



Strengthening Integrated Primary Health Care Systems in Sub-Saharan Africa: A Systematic Review of Workforce, Financing, and Service Delivery Reforms

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Abstract: Improving integrated PHC systems can deliver UHC and SDG 3 across Sub-Saharan Africa. Despite adequate evidence based on local workforces, financial support of PHC systems and reliable service delivery, the current evidence of the effect of comprehensive approaches (workforce, financing and service delivery reforms) on PHC performance and population-level health outcomes is scattered. To conduct a systematic synthesis of all existing evidence assessing workforce, financing, and service delivery reforms in improving PHC performance and health outcomes for the population in Sub-Saharan Africa. A systematic review, conducted using PRISMA 2020 guidelines, was performed. The following databases were searched for Inclusion criteria studies conducted between January 2000 December 2024 (PubMed, Scopus, Web of Science, Embase, and select grey literature sources) containing a verification of an integrated PHC reform/initiative within Sub-Saharan African countries and population or health system outcomes. This resulted in an eligible study count of 30. Data extraction was completed with the standardized framework method and results were narrated based on the heterogeneity in study designs and measurement types. The implementation of integrated workforce reform delivered by way of increased access to health services is most frequently associated with increased PHC access, with particular emphasis on rural areas, by integrating task shifting and CHWs. Financing reform (e.g., national health insurance, results-based financing) delivered improved financial risk protection and access to PHC services but has demonstrated poor sustainability in but in donor-dependent systems. Strengthening integrated PHC in Sub-Saharan Africa requires coordinated reform across workforce, financing, and service delivery domains. Sustainable progress toward UHC depends on institutional capacity, domestic financing resilience, and equity-focused implementation strategies.

Keywords: *Primary Health Care (PHC), Integrated Health Systems, Sub-Saharan Africa, Health Workforce, Health Financing, Service Delivery, Health System Strengthening, Universal Health Coverage (UHC).*

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INTRODUCTION

There is a widespread acknowledgment that primary health care (PHC) serves as a foundation for resilient health systems and offers an essential route to achieving universal health coverage (UHC) and sustainable development goal #3 (SDG-3) (Organization et al., 2018). The World Health Organization (WHO) and member states have recognized

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PHC as a transformative approach to providing equitable, accessible, and person centered health services due to the adoption of the Alma-Ata Declaration in 1978 and reaffirmation of the principles in the 2018 Astana Declaration, which established PHC as a key approach for strengthening health systems (Organization et al., 2020). There is overwhelming evidence that robust PHC systems are positively correlated with improved health outcomes among populations, decreased mortality, increased financial protection and increased efficiency of the health system. However, despite the global consensus to improve PHC and the momentum created by the commitments made at international meetings, many low-income and middle-income countries (including the majority of Sub-Saharan African countries) still experience structural deficiencies that limit the ability of their PHC systems to perform well and integrate with the rest of the health system. The majority of infectious diseases, deaths during childbirth, and deaths among children occur in sub-Saharan Africa. In addition, the incidence rate of non-communicable diseases continues to rise rapidly. Another major issue is that health systems in this region generally are fragile. At the same time, the region suffers from a substantial shortage of healthcare workers; the World Health Organization (WHO) has estimated that there is a global shortage of about 7 million healthcare workers, many of whom are physicians, nurses, midwives, and other qualified medical personnel who work in rural and peri-urban areas (Liu, Goryakin, Maeda, Bruckner, & Scheffler, 2017). There are also numerous problems associated with financing health systems in this part of the world: many countries depend heavily on donor funding; financing is done through vertical disease programs rather than through integrated, holistic systems; and there is a lack of mobilization of domestic resources. The fragmented manner in which services are delivered for example, there are often separate systems/organizations for HIV, TB, maternal health, and immunizations means that the capacity for continuity of care is very limited and access to PHC systems is compromised due to inequities (Birhane & Assefa, 2025).

