HEALTH CARE IN AFRICA:

CHALLENGES, OPPORTUNITIES AND AN EMERGING MODEL FOR IMPROVEMENT

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1. INTRODUCTION AND BACKGROUND

1.1 A Paradigm Shift in Order to Reverse the Trends in Health and Development

An appropriate, robust, and sustainable model for improvement in health system performance is essential in order to reverse the declining trends in health and development status and break the vicious cycle of poverty and ill-health in Africa. Given the diversity of the health systems across Africa, improvement would be contingent upon the convergence of commitment, expertise, and resources throughout the system. A robust model for improvement would embrace all the dimensions that are critical to health by addressing not only the risk factors of disease but also cross-cutting issues and linkages between health and employment, food security, nutrition, and financing for health. Such an approach would be better attuned to issues unique to the African continent, with enhanced responsiveness to the needs and capacities of the people.

This paper suggests a model for sustainable improvement of health system performance which takes into consideration historical lessons, and current opportunities and challenges facing Africans. The essential elements of the suggested model include decentralized governing structures linking the health system to communities; identification of an essential care package for health (ECPH) based on peoples' priorities; an improved information system to provide evidence of improvement in service access, delivery, and outcomes; and regular dialogue among stakeholders to enhance informed demand, responsibility, and accountability. The model attempts to pay due regard to the people's own beliefs, knowledge, customs, experiences, practices, systems, and structures that give meaning to the ECPH and mitigate the discontinuity between people's perceptions and the health intervention package through regular dialogue.

1.2 Context

Improved health status leads to increased productivity, educational performance, life expectancy, savings and investments, and decreased debts and expenditure on health care. Ultimately this would lead to greater equity, economic return, and social and political stability. Therefore, improved health is a key factor for human development. However, many policy analysts have expressed fears that at the current rates of progress, sub-Saharan Africa (SSA) will not be able to provide satisfactory health care to its inhabitants by 2020, and will not achieve any of the United Nations millennium development goals due to increasing poverty. Health must be seen as a central element of productivity, rather than as an unproductive consumer of public budgets.

1.2.1 Unacceptable Disparity and Inequity

Globally, more advances in health, science, and technology have been made in the last 50 years than in the 500 years before the 20th Century (World Health Organization, 2002). Health infrastructure has been expanded and education, incomes, and opportunities have improved. Public health interventions and socioeconomic development have reduced mortality and raised life expectancy. Unfortunately, these gains have by no means been universal. The health gaps within and between countries have widened, perhaps due to inequality in the absorption of new technology as well as unequal distribution of new and re-emerging health problems (Von-Schirnding, 2002). Disparity has increased, with a third of the global population wallowing in

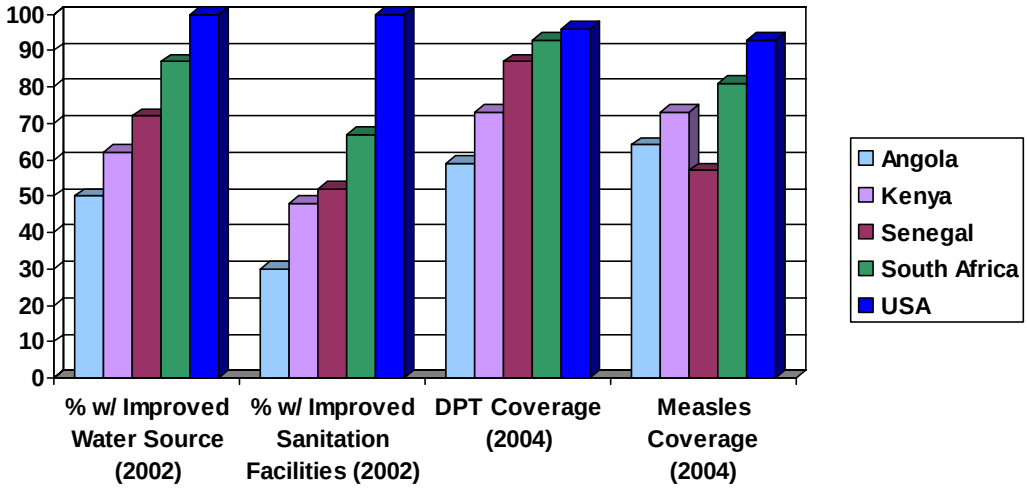
absolute poverty (Taylor and Taylor 2002). Each year, we are losing more than 11 million children to preventable diseases as a result of inequalities in health and development and problems are worst where resources are least available; those who need more care have the least access (Gwatkin et al., 2000).

1.2.2 National Government Resource Scarcity in the Health Sector

Most SSA countries are constrained by resource scarcity; undermining the implementation of decentralized public services. In competing with other public services for scarce resources, the health sector is often ranked relatively low among national development priorities. In 2001, the heads of states in the African Union committed themselves to allocate 15 percent of their national budget to health in the Abuja Declaration. However, this commitment has not been realized by the majority of the countries. The average expenditure in the health sector in SSA rarely exceeds 5 percent of GDP with most African countries spending less than US $10 per person per year on healthcare when at least US $27 is needed.

