Renewing health districts
for advancing universal health coverage in Africa

Report of the regional conference
"Health districts in Africa: progress and perspectives 25 years after the Harare Declaration"
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Community of Practice Health Service Delivery

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Support material:

The program of the conference, presentations and country reports can be accessed via the website of the community of practice: http://www.health4africa.net/

EXECUTIVE SUMMARY

The Harare Declaration…

From August 3-7, 1987, the World Health Organization (WHO) organized an interregional meeting in Harare (Zimbabwe) on strategies to strengthen health districts. Building on the "Health for All" movement from Alma Ata (1978), this meeting was a key milestone that established and gave political endorsement to the district health system as the backbone of primary health care; it resulted in what is now called the "Harare Declaration on strengthening the district health systems based on Primary health care".

More than twenty-five years later, it is clear that African health systems - particularly in rural areas – have been defined by these efforts. However, many challenges remain especially low-quality care and limited access to key services. This partial success has several causes, including the economic crisis which swept Africa at that time, a too selective implementation of the twelve Harare provisions, a too rigid and bureaucratic reading of the health district strategy and the lack of alignment of major funding and initiatives in support of the health district.

… the need for an enhancement

Twenty five years have gone. Globalization, democratization, emergence of the civil society, political and administrative decentralization, economic liberalization, increasing urbanization, progress in overall education, emergence of a vocal middle-class, population and economic growth and new science and technologies, among many other changes, have transformed African societies.

As for the needs, there have been also some changes, in varying directions, in different country contexts. Many challenges are still there. New health problems have also emerged, with HIV/AIDS being the most obvious one. The continent is also facing the growing insecurity, increasing urban populations, growing private sector, rising incidence of non-communicable diseases and other health challenges related to new lifestyles (e.g. road traffic accidents, hypertension...).

The global community, countries, health actors have not been unresponsive: they have developed new goals, practices, health programs and tools. A game changer was the adoption of the Millennium Development Goals. This has had positive effects such as renewed political and financial commitment to the health sector, but the multiplication of initiatives, often vertical, has also sometimes undermined local health systems.

More than 25 years after the Harare Declaration, it is time to take stock of what has been achieved and to acknowledge what remains to be done. While we still strongly believe in the structuring power of the health district strategy, it is time to revisit how to implement it in markedly changed contexts.

The meeting in Dakar – 21-23 October 2013

It is with this ambition that the Regional Conference on "Health districts in Africa: progress and perspectives 25 years after the Harare Declaration" (Dakar, 21-23 October 2013) was organized by the *Harmonization for Health in Africa* Community of Practice "Health Service Delivery" – a community which brings together hundreds of African experts – in coordination with UNICEF, WHO AFRO, WAHO, the Belgian platform Be-Cause Health and the Institute of Tropical Medicine (Antwerp).

Around 20 country delegations and 170 experts – district medical officers, national directors, researchers, technical assistants, social entrepreneurs and innovators – attended it. During three days, experts shared their experience and knowledge on organizing primary health care services at local level. The following sections summarize the main highlights and messages of the conference.

… inspired by new knowledge and platforms

Over the last 25 years, theoretical thinking and knowledge have also evolved. The district model was conceptualized in the eighties, at a time when concepts such as stewardship and governance, institutional arrangements and incentives were not yet mainstream. Today we have a much better understanding for instance of how institutions shape incentives to influence behaviors, organizational performance and thereby health system.

As a community of actors, we have also learned how to work together to align efforts for strengthening health systems to improve health outcomes. The Paris Declaration on aid effectiveness, adopted in 2005, gave a new vision for optimizing the impact of aid on development, anchored on the principles of ownership, alignment, harmonization, results and mutual accountability. In Africa, multilateral agencies and several bilateral aid agencies have joined forces to work together under the Harmonization for Health in Africa banner. Among other things, they have encouraged the creation of communities of practice, as the one which led the organization of the conference.

Africa will change even more in the next 25 years

Seen as the hopeless continent only ten years ago, Africa hosts now several of the fastest growing economies. This is rightfully a major reason for hopes for a continent which still hosts the poorest countries of the world. The economic and societal transformation of Africa will accelerate.

The ongoing changes and the even bigger ones to come in the future are having major implications for local health systems. The rapid urbanization of Africa requires major investment in infrastructure and policies to increase access to services and secure a healthy environment for the population, and for the poorest in particular. Aging and the double burden due to the epidemiological transition will put new pressures on the health services.

For coping with these many challenges, Africa will continue to benefit from aid. Unlike the MDG agenda, the emerging global agenda of *sustainable development* will require health to relate itself with its economic, social & ecological dimension.

At district level, business as usual will not do. During the conference, thanks to sharing of innovative approaches and experience, participants identified some of the implications of these contextual changes on the health district strategy. Their analyses are integrated in their **12 recommendations** (listed at the end of this report).

The health district remains a valid strategy…

Should one, because of this profound transformation of the continent, completely rethink the architecture of health systems in Africa? At the end of the Dakar conference, participants have come to the main conclusion that the health district strategy and its underlying values remain as compelling as they were in 1987. Adaptations to be brought are mainly at the level of the implementation.

This is consistent with the fact that the concepts and principles underlying the design and functioning of "districts"/local health systems (e.g. the need to have a multi-purpose health worker at the first line, the importance of close coordination among health care providers, the need for local action…) are universal. There is no one-size-fits-all district solution; accordingly, there is no blueprint for implementation. Country-specific strategies and flexibility are required even more so within country.

… but will benefit from a renewed vision

Participants at the Dakar conference extensively discussed the greater role that could and should be played by **individuals, households and the community** as co-producers of their own health. Their assessment is that individuals, households and communities will be key 'resources' to prevent and mitigate suffering, morbidity and premature death due to the demographic and epidemiological transitions. Education and transmission of information and knowledge will be key weapons in this battle. Their empowerment, voice and freedom should therefore receive much more attention. **Several directions for action have been identified**; they are detailed and listed per actor in this report.

The reality of market liberalization has also to be better acknowledged, both in terms of opportunities and risks it conveys. **A top priority for African health authorities is to recognize the very pluralistic nature of the health sector of today** and the responsibilities bearing on them, as stewards of the health system (which does not stop to their health facilities only).

This new vision entails **a substantial shift in terms of approach at district level. The strategy should be much more flexible, inclusive, open to dialogue with the many actors, supportive to innovation and learning at organizational level.** This indicates the need for a revision of the role, the skills and policy instruments in the hands of those in charge of optimizing the local health system.