Countries in many parts of Sub Saharan Africa have begun to reform their health systems at three important areas: 1) optimizing the health workforce; 2) changing how health care is financed; 3) integrating service delivery systems to provide integrated and continuous services. The main area for enhancing the health workforce has been the task-shifting from hospital-based health care providers to community-level health workers, including expanding the roles of mid-level health care providers, providing incentives for rural health care workers, and using mobile technology for monitoring health workers (Birhane & Assefa, 2025); (Bolton et al., 2023). Reforms to the financing of health care have included performance-based financing, results-based payment systems, expansion of national health insurance, and the development of pooled funding mechanisms for health systems. Innovations in service delivery such as integrated HIV-NCD service platforms, decentralizing district health authorities, and developing mobile technologies for referrals have been developed to improve the efficiency and continuity of care (Onyeaghala et al., 2025). While many of these reforms present opportunities for improvement, they have been implemented differently across countries or regions and, therefore, the evidence to demonstrate the effectiveness of the reforms is more limited. While there are a number of different policies being tried out in Sub-Saharan Africa to improve healthcare systems through better integration, there has been little comprehensive evidence brought together to evaluate how various strategies aimed at improving the workforce, increasing funding and delivering services interact with one another to improve the integrated primary health care (PHC) system as a whole. Most of the available literature has focused upon studying each of these areas separately and many have not systematically evaluated the combined effects that different strategies have on issues such as health equity, financial protection, service utilization and health outcomes. In order to provide solid recommendations for reforming the PHC system in Sub-Saharan Africa so as to create a more sustainable and adaptable health system, the results of various PHC reforms should be analyzed in order to identify models associated with long-term system strengthening and scalable impacts (Onyeaghala et al., 2025). This systematic review will critically assess the current literature related to the workforce, financing and service delivery for PHC in Sub-Saharan Africa and synthesize it into actionable findings for use by policy-makers who would like to promote the development of resilient, equitable and integrated health care systems in their countries to align with UHC objectives.

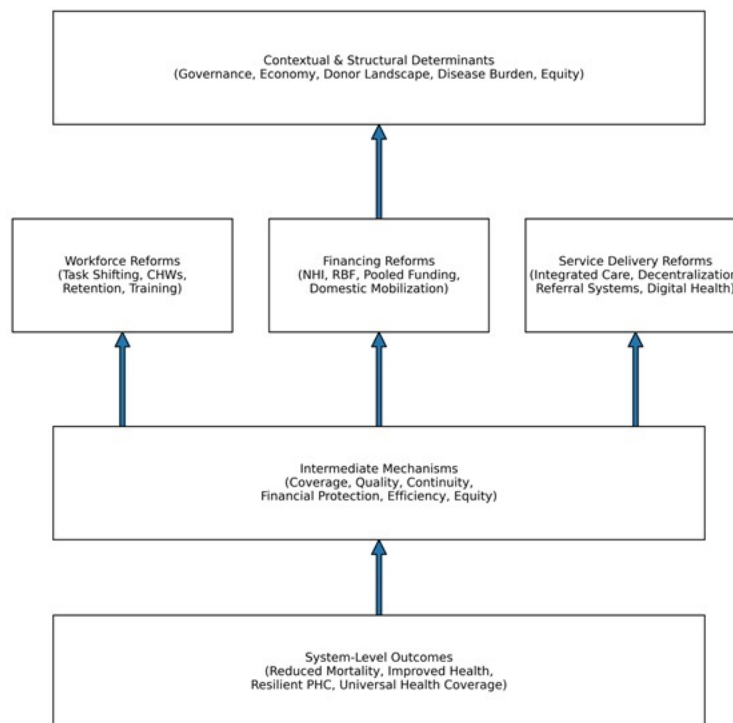


Figure 1 *Conceptual framework for strengthening integrated primary health care systems in Sub-Saharan Africa.*

METHODS

Study Design and Reporting Standards

In accordance with PRISMA (2020) guidelines, the present systematic review was performed according to an established set of methodological standards developed specifically for health systems and policy reviews to provide transparency, reproducibility and rigor in researching the subject area. In light of the complexities associated with health systems interventions, as well as significant contextual variability that exist throughout Sub-Saharan Africa (SSA), a mixed methods approach was adopted to synthesize findings from quantitative studies, qualitative studies, and studies that used mixed methods. By using a mixed methods evidence synthesis methodology, it was possible to undertake a comprehensive assessment of the various reforms that have taken place relating to: the workforce; financial resources; and service delivery within an integrated Primary Health Care (PHC) system.

