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STRENGTHENING THE STEWARDSHIP FUNCTION OF LOCAL HEALTH SYSTEMS IN FRANCOPHONE WEST AFRICAN COUNTRIES: IS THE DIRECT FINANCING MECHANISM A VALUABLE APPROACH?

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Strengthening the Stewardship function of local health systems in Francophone West African countries: is the direct financing mechanism a valuable approach?

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An abstract of
A thesis submitted to the Faculty of the Rollins School of Public Health of Emory University in partial fulfillment of the requirements for the degree of Master of Public Health in the Hubert Department of Global Health

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ABSTRACT

If most African countries are implementing on-going reforms to better decentralize their health systems (Lambo and al., 2003), they are still facing major challenges including inadequate funding, lack of autonomy and poor governance of local health systems (WHO, 2002). There is growing evidence suggesting that a broader concept of governance is required. The World Health Organization (WHO) proposed in 2000 the notion of stewardship applied to health systems. It combines accountability and sense of service, cost-effectiveness, and equity.

Previous research has demonstrated that stewardship is a complex concept, challenging to apply and neglected as a research topic for effective health reforms (Murray and Evans, 2003.) There is, in particular, a need for studies on how to strengthen the stewardship function at a decentralized level in West African French-speaking countries.

The purpose of this study is, therefore, to examine approaches to improving the stewardship function at a decentralized level, in the context of health reform. This present study is based on a literature review and a case study on a contracting practice implemented in Senegal by USAID and Abt. Associates: the direct financing mechanism[1]. It contributes to answering the following research question: is the direct financing mechanism relevant for reinforcing stewardship at the decentralized level in Francophone African countries?

This exploratory study demonstrates that this mechanism has several strengths that could benefit initiatives intended to improve the stewardship function at a local health system level. These strengths include the direct provision of additional resources reinforcing the autonomy in decision-making processes, improved financial management capacities and the building of partnerships with the major players at the decentralized level. The direct financing mechanism could be considered as a conducive environment for effective stewardship and more effective health reforms. The findings of this thesis authorize a more comprehensive understanding of the concept of stewardship as compared to governance and argue in favor of the adoption of stewardship as an entry point to health system reform in Africa.

Key words: Stewardship, decentralization, contracting practice.

[1] In this document, the direct financing mechanism is also referred as a project.

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ACRONYMS

ACA	*Association Conseil pour l'Action*
AHILA	Association for Health Information and Libraries in Africa
AWP	Annual Work Plans
CIB	Consolidated Investment Budget
CONGAD	*Conseil des Organisations Non gouvernementales d'Appui au Développement* (Council of Non-Governmental Organizations for Development Support)
CME	Continuing Medical Education
DPPD	*Document de Programmation Pluriannuelle des Dépenses* (Multiannual Expenditure Programmation Document)
FAA	Fixed Amount Awards
FARA	Fixed Amount Reimbursement Agreement
FDD	*Fonds de Dotation à la Décentralisation* (Decentralization Fund)
FHI	Family Health International
HIV	Human Immunodeficiency Virus
HRH	Human Resources for Health
HSS	Health System Strengthening
IPM	*Institution de Prévoyance Maladie* (Institute of Health Insurance)
IPRES	*Institution de Prévoyance Retraite du Sénégal* (Retirement Planning Institute of Senegal)
ITM	Institute of Tropical Medicine
LGEF	Local Government Equity Fund
LGHOP	Local Government Health Operational Plans
MSAS	*Ministère de la Santé et de l'Action Sociale* (Ministry of Health and Social Welfare)

MSMP	*Ministère de la Santé et de la Prévention Médicale* (Ministry of Health and Medical Prevention)
NGO	Non-Governmental Organization
NPLD	National Program for Local Development
PBF	Performance Based Financing
PHC	Primary Health Care
PHE	Public Health Institution
PNDS	*Plan National de Développement Sanitaire* (National Health Development Plan)
PRB	Population Reference Bureau
PSE	*Plan Sénégal Emergent (Plan for an emergent Senegal)*
RDA	Regional Development Agencies
UEMOA	Union Economique et Monétaire Ouest Africaine (West African Economic and Monetary Region)
UHC	Universal Health Coverage
USAID	United States Agency for International Development
WHO	World Health Organization

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CHAPTER 1. INTRODUCTION

1.1 Context and rationale

Decentralization is increasingly emerging as a fundamental principle and pillar of democracy and good governance in Africa and the world (Bossert 1998, Saltzman and al, 2006;). Announced as an effective means of meeting the needs of grassroots populations, decentralization is often associated, from a public health perspective, with better health (Saltman and al., 2006; Bankauskaite, 2007). The local level appears to be the appropriate and privileged level for the design and the implementation of health policies and strategies.

Most health systems in Africa are in the process of on-going reform (Lambo and al, 2003). While the decentralization of health services is central to these changes, it is very challenging to implement. In fact, it is often observed that administrative decentralization and the transfer of powers to local authorities are mostly not accompanied by the transfer of adequate human and financial resources (Bossert, 1998). Consequently, empowering the Ministries of Health, as well as core actors at the regional and district levels, for their new responsibilities and tasks has become a necessity for well-performing healthcare systems at all levels.

WHO has emphasized a health system strengthening framework with six functions: "service delivery; health workforce; health information; medical products, vaccines, and technologies; financing; and leadership and governance" (WHO, 2007, p. V.) These functions are pivotal to leverage health systems performance.

During a conference, held in Ouagadougou, Burkina Faso in 2008, the countries from the Africa Region recommended that the WHO readjusts this framework to reflect their challenges and their renewed commitment to Primary Health Care (PHC) and Health System Strengthening

described in the Ouagadougou Declaration (WHO, 2008). Three functions have been added: "community ownership and participation, partnership for health development and research for health" (Figure 1) (WHO, 2008, p.12). The leadership and governance function was therefore placed at the heart of the health system and presented as pivotal for the dynamics between its different components.

Figure 1: Ouagadougou Declaration Framework (WHO, 2008)

The Ouagadougou Declaration highlighted the fact that governance is central, and requires vision, influence and knowledge management, primarily by the Ministry of Health at different levels. This function has to be strengthened in the process of improving health reforms and decentralization. Good leadership and appropriate management at various levels of the health system imply that there is general guidance and also that effort is mobilized to achieve the goals, and ensure that resources are spent efficiently.

The concept of stewardship, close to the notion of governance, is used increasingly often. According to WHO (2010), it is a cost effective and outcome-oriented approach to governance, in a spirit of ethics, equity, and social justice. It is also a political process that involves matching opposing influences and demands. Some authors (Boffin, 2002; Caufield and al, 2012; Kapoor and al., 2014) define stewardship as an oversight role of all the components and functions of a given health system. This notion has become less ideological; the goal is to demonstrate that health reform and decentralization require skillful stewardship, essential for managerial effectiveness (Lipsky and Gribble, 2014; Swanson and al., 2015; Seitio-Kgokgwe and al., 2016).