BACKGROUND

The Harare Declaration

From August 3-7, 1987, the World Health Organization (WHO) organized an interregional meeting in Harare, Zimbabwe, on strategies to strengthen health districts. Building on the "Health for All" movement from Alma Ata (1978), this meeting was a key milestone that established and gave political endorsement to the district health system as the backbone of primary health care. It resulted in what is now called the "Harare Declaration on strengthening the district health systems based on Primary health care".

In this statement, experts and representatives of different countries agreed on a number of action points including: i) the decentralization of the management of human and financial resources, ii) the establishment of a decentralized planning process at the district level, iii) more community involvement, iv) the promotion of an intersectoral approach v) the development of leadership in primary health care and vi) the mobilization of actors and the redefinition of the operational role of the hospital. A few weeks later, many of these proposals were included as part of the Bamako Initiative.

In the decades that followed, many actors working in Africa - multilateral and bilateral agencies, national and international NGOs - joined forces with Ministries of Health to implement a revamped primary health care strategy including a 'minimum package of activities' available at health center level (viewed as the entry point to the health system) and a 'complementary package of activities' to be delivered at the referral hospital with both levels being coordinated by a district management team.

A key strength of the health district model – and a key reason why a whole generation of health system people endorsed it – was that it combined strong values (equity, efficacy, efficiency, autonomy and solidarity) with conceptual neatness and operational relevance. For Ministries of Health, the health district model facilitated the expansion of coverage of essential services in a fast, efficient and equitable way. The model made it possible to make decisions about investments in infrastructure (based on a comprehensive coverage plan) and on the distribution of key resources within the country (health staff, drugs, equipment, allocating the limited public budget and international support).

More than twenty-five years later, it is clear that African health systems - particularly in rural areas – have been shaped by these efforts. Achievements at the country level are many, notably: the strategy makes up the backbone of nearly every national health system, activity packages focus on priority services and there is fairly good population coverage by health facilities, including thanks to the integration of private faith-based health facilities in national health systems.

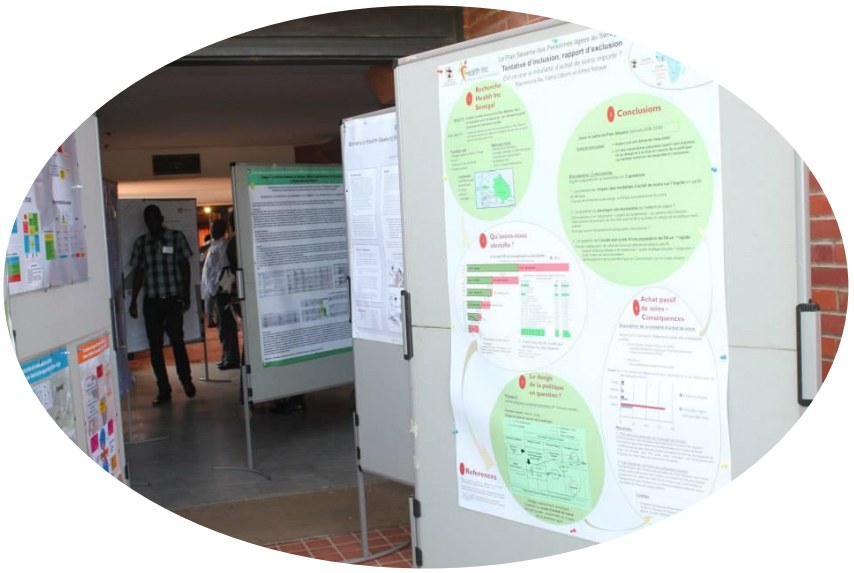
However, many challenges remain, especially low-quality care and limited access to key services. The local health system 'glass' is still half empty… and African populations are thirsty.

This partial success has several causes. The context first of all: the eighties and early nineties were a very tough period for African economies; the resources required to implement the health district strategy and give the approach all the chances it deserved, were often not available. Second, in many countries, there has also been some 'cherry-picking' in the implementation of the 12 Harare provisions. Ministries of Health and their partners have often left aside the most challenging action points, such as full decentralization, real community empowerment or multisectoral action, partly maybe also because of political constraints at country level. Finally, several action points have been implemented in a rather bureaucratic, standardized and top-down fashion, with insufficient adaptation to context (e.g. the lack of adaptation of the district system to the complexity of urban settings) and maybe with too much faith in the power of planning and command and control.

Twenty five years have gone. It is time to take stock of what has been achieved and to acknowledge what remains to be done. First and foremost it is time to thank all experts who dedicated sometimes their whole life to the establishment of strong local health systems in Africa. They will not be forgotten. It is, however, perhaps also time to entrust a new vision to the next generation. Although the relevance of the health district strategy is still strong, it is time to reconsider how to implement it in dramatically altered contexts.

The meeting in Dakar – 21-23 October 2013

Against this backdrop the Regional Conference "Health districts in Africa: progress and perspectives 25 years after the Harare Declaration" (Dakar, 21-23 October 2013) was organized by the *Harmonization for Health in Africa* Community of Practice "Health Service Delivery", a virtual community which brings together hundreds of African experts, in coordination with UNICEF, WHO AFRO, WAHO, the Belgian platform Be-Cause Health and the Institute of Tropical Medicine (Antwerp). The level of ambition was high, as mentioned above.



Around 20 country delegations and 170 experts – district medical officers, national directors, researchers, technical assistants, social entrepreneurs and innovators – attended the conference. During three days, experts shared their experience and knowledge on organizing primary health care services at local level. A spirit of creative discussion between equals pervaded the keynote speeches, plenary sessions, commissions and debates. Participants highlighted African-grown innovative approaches to local health system coordination and delivery, formulated recommendations to key actors and identified questions deserving further attention in terms of research and knowledge sharing. Due to time constraints and the need to maintain some focus, some important matters – such as financial access to health services, human resources, infrastructure and drugs - have purposely not been covered by the conference.

The following sections provide the main analyses and messages shared at the conference, including results of the intense deliberation which took place during the 3 days.

ANALYSIS

In 25 years, African countries have changed a lot

Over the past 25 years, Africa has experienced its longest period of economic growth. Income per capita has more than doubled in 23 African nations since 1990, and GDP growth rates have averaged 5% per year over the last ten years.