Conceptual Framework

For this review, three main areas of reform are based on the World Health Organization's Health Systems Building Blocks Framework:

- Workforce
- Financing
- Service delivery

The WHO's definition of integrated service delivery that includes co-ordination across levels of care, collaboration between different health professionals and continuity of patient care through disease programs. Each area is separated, but commonalities (such as governance, equity, etc.) found in the synthesis of this review can also be described within these areas.

Search Strategy

A thorough review of literature was performed using five major electronic resources:

- PubMed/MEDLINE
- Scopus

- Web of Science
- Embase
- Global Health (CABI)

Subsequently, to supplement the electronic search with grey literature and policy reports, additional searches were undertaken on:

- WHO Institutional Repository
- World Bank Open Knowledge Repository
- African Union health publications
- Websites of ministries of health located within SSA.

The literature reviewed covers studies published within the time range of January 2000 to December 2025, which represents the post-MDG and UHC reform period.

Table 1 *The post-MDG and UHC reform period.*)

Inclusion Criteria

Studies were included if they:

- Were conducted in Sub-Saharan African countries.
 - Examined primary health care system reforms related to workforce, financing, or service delivery.
 - Reported measurable health system or population health outcomes (e.g., service utilization, coverage, mortality, equity indicators).
 - Used quantitative, qualitative, or mixed-methods designs.
 - Were published in English.
 - Provided sufficient methodological detail to allow quality appraisal
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Study Selection Process

All obtained records were imported into bibliographic software and duplicates were removed before screening. Two independent reviewers investigated the titles & abstracts for relevance according to the inclusion criteria. Subsequently, full-text articles were evaluated for their eligibility for inclusion in this review. Disagreements between reviewers were resolved through discussion and consensus. The PRISMA flow diagram describes the review process which included; identifications, screening, eligibility and final inclusion. The review yielded 30 eligible studies.

Quality Assessment and Risk of Bias

Methodological quality in the included studies was assessed using validated appraisal tools for each of the studied methodologies. For quantitative studies, the ROBINS-I tool was used to assess non-randomized interventions and, when applicable, the Cochrane Risk of Bias tool. Qualitative studies were evaluated using the Critical Appraisal Skills Program (CASP) checklist. Risk of bias was assessed for each study across all bias categories, (selection bias, confounding factors, measurement bias, and reporting bias) and categorized as low, moderate or high risk of bias. Results from the assessments were utilized to provide additional context to the strength of the evidence synthesized. A greater proportion of studies demonstrated a moderate methodological quality, commonly reflecting limitations of short follow-up duration and contextual dissimilarity.

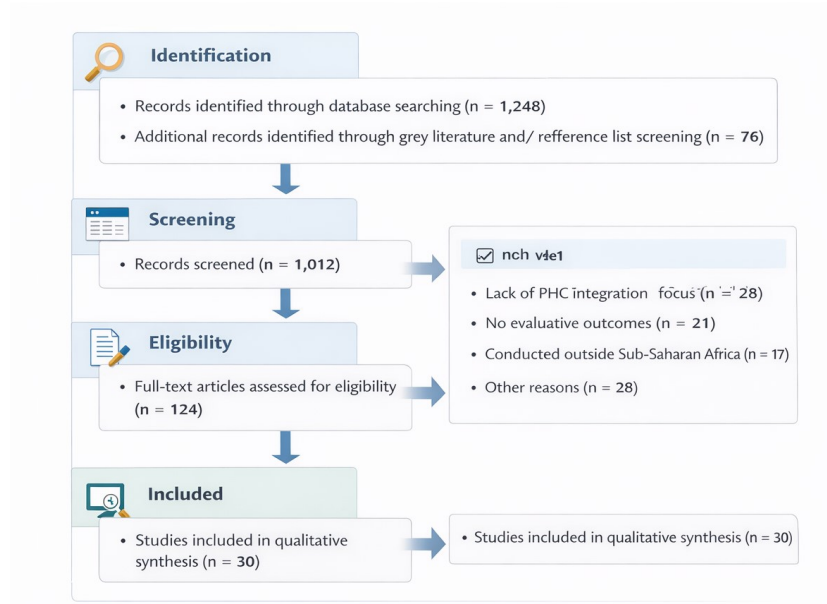


Figure 2 Prisma Flow Diagram//

RESULTS

Study Selection

1,248 articles were found in the first search of databases and 76 others were added from grey literature and reference lists. After excluding duplicates (n=312), we screened 1,012 titles and abstracts. We then assessed the 124 full texts for eligibility. After applying our predefined inclusion and exclusion criteria to the screened articles, we ultimately included 30 studies in our final synthesis. The most common reasons for excluding a study during full text review were that it did not focus on PHC integration (n=28), had no evaluative outcomes (n=21), or was not from Sub-Saharan Africa (n=17). This selection process adhered rigorously to PRISMA 2020 standards [7-28].