More than 50% of African populations do not have access to modern health facilities and 40% have no access to safe drinking water and sanitation. High levels of maternal, child, and infant mortality and low rates of immunization, are symptomatic of the gross neglect of Africa's rural communities (Figure 1).

Figure 1: Profile of Disease Prevention Interventions



World Bank (2006) World Development Indicators

Health care financing in Africa depends heavily (52% in Kenya) on out-of-pocket payments for services. These services are complemented with financial assistance from bilateral and multilateral donors. This creates a situation whereby the ministries of health in Africa spend a lot of time attending workshops and responding to donor inquiries and concerns and less time providing service to the households. Households contribute a larger portion of funds to the health system yet they have minimal voice in demand for service. The role of the state as public service

provider is rapidly changing, necessitating an increased role for non-state actors. This underlines the need for public-private partnerships (PPP) in the health system.

1.2.3 Deepening Poverty

The UNDP Human Development Report (2004) and the World Bank World Development Report (1997) estimated that 54% of the total population of SSA is living in absolute poverty. This poverty limits access to services, increasing vulnerability, while ill health directly affects productivity, especially in labor-intensive economies. The poor are the most exposed to the risks of hazardous environments, and the least informed about threats to health. It is the poor who bear the brunt of crude structural adjustment policies, unregulated globalization, HIV/AIDS epidemics, malaria, and tuberculosis.

Africa experiences a disproportionate burden of poverty, disease, and death with appalling disparities within and between countries. This is complicated by the attenuation of the human resource capital through death, disease, civil wars, brain drain, as well as inappropriate training programs. Africa continues to suffer under the yoke of the unjust world order: unbalanced global trade; reduced prices of the primary products that Africa relies on for international trade; and a rising debt burden. The era of structural adjustment and free market approaches to health care has resulted in reduced public-sector involvement in health, including the loss of health workers through retrenchment and recruitment embargoes that may have deprived the poorer and rural communities of access to health services.

Most workers in Africa are in the agricultural sector, characterized by seasonal underemployment, drought, famine, and other disasters also, many rural families have taken on additional children due to the increasing numbers of AIDS orphans. This has led to a relentless rural-to-urban migration in the last three decades due to poverty, access to free ARVs, insecticide treated bed nets, and costs related to treatment.

Poverty compounds powerlessness and increases ill-health, as ill-health increases poverty (vicious cycle), making reform efforts that emphasize privatisation impossible to implement on a large, sustainable scale. This situation perpetuates the entrapment of households (Figure 2).

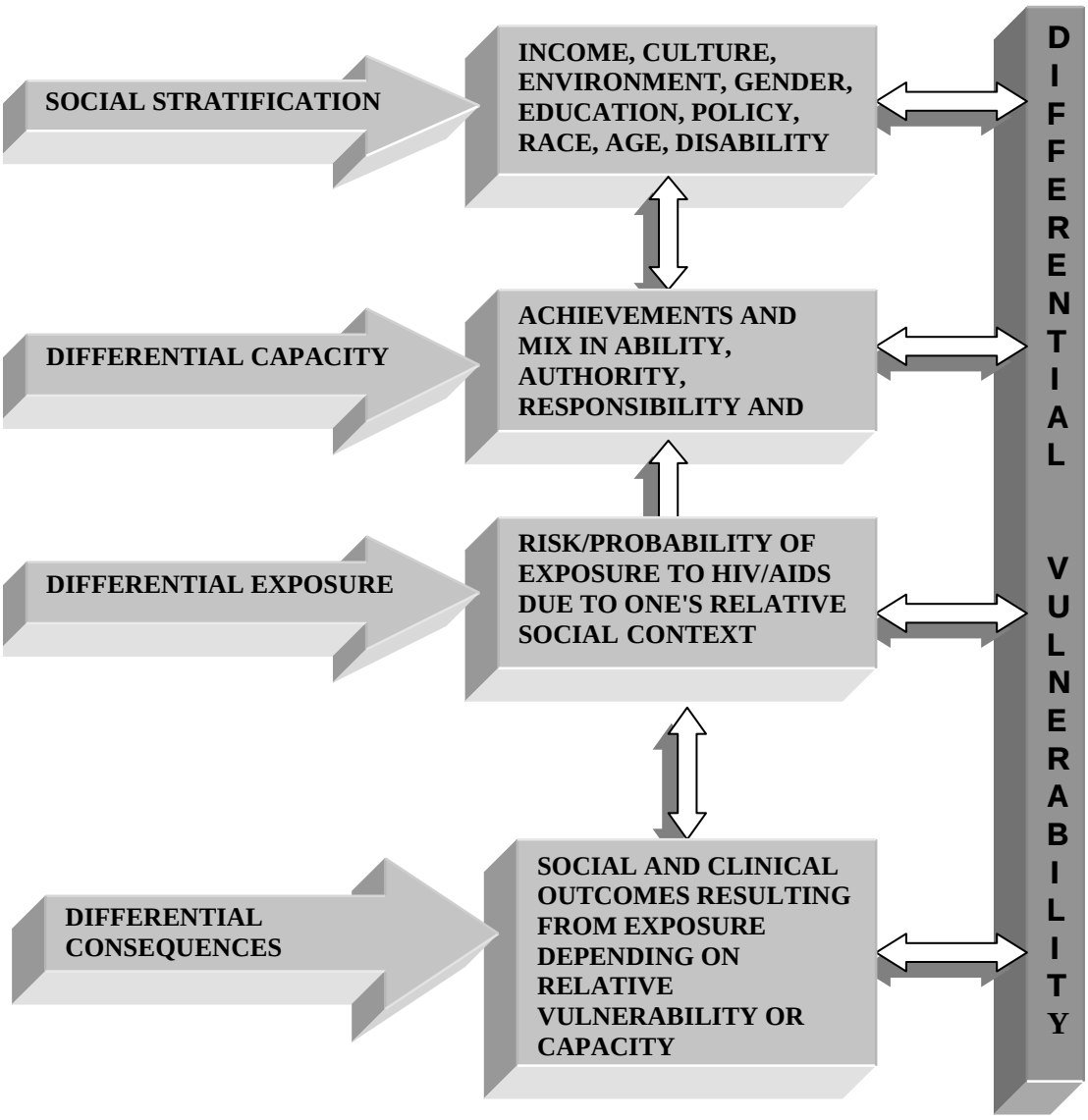
Figure 2: Vicious Cycle of Poverty and Ill-Health