Democratization, the emergence of civil society, political and administrative decentralization, economic liberalization, increasing urbanization, progress in overall education, emergence of a vocal middle-class, demographic dividend, epidemiological transition and new technologies, globalization, among many other changes, have transformed African societies. Among many other implications, **these changes have led to an upward revision of expectations and demands of citizens towards their local health systems**.

As for the needs, the picture has also changed substantially. True, many challenges from 25 years ago are still there. In most African countries, health needs related to widespread poverty (e.g. childhood diseases) remain. This is particularly true in countries afflicted by recurring natural or man-made disasters, armed conflicts in particular. However, new health problems have also emerged, with HIV/AIDS being the most obvious one. The continent is also facing the rising incidence of non-communicable diseases (NCDs) and other health challenges related to new lifestyles (e.g. road traffic accidents, hypertension...) and further demographic change, thanks to progress in reducing mortality and in particular child mortality rates.

The global community, countries, health actors have not been unresponsive. They've developed new goals, practices, health programmes and tools. A game changer was the adoption of the Millennium Development Goals (MDGs), which set clear priority objectives for health systems and renewed political and financial commitment to the health sector. As a result of these global initiatives, new technical solutions like insecticide-treated bed nets and antiretroviral drugs have been tested and scaled up. Unfortunately, the international part of the reinvestment in health has also led to a proliferation of actors and an increasing number of top-down and sometimes parallel single-purpose Global Health Initiatives (GHIs); in many countries, because of the major influence of international actors, this has often in effect led to the fragmentation, distortion and ultimately weakening of the health district system which was meant to offer comprehensive responses to people's needs.

Frustrated by the recurrent shortcomings of local health systems, actors have innovated. The economic liberalization allowed a strong market response 'outside' the health district system, with rapid expansion of the private health sector. This led to a wide diversification of levels of care trying to meet the rising expectations of people (paying clients) with respect to quality of services and health staff attitudes . The strong growth of the private sector is (potentially) an opportunity, as the sector taps additional resources, but this growth also presents new hazards (over prescription, unnecessary diagnostic tests, drugs of dubious quality, prioritization of curative services at the expense of preventive services…).

The increased awareness of the need to optimize health providers' behavior and to align public, faith-based and private providers around Ministries of Health's own priorities led to the testing and expansion of new incentive structures, including financial ones (like for instance performance-based financing). Other innovations – like the '*médecins de campagne*' (community doctors) in Mali for instance – may have had less visible success, but also point to the need to rethink the functioning and profile of first line health service providers in local health systems.

New knowledge, new partnerships and new platforms for better health systems

Over the last 25 years, theoretical thinking and knowledge have also evolved. The district model was conceptualized in the eighties, at a time when concepts such as complexity, stewardship and governance, institutional arrangements and incentives were not yet mainstream. Today we have a much better understanding of what a stewardship function entails, and we understand better how institutions shape incentives to influence behaviors, organizational performance and thereby the health system. We are also more realistic about what is actually under the control of the planner (much less than what we would like). Such understanding and new frameworks provide interesting new directions for action.

Having new ideas and inspiration is great, but we have also learned to be more careful. We care a lot more now about building the evidence base for new approaches, about measuring their impact and about understanding their pathways, partly because we are more aware of possible political interferences from different stakeholders, at all levels.

As a community of actors, we have also learned a great deal on how to work together in order to align efforts for strengthening health systems for better health outcomes with a greater focus on results (by the way, we have also improved techniques to measure these outcomes and more particularly, their distribution across socio-economic groups). The Paris Declaration on aid effectiveness, adopted in 2005, offered a new vision for optimizing the impact of aid on development, anchored on the principles of ownership, alignment, harmonization, results and mutual accountability. In 2006, multilateral agencies and several bilateral aid agencies joined forces to work together under the Harmonization for Health in Africa banner. Actors have also learned to seize the new opportunities provided by the Information and Communication Technology revolution. Technologies allow today to connect people, citizens and experts in ways just unthinkable 25 years ago. Virtual groups like communities of practice are emerging as new platforms for disseminating ideas and building new knowledge.

It is time to capitalize on these new opportunities to strengthen local health systems.

African countries may change even more in the next 25 years

Globalization is redistributing the cards. Africa hosts now several of the fastest growing economies. For a continent which still hosts many of the poorest countries in the world, this is a major reason for hope. The continent is indeed becoming more heterogeneous. Unfortunately, inequality within countries is also increasing.

The persistent strong population growth could be an opportunity, through the so called 'demographic dividend', but it could also be a threat: indeed, if political and economic governance issues are not fixed, national economies will not have enough jobs for the hundreds of millions of youth arriving on the labor market in the coming decades. Many African countries can hope to lift their population out of poverty, but they would better also build enough capacity to deal with the (increasingly common) external and internal shocks caused by climate change, the globalized world and an economic system that needs substantial transformation. Building resilience will be vital in the decades ahead.

These ongoing changes and the even bigger ones to come in the future (that we might still be unaware of now) are having major implications for local health systems. The rapid urbanization of Africa requires major investment in infrastructure and policies to secure a healthy environment for the population, and for the poorest in particular. Aging and the double burden due to the epidemiological transition will put new pressure on the health services.

For coping with these many challenges, Africa will continue to benefit from international assistance, especially loans at subsidized interest rates, grants and technical assistance. However, because of new global challenges and changing geopolitics, the most probable scenario is that "aid for health" will decrease and even more focus on the poorest and most fragile states. This will probably both force but also allow national actors to reclaim control over their health systems. Governments will have to make better use of domestic financing (including out-of-pocket payment) and commit more of their own resources to health, but this will also allow them to focus on critical areas, such as health system strengthening, that have been overlooked by donors. This will put them in a stronger position in their relationship with the external actors still willing to invest in health.

This seems consistent with the emerging global agenda of *sustainable development*, which, unlike the MDG agenda, will require health (and the health community) to relate itself with the economic, social & ecological dimension of sustainable development.

Hopefully, human rights based approaches, enshrined in national and international law, will play a greater role in the definition of responsibilities among different levels of actors, from the local to the international. This may reduce the uncertainty and unpredictability of some contributions. Arguably, the Universal Health Coverage (UHC) agenda is also a step in this direction.