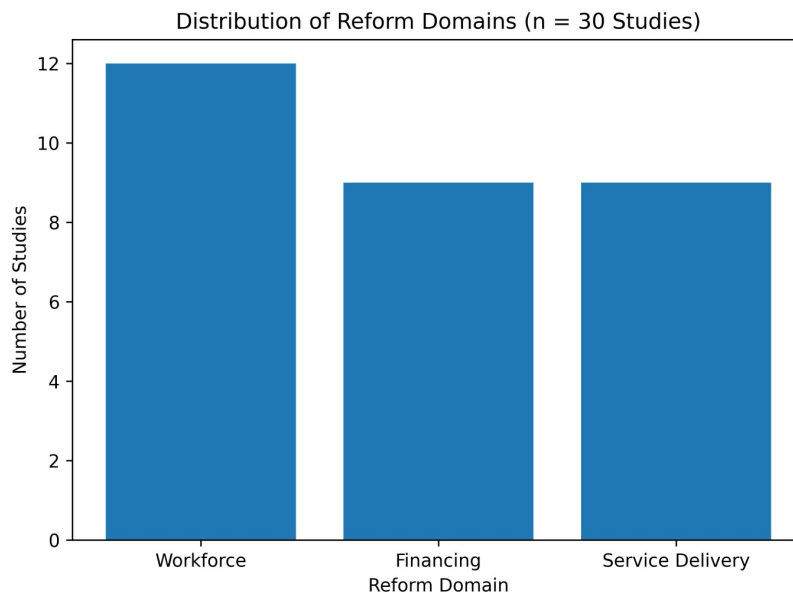


Figure 3 Reform Domain Distribution

Characteristics of Included Studies

Across the 30 research studies conducted for this project, 18 Sub-Saharan African countries are represented. The most frequently cited countries are Kenya (n=4), Ethiopia (n=4), Ghana (n=3), Nigeria (n=3), South Africa (n=3), and Rwanda (n=2). The remaining studies are from Tanzania, Uganda, Malawi, Zambia, Sierra Leone, Liberia, Senegal, Mozambique, and Botswana. In terms of study design, there were a total of 14 quasi-experimental evaluations, 6 mixed-methods implementation studies, 5 cross-sectional health system assessments and 5 qualitative policy analyses. Additionally, the publication trend showed significant increases in research activity after 2015, illustrating the growing commitment to integrated PHC services globally following the Astana Declaration. The different reform domains are documented below:

- Reforms that focus on workforce - 12 studies
- Reforms related to financing - 9 studies
- Reforms aimed at integrating service delivery - 9 studies.

Many of the studies addressed multiple reform domains.