WHO (2002), Vicious Cycle of Poverty

1.2.4 The Disease Burden and Poor Indicators

A wide range of economic, cultural, behavioral, political, demographic and biological factors create disease vulnerability in SSA. Fueled by these forces, communicable diseases ravage the continent (Figure 3). However, vulnerability to diseases refers to not only an increased likelihood of exposure to or infection with agents of disease but also an increased likelihood of suffering needless consequences of infection.

Figure 3: Determinants of Health Status



The biggest causes of morbidity in SSA are malaria, respiratory tract infections, diarrhea, intestinal worms, HIV/AIDS, anemia and malnutrition. The main cause of malnutrition is low caloric intake due to seasonal shortage of food, which results from low agricultural production compounded by poor dietary practices. In addition there is a rapid increase in lifestyle-related

non-communicable diseases such as hypertension and diabetes making end stage renal disease a health problem that cannot be ignored. The life expectancy of Africans is, on average, declining.

In spite of prolonged efforts in reforms, meetings, declarations, policy rhetoric as well as the massive input of financial and technical resources, the continent records some of the highest rates of infant deaths and maternal mortality in the world. Also, Africa represents about 10 percent of the global population but accounts for 63 percent of individuals living with HIV/AIDS and 90 percent of malaria infections worldwide.

Good health is linked to the human capacity to contribute to development. In this regard, controlling diseases and investing in health is critical to achieving poverty reduction within the framework of the MDGs.

1.2.5 Weak, Inappropriate Health Systems

Most African health systems are replicas of what was inherited from the colonial era and are therefore unevenly weighted toward privileged elites and urban centers. Perpetuating colonial systems and mentalities, simply replacing the colonialist, did not help. Investigations into continent appropriate health systems are needed.

Despite the increase in spending in the 1960s and 1970s, substantial progress has not been made in ensuring equity in health care. The health systems, as organized today, are not adequately addressing the increasing burden of disease. More recent cutbacks in health budgets have eroded previous advances in health care and weakened the capacity of African governments to cope with the growing health crisis; the poorest sections are being disproportionately hit by pro-rich national and international policy decisions. The health system is neither robust nor flexible enough to respond to emerging scenarios that lead to reversal of gains. Traditional, faith, and other informal sources of care are used more because they are more available, accessible, affordable, and acceptable yet they are ignored and therefore unregulated and unsupported.

New and re-emerging diseases have created a new scenario in service delivery as many diseases have defied conventional medical technology. The development of drug resistance complicates the already unbearable situation and the situation worsens as people seek health care too late requiring sophisticated treatment, additional drugs, prolonged hospital visits, and unsatisfactory recoveries (WHO, 1999). This is aggravated by weak systems of governance on one hand and ecological stress on the other. Also, the inability to quantify and analyze the situation with credible data regarding the performance of the health system and the health status undermines the ability of effective decision making.

1.2.6 Human Resource Crisis in the Health Sector

The human resource crisis is caused by many factors such as inadequate production in some countries, inability to hire in others, brain drain, poor motivation, conflict of interest, corruption, and misuse of resources—including time—in most countries. In many countries, an overwhelming majority of health workers are concentrated in a few urban areas. All categories, particularly doctors and nurses, are in short supply compared to the standards of population

ratios for nurses and other health workers (Table 1).