During the workshop, participants brainstormed on the implications of these contextual changes on the health district strategy. Here are some of their findings:

- The greater circulation of people (thanks to transportation and the road network) and the market liberalization will transform health seeking behaviors. We will have to rethink the modalities at first line level of the much needed longitudinal and privileged relationships between people and their health services (e.g. via voluntary subscription of people to a health provider instead of the system whereby providers were responsible for a geographical area). Because of the users' quest for more advanced diagnostics and medical technologies, one can also expect more and more people to go straight to second level referral hospitals, at the expense of district hospitals; a redefinition of the role and functioning of district hospitals will thus have to take place.
- Thanks to democratization, media liberalization and social media, people will be more vocal in sharing their frustrations and stating their preferences. Integrating the many preferences into actual services and interventions will be challenging, as the epidemiological and demographic transition will increase the heterogeneity of the needs and demands. Provider payment mechanisms will become key instruments for the government to control costs.
- A challenge for the UHC agenda at national level will be the growing intra-society inequality. The latter could go hand in hand with a fragmentation of risk pooling mechanisms. This would impede the construction of coherent and equitable local health systems.
- The emergence of non-communicable diseases requires us to rethink and consider in a more dynamic way the content of the so-called minimum and complementary packages of activities offered at the first and second line respectively, with even greater attention to the need for a strong evidence-base to counter new market forces (e.g. pharmaceutical companies).
- The growing urbanization challenges the 'default' health district proposition (i.e. public health centers in charge of a responsibility area + a first referral hospital). The complex reality of mixed health systems involving private sector actors at the various levels of the system (hospitals, clinics, drug shops) requires the definition by the central level of new regulatory frameworks, partnership policies and implementation guidelines.
- New coordination responsibilities will fall upon the health district management teams. In particular, they will have to participate in the process of licensing, accreditation, supervision and quality control of private facilities. If this materializes, health district management teams will, instead of being simple representatives of the Ministry of Health at district level, have become the focal body in leading and coordinating health activities at local level.
- The complexity and insufficiently understood characteristics of these new contexts indicate a strong need for operational research to generate the necessary insights and managerial know-how to properly address these emerging challenges.

Health district: still a valid strategy

Should one, because of this profound transformation of the continent, completely rethink the architecture of health systems in Africa? Of course not.

At the end of the Dakar conference, participants came to the following conclusions:

1. The health district strategy and its underlying values remain as compelling as they were in 1987. Necessary adaptations are mainly at the level of the implementation. This is fully consistent with a similar assessment of primary health care, done 30 years after the Alma Ata conference, in Ouagadougou in 2008.
2. The new mobilizing global cry for UHC will remain an empty promise if it does not focus on providing quality essential services to everyone – and this will not happen without reinforcing local health systems.
3. Health is first of all about protecting and empowering individuals, households and communities, acknowledging and respecting their crucial role in the production of health, and, last but not least, through a genuine partnership with health care professionals. Only then it's about health care organizations, public management bodies, administrative boundaries and systems.
4. This vision provides strong support to the health district strategy. Indeed, geographical and social proximity, continuity of the relationship between people and their health services, and mutual trust are key 'enhancers' in the co-production of health and wellbeing by individuals, households and communities together with professional health care actors. This indicates the need for **local action** across the whole spectrum of health interventions (promotion, prevention, cure, rehabilitation). For reasons of resource mobilization, efficiency, efficacy and responsiveness, this local action must be **coordinated** and **planned.**
5. Some organizational principles also still hold. Our vision fits with the international consensus that a multi-purpose health professional is crucial at the **first line** in order to facilitate people's access and to enable patient-centered, integrated and continuous care to the patients visiting him/her. For reasons of effectiveness, this polyvalent first line health worker needs to rely on a technically more sophisticated **second line** provider (traditionally a hospital). For efficiency reasons, searching for complementarities between these two levels of care remains important.
6. We acknowledge that the concepts and principles underlying the design and functioning of "districts"/local health systems are universal. The contribution at the conference by speakers from the North illustrated the fact that the challenges are indeed universal. The concrete outlook, architecture and functioning of local systems of course needs to be context-specific. There is no one-size-fits-all district solution, even at country level.

Changing our perspective

Empowerment, freedom and voice

Participants at the Dakar conference discussed the greater role that could and should be played by individuals, households and the community. Countries should move from a vision considering them as passive recipients of public policies to a vision whereby they are actors of their own health.
This will be obtained through three complementary routes: empowerment, freedom and citizen voice.

Empowerment – understood here as a purposeful process aiming at increasing someone's ability to choose within his choice set and to develop action in an autonomous way – is intrinsically valuable as a goal and a right in itself, whether it suits the objectives of the health services or not. Experiences shared from Uganda demonstrated that the community or patients could be major co-producers of good health. Their empowerment, which is obviously a gradual process, can be instrumental to fight both 'old' challenges, such as poor sanitation, and new ones, such as the follow-up of chronic diseases such as HIV. Our assessment is that individuals, households and communities will be more in particular key 'resources' to prevent and mitigate suffering, morbidity and premature death due to the demographic and epidemiological transitions. Education and transmission of information and knowledge will be key weapons in this battle.

This implies a substantial shift in terms of approach at district level. All together, we must, through a genuine dialogue with people, experimentation, innovation and experience-sharing, identify what the right mix of policy instruments is needed to win this battle. **It will also be about changing some existing practices and revisiting some ethical standards.** For instance, we should make sure that public health related information collected from communities is owned by them and should be fed back so that they can take timely actions.

We also believe that *expansion of freedom* – understood here as a purposeful process aiming at increasing people's choice sets and better protection in the exercise of their rights – is **an insufficiently tapped process towards better performance of local health systems in Africa**. One should move away from a view which assumed passivity and expected discipline from individuals and households (e.g. respect of health administrative boundaries). The decision to make use of provided health services rests entirely with them. This is certainly already a (challenging) reality in cities and their suburbs. Because of the extension of the transport network, it will soon be a reality in some rural areas as well.

Freedom of choice is valuable in itself, but if users are well-informed it can also be a powerful mechanism to ensure accountability and greater responsiveness of health providers. This was insufficiently recognized in the past. Mechanisms which ensure that money follows the patient (e.g. results-based financing) are tools deserving more attention in this respect.

Due to market liberalization in Africa, freedom now also exists on the side of the providers**. A top priority for African health authorities is to recognize the very pluralistic nature of the health sector**

today (public providers, private-not-for profit providers, private clinics, informal providers…). The time when ministries of health could focus only on their own health facilities is clearly over. There is an urgent need for them to develop the appropriate toolbox to align private-for-profit providers on public goals, and UHC in particular. Experiences shared at the conference from Cameroon, Rwanda and Uganda demonstrated that this is possible.