1.2 Problem statement

As mentioned by Dr. Margaret Chan in the foreword section of WHO's Framework for Health Systems Strengthening (WHO, 2007), several concrete strategies for improved performance need to be developed and implemented to meet health systems' national priorities and context-specific needs.

Despite a significant body of literature on health systems strengthening, based on the improvement of these functions (WHO, 2007; Adam and al, 2012; Senkubuge, 2014), and the development of many initiatives by international organizations and donors, the critical issue of stewardship has received limited attention. There is, in particular, a need for studies on the function of stewardship at a decentralized level and how to strengthen it in Africa, and more importantly in West African French-speaking countries.

As a matter of fact, the West African region is characterized by its bad health indicators, the weak quality of care delivery, and systemic corruption in the health sector (Olivier de Sardan and al., 2015). Moreover, the region is disrupted by internal conflicts that further deteriorate the sanitation situation. The recent Ebola outbreak in West African countries is a

glaring reminder of the limited capacity of their health systems (O'Hare, 2015). In most of the West African countries, their financial resources depend on the national and global economy (O'Hare, 2015).

The francophone countries in West Africa, notably, are lagging behind their English-speaking neighbors in West Africa. As an example, they have the highest rates of maternal and child mortality, the highest fertility rates and the lowest contraceptive prevalence rate (PRB, 2015). English-speaking countries are also ranked in a more favorable position regarding health systems research (Aidam and al., 2016).

Finally, there is a need for a strategy to support local health systems to overcome their challenges: insufficient resources, lack of control over resources and planning at the regional and district health system, lack of skilled health workforce, poor coordination and limited regulation.

1.3 Purpose statement and research questions

The purpose of this study is, therefore, to examine approaches to improving the stewardship function at a decentralized level, in the context of health reform. This qualitative study will contribute to answering the following research question: what are the strategies to improve stewardship at a decentralized level? And more specifically, the following sub-questions:

- What approaches are described in the literature to strengthen the stewardship of regional, provincial and district health systems, and more specifically in Francophone African countries?
- Does the direct financing mechanism improve the stewardship of local health systems?
- Is it consistent/compatible with the district-level reforms strategies?

- Could this approach be relevant for reinforcing stewardship at the decentralized level in Francophone African countries?

The scope of the study is the area covering the following nine French-speaking West African countries: Benin, Burkina Faso, Cote d'Ivoire, Guinee, Mali, Mauritania, Niger, Senegal, and Togo.

1.4 Significance statement

This study is relevant to public health for several reasons. First, it could reinforce the body of knowledge about stewardship in Francophone African countries, and provide exploratory evidence on potential approaches to improving this function at a decentralized level. Also, a conceptual framework, providing a rationale for the assessment of the effects of a health governance and financing program on the function of stewardship, is proposed and tested. The aim is to contribute to the operationalization of the notion of "stewardship" in a context of reforms in the local health system, and the optimization of health governance and financing programs in their capacity to strengthen this function.

Secondly, in this past decade, African countries have increasingly made use of contracting practices with the intent to strengthen health systems and improve health reforms (Kadai and al., 2006). In countries like Senegal, even though the Ministry of Health has put in place a contracting policy, no such study exists on contracting practices as means to enhance stewardship at a decentralized level. The probable benefit is that Ministries of Health, donors, as well as programs, are provided with improved evidence-based knowledge which they can apply to accelerate regional health reforms, considering that the universal argument for stronger decentralized health systems is the potential for improved quality and coverage of services.

Finally, it is important to underline the influence of stewardship on all other functions of a given health system. An essential question is to what extent regional and district health systems are exercising effective stewardship. This study recalls the need to strengthen the managerial capacities of local health systems to guide, oversee and monitor the technical and financial activities of actors and stakeholders in the best interests of the populations.

1.5 Glossary

Accountability: According to WHO (2011), it refers to the end product of the process which guarantees that health actors are responsible and made accountable for their actions.

Decentralization: As applied to health care, it describes all types of transfer of skills or activities (planning, actions, management, supervision, fiscal, administrative, ownership and/or political authority) from the central Ministry of Health to the periphery (Saltman and al., 2006).

Fixed Amount Awards (FAA): As reported by to the United States Agency for International Development (USAID), FAA is a legal agreement between their institutions and a Non-Governmental Organization, that focuses on outputs and results, limits risk for both sides, and requires only limited financial and management capacity (Barrington, 2010).

Fixed Amount Reimbursement Agreement (FARA): It is a financing mechanism – not a procurement mechanism – where there is an agreement to give to a governmental institution a fixed amount upon a consensual determination of a package of activities to be implemented (Barrington, 2010).

Health system: WHO has referred to the term as a very complex system that includes "all the activities whose primary purpose is to promote, restore or maintain health" (WHO, 2000, p. 5). A health system, therefore, requires a qualified workforce, a robust financing mechanism, well-maintained facilities, and reliable information.

Health system performance: There is no single unanimously accepted measure to assess health system performance. However, WHO has suggested that health systems perform well if they achieve the goals for which they should be held accountable. Health outcomes, for instance life expectancy and child mortality, are commonly used to evaluate health systems performance (WHO, 2011). Other measures also exist such as health system's responsiveness, meaning how well a health system meets the legitimate expectations of its populations and how fairly the system is financed.

Governance: No single universally accepted definition exists for the term, which commonly refers to the way a country is governed. It includes the process by which authority and power in a given country are exercised to formulate and implement effective policies and strategies.

Stewardship: Saltman and Ferroussier-Davis define stewardship as: *"…a function of government responsible for the welfare of the population, and concerned about the trust and legitimacy with which its activities are viewed by the general public"* (Saltman and al., 2010, p. 735). Stewardship in health is the very spirit of good government.

1.6 Organization of the document

The thesis is organized as follows. First, a global introduction to the topic presents the context and the rationale, as well as the purpose statement and the research questions. Then a literature review focuses on the theoretical understanding of stewardship, the evolution and application of the concept in Africa, and the Senegalese context. This chapter is followed by a presentation of the methodology used. The next two sections are dedicated to the results of

the case study on the direct financing approach, analyzed through the lens of the stewardship function, as well as the discussion of the implications in terms of capacity building. The final section concludes with general remarks and practical recommendations.

CHAPTER 2. CONCEPTUAL AND CONTEXTUAL BACKGROUND

This chapter presents a comprehensive understanding of the concept of stewardship applied to a health system, its functions as well as its interconnection with health governance. This section also examines the Senegalese health system, with a focus on the process and model of decentralization, the progress made and the current challenges. To complete this overview of the Senegalese context, the function of health financing is also analyzed, since this study will explore how a contracting model, aiming to provide resources to the local health system, can contribute to strengthening the stewardship function at a decentralized level.