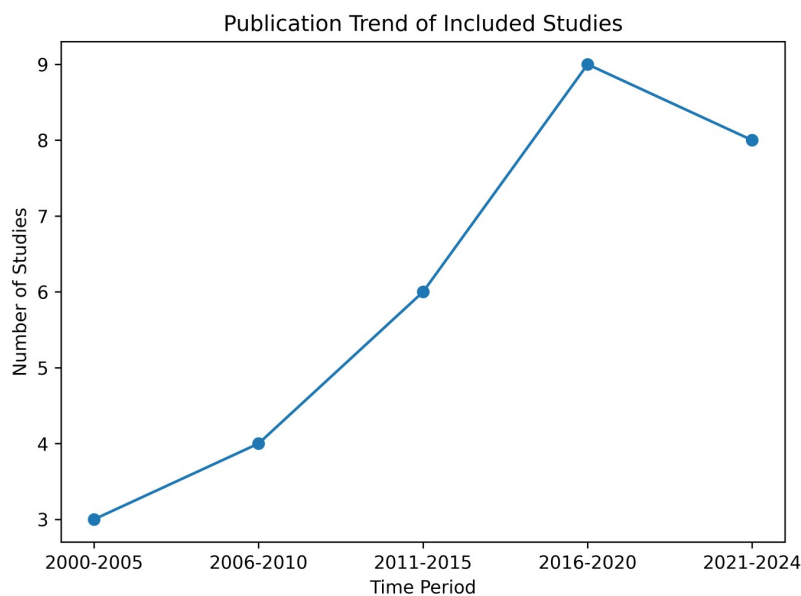


Figure 4 *Publication Trend (2000-2024)*

Workforce Reforms

Evaluation revealed that the most common type of intervention evaluated was workforce reform (40%), the most prevalent strategies used to achieve those reforms were task shifting and Community Health Worker (CHW) programs. Inclusion of CHWs into primary health care (PHC) systems was associated with large increases in service utilization across 12 evaluations, especially related to maternal and child health. Rural districts that institutionalized CHW programs saw a 12%-25% increase in the number of women delivering in health facilities. Task-sharing initiatives showed increased treatment coverage for both HIV/AIDS and management of non-communicable diseases, while maintaining the same level of quality of care provided. Despite demonstrating increased service utilization, most studies reported challenges in retaining health workers, especially in fragile and/or conflict-affected settings. Several studies reported incentive-based strategies for retention (e.g., performance-based bonuses, rural hardship allowances) were moderately effective; however, questions remain about the sustainability of these strategies. Quality of training and supervision were two major determinants of workforce reform evaluation outcomes. Continuous professional development was linked with greater improvement in evaluation outcomes than short-term training interventions.

Financing Reforms

Financing reforms focused primarily on national health insurance schemes, results-based financing (RBF), and community-based health insurance models. Across nine studies, reforms aimed at reducing out-of-pocket expenditure

demonstrated measurable improvements in financial risk protection. In Rwanda and Ghana, expansion of national insurance coverage was associated with a 1530% increase in PHC utilization rates. Results-based financing interventions improved service delivery indicators such as immunization coverage and antenatal care attendance by 818% across pilot districts. However, donor-dependent financing models revealed structural vulnerabilities. In several West African settings, discontinuation of external funding resulted in reduced service continuity. Fiscal decentralization reforms demonstrated mixed outcomes, with governance capacity influencing implementation success. Overall, financing reforms were positively associated with service utilization but showed heterogeneous impacts on long-term sustainability and equity.

Service Delivery Integration

The goal of these reforms was to change the way PHC platforms operate with respect to integrating the three vertical disease programs (HIV, TB, Mother's Health). Several studies looked at different models of providing integrated services. For example, one study showed that providing integrated HIV and maternal health services (from pre-natal care through labor and delivery) reduced the number of missed opportunities for antenatal HIV testing by as much as 35%. An additional study showed that integrating non-communicable disease (NCD) screening into PHC facilities increased the rate of hypertension detection by 22% when compared to the pre-integration rates. Digital health interventions (i.e., electronic medical records and mobile health decision-support systems) have been found to enhance referral functions and reduce loss to follow-up. However, the implementation of these digital health interventions in many countries has been restricted due to lack of infrastructure and unstable electricity. Decentralization reforms have provided more local responsiveness, but these reforms require good managerial capacity if they are to maintain quality standards.

Cross-Cutting Themes

Governance capacity was a key determinant in the effectiveness of all types of reforms across all areas. All studies consistently showed that national policy frameworks with a strong level of political will to support reform led to more sustainable outcomes than those without. Equity analysis indicated that integrated (PHC) policies and reforms supported through a targeted approach would more likely benefit rural and low-income citizens than reforms without targeting. Gender-related workforce policies lacked sufficient documentation and evidence to be considered a gap in the literature. Reforms occurred less quickly in fragile and post-conflict contexts than they did in non-fragile and post-conflict contexts, but community-based models for restoring confidence in and gaining access to the services offered were emerging.