Voice – understood here as the mechanism through which citizens and users express their preferences to give direction to collective action – is also both intrinsically valuable as a goal (democracy and political rights), and a means towards better performing services (through the expression of dissatisfaction and frustrations). Community participation was a key axis of the Harare Declaration and of the Bamako Initiative; as a result, a "health committee" was set up in each health center, with mixed results though in many countries. Still, the community represents a valid instrument to correct old problems such as absenteeism and poor performance of health staff and to support the district health management team in its supervisory role. New mechanisms – such as information about budget and balanced score cards – have been explored over the last decade. They are still insufficiently integrated into practices at district level.

Coordinating the full array of actors

All these actors need to be coordinated. Several presentations at the conference have shown that institutional arrangements have a key role to play in this respect; examples of performance-based financing schemes in Cameroon and DRC indicated that the overhaul of incentive packages, redistribution of roles, better delineation and separation of functions are probably all needed.

Coordination is also about establishing a legitimate body or platform to steer the local health system. In societies increasingly valuing freedom, such legitimacy does not stem from administrative authority: it has to be conquered, mainly through leadership, dialogue and trust. Coordination probably requires a sound balance between top-down coordination mechanisms and more horizontal, trust-based, coordination arrangements between the different actors operating in the local health system.

Obviously, the Ministry of Health should take the leading role in this coordination effort. The creation of a supportive legal and institutional environment to work with other sectors and the establishment of the consultative and coordination bodies necessary to bring all stakeholders around the same table remains its responsibility. At district level, the Health District Management Team's district planning should change from a process to prioritize and allocate public resources (Ministry of Health planning) to a more comprehensive coordination tool aiming at aligning and harmonizing different actors present in the district and capitalizing on the full potential of all stakeholders in the health sector (Health Sector Planning). Both processes will strengthen the stewardship function at central and district level.

However, it is also time to move to a more pluralistic view on the stewardship function. Stewardship has to be shared with other actors, certainly with local authorities but sometimes, through consultation processes, even with private actors. At the conference, we heard about some coordination carried out by professional networks in Mali and Guinea. We even heard about an experience in DRC where the

Ministry of Health successfully delegated the governance of health districts to a private non-for-profit body.

Whereas this new vision is required by the emerging context, it is important to note that **its implementation will have to overcome new challenges also brought about by this new context**.

For instance, the changes in the composition of the health needs and demands, but also their growing heterogeneity – especially now that countries increasingly face a double burden of infectious and life style diseases – will challenge the current practices and mechanisms which determine the provision of services.

Institutional arrangements allowing to organize the allocation of resources in a way that is efficient, equitable and responsive to the new needs and demands, will be key. They include priority setting processes, packaging of services, essential drug lists (eligible for reimbursement by social health insurance schemes for instance), protocols but also, for instance, provider payment mechanisms and accreditation mechanisms.

Securing, in this emerging environment, the ideal of a localized response to a population's felt needs will be challenging. Besides platforms for dialogue, new instruments will be needed, such as schemes to encourage medical doctors to work in rural areas or matching grants for encouraging communities to realize their own vision.

DIRECTIONS FOR ACTION

Recommendations per actor

At the end of each session of the conference, participants were invited to identify action points. We present them per category of actors contributing to local health systems.

At health delivery level

One of the important characteristics of quality care is its patient-centered character, i.e. a process whereby a bio-psycho-social perspective is used by health workers in a broader approach where both disease and illness experience are actively explored, and where attempts are made to find common ground between patients and health workers leading to mutually agreed decisions. Achieving patient-centered care is not an easy endeavor. It requires not only appropriate clinical methods, but also a structural and organizational environment (e.g. enough time for each patient) where patient-centered care can thrive. **Patient-centeredness, but also overall quality of care and services have to receive much more attention from all actors.** At facility level, this will in many places require the structural transformation of habits and practices. The importance of addressing patient-centered care already in undergraduate training curricula was emphasized.

The demographic and epidemiological transitions make it inevitable to reassess the composition of the package of activities and more fundamentally, to carefully reconsider the allocation of resources, and medical expertise in particular. The time when all medical doctors were working as clinicians at the hospital or at managerial positions is over. **This transformation has to be proactively managed.** The growing presence of medical doctors in ambulatory care (as first line providers, but also providers of specialized care) reflects changes both on the demand and the supply side. This transformation is at the same time a powerful opportunity but also a potential source of "tension" in the local system. It is an opportunity because in principle it allows to dramatically increase technical capacity, including expanding the package of services, offered at the first line. It is a source of tension too though because it requires re-assessing the nature of the interaction between these medical doctors and the district management teams. How should this interaction be streamlined? Is there still a role for supervision or should we rather opt for *intervision,* i.e. with peers giving feedback to each other? What is the impact of first line doctors on the definition of the activity package at the hospital level? How should referral and counter-referral systems be re-organized (including involving specialists)? And, last but not least, what regulatory framework should be designed in order to ensure that doctors in a private practice operate according to a public logic, safeguarding people's access to quality and safe health care?

Delegation of medical tasks (also known as 'task shifting') to less qualified health staff has been a characteristic of health systems in Africa for a century. At the establishment of the modern health system, the practice consisted in medical assistants and clinical officers taking over tasks from over-

burdened and thinly spread medical doctors. Today, nurse-practitioners (still) constitute the backbone of African primary health care systems, especially in rural areas. There is however yet a wider scope to delegation of tasks: i.e. delegating tasks to community health workers and lay people. Among the latter category there is the special case of experts-by-experience (like for instance expert patients) who combine a unique insight in the reality of the illness (that professionals do not possess) with a strong intrinsic motivation. Community health workers, for their part, are firmly back on the health policy agenda. In an increasing number of situations, they complement formal first line health services, bringing a number of essential services closer to people while being a motor to community development and empowerment. Together with the increasing presence of medical doctors at the first line, but also pharmacies, including in rural areas, this is gradually changing the game altogether: local health systems will incorporate a greater mix of providers with much more heterogeneous qualifications. This evolution needs further monitoring and evaluation. A key responsibility of district management teams will be to ensure that the comparative advantages of each type of service providers are seized and that **all these actors work together so that a coherent local health system can be built**.

At health district team level

After the Harare Declaration, the health district management team was entrusted with a pivotal role in the development of the health district system. Many expectations were put upon these teams, probably too many: health data analysis, planning, budgeting, allocation of resources, leadership, coordination of response to emergencies, supervision, training, coaching… The discrepancy between this vision and the reality has been sometimes huge, especially in places where the district strategy has been implemented in a too bureaucratic fashion, ignoring the complex nature of health systems and lacking the necessary responsiveness to integrate people's priorities in district planning in a bottom-up way.