Table 1: Health Workforce crisis

WHO region	Total health workforce		Health service providers		Health management and support workers	
	Number	Density (per 1000 population)	Number	Percentage of total health workforce	Number	Percentage of total health workforce
Africa	1 640 000	2.3	1 360 000	83	280 000	17
Eastern Mediterranean	2 100 000	4.0	1 580 000	75	520 000	25
South-East Asia	7 040 000	4.3	4 730 000	67	2 300 000	33
Western Pacific	10 070 000	5.8	7 810 000	78	2 260 000	23
Europe	16 630 000	18.9	11 540 000	69	5 090 000	31
Americas	21 740 000	24.8	12 460 000	57	9 280 000	43
World	59 220 000	9.3	39 470 000	67	19 750 000	33

Note: All data for latest available year. For countries where data on the number of health management and support workers were not available, estimates have been made based on regional averages for countries with complete data.

Data source: *(3)*.

Source: ***The World Health Report (2006) Working Together for Health***

The attenuation of the human capital base due to decimation or diversion of the productive workforce by HIV/AIDS and or conflicts is a reality in Africa. School dropout rates are rising and many countries are experiencing both internal and external brain drain in the search for 'greener pastures;' usually to temporary non-governmental structures and projects that contribute little to overall development of a country. Paradoxically, this occurs against the backdrop of an increasingly dependent population to feed and care for.

In proposing a sustainable African health system for the 21st century, it is important to appreciate the fact that the human resource issue is both a quantitative (appropriate numbers) and qualitative (appropriate skills, mix, motivation) issue. Focusing on such issues as the shortage of the right people, in the right place, with the right attitudes and skills mix must be addressed in order to produce professionals with skills that are not only technical but also managerial and relational. Health professionals need to be able to see beyond direct causes of ill health to indirect and proximate determinants of health such as poverty, disparity, ignorance, and marginalization. They should be able to facilitate, mobilize, organize, discuss, work, and provide feedback with people as partners (World Bank, 2004).

2. LESSONS FROM HISTORY AND CURRENT OPPORTUNITIES

In the period following independence, countries in sub-Saharan Africa rapidly expanded access to health services to wider segments of their populations, and there was rapid improvement in health indicators. Major communicable diseases were brought under control through public health measures. Investments were made in child and maternal health, health systems strengthening, and the inclusion of all actors, institutions, and resources involved in improving the health status of populations. However, these gains have now been reversed due to economic stagnation, rapid population growth, the spread of HIV/AIDS, and inadequate allocation of funds

to the health sector.

Primary health care for all, as stated in the Declaration of Alma Atta towards the end of the 20th century raised hopes of health driven development and empowerment of poor populations (UNICEF, WHO, 1978). It led to a significant expansion of the network of health centers and primary care services, offering a significant opportunity for increased coverage through an essential care package and better control of diseases through affordable public health interventions, and reduced maternal and childhood mortality and morbidity at the frontlines of care. As a result, health system infrastructures were strengthened—in line with the primary health care (PHC) approach—and various attempts were made to integrate clinical medicine into public health, while at the same time integrating health into other sectors. However, a significant portion of financing for health was external or household (WHO, 2005), and the state lacked the capacity to sustain the improvement initiatives.

Today, new technologies have emerged and have been adopted globally to address health issues (Baggot, 2000). Borrowing from various disciplines beyond epidemiology and biostatistics has led to an expansion in the scope of public health; embracing all issues that affect social determinants of health status. This implies an increasing range of stakeholders and service providers, setting the stage for a renewed public health revolution. The renewed public health system must promote justice in health and development, addressing the marginalizing factors such as gender, ethnicity, and economic differentials that deny the majority in Africa the enjoyment of their basic rights.

2.1 Civil, Public and Health Sectors Reforms

Many African countries are undergoing civil and public service reforms as well as health sector reforms. Most of these involve restructuring of the sector and the creation of new systems, procedures, and functions that are expected to promote efficiency and responsiveness. The roles of the private and informal sectors in public health need to be clarified and enhanced. The fear is that some reforms may be externally driven and thus cannot be sustained when national capacity and acceptance is not adequately secured. Involvement in countries' reform processes may not reflect the right spectrum of stakeholders and players necessary to create true national debate and consensus. Problems exist with the capacity of the stakeholder organizations themselves to communicate effectively with their internal constituents about the reform process and obtain their consensus on decisions.

Lessons from countries that have implemented reform such as Uganda, Cameroon, Zambia and Ghana highlight the facts that reform are inherently political, and may not be sustained without a strong political will and legal framework (Bossert, 2000). Other factors mentioned concern the resource intensiveness of sustaining a reform process, the necessary improvements in managerial systems and capacity, the need for good data as a basis for action, and pacing the reforms within each country's absorptive capacity. Even more important is the preparation to manage and mitigate the inevitable tensions that arise. Managing the reform process and setting out clear policy intentions and objectives are critical in avoiding the processes becoming forums for negotiating individual interests of stakeholders. Decentralization and other public service reforms, if poorly conceptualized and managed, can have negative results that then may become

a constraint to further change.