2.1 Stewardship

2.1.1 Clarification of the concept and its evolution in the health literature

Stewardship is a concept attracting growing international interest. It emerges in the health literature in the World Health Report in 2000. In this report, WHO organizes health systems in four “functions”: stewardship, resource creation, service delivery, and financing. The emphasis is placed on the stewardship role, described as having a limitless influence on the other functions and their outcomes. In this WHO report, stewardship is viewed as “oversight and influence,” along with ‘‘the effective trusteeship of national health’’ (WHO, 2000, p. 104).

Satlman and Ferroussier-Davis (2000) further explore the concept and define it as a function of a fair government, responsible for the welfare of a population, and attentive to the trust and legitimacy of its actions from the perspective of the members of this community. While insisting on the dimensions of trust and legitimacy, the notion of “responsibility” is key in this definition: moral, political, financial responsibility, as well as responsibility for the overall performance of a country’s health system. These three notions highlight the ethical dimension of stewardship. These authors also present other definitions of stewardship that merge the pursuit of ethics with efficiency. Amstrong (1997), for instance, describes stewardship as “... *as the willingness to be accountable for the wellbeing of the larger organization by operating in*

service, rather than in control, of those around us. Stated simply, it is accountability without control or compliance” (Armstrong, 1997, p. 20.) It is also the act of holding something in trust for another. Paradoxically opposed to these more traditional views of stewardship, the expressions commonly found in the health literature to define stewardship are “accountability,” “performance,” “cost-effectiveness,” “evidence-based decision-making process,” “outcomes” (Boffin, 2002; Siddiqi and al, 2009; Veillard and al, 2011; Munthali, 2016).

2.1.2 Stewardship functions

The concept of ‘stewardship,' as described by WHO, constitutes a set of six domains, presenting in Figure 1 and Table 1 (Saltman and Ferroussier-Davis 2000; Travis *et al.* 2002).

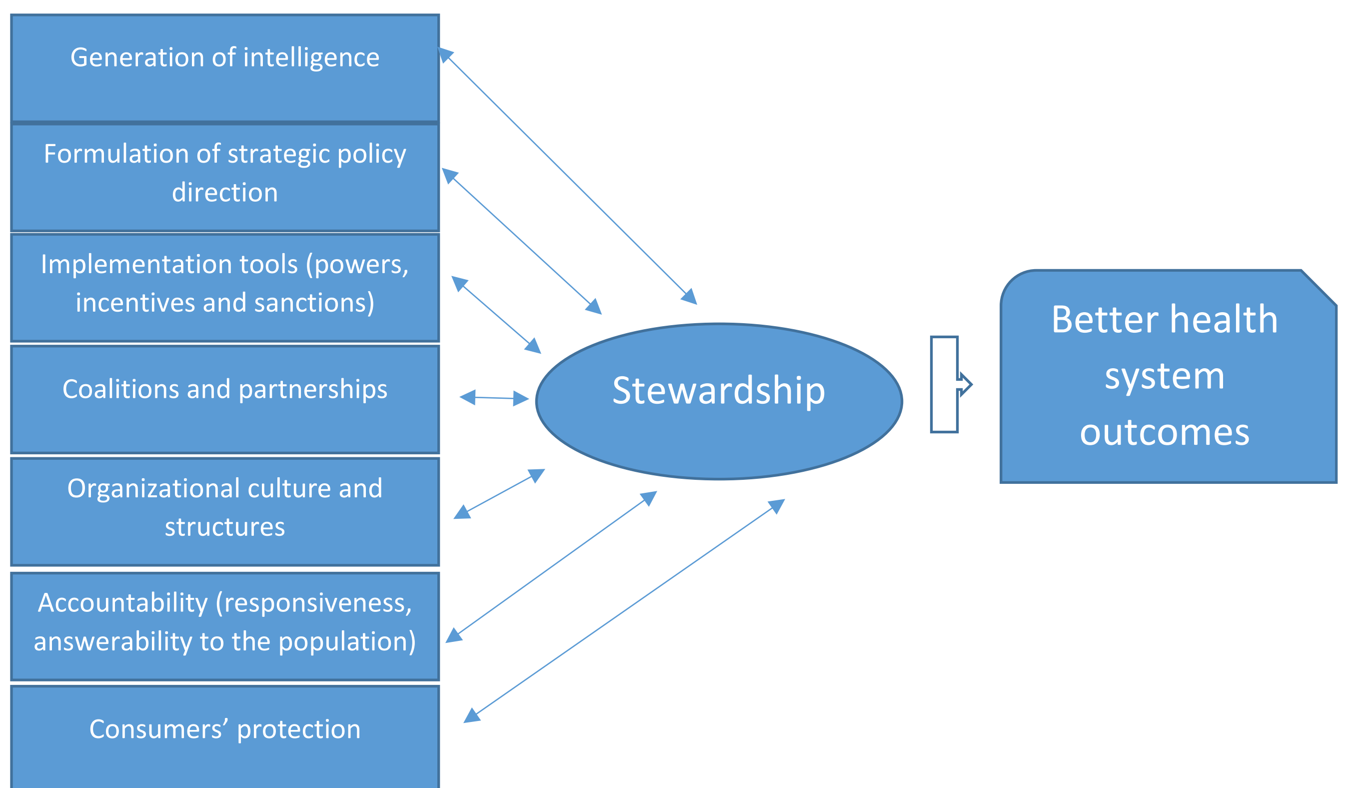

Figure 2: Sub-functions of stewardship. Source: Boffin, 2002

Core domains	Signification
Generation of intelligence	Ability to provide the health system, all its stakeholders and, in particular, informed leaders, with a synthesis of the best available information (strategic, contextual, scientific) to inform the decision-making of better-performing, more effective, efficient and equitable health policies and programs.
Formulating strategic policy direction	Ability to define national health policy based on established priorities and provide a strategic framework for the health system (system objectives, system architecture, budgetary arbitrage, roles of each actor, the introduction of strategies for change, the proposal of strategies to measure system performance).
Ensuring tools for implementation	Ability to mobilize and have available the necessary means (power, incentives, sanctions) for the implementation of the chosen health policy. The power that goes hand in hand with responsibilities. Tools to regulate, sanction or provide incentives for.
Building coalitions and partnerships	The state has many divisions that make up the public sector. The private sector, civil society, non-governmental and community-based organizations, bilateral, multilateral and international cooperation agencies are present in the country. A capacity for coordination, consultation, collaboration, and communication is essential to create beneficial relationships and to exert the necessary and indispensable influence for the proper functioning of the whole system.
Ensuring a fit between policy objectives and organizational structure and culture	The principles of management posit that structure should follow the strategy and vice versa. It is necessary to eliminate "structural" obstacles from the application of the defined policy. One must be able to minimize overlaps, fragmentations, duplications; one must be able to reflect the vision of integration of certain functions and the desired separation from others when necessary. Finally, it is necessary to be able to trace the lines of communication within the overall architecture of the system.
Ensuring accountability	Ability to assume responsibility for its policy. Ensure that actors in the system are accountable to the central authority; ensure that the system is accountable to the public. Administrative, technical, financial and communication tools (media or observers) to ensure the transparency of the operation of the system.
Consumer protection	Ability to protect populations from side effects of policy. Introduce recourse mechanisms (consumer associations). Ensure strict compliance with professional ethics.

