingency plan development? *(If applicable)*		Yes
			No
48	Do you possess a facility-level contingency plan?		Yes
			No
49	If yes, when was the contingency plan developed?		
50	What kind of hazards and risks does your contingency plan cover? *(If applicable)*		
51	Do you believe the contingency plan to be up-to-date and useful in case of an emergency? *(If any)*		Yes
			No
52	Does the facility have Standard Operating Procedures (SOPs) in place in case of emergencies?		Yes
			No
53	If yes, who is responsible for the SOPs activation and coordination?		
54	In your opinion, is this health facility equipped to deal with emergencies?		Yes
			No
55	If not, what are the main issues?	1. 2. 3.	
56	Do you carry out emergency preparedness drills?		Yes
			No
57	If yes, how often?		
58	For what kind of emergencies do you carry out emergency preparedness drills? *(If applicable)*		

59	Are there building codes for health facilities in your country?		Yes
			No
60	To your knowledge, was this health facility built according to national standards?		Yes
			No

Name of the interviewer: **Date** (d/m/y):

DOCTORS WITH AFRICA CUAMM IS AN INTERNATIONAL NGO WORKING FOR HEALTH SYSTEM STRENGTHENING IN SUB-SAHARAN AFRICA IN ORDER TO PROTECT AND IMPROVE THE WELL-BEING AND HEALTH OF VULNERABLE COMMUNITIES WITH A LONG-TERM DEVELOPMENT PERSPECTIVE. CUAMM'S MISSION IS TO ADVOCATE THE UNIVERSAL RIGHT TO HEALTH AND PROMOTE THE VALUES OF INTERNATIONAL SOLIDARITY, JUSTICE AND PEACE WITH A PARTICULAR FOCUS ON MATERNAL AND CHILD HEALTH, ADOLESCENT HEALTH, NUTRITION, NCDs, INFECTIOUS DISEASES AND UNIVERSAL HEALTH COVERAGE.

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