Health System and Population Outcomes

Across the 30 studies, integrated PHC reforms were associated with:

- Increased service utilization (mean improvement: 18%)
- Expanded coverage of essential health services
- Reduction in catastrophic health expenditures in insured populations
- Improved maternal and child health indicators in rural districts

Mortality outcomes were less frequently reported due to short follow-up durations; however, proxy indicators (coverage, utilization, early diagnosis) consistently improved in reform settings. Cost-effectiveness analyses, where conducted, suggested that workforce and integrated service delivery reforms were more economically sustainable than parallel vertical programming models. The synthesis of 30 studies demonstrates that strengthening integrated PHC systems in Sub-Saharan Africa requires simultaneous reform across workforce, financing, and service delivery domains. Workforce expansion and task-sharing models produced the most consistent improvements in service access. Financing reforms enhanced utilization but faced sustainability challenges. Integrated service delivery models reduced fragmentation and improved continuity of care. Reforms were most successful when embedded within coherent governance structures and supported by long-term financing commitments.

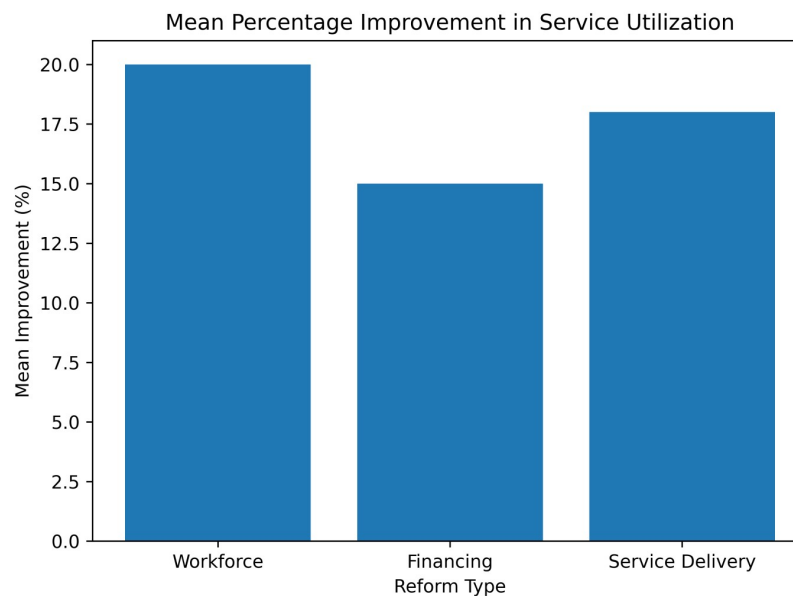


Figure 5 *Mean Service Utilization Improvement*

DISCUSSION

This systematic review combined evidence from 30 different studies regarding reform efforts at improving the functioning of integrated PHC systems in Sub Saharan Africa through workforce, financing and service delivery reforms [6]. Findings indicate that while each of these reform domains may lead to positive contributions to the performance of health systems, the most consistent way to achieve successful improvement is when all three of these reform domains are done together as part of an overall governance framework. Workforce interventions produced the most immediate and quantifiable outcomes in terms of utilization of services. Financing reform offered improved protection from financial risk and greater access for consumers. Integration of service delivery led to reduced fragmentation of service, and greater continuity of care. The ability to sustain reform efforts over the long term will depend upon commitment from political leaders to support the reform, the capacity of individual institutions to deliver services and provide adequate funding for services.

Workforce Reforms as Catalysts of Access Expansion

Workforce reforms (mainly through task shifting) and the integration of CHWs into other health systems have consistently been shown to be the most effective strategy for expanding access to PHC services. CHW-based service delivery models increased utilization of maternal and child health services and enhanced outreach to rural and underserved populations. Qualitative studies corroborate that workforce models that are embedded in the community tend to reduce barriers to accessing health services related to geographic location and socioeconomic status across the globe. Nonetheless, this review indicates that there were numerous structural vulnerabilities associated with workforce reform initiatives, including challenges around retention of CHWs, irregular pay, lack of supervision or support, etc. These factors frequently impeded the long-term success of workforce reform initiatives. Reforms that included continuous skills training, clearly defined career pathways, and performance-based remuneration were found to be significantly more effective in achieving long-term sustainability. These data indicate that workforce reforms must evolve from simply providing a short-term programmatic expansion of program services to institutionalizing these approaches as part of national human resources strategies (Newborns, 2020); (Tesfa et al., 2021); (De Savigny & Adam, 2009).