Table 1: Subfunctions of stewardships and meaning. Source: translated and adapted from Meda et Sondo, 2011

2.1.3 Stewardship versus Governance

The World Health Organization defines stewardship as— "…the careful and responsible management of the well-being of the population, the very essence of good governance" (WHO, 2000), thereby linking these two concepts. Why are these two terms used interchangeably in the literature related to health? What are the commonalities and differences? Which of them has a broader scope?

Defining "governance" is the first step. There is no one universal definition of "governance"; instead there is a multitude of definitions and frameworks proposed by international organizations to describe this concept and its application to health systems, including those described below (Siddiqi and al, 2009).

According to the World Bank, "governance" relates to all "traditions and institutions by which authority in a country is exercised." It also describes the ability of a given government to "effectively formulate and implement sound policies," as well as "the respect of citizens and the state for the institutions that govern economic and social interactions among them" (Kaufmann and al., 2013, p. 4). This definition can be applied to the Ministry of Health, as the principal governing body of the health system, responsible for the welfare of the population on behalf of the government. The bank recommends six groups of variables to evaluate the quality of the governance function: "(i) Voice and Accountability; (ii) Political Stability and Absence of Violence; (iii) Government Effectiveness; (iv) Regulatory Quality; (v) Rule of Law; and (vi) Control of Corruption" (Daflon and Madies, 2012).

WHO defines "governance" as the process of guaranteeing that strategic policy frameworks are developed and "combined with effective oversight, coalition building, provision of appropriate regulations and incentives, attention to system design, and accountability" (WHO, 2007). Governance is associated with leadership, as one of the six health system building blocks (WHO 2007). In a toolkit developed in 2010 to assess health systems, WHO (2010) proposes several indicators to assess governance, with a particular focus on the existence of

updated national strategies and policies. This involves overseeing and guiding the whole health system, private as well as public, in order to safeguard the public's best interests. However, all leadership and governance functions do not have to be fulfilled by the Ministry of Health at the central level (WHO 2007).

USAID, for its part, does not dissociate governance from stewardship. Governance comprises "(1) setting strategic direction and objectives; (2) making policies, laws, rules, regulations, or decisions, and raising and deploying resources to accomplish the strategic goals and objectives; and (3) overseeing and making sure that the strategic goals and objectives are accomplished" (USAID, 2013, p. 1).

The literature on health systems shows, therefore, a variety of definitions of health system governance. These three selected definitions demonstrate how the concept of governance is complex and comprehensive and imbricates with the stewardship function.

There are several commonalities between these two concepts. First, they both are considered essential components of a well-performing health system (WHO, 2000; WHO, 2007). They also set the pace for all other functions of a health system. Moreover, the underlying terms most commonly used to describe both governance and stewardship are "policy formulation and guidance," "oversight," "accountability" and "partnership" (Siddiqi and al, 2009; Brinkerhoff and Bossert, 2014). Finally, in a context of scarcity of resources, they both ensure that decisions made by ministries of health respond to the health needs of the population, as well as an efficient use of resources. Another similarity is their obligation to provide information and justifications regarding their decisions, in particular regarding rules and regulations (Sheng, 2011). All these similarities could explain why "governance" is considered synonymous with "stewardship."

The literature review has also shown differences between these two concepts. Governance does not sufficiently address: (1) the multiplicity of actors and sectors involved directly or indirectly at different levels of health systems, (2) the distribution of roles and responsibilities among them, (3) their capability and willingness to fulfill their functions and responsibilities (Brinkerhorff and Rossert, 2014). The notion of stewardship has the added benefit of taking into account processes involving all actors that have an impact on the health system: "the stewards" who ensure that the outcomes of decisions made collectively are equitable and in the best interest of the population (Sheng 2011). They are also responsible for managing carefully and in a transparent manner the limited health care resources available. An essential characteristic of stewardship is indeed that it encourages a culture of self-determination, fairness, and cost-consciousness among these actors. Thus, its goal is to revitalize a sense of social purpose among health managers and restore a value of trust and legitimacy to their role (Saltman and al., 2000). Moreover, the stewardship function relies on the sociocultural and political context of a country and anchors the health sector within the broader society (Boffin, 2002).

In addition, intelligence, essential for the decision-making process, is rarely included in governance definitions (Sidiqi and al., 2009). The generation of "intelligence," a broader term than information, is one of the key assets of the stewardship function. It ensures that actors of the health system, as well as a population that benefits from its services, are provided with all the information they need to make their contribution to present and future health system outcomes (Travis and al., 2002).

Lastly, several articles (Boffin, 2002; Sidiqi and al, 2009; WHO, 2007) present stewardship as a form of governance, ethically-informed, outcome-oriented, and directed toward the health of the population. In contrast, governance is designed to operationalize the health system and involves a hierarchical structure of power from one level or structure to another. Governance is about strategy and planning, processes and structures; stewardship is an improved, ethically-sound and inclusive governance (Saltman, 2000).

These articles also highlight the broader scope of stewardship, occasionally narrowly defined as governance. Stewardship refers to the full range of functions that actors, with stewardship responsibilities, implement to achieve national health policy objectives and ensure equity in sustainable access to quality care (Travis, 2002).

To conclude, the governance function answers mostly the question “What should be done?” versus “How should things be done?” for the stewardship function (Murray and Evans, 2003). Since stewardship is a concept, more recently applied to health systems, difficult to define and to measure, the tendency is to focus on health governance. This study will help document how to measure stewardship and consider strategies that will contribute to the development of this function.

2.2 The stewardship function in Africa

As a reminder, the introduction of the concept of stewardship was in 2000 in the World Health Report. It was not until 2002 that this concept was officially discussed in the African community during the fifty-second WHO regional committee session for Africa (WHO, 2002). The focus was on the importance of enhancing the stewardship role of the government in the interest of successful health reforms in Africa. The delegates to this regional session discussed the necessary conditions for the government to assume their stewardship role effectively. These conditions included peace and security, continuity in policies developed by ministries of health, coordination of the work of donors and intersectoral collaboration. The delegates also highlighted the fact that decentralization was a critical dimension of health sector reforms in Africa. They recalled that decentralization required delegation of decision-making authority to local health systems, and should ensure equitable access to health services. Finally, they were concerned that without a sustainable financing mechanism, the decentralization process would be ineffective.