In the emerging new environment, which is much more "open", but also more complex, direct control is obviously no longer an option. The new environment requires district managers to strengthen their capacity of stewards of the local health system.

This requires first of all that the Ministry of Health and its partners help district offices to become **learning organizations.** District management teams have to put more effort in listening to people, respecting their autonomy, but they also need to gather quantitative and qualitative information on their health needs, identifying what could be done *together* to address these needs. They also need to gather intelligence on the performance of the different components of the local health system and on the bottlenecks which constrain them. The mindset of health managers needs to change, first and foremost. At the conference, we also learned that technology has a role to play: ICT can provide exciting new opportunities for empowering district management teams in this role. ICT can enhance, among other things, performance-data collection, benchmarking and feedback to stakeholders, all facilitating greater accountability and responsiveness within the health system. We also believe that district management teams working in a learning organization mode will be more attentive to facilitate innovation and to support adoption of good practices (which should not be exclusively expected to come from the top or from technical and financial partners).

If health district teams have a key role to play in the stewardship of the local health system, they should however not carry out this task alone. Their concern should be **to build coalitions of local actors dedicated to the health of the population**. This implies a shift in their practices. For instance, they have to redesign the planning process to make it a flexible instrument of coordination and alignment of all actors; instead of being mainly an authority, they have to become **conveners, organizers and process facilitators**.

To operate this transition, a shift in the skills and profile of district management teams will be needed. The latter have to be highly performing multi-disciplinary teams in which at least some people possess a range of competences (e.g. negotiation skills) which enable them to effectively coordinate the increasingly diverse and autonomous array of health actors. This will require active support, including the adoption at national level of policies, guidelines and regulations clearly defining the new tasks and responsibilities of the district managers. Substantial capacity building will be needed too.

At local authority level

Decentralization was a key tenet of the Harare Declaration. Decentralization offers unique opportunities for stronger local health systems, as it forces the district manager and health services to work in close collaboration with the population they serve. The Harare Declaration related action point has been implemented with variable determination, across countries and domains (cf. the persistent over-centralization of the allocation of health staff).

Taking a historical perspective is important for fully grasping the decentralization matter. Thanks to the health district strategy, the health sector was actually a pioneer sector in the decentralization agenda in many African countries. Unfortunately, after this head start, the health sector has tended to live in its own 'bubble' in many countries. By and large, it has failed to pay sufficient attention to the new agenda of political and administrative decentralization which has swept the whole continent over the last decade. In many places, when the reforms were implemented, the health sector has 'exempted' itself from local governments, largely based on the assessment that the latter were anyway too weak technically to play any relevant role.

However, the redistribution of power between central and local governments will only increase, given rising citizen expectations and growing economic dominance of metropolitan areas. **It is thus critical for health authorities to adopt a more pro-active approach towards the decentralization agenda**.

A priority is to open dialogue on the elements which are being (or need to be) decentralized. Of course central health authorities (with substantial involvement of State or Provincial authorities in big countries such as the Democratic Republic of Congo, Ethiopia or Nigeria) have to secure their leadership in the steering of the whole health sector. It is, for instance, up to them to gather intelligence on health needs and the cost-effective interventions to address them, and to set priorities and standards, through instruments such as policies, regulation, packages of activities, essential drug lists but also through new levers, such as strategic purchasing. Many other responsibilities – for instance, ownership of facilities –

can probably be delegated to local authorities. In many places, the coordination of local health systems would also be easier if health district boundaries were adjusted in line with administrative boundaries.

The dialogue with local authorities and actors present at decentralized levels should also aim at facilitating the flexible transfer of competencies and financial resources, with the required human resource capacity building programs. Given its high technical profile, the district management team will still have a key role to play in such decentralized systems; an issue will be to find the best articulation with local authorities while maintaining a good connection with the Ministry of Health. Effective coordination with local governments is key in ensuring inter-sectorial collaboration and action at the local level upon the social determinants of health.

At national level (whole government)

The Harare Declaration has been followed by many declarations and commitments, which have not always been fully implemented. We remind governments and ministries of finance of their commitment in Arusha and more recently in Tunis at the Value for Money conference.

Reforms to boost the accountability of governments and public sectors to citizens and users have to be sustained. Central governments can facilitate the transformation of their Ministry of Health into a learning organization in charge of strategically steering the health of the nation by (1) enriching its policy toolbox with instruments such as data intelligence, partnering for health promotion, strategic purchasing, contracting and regulation and (2) opening up political and technical spaces for the ministry of health to develop leadership for inter-sectorial action and 'health in all policies'.

These changes at national level will ensure a supportive environment for a similar attitude and action at district level.

In order to send a clear signal, we recommend governments to allocate resources for inter-sectorial action in the next national budget. Especially the dramatic underfunding of the social welfare sector should be addressed.

At national level (Ministry of Health)

We remind Ministries of Health of other and more recent commitments, especially the ones they made in Ouagadougou in 2008 ("Ouagadougou Declaration on Primary Health Care and Health Systems in Africa") and in Tunis in July 2012 ("Tunis Declaration on Value for Money, Sustainability and Accountability in the Health Sector"). We also see the 2012 UN General Assembly resolution in favor of UHC as a major step forward. We see all these political commitments as conducive to strong local health systems.

One of the flaws in the implementation of the Harare Declaration has been a rather restrictive interpretation of what the health system is: just health facilities, even excluding private for profit providers from the picture. **We urge Ministries of Health to embrace a much more inclusive and flexible vision of the health system.** The latter also includes actors not under their direct authority, such

as individuals, households, communities, community health workers, private for profit providers or actors from other sectors. Embracing such an inclusive view requires new policy orientations at country level.