The World Bank and IMF structural adjustment programs (SAP) demanded of many African countries during the 1980s and 1990s had the aim of increasing access to quality health care. The reforms included reductions in public expenditure and hence reduced the role of the state in service provision. SAP targeted overall reductions in government spending as a strategy for reducing budget deficits; freeing up money for debt servicing. This SAP approach led to massive cuts in social spending at a time when HIV/AIDS was rearing its head in the continent. Such cuts in expenditure hit health services hardest since most patients were too poor to pay user fees. They had a devastating impact in rural areas and urban slums and, the unattractiveness of working in the public-sector, coupled with hiring freezes contributed to the health service crises in many parts of Africa.

SAP reduced the ability of poor countries to provide even the most basic levels of health care for their people. Even with the onslaught of HIV/AIDS and the attendant overwhelming of health systems in many African countries, governments under SAP had little room to maneuver regarding financing of health services. The subsequent devaluation of the national currency under SAP also had devastating consequences on local industries and the purchasing power of citizens. In addition, devaluation made imports more expensive, creating serious supply shortages in pharmaceutical goods and other medical equipments.

In a further attempt to cut government expenditure, the IMF and the World Bank encouraged 'cost-recovery' for health care. The introduction of user-fees placed basic health care beyond the means of many poor and sick people. The increase in health care costs resulted delayed health-seeking behavior and undermined access to better and/or more advanced care. The requirement that governments slash their expenditure under SAP also forced many African governments to remove price subsidies, resulting in spiraling prices for staple foodstuffs. Overall, the decline of the public health system had major repercussions. Preventive programs suffered from financial and technical constraints, community health systems were dismantled or whittled down, and public health outreach programs disappeared.

These experiences need to be taken into consideration when moving forward with future health system reforms. In addition, member States are urged to take the lead in trade-related aspects of intellectual property rights (TRIPS) negotiations and implement measures identified for promoting access to affordable generic medicines in situations of emergency, producing quality generic medicines in Africa, supporting industrial development, and making full use of the flexibility in international trade law.

2.2 New Partners in Tackling Health Issues

There are several new partners and strategies which could and should be further utilized to strengthen existing health systems:

> **Universities** can address a broad range of conditions essential to ensuring the well-being of individuals, communities, and nations and have high-powered, often idle, human resources. Linkages and cooperation among universities, governments, international

organizations, non-governmental organizations, and faith-based organizations have great potential in contributing to the transformation of the health situation in Africa. Their role includes finding the proper nexus between research, policy, and action to improve the evidence base.

The militaries have well trained, disciplined workforces that are well prepared in operations but normally have few wars to fight. The National Army Medical Corps and its personnel have played a pivotal role in the development of healthcare systems world-wide. They could lead campaigns in tackling health and environmental problems in partnership with other agencies and stakeholders. The Nigerian model as described by A.E. Ajemba (2005) may be useful as a framework for action. He observes that military health systems in Africa have some of the best complements of medical expertise and have tremendous experience in public health disaster response, specialized clinical care, and public health national campaigns against specific diseases.

Public-private partnerships can be established through discussions on how the formal and informal private sector can assist in expanding access and opportunities for quality care to the vast majority of Africans. Despite the success of clinics and hospitals run by conglomerates and large entrepreneurs in Africa, the participation of the organized private sector as investors, equity partners, managers and operators of health facilities and programs in Africa remains modest. The leadership of the organized private sector need to be more engaged in various strategies and initiatives that promote employment opportunities, create better social programs for vulnerable populations, encourage best corporate ethics, and implement best customer practices. In particular, the private sector should assist African governments in the areas of logistics and distribution so that public programs reach intended target populations in remote locations.

The target population should play an active role in the design, implementation, monitoring and evaluation of health programs intended to meet their felt needs. It is crucial to incorporate the household- and community-based resource people as equal partners in all initiatives designed to improve their situation. The large-scale approach to using volunteers and community health workers in communities could be strengthened, learning from isolated sites (Kenya, Tanzania, Ghana, Swaziland, South Africa) and scaling up to district wide programs, (Simba, 2003; Bailey, 2003; and Erasmus, 2003).

Traditional healers are integral to African culture. Chatora (2003) has shown that availability of traditional practitioners generally far outstrips that of doctors in most parts of Africa. Expanding the utility and integration into the health system of traditional healers would relieve conventional western practitioners to concentrate on the areas they do best, while improving and regulating traditional practices for the benefit of the clients (Kasilo, 2003). Engagement with this widespread human resource and further enhancing its utility to the populace through training, inclusion in health services, regulation and enhanced practice would be essential steps and the evidence exists that this can be done.

2.3 Learning From Others' Experiences

Sustained improvement in African health systems requires a paradigm shift in the way health

services serve communities. This shift should be modeled based on the research, theories and experiences of others.

Paulo Freire (1972) made a significant contribution towards a paradigm shift in the way health professionals must relate to those they seek to serve. Freire's educational model is one in which both the consumer and the professional bring their experiences together and use this to guide their exploration of the subject of their interaction in the process of service delivery, both of them become subjects of the health care context. The main feature of this approach is its tendency to reduce the dichotomy between 'the ones who-provide' and the 'ones-who-receive'. Each is ultimately transformed by the experience if they are both engaged in the service provision as partners, and by what they learn from each other. In this context the professional provider is more than a catalyst for change and cannot bring change to individuals or communities, without being touched themselves by the process.