A conceptual framework to strengthen the stewardship role of governments, with three components, has been presented: stewardship *in* health, stewardship *of* health and

stewardship *for* health. First, the stewardship in health is related to how the stewardship function ensures the implementation of the other three functions of a given health system: stewardship in health financing, stewardship in health resource generation, and stewardship in health service delivery. Secondly, the stewardship of health is concerned with the general guidance, oversight and strategic management role of the health system. Finally, the stewardship for health considers the broader socio, political and economic context in which the health system operates. This form of stewardship considered the determinants of health and the necessity for a government to maintain oversight over the multiple players undertaking stewardship tasks.

The same year, a multicenter study in seven French-speaking countries[2] of the South (Boffin, 2002) focussed on one request of the delegates: what strategies should be used to strengthen the stewardship function in health systems? This study has concluded that a wide range of strategies has contributed mostly indirectly to the improvement of the stewardship function. However, few of them covers at the same time all sub-functions. Moreover, the study showed that stewardship and capacity building are linked. They both foster a culture of empowerment, and stress the interconnectivity between the performances of an individual, an organization, and a system.

A 2014 literature review in the WHO Africa region tried to answer the following question: Do African health ministries have the capacity to fully play their stewardship role, when trying to reach the sustainable development goals (SDGs)? Findings of this review show that ministries of health still are facing multiple challenges that prevent them from fulfilling their stewardship role: shortage of staff, rampant corruption and fraud, weak leadership and management, lack of funding and political interference in the functioning of the Ministries of Health (Munthali, 2014.)

[2] Burkina Faso, Haiti, Mali, Morocco, Central African Republic, Democratic Republic of Congo, Tunisia

2.3 The Senegalese context

2.3.1 Overview of the Senegalese Health System

Well organized in theory, the health system of Senegal takes the form of a pyramid at three levels. The peripheral level called the health district corresponds administratively to a whole department or part of a department. Each health district is headed by a District Chief Medical Officer, assisted by a Deputy Medical Officer, a midwife, a Primary Health Care Supervisor, a Head of Health Education, a Head of Reproductive Health, the hygiene officer, etc. At the district level, there is at least one health center and a network of health posts headed by a post nurse, rural maternity units headed by a midwife and health huts managed by a matron. The number of health posts, health points (huts) and rural maternity units depend on the population density of each district.

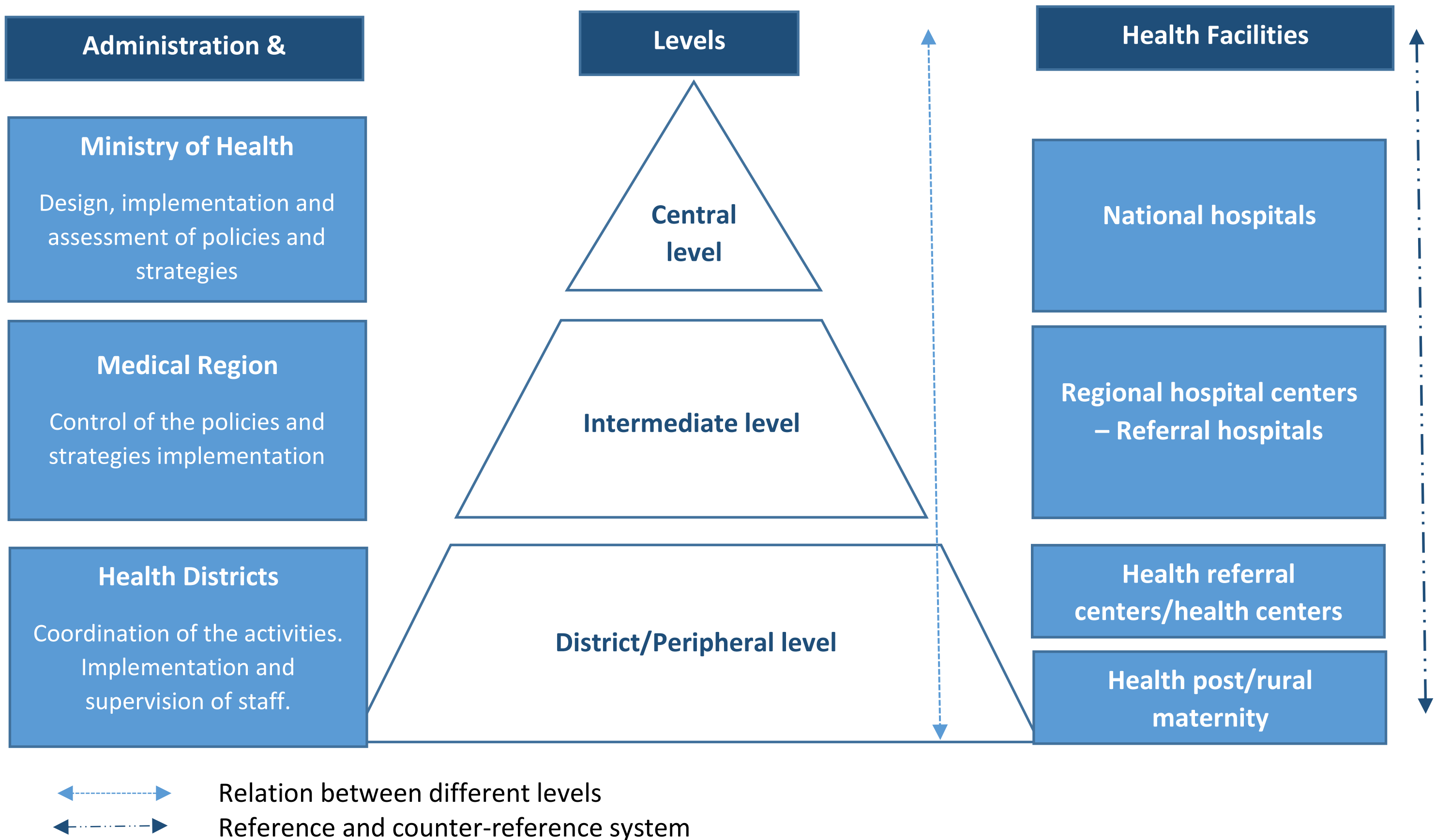

Figure 3: Senegalese Health System Pyramid. Source: Adapted from Boffin, 2002

The regional level called the medical region corresponds administratively to a region. The medical region is headed by a public health doctor known as the Chief Medical Officer, assisted by the Regional Executive Team, composed of several heads of departments of the regional hospital or attached to the medical region. The medical region is responsible for the planning and the evaluation of health programs and activities, the coordination of the health facilities, their supervision and the training of health workers over the entire geographical extent of the region. It is led by a Chief Regional Medical Officer. There is at least one hospital level in each medical region. These hospitals are legally autonomous.