1. It is the Ministry of Health's responsibility to steer the whole process by pro-actively gathering intelligence on (1) the appropriate way to address bottlenecks constraining the unfinished agenda of reducing child and maternal mortality; (2) the implications of epidemiological and demographic transitions on national and local health systems.
2. It is also its responsibility to develop innovative partnership policies with all actors of which the activities have a direct or indirect impact on the health of the nation. Dialogue, advice and monitoring will be key processes to develop influence.
3. The Ministry of Health can already orientate health district teams towards this new program, by revisiting, together with them, their exact role. This may involve assigning them new roles (see sections above), investing in capacity building (e.g. to operate as 'learning organizations'), but also maybe recognizing that some functions assigned to them so far may be better handled at another level. The reorientation process should include a critical revision of the planning process, guided by the center but undertaken in consultation with district managers, to adapt this tool to the changed context.
4. The Ministry of Health must ensure that district teams have the resources required for their mission but are also held accountable for their performance, possibly through league tables, benchmarking, transparent sharing via online platforms, financial rewards or sanctions.
5. We encourage Ministries of Health to expand their policy toolbox, both at central and decentralized level. Both the central level and the health district teams must be able to use a much broader spectrum of approaches and instruments to align all actors on UHC. These instruments include: platforms of dialogue, capacity building, health sector planning, provider payment mechanisms, regulatory authority…
6. Within the whole health system, there is a need to promote a culture of innovation, to have strong monitoring and evaluation capacities, to rapidly disseminate lessons and to scale up successful strategies. Internal dialogue should be promoted in order to bring innovations autonomously developed by community actors and district teams to the attention of the Ministry of Health, as they may be ignored by technical and financial partners.
7. Within the whole public health pyramid, there is a need to promote a culture of accountability for results, with upward and downward accountability mechanisms. Institutional arrangements such as contracts are key instruments for such a purpose. We recommend the Ministries of Health to pilot and develop innovative strategies which help actors adopt behaviors consolidating good health and wellbeing. These include incentive schemes ensuring the presence of qualified personnel in underserved areas, supply-side and demand side health care financing mechanisms, transfer of information to different actors about their rights and duties, but also the careful and progressive transfer of some key decision rights to health facilities (e.g. hire and fire, opening hours).
8. The recommendation to empower individuals, households and communities suggests a line of action towards them which should not only be instrumental. There is a need for policy

instruments leveraging the capacity of these actors to identify problems by themselves and allowing them to decide on priorities and solutions.

9. Ministries of Health must be more committed to aligning private health care providers on UHC to prevent and correct counterproductive effects of the market economy on health services. We think regulation is not enough. Governments should create the conditions to bring on board the private sector, with public-private partnership policies which offer a long term perspective to the collaboration. Hence we call for innovative institutional arrangements, including schemes, such as accreditation, contracting and performance-based financing, incentivizing and enticing them to improve their practices.

At regional level

The Dakar conference was jointly organized with WHO AFRO, WAHO and UNICEF, all agencies active at regional level. Together, we agreed that they have a key role to play in the promotion of and support to the roll-out of this new health district vision at country level. This is fully consistent with their renewed commitment in favor of primary health care, as formulated in the "Ouagadougou Declaration on Primary Health Care and Health Systems in Africa" (2008).

They can contribute in many ways (see also "technical and financial partners"), but one of their comparative advantages is the fact that they link countries with each other and thus allow for networking between country decision makers and technical experts. They facilitate the exchange of experiences, in other words, including at regional level.

We invite them to:

1. Assist countries in implementing this new vision, in alignment with the Ouagadougou Declaration.
2. Support a regional knowledge program on issues which can particularly benefit from the exchange of experiences across countries. More particularly (but not exclusively) we have the following challenges in mind: how to develop new capacities (e.g. stewardship and organizational learning) at decentralized level, how to position the health district system in the ongoing political and administrative decentralization process, how to enhance coordination of health providers in cities, how to engage with private-for-profit providers, how to implement a multisectoral approach and how to empower communities and individuals in the management of their health. These questions definitely provide an important role for research.
3. To enhance this regional knowledge program, we urge regional agencies to support platforms and mechanisms facilitating the exchange of experiences, such as study tours and exchange visits, regional face-to-face events and online knowledge activities. We hope that the excellent partnership with the HHA communities of practice will go on.

We welcome their encouragement for the project to be launched by the Community of Practice Health Service Delivery which aims at building a network of district management teams over the whole continent.

At the level of technical and financial partners

Several technical and financial partners of African countries, besides multilateral and regional agencies, were present at the Dakar Conference. We hope that the very conducive partnership in favor of health districts which prevailed in the eighties and nineties can be reinvigorated.

To partners willing to contribute to implementing this new vision, we recommend the following areas for action.

Our first recommendations go to technical and financial partners as a group of actors:

1. To accompany countries in this transition towards a more open and flexible approach to health districts.
2. To work first on the bottlenecks which are partly due to insufficient coordination, alignment and harmonization of their aid instruments. A priority is the burden created upon district teams and facilities by the multiplication of parallel data collection processes. All technical and financial partners should recognize and support the new role of the district management office as overall coordinator of all health related activities and accept to move towards integrating their interventions in the district plan (one plan, one budget, one monitoring process).
3. To contribute to greater intersectoriality by also setting up coordination mechanisms between aid agencies which are active in different sectors, in full coordination with different line ministries, of course.
4. To maintain their efforts towards strengthening local health systems in distant rural areas.
5. To progressively move away from a paradigm stressing short term gains – "quick wins" – in favor of the emerging paradigm of sustainable development, while securing a key concern for poverty reduction and greater equity.

To each individual partner, we recommend to:

1. Adapt your interventions to the local context. In fragile states, favor holistic support to health districts.
2. Put real dialogue between people and health professionals (again) at the top of your agenda.
3. If your main aid instrument is the project approach, use its flexibility to pilot new strategies for challenges insufficiently addressed so far (e.g. coordination of health actors in cities, alignment of private-for-profit providers). Involve social entrepreneurs and ICT innovators to tap new ideas and energy. Make sure that new strategies are well documented and are rigorously assessed (a weakness today of many of your projects).
4. Do the investment that other actors cannot or are reluctant to do. For instance, we encourage you to develop leadership in new domains such as the development of ICT tools for more performing health systems. This includes building tools and capacities for public health intelligence at national and decentralized level and accountability through data, with particular attention to: tailoring solutions to operational constraints in some countries; user friendly

interfaces; interoperability across programs and actors; control by country through preference for open-source software.

5. Ensure that district health teams are fully involved in the redefinition of their roles and missions. Other sectors than the health sector should be involved in this process.
6. Consolidate, at national and decentralized level, technical capacities required for new functions (e.g. strategic purchasing, district as a learning organization…).
7. Support documentation and dissemination of experiences related to the new health district agenda.