Community Oriented Primary Care originated from the rural areas of South Africa in the early 1940s (Kark & Kark, 1999). By taking time to get to know their clients and family members in the clinic and within family settings they began the process of involving the community in their own health care. Sydney Kark defines COPC as a form of integrated clinical care that brings together personal health and community medicine within primary care settings. This integrated system of care focuses on the target community as the foundation for needs assessment, health planning, service delivery, and evaluation of defined services. It was a primary care delivery strategy that relied heavily on established priorities of target populations in the design and implementation of services, integrating all aspects of health issues that concern target communities. The felt needs and priorities of the target population were central to program operations, facilitated by flexible health practitioners able to detect and respond to changing needs and priorities of those they serve through dialogue.

Investment in Social Capital: A rapid review of the economic changes that happened in East Asia (Bloom et al., 2004) suggests that improvement resulted from the growth of physical, human, and social capital. The model must promote investment in human capital to expand people's capabilities and access to opportunities in the social, economic, and political arenas (Kenya Human Development Report, 2001) leading to improved quality of life by achieving the essential elements of dignified living (Kaseje & Oyaya, 2002). It must promote investment in social capital to ensure complete well-being, as well as a sense of identity and belonging, giving people the ability to live and to be what they wish to be (UNDP, 2004; Kawachi, 2001). Flexibility in application of principles is important to permit adaptation of methods to local contexts, addressing public policy and market forces that can produce powerful incentives for change.

3. A MODEL FOR SUSTAINABLE HEALTH SYSTEMS IMPROVEMENT

The diversity of the health and development situations on the continent necessitates a flexible, continental framework. This framework would provide guidelines on governance, management,

monitoring, and evaluation towards health systems improvement but would have to be customized to local settings. The essential elements of the model developed from the experiences, principles, and strategies summarized above would include the following elements:

3.1 Partnership for Effective Health Action

Emphasis on partnership recognizes that there are multiple stakeholders involved with different interests, strengths, capacities, resources, experiences, and commitments but with similar concerns about health status improvement in Africa. Therefore, it is necessary to mobilize such stakeholders as individuals, households, communities, the private sector, the public sector, and research and learning institutions to be partners in the improvement of health systems performance.

Critical to partnership is the need for partners to recognize the skills and contributions of each other as equal in value to establish relationships of mutual trust and confidence. This is possible only if the contributions and actions required of each partner are based on each partner's capacities and areas of their own influence; not on areas of concern or need. It is in the areas of influence where any effort or time investment would reap maximum returns. This is a way of ensuring that each partner also benefits or reaps results from their contribution. Partners may benefit in areas of need because of the partnership but, partnership building should not be based on needs.

Because issues needing action are limitless, partnership action must start not with the most urgent issues but with those they can address given the resources, experience, and skills they possess. This provides an entry-point and leverage for change, significantly impacting change beyond the action point. It increases confidence among partners and generates more energy, increasing the area and extent of effective individual and joint action. In this way the partners, as a group, and individually, gain control over their situation. It is encouraging to note that when one element of a difficult situation is changed the whole situation actually changes, bringing about positive results. Continuous improvement creates an upward spiral for positive change as partners pool effective action within their areas of influence. The approach underpins the fact that where there is investment by all partners each partner can gain more if they work together.

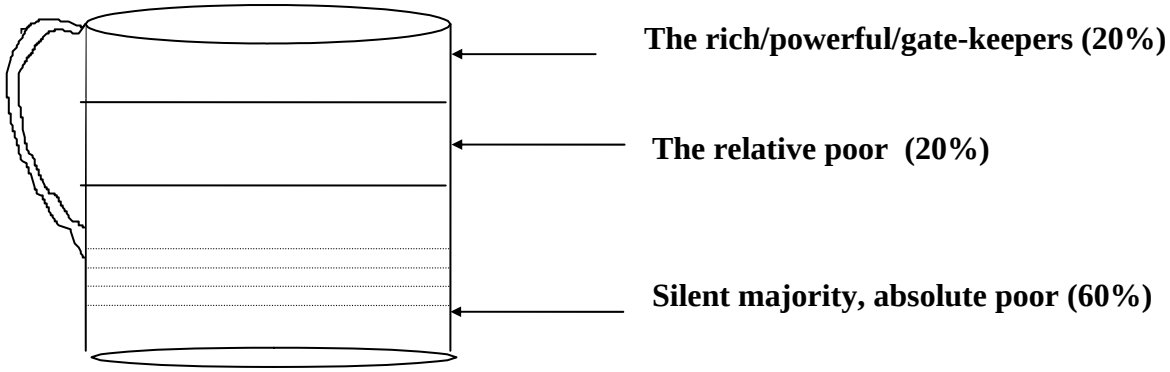
It is to be noted that the partnership approach ought to include the clients. As Holman and Lorig (2002) observe, health care should facilitate an ongoing relationship between providers and consumers, making it possible for the clients to make full use of their own, and their community's, resources for health. Partnership becomes the basis for any needed intervention in which provider and consumer must participate. The partnership approach should recognize that communities are not homogeneous, and processes of joint action could exclude the most needy.