The central level includes, in addition to the minister's office, the divisions, services, and units attached to it. Its prerogatives are the formulation of health policies, the allocation of resources, the control and regulation of technical and strategic support to the regions and the coordination of international partners (Tine and al., 2014).

However, besides the public sector, there is a private sector which is very well developed and participates extensively in health coverage. This latter includes the Army Health Service, School Medical Centers providing care in schools and universities, as well as health centers entirely run by large companies. The private sector consists of private hospitals; private clinics; physicians' offices; health posts with and without maternity wards; urban and rural not-for-profit clinics (generally faith-based). It also includes pharmacies, laboratories, and ambulatory care health centers accessible to the employees of private companies and their families, as well as the local community where they operate (Tine and al, 2014.)

As in many other countries of Africa, the Senegalese use traditional medicine. The government shows its willingness to promote this traditional medicine, through the census of traditional healers, the inventory of settlement areas, the creation of centers for clinical trials of herbal medicine, the production of drugs, as well as the development and the validation of documents regulating the traditional pharmacopeia (MSAS, 2014).

2.3.2 Decentralization model and process

2.3.2.1 Historical background

Since its accession to national sovereignty in 1960, where all municipalities were established as full-function communes, Senegal has developed several public sector reforms to change its Francophone legacy of high centralization. Senegal has experimented with a variety of reforms. The most significant are those initiated in 1972, 1990 and 1996 (Ndegwa, 2003). In 1972, regions and communes were provided with a legal personality and a goal of financial autonomy (Toure, 2011).

In the early 1990s, the Economic and Social Council of Senegal recommended "the involvement of the private sector in the management of basic infrastructure and social services," thus laying the foundations for recourse to contracting practices. Also, the power of the presidents of rural councils has increased since they can now authorize budgets (Toure, 2011)

Following the application of Decree No. 96-1135 of 27 December 1996, Senegal established new territorial boundaries and institutions to improve the progress made to date regarding decentralization, with 11 regions, 103 communes and 320 rural communities (Azevedo, 2017). These municipalities are elected bodies and have elected executives while the regional authorities are elected, but their officials are appointed by the president. This decree transferred nine[3] competencies, including those in health matters to regions, municipalities and rural communities (Toure, 2011).

[3] planning, land planning, public land administration, urbanization, health, education, environment, youth and sports/culture

In 1997, the Ministry of Health, through its Sector Policy Letter and the National Health Development Plan, has identified contracting practices as a way of involving local communities, Public Health Institutions (PHE), Health Committees, NGOs and Community Based Organizations (Toure, 2011).

In 1998, the hospital reform (law 98-12) transformed national and regional hospitals into companies called Public Health Institutions. The primary objective was to increase the management of these structures, with methods and management tools borrowed from the private sector, and a greater participation of communities. These institutions were required by this law, to develop a strategic plan, a budget (from public endowments and revenue from users) and a management audit unit. There was no mention of the following functions: financial management, human resources management, and marketing. Before this reform, there were no management controllers.

This hospital reform has coincided with the implementation of the National Health Development Plan (PNDS) 1998-2007. Several other initiatives were implemented to facilitate the application of the regulating texts on the transfer of health competencies to local authorities. The focus was on the clarification of roles and responsibilities of the diverse actors at the different levels of decentralization, and reinforcement of the collaboration between the Ministry of Health and the National Association of local elected officials. In the area of health, each local authority has thus been assigned responsibilities to participate fully in addressing the concerns of the population. This decentralization should above all introduce profound changes in the methods of allocation and the management of resources (Toure, 2011).

In 2000, the change of administration made it possible to introduce significant advances. These include the reform of the Local Government Equipment Fund (LGEF), the decentralization of the internal resources of the Consolidated Investment Budget (CIB), the restructuring of the Regional Development Agencies (RDA), the substantial increase in

allowances for local executives, the harmonization of the partners' intervention through a unifying program, the National Program for Local Development (Senegal, 2017).

In 2004, a new regulation called the "Build-Operate-and-Transfer Law" promoted the involvement of private sector in the development of public infrastructure (Rondinelli, 2003). In 2009, the government put into place a Ministry of Regional Development and Local Government (Ministere de l'Amenagement du Territoire et des Collectivites Locales). The objective was to reinforce initiatives aimed at accelerating the decentralization process and addressing challenges, in particular, the lack of administrative capacity and fiscal control (Dafflon and Madies, 2012).

In 2013, the current President of Senegal officially announced the establishment of the third phase of decentralization (Act III of decentralization), followed by Decree No. 2013-581 of 29 April 2013 (USAID, 2014). This new decree aims to harmonize the decentralization and local governance efforts. Under the General Code of local government adopted in 2013, local governments are responsible for the design, programming, and implementation of all actions developed in the interest of the communities. Moreover, this code requires the establishment of a community consultation framework on plans for local development projects, implementation agreements, and other local concerns. That same year, Senegal developed and started the implementation of its Universal Health Coverage (UHC) Strategic Plan 2013-2017 (Tine and al., 2014).

Today, the mapping of local authorities in Senegal is as follows:

- 14 regions led by a governor selected by the president and an elected regional council,
- 104 municipalities run by a mayor and an elected municipal council,
- 46 borough districts and 370 rural communities, led by a directly elected rural council and a President elected from among the council members, making a total of 534 collectivities (MSAS, 2014).

2.3.2.2. Model of Decentralization of the Health System

The model of decentralization applied in Senegal is mixed, political (administrative decentralization and deconcentration to regions and districts) and economic (decentralization through the development of contractual procedures) (Daflon and Maddies, 2012; Azevedo, 2017).

Deconcentration within the health system is a delegation of power and health decision-making responsibility from the Ministry of Health to its services, to deliver tailored services to meet the needs and expectations of the population (Berman & Bossert, 2000). The central government always decides for local governments, but decides on the spot and not from the capital. This administrative decentralization is a reassignment of responsibilities, generally associated with fiscal decentralization. The 1996 law made provision for the creation of two funds to offer budgetary support. The first fund, called Decentralization Fund (Fonds de dotation à la décentralisation, FDD), is intended to finance current expenditures. The second is a fund to finance local investment (Fonds d'équipement des collectivités locales). The bulk of public health expenditures was covered by allocations distributed to the regions from a national budget (administrative allocation of resources) (Toure, 2011).