At the level of the scientific and educational community

During the 3 days of the conference, we identified several priority research questions related to the new health district agenda. There is a urgent need for gathering more empirical evidence, among other issues, on bottlenecks to the delivery of high impact interventions, on appropriate institutional arrangements, on how to develop local health systems in an urban environment, on how to engage with private providers, on how to implement a multisectoral and multi-actor approach and on how to empower communities and individuals in the management of their health. We recommend careful assessment of strategies relying on high-powered incentives. The fact that many of these questions are 'how' questions suggests the need for (1) an operational research program, involving district management teams, with the aim to produce clear and feasible operational recommendations and (2) an *implementation research* program paying sufficient attention to context, actors and interventions being implemented, relying on methods such as (comparative) case studies, action-research…

Numerous gaps exist in the skills and competencies of national and local health managers, especially in the areas of management and leadership. Filling these skills gaps will require updating training curricula and utilizing a flexible training approach to meet the needs of present and future health systems managers. African education institutions (e.g. faculties of medicine, schools of public health) have a key responsibility in this respect.

At the level of the HSD community of practice

We, participants, enjoyed the sense of passion and commitment during the 3 days of the conference. We encourage the facilitation team to support the involvement of more experts in the general facilitation of CoP activities.

We welcome their new project to link district management teams over the whole continent. We commit to help them in this ambitious endeavor.

Twelve priorities for better performing health districts in a changing Africa

We, participants of the regional conference or members of the Community of Practice 'Health Service Delivery' call upon Ministries of Health to be much more pro-active in identifying the consequences of the ongoing and forthcoming major changes in African societies upon populations and therefore local health systems.

1. **Steering pluralistic health systems -** Ministries of Health and other actors have to embrace a much more inclusive and flexible vision of local health systems which recognizes that the African societies of today are pluralistic. This new vision has many major institutional and operational implications. The main one is the requirement to adopt comprehensive, informed and flexible stewardship approaches that mobilize, both at national and district levels, new mindsets, skills and policy instruments (such as data intelligence, benchmarking, strategic purchasing and mechanisms ensuring accountability to citizens).
2. **Accountability for results** - Given rising expectations of citizens, Ministries of Health and governmental agencies have to embrace a culture of accountability for results, with upward and downward accountability mechanisms. In many countries, greater performance of local health systems will require substantial reshaping of institutional arrangements and incentive schemes (e.g. results based financing).
3. **Empowerment of communities and individuals** - We invite central and local governments, Ministries of Health, programs, district management teams and their partners to develop an ambitious inter-sectorial action program to empower communities and individuals to help them tackle existing health needs but also emerging ones (e.g. determinants of NCDs) . Their capacity should be strengthened so that they become a real partner for analyzing their own health problems and for planning, implementing and assessing both their own health interventions and those delivered by professional providers.
4. **Quality of care** - In order to meet the rising means and expectations of users, Ministries of Health, district teams and health facilities have to adapt and improve the provision of services. At facility level, quality of care, and more particularly patient-centeredness, has to receive much more attention. At system level, there is a need for a more flexible definition of the role and functioning of hospitals in their specific context.
5. **Multisectoral action** - Ministries of Health and their partners have to adjust the district system and the provision of services to epidemiological and demographical changes. We encourage countries to experiment with new health service models, carefully documenting the lessons learned. The epidemiological transition but also the unfinished agenda of reducing child mortality require Ministries of Health and district management teams to develop sufficient capacity to engage with other sectors to implement ambitious multisectoral approaches for better health.

6. **Health in cities** - Urbanization is accelerating; we encourage all actors to develop an extensive and sustained knowledge and research program (what to do and how to do it) on health in cities and peri-urban areas.
7. **Public private partnership** - Private providers are both a challenge and an opportunity. We strongly recommend governments to create the right conditions for bringing the private sector on board, by defining partnership policies, guidelines, criteria for collaboration and health care financing schemes which offer a long term perspective to the collaboration; this requires the development of the expertise and the appropriate toolbox of policy instruments to align private-for-profit providers on the goal of UHC, and this both at central and district level.
8. **Equity** - All actors will have to unite behind the UHC banner to mitigate the current injustice and unequal access to quality services which may be worsened by the (further) rise of inequality within countries. Stewards of local health systems need to develop meaningful collaboration with social welfare actors engaged in the fight against poverty.
9. **Decentralization** - It is critical for health authorities to adopt a more pro-active approach towards the decentralization agenda; the priority in many countries is to start a dialogue on the elements which need to be decentralized, the transfer of resources and capacities and the best linkage of the district management teams with local authorities while maintaining a good connection with the Ministry of Health.
10. **ICT** - The power of ICT to enhance governance and accountability, equity, effectiveness and efficiency of local health systems has been insufficiently tapped so far. We believe that Africa can quickly progress in this respect and needs to develop solutions tailored to its needs. We recommend technical and financial partners to financially support the development of ICT solutions adapted to African health systems.
11. **Constant learning** - Given the rapid transformation of societies, it will not be possible anymore to have blueprints valid for the whole country. Within the whole health system, there will thus be a need to encourage organizations to become 'learning organizations' able to adjust smoothly to their (complex and constantly changing) environment. This is particularly relevant at the level of actors in charge of the local coordination of the health system (district management teams, but not exclusively). The Ministry of Health and its partners have to help them to acquire the required new skills and methods, but also grant them the required autonomy.
12. **Aid** - Technical and financial partners can greatly assist in the implementation of this knowledge and policy agenda. They can also make a key difference, by adopting themselves approaches which strengthen, rather than instrumentalize or undermine, local health systems, including by integrating their activities in the sector planning and adopting time frames more in line with the challenges that need to be addressed.

Three wishes

We, participants of the regional conference or members of the CoP Health Service Delivery believe that knowledge is a major driver for change.

1. We recommend the set-up of a **regional working group** in charge of (1) following up the implementation of the twelve recommendations listed above, (2) gathering data on how the transformation of the context will reshape health systems and policies in Africa. Under the leadership of WHO AFRO and working in close collaboration with the CoP, this group will be multidisciplinary (economists, sociologists, town planners, epidemiologists, health systems specialists…) but also involve representatives of actors who can be part of the solution (first of all, Ministries of Health), and consult an even larger group of stakeholders through online platforms. The terms of reference of the group will be to produce data to monitor progress, challenges and provide guidance to governments, for instance through a 'white paper'.
2. We call upon WHO AFRO to lobby WHO Geneva for dedicating one of the future WHO annual Reports to "Health in the Cities".
3. The community of actors should give a key role to African experts to fully contribute to the knowledge and policy agenda for better performing and equitable local health systems. We believe that the **CoP Health Service Delivery** is the best vehicle for such an involvement.