It is because of this that the dialogue process must be continuous down to the household level, until the most vulnerable are included. Developing and using a village register is useful not only for monitoring and evaluation but also for ensuring that every household and individual is included.

It is crucial to include the households in the partnership for health improvement, noting that

between 70% and 90% of all sicknesses are taken care of at the household level (WHO 2000). In Africa the majority of deaths (60%) occur at home without any health system contact (UNICEF 2002). It is at the level of the household that primary decisions and actions that influence the health outcomes of a community are made. It is because of this that health workers that are close to the households such as community based workers have been useful in accelerating health status improvement (Kaseje et al., 1989; Taylor & Taylor, 2004). They are particularly effective if they are seen as an extension of care from the home rather than being an extension of the formal system into the community, hence the need to keep them as volunteers. It is hard for health workers to identify with the community if they are being paid by the formal system. It is in this way that household participation in the health system is enhanced. This approach strengthens the community based system, not as an alternative, but as an integral component of the health system.

Community Structure



3.2 Dialogue for Effective Health Action

Partners need to engage in an iterative process of dialogue based on available, current information. This approach works because it links action to available evidence, demonstrates progress towards the goals set by the partners, and justifies continued action based on accountability and responsibility. The process involves joint assessment and dialogue as well as joint planning and action (ADPA), each stakeholder concentrates on elements of their core business that contribute to the common goal of health improvement. Many workers have demonstrated the fact that regular planning based on informed dialogue can facilitate change through enhanced self-efficacy (Bandura, 1997, 2000). Dialogue forums are organized to synergize efforts and motivate each other through ADPA. In this way each sector achieves their own objectives, according to their mission, while bringing about health improvement among populations they serve as they deal collectively and severally with complex causative factors beyond the health sector.

This approach focuses on filling the gap between the possible and the current situation by many concerned partners towards a common goal (Oldham, 2004). It applies principles of appreciative inquiry methods as described by Cooperrider and Srivastas (1987) and continuous improvement

as described by Berwick (1989). The outcome of discussion is transformed into a plan, focusing first on a small number of positive deviants but aiming for the tipping point of 20% of the target group informed by data (Rogers, 1998).

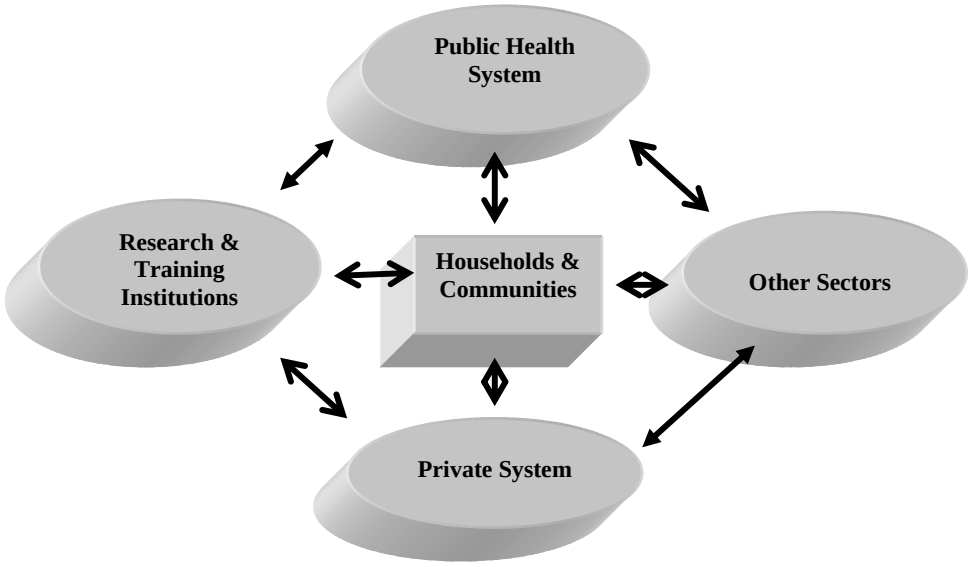
Dialogue ensures that health professionals test their theoretical frameworks on the real life experiences of the clients and communities and discuss opportunities and limitations of various alternatives proposed. In this way the professionals are transformed from being top down service providers to joint problem solvers, with a deeper appreciation of the role and capacity of people to enhance their control over their situations.

3.3 Governance for Effective Health Action

A critical aspect of strengthening health systems lies with improved governance, based on principles of decentralization; inclusive representation; defined constituency and mandate; and democratic mechanisms of selection and accountability. Creating new efficiencies can result from new organizational structures and processes (Bossert, 2000). Sohani et al. (2003) demonstrated that democratically elected governing structures markedly improved the quality and sustainability of health and development initiatives. This is particularly so when they have full control of the income generated by themselves. The empowerment elements include internal **resources,** enhanced **ability** through training, **authority** to participate in decision making and **responsibility for action**, enhancing capacity for partnership engagement.