For the second model of decentralization used, the state services are invited to sign conventions. The contract system is considered one of the most suitable strategies to boost decentralization of health services. It has several advantages: committing to a mutual agreement defining the obligations that each one agrees to fulfill as well as the means to be mobilized, the timetables to be respected and the methods of consultation to be implemented in order to achieve shared objectives (Moussa and Ilboudo, 2012).

In conclusion, it is important to note that Senegal is among the most stable countries in independent Africa (USAID, 2014). The decentralization of the health system in this country is characterized by its gradual evolution, with the multiplication of the local communities, from four in 1960 to 534 (Toure, 2011) today and a progressive transfer of responsibilities and power

from the central level to these communities. Another characteristic of the decentralization process is the policy of shared responsibility: even when a competency is transferred to a particular sector, responsibilities are shared between the state and the local community.

2.3.2.3 Progress made and current challenges

Senegal is among the more decentralized countries in sub-Saharan Africa, ranking (in a comparison by one of the present authors) as the eighth most decentralized of a group of 30 countries (Ndegwa, 2002).

Examples of strengths of decentralized reforms in the health system in Senegal include:

- a clear political will;
- a comprehensive, well-defined framework of territorial governance and administrative network;
- the existence of a very clear legal and regulatory framework enshrined in the constitution and the code of local authorities;
- the endowment funds for the functioning of these local communities;
- the authorization for the public sector to develop partnerships with private for-profit and non-profit sectors.

Several constraints (Toure, 2011) still need to be addressed. Corruption and the absence of transparency are issues of sufficient importance that the progress of local communities is severely affected. Also, Senegal did not back up the expanded scale of assigned responsibilities to the local government with the provision of adequate fiscal resources, in a context dominated by a weakness of local resources linked to very limited local taxation revenue. As well, as in other Francophone African countries, there is no staff recruited by, and accountable to, local authorities. At the central level, there was a natural bureaucratic resistance to decentralization. Finally, there is a slow involvement of civil society and the private sector in the management of local affairs.

2.3.2.4 Planned reforms

Senegal is contemplating restructuring its health system (Senegal, 2017), at every level of the pyramid.

At the central level, many changes have occurred since 1998, notably the establishment of a General Directorate of Health that reinforces the coordination of all actions related to the health system as a whole. In addition, the creation of the Directorate of Studies, Research and Training, has made the decentralization of paramedical training a reality. The takeover of the Information System for Management is now in effect, despite the delay in the computerization component. The establishment of the Health Institutions Directorate has also helped to advance hospital reform. Similarly, the strengthening of the National Laboratory for the Control of Medicines is beginning to ensure the quality of drugs and vaccines used in Senegal. All these "young" services and directions are still in the process of development. Another necessary proposed reform at the central level was the establishment of the Regional Directorate of Health and Social Action, responsible for monitoring the implementation of health and social policies and coordinating all structures in the regions, including public health establishments. As such, this directorate should have been responsible for, in particular:

- coordination of the activities of the deconcentrated health and social action services at the regional level;
- control of the public and private health structures in the region and ensuring performance tasks of the public health facilities;
- availability and operation of health and social infrastructure and facilities;
- collection, processing, and transmission of statistical data;
- human resource management in the region;
- planning and monitoring of programs;
- promotion of partnership, multisectoriality and contracting (MSAS, 2014; Senegal, 2017)

Unfortunately, this planned reform has not been operationalized, because the implementing decrees of the three successive organizing bills have never been finalized for political reasons.

At the decentralized level, in keeping with the actions planned for the implementation of the Act III of decentralization, the focus is on the reinforcement of contracting practices (Tine and al., 2014). Compulsory or voluntary health insurance schemes are encouraged in order to develop contractual relationships for the provision of care. It is recommended that mutual health organizations, as well as health service providers, come together to establish framework agreements (Tine and al., 2014). Performance contracts between the central level and the decentralized administration (region and health district) must define the necessary incentives and penalties to comply with the commitments of both parties to the contract (Tine and al., 2014).

Additionnally, new coordination responsibilities will be assigned to the health district management teams. In particular, they will participate in the processes of licensing, accreditation, supervision and quality control of private structures. If this happens, instead of being mere representatives of the district health ministry, district management teams will have to become the central body in the conduct and coordination of health activities at the local level. Planning for the health district management team should evolve from a process that determines priorities and allocates public resources (Ministry of Health planning) to a more comprehensive coordination tool to align and harmonize the different stakeholders in the district. Thus, there will be a capitalization of the full potential of all stakeholders in the health sector (Health Sector Planning). These two processes will strengthen the stewardship functions at the central and district levels. The stewardship must be shared with other actors through consultation processes, with the private sector.

2.3.3 Health Financing system in Senegal

Health Financing is one of the six building blocks of a health system and is considered a vital function, taking into account its effects on the improvement of health outcomes, the financial protection of vulnerable populations and the efficient, equitable and sustainable response to the population's health needs (WHO, 2010).

As a reminder, the three health financing functions are (i) revenue contribution and collection, (ii) risk pooling and (iii) purchase of services (WHO, 2010). Stewardship and governance have a critical role to ensure that a country is effectively implementing these three functions.