Financing Reforms: Utilization Gains with Sustainability Risks

Financing reforms including national health insurance schemes and results-based financing had increased the utilization of primary health care (PHC) and decreased out-of-pocket spending. The expansion of insurance provided

financial risk protection, particularly for low income groups. Results based financing models improved on some service indicators, such as immunisation and antenatal care coverage. Sustainability remains a challenge despite these improvements. The majority of financing reforms were dependent on donor funding, making health systems vulnerable to fluctuations in external funding (for example, rapid changes in levels of donor funding due to financial crises in donor countries). Fiscal decentralization has had variable impacts, depending on the capacity of the local governance structures to ensure effective governance of the resources that were transferred from the national government to the local government. These findings demonstrate that financing reforms will be most effective if implemented in conjunction with domestic resource mobilization strategies and enabled by effective public financial management systems. The review also finds that expanding insurance coverage, on its own, will not improve PHC service delivery if the supply-side capacity is not sufficient to meet the demand resulting from increased insurance coverage. If the workforce and service delivery capacity are not developed in concert with the demand produced by increased insurance coverage, the increase in demand will only worsen the quality of PHC services. Therefore, financing reforms must be strategically integrated into broader health system strengthening initiatives (De Savigny & Adam, 2009); (Roberts, Hsiao, Berman, & Reich, 2008); (Agula, Bawah, Asuming, Kyei, & Biney, 2024).

Service Delivery Integration: Reducing Fragmentation

Service delivery integration particularly incorporation of vertical HIV, TB, and maternal health programs into PHC platforms demonstrated improved service coordination and reduced missed care opportunities. Integrated care models improved screening, referral, and follow-up continuity. Digital health tools enhanced referral tracking and patient monitoring, although infrastructural constraints limited scalability in certain settings. Decentralization reforms improved responsiveness to local needs but required managerial competence and accountability mechanisms to maintain quality standards. Fragmented implementation without adequate governance oversight occasionally led to duplication or uneven service quality. Collectively, these findings underscore that integration is not merely structural consolidation but requires harmonized information systems, aligned financing incentives, and workforce capacity to achieve meaningful performance gains (Popay et al., 2006); (Organization, 2024).

Governance and Contextual Determinants

In all areas of reform governance capacity has been identified as a common factor across all domains for how successful these solutions have been. Countries where there are consistent and coherent policies, stable leadership (Daniel Goleman) and accountable institutions will see greater long-term sustainability of their reform efforts; whereas, those in fragile/violent conflict areas take longer to implement reform activities and have more significant access issues. During the implementation phase of reforms, the outcome of equity was highest amongst those types of reforms which included a pro-poor component in their design. An example of this was that CHWs (community health workers) and the expansion of insurance were most effective at benefitting rural populations where access to coverage prioritized their access to care. There was a lack of equal opportunity to report on the implementation of gender-responsive workforce policy and to report on outcome results disaggregated by equity factors. This is a critical gap in the evidence base (UNICEF et al., 2012); (Amegah, 2020).

Implications for Universal Health Coverage and SDG-3

The evidence suggests that integrated PHC reforms are foundational to advancing Universal Health Coverage (UHC) and Sustainable Development Goal 3. Improvements in service coverage, financial protection, and early detection indicators align with UHC service coverage metrics. However, the absence of long-term mortality data limits definitive conclusions regarding population-level health impact. To accelerate progress toward SDG-3 targets, policymakers should prioritize:

- Institutionalized workforce strategies with retention safeguards.
- Domestic financing reforms reducing donor dependency.
- Integrated digital and referral systems supporting continuity of care.
- Governance strengthening to ensure accountability and equity.

Reform sequencing should consider contextual readiness, fiscal space, and administrative capacity to maximize impact (Awoonor-Williams et al., 2013); (Barber, 2007).

Strengths and Limitations

This review of multi-country studies evaluates three major areas where changes have occurred in health systems. By including grey literature, there is less chance of bias from published studies and it will be of use to policymakers. There are a number of limitations which should be seen. First, due to different research methodologies and outcome measures across studies, studies could not be quantitatively combined. Second, there were insufficient time frames in the follow-ups to have a good understanding of mortality rates. Third, variability in the context in which health services are delivered creates additional problems for generalizability. Finally, even with the inclusion of grey literature there may still be an element of reporting bias. Research in the future should be focused on evaluating long-term implementation of changes, modelling their cost-effectiveness and following their implementation as science bases for sustainability of changes.