These governing structures that are built on existing family networks, administrative, or faith based structures and improve performance continuously through a regular process of ADPA, informed by **timely information** for decision-making and accountability. The information sources, indicators, collection, and processing mechanisms are based on the ECPH derived from people's priorities for improvement.

Fig 4: The Partnership model



Source: The Tropical Institute of Community Health (TICH) toolkit, 2002.

3.4 Sustaining Effective Health Action

Health professionals need re-orienting by an experienced facilitator for them to work with communities and clients as partners. This approach requires relational, leadership, and communication skills that they may not currently have. Regularized dialogue, as well as forums for recognition and celebration are necessary to keep partners enthusiastic.

Although the model promotes community based approaches, it should be funded by the state budget and complemented by local funds and in-kind contributions. Various options of financing exist including: public financing; setting up social insurance schemes; targeted out of pocket contributions and cost-sharing by those who can afford it; prepayment schemes; and government-supported voucher systems. In addition, traditional modes of payment may be applied based on client satisfaction. In this model, the focus is on relationship rather than fee for service. Consumers are encouraged to pay in kind on the basis of satisfaction rather than actual cost of care.

Government-supported voucher systems could be designed to cover the most critical effective-elements of care for those who are unable to pay. These vouchers can be provided at a standard price by state or private sector agents to consumers to cover a defined package of services, no matter what the direct costs are. This ensures economic access for all and distributes costs among users of the services. The service providers contracted by the agent are then paid based on the number of clients they have served according to agreed cost per service and per consumer rather than the actual cost of treatment received. The problem with this and other targeting mechanisms is that there is little evidence they have worked in practice, due to difficulties in appropriately identifying beneficiaries (Kivumbi and Kintu, 2002).

The community-based options among the suggested health financing schemes tend to work best when linked to economically productive initiatives that strengthen people's ability to pay premiums or purchase vouchers. In this regard, the government can work in partnership with the communities and private sector to establish financial support systems based on the context. Such schemes could be supported by the national social health insurance scheme; supported by regular income earning citizens able to cover costs beyond their own health care needs. This would reduce the out of pocket expenditure on health care by poor households and increase the success rate of community financing initiatives.

3.5 Measuring Effective Health Action

The measurement of system effectiveness should be based on the agreed upon essential care package. ECPH should be based on the life cycle to ensure participation and access. Critical elements of ECPH may include newborn care, nutrition, breast feeding, focused pre-natal care, prevention of mother to child transmission of HIV, delivery by trained midwives, family planning, family and community support, shelter, water and sanitation, community integrated management of childhood illnesses, education, employment, investment, and screening. All these elements should be reflected in the information system developed.

The existing information systems are usually not timely enough in analysis and feedback for

informed decision making in planning and action (WHO, 2005). Such systems should include data related to service provision and population based information, including census data, vital registration data and household surveys. The World Bank's World Development Report from 1993 proposed that health status could be substantially improved without the investment of a large amount of financial resources if priority setting, planning, and action were based on the evidence of disease burden. It predicted that the provision of cost-effective packages of essential interventions could, by reaching 80 % of the population, result in a 32% reduction in the burden of disease.

At individual and community levels, information is needed for assessing the extent to which services are meeting the needs and demands of the communities (Abouzer and Boerma, 2005). Better availability and use of information has been shown to deliver cost savings, reduce systems inefficiencies, and improve health outcomes (Stanfield, 2005). The health system should permit the selection of effective and affordable health interventions to address the priority health concerns revealed by the information system. Others have demonstrated the effectiveness of using up-to-date information for planning and resource allocation in improving health status (De Savigny et al., 2004).

Measurement elements in the health system focus on structures, processes, and outcomes of care. Often the concerns of the consumers such as client satisfaction are not included (Rundall et al 2002). The suggested approach must include all stakeholders in designing and implementing the measurement of progress towards partnership goals. The indicators for assessment must relate to outcomes that people care about. These are indicators that are likely to trigger a strong response from the community and the health system while paying attention to the assessment of progress towards the MDGs. The main objective is to facilitate improvement in the performance of the district health systems by strengthening evidence-based governance and management, through dialogue between service providers and consumers. This would generate a lasting connection for sustained health improvement. Taking the above into account, I would recommend the following indicators to be discussed among partners: proportion of children fully immunized by age; percent of the population treating drinking water at point of use; proportion of households with children under 5 years of age sleeping under insecticide treated bed nets; proportion of mothers delivering with a skilled birth-attendant; and proportion of clients satisfied with service provision.

4. CONCLUSION

In conclusion, the worsening indices of health status in Africa demand a fresh look at the way health systems are organized and, how these systems address the complex causal pathways that lie beyond the influence of the formal health sector. This recognition suggests that effective action will only be possible when the formal system providers work in partnership with other stakeholders, particularly the community, as joint problem solvers through regular, evidence-based dialogue. This approach requires decentralized, inclusive democratic structures in the health system with effective representation of the needy households to ensure that their voices are heard. All stakeholders in the proposed participatory structures require training and orientation in skills such as communication, leadership and relationship building to ensure effective joint action for health, starting with what is possible and expanding to what is needed

for sustained improvement in health status to occur.

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