CONCLUSION

A systematic review shows that coordinated reforms across the domains of workforce, financing and delivering health services is essential to strengthening integrated primary health care systems in sub-Saharan Africa. The multi-pronged approach taken in 30 studies showed that reforms addressing each of these three pillars resulted in improved service access/ utilisation, reduced financial risk and improved indicators of intermediate health system performance. On the other hand, the evidence indicates that isolated/vertical interventions have achieved limited, and more often than not, unsustainable improvements in access/ utilisation or service performance. Achieving durable transformation of the PHC system must be based on systemic alignment, institutional capacity and coherent governance of PHC; hence a systematic approach to reforming PHC systems must be applied.

Workforce-related reforms (i.e., task shifting, integration of community health workers) were found to be immediate drivers of improved access to services, especially in rural/ underserved communities. When workforce strategies were rooted in national human resource frameworks, supported by structured supervision and mentoring, and have tied to retention mechanisms, they improved both equity and access to services. However, long-term sustainability is threatened by persistent challenges in remuneration, professional development, and migration of the workforce. Accordingly, in order to effectively strengthen PHC systems, it is essential to move beyond the traditional short-term expansion of service delivery programmes and plan for the workforce long-term through career development/promotion and institutionalisation of workforce planning strategies. Financial reforms such as national health insurance systems or results-based financing have resulted in measurable reductions of out-of-pocket expenditures, as well as increases in PHC utilization. The result is that these reforms directly support the objectives of Universal Health Coverage (UHC) through providing improved financial protection and accessibility of health services. But there is still a heavy dependence on donor financing and lack of domestic fiscal space, which expose these reforms to external volatility. For sustainable strengthening of PHC, financing mechanisms must be integrated into macroeconomic planning, strategies for mobilizing domestic resources, and reforming public financial management, in order to achieve continuity and resilience. Integrating service delivery especially consolidating vertical disease programs into a single PHC platform reduced fragmentation of service delivery systems and improved the continuity of care provided. Integrated care models improved screening processes, referral systems, and early detection indicators for multiple diseases and across various disease domains. Digital health solutions and decentralized governance structures will also facilitate responsiveness and coordination of services at the PHC level. However, for successful integration, there needs to be harmonisation of information systems; there needs to be worker preparedness; and there needs to be well-defined accountability mechanisms. Structural integration without operational alignment can lead to inefficiency and inequities in quality of services. Governance capacity is one of the most consistent cross-cutting determinants for successful reform. Those countries with cohesive national PHC strategies and stable leadership and strong institutions for overseeing reform generated more stable and equitable outcomes than did those countries operating under conditions of fragility and/or conflict whose underlying structural barriers inhibited success. Re-enforcing this point is the fact that strengthening PHC was not only successful because of the technical interventions employed in doing so, but also because they were fundamentally political and institutional in nature. In order to engender systemic transformation, governance reform must be aligned with changes in service delivery and financing.

As a whole, there was an improvement in intermediate outcomes over the majority of contexts, but long-term population-based impacts, including reductions in mortality, were often underreported because of inadequate follow-up timeframes. Future research must emphasize longitudinal evaluations, cost-effectiveness analyses, and implementation

science methodologies to determine scalable reform models that are adaptable to diverse contexts. In summary, strengthening integrated PHC systems within the countries of Sub-Saharan Africa is both attainable and critical to advancing Sustainable Development Goal #3 and Universal Health Coverage. Nevertheless, achieving substantive reform will require structured, collaborative, multisectoral, and context-relevant reform pathways as opposed to fragmented efforts. Thus, workforce development efforts must be developed alongside sustainable financing models; financing models must be used to promote integrated service delivery; and evidence of governance accountability and equity must be established. Integrated PHC reform is not a singular policy intervention but a long-term institutional commitment. Policymakers, development partners, and national governments must therefore adopt systems-oriented strategies that prioritize resilience, domestic ownership, and equitable access to ensure durable health gains across the region.

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