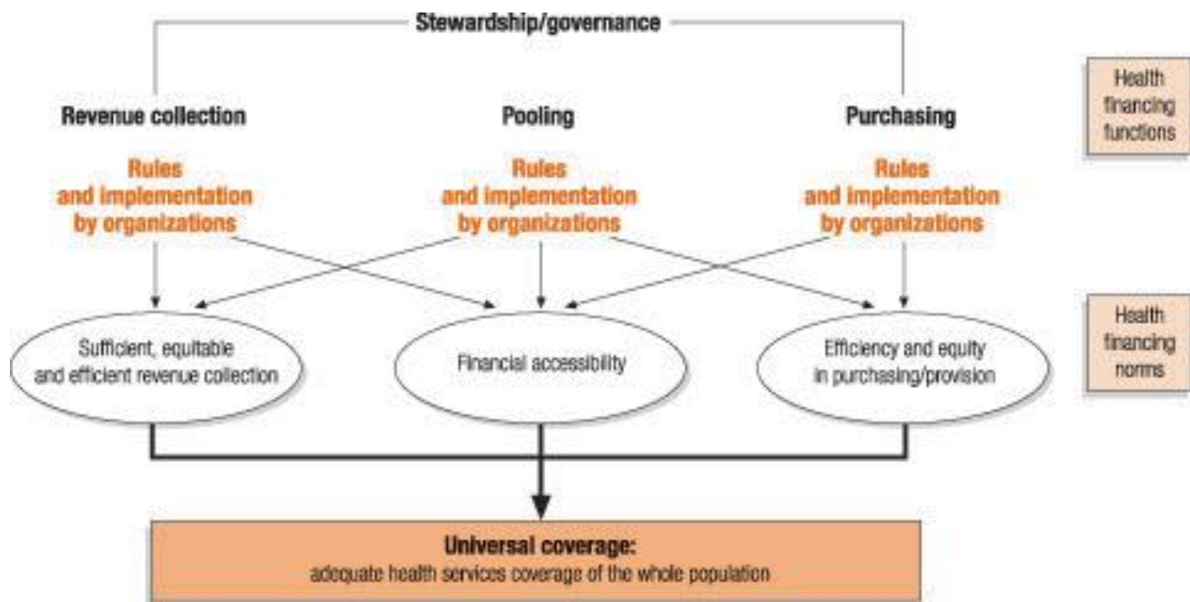

Figure 4: Stewardship and Governance

Source: Carrin and al, 2008

2.2.3.1 Political context in Senegal in regard to health financing (MSAS, 2014)

The National Strategy for Economic and Social Development 2013-2017 has evolved into the Emerging Senegal Plan (PSE), launched by the current president of Senegal. This priority action plan 2014-2018 defines the framework for the implementation of the political orientations for the extension of social protection in general, and particularly health risk coverage. Government authorities include social protection and especially universal health coverage as priority actions. The National Health Development Plan (PNDS 2009-2018) takes full account of this move towards the introduction of a system of universal health coverage.

In 2013, the conclusion of the national consultations organized by the Ministry of Health reaffirmed the option of reducing social inequalities and strengthening national solidarity. The acceleration of the implementation of the National Strategy for the Extension of Health Risk Coverage was one of the key recommendations of these consultations, which also made it possible to define strategic measures in the context of the promotion of mutual health insurance schemes and the strengthening and managing of free-of-charge policies. The three essential elements of success of Universal Health Care are breadth, scope, and depth (WHO, 2010), and are the focus of the Senegalese government.

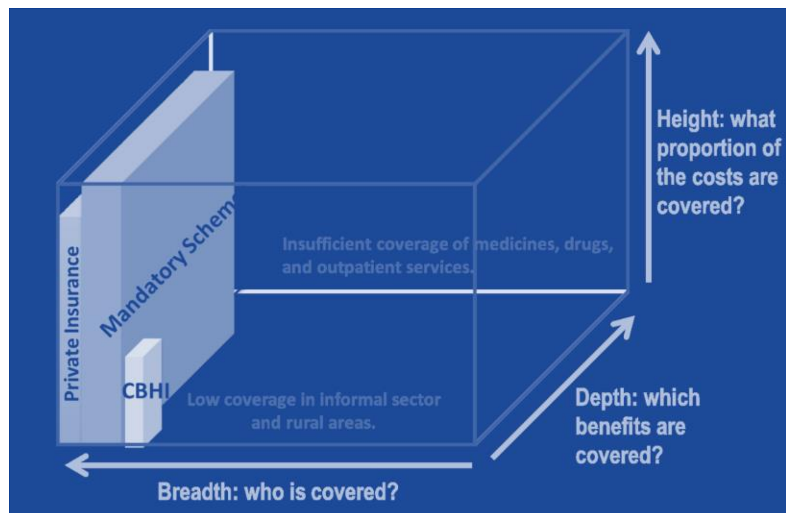

Figure 5: Health Care Insurance in Senegal, by UHC Dimensions of Coverage.

Source: Tine and al., 2014

2.3.3.2 Characteristics of the Health Financing System

As in many other developing countries, the health financing system in Senegal is characterized by the preponderance of direct payment by users (Sylla, 2014). Out-of-pocket payments generate financial barriers that reduce the number of persons that will have access to health services (Carrin and al., 2008). Thus, the health financing system is inequitable, and financial protection insufficient. According to Carrin and collaborators, there is a strong association between the incapacity to access health services, catastrophic expenditure and impoverishment and the extent to which countries rely on out-of-pocket payments as a means of financing their health systems.

Revenue contribution and collection: The government and the households are the main payers of health care services. These payers could be divided into public (central/decentralized government, *Institut de Prévoyance Retraite du Sénégal* or IPRES, civil servants fund, and employers) and private entities (*Institut de Prévoyance Maladie* or IPM, *mutuelles,* private insurance firms, households, employers, not-for-profit organizations, and donors). Public revenue collection needs to be increased, using efficient systems of taxation and premiums (Tine and al., 2014)

Risk pooling: The Senegalese health financing system has several pooling mechanisms, made up of a range of funds and payer mechanisms, which mostly provide coverage to employees and retirees in the formal public and private sectors. Otherwise, only individuals who can afford to pay out of pocket can access care when health insurance does not cover them (Sylla, 2014). Health insurance is poorly developed and fragmented, managed by the Health Insurance Institutions, in which employees and employers contribute equally. The mutualist movement is dynamic and constitutes a strong focus of the national health policy. Health mutuals, or community-based health insurances, are private entities that provide coverage by monthly or annual premiums. Plans and premiums vary by health mutual.These community health mutual offer medical services to workers in the informal sector in some parts of the country (Sylla, 2014). The Senegalese social security scheme covers all risks except sickness and unemployment. The risk of illness is not guaranteed under the Social Security Code (Law 73.37 of 31 July 1973) but in the provisions of the Labor Code issued by Act No. 75-50 of 3 April 1975 (on the institutions of social welfare). Employers have an obligation to affiliate their employees with a social welfare organization to guarantee them health insurance. Social welfare institutions comprising all or part of the personnel of one or more enterprises are set up for the benefit of employees and their families. Their creation is authorized by the Minister of Labor and Social Security. The

competent authority may make compulsory social insurance schemes for non-adhering groups (USAID, 2014).

Purchase: Providers from the public sectors are remunerated based on an annual budget and revenues from fee-for-service. Insufficient funds generate debts for public health facilities that struggle to manage financial constraints with a constant demand for services. This situation leads to demotivation among health workers at every level of the health pyramid and poor quality services (USAID, 2014). Donors have helped Senegal put in place a performance-based financing (PBF) program, that increases motivation among health workers, and improves the quality and accessibility of care. Another approach called the direct financing mechansim is also used. It will be analyzed in the case study section of this research. Contracts with health districts and medical regions increase their capacity to provide healthcare services to the population (USAID, 2014).

2.3.3.4 Challenges

A significant challenge is the lack of sufficient resources, especially at the decentralized level. The Ministry of Health depends upon the Ministry of Finance for resource allocation. The effectiveness of the health system is, of course, dependent on the overall functioning of the economy, which constrains the budgetary resources voted in the budget laws by parliaments (Daflon and Madies, 2012). WHO directions to allocate 8% of GDP to the health sector are rarely reached and external inputs from international cooperation organizations are decisive for both investment and the functioning of health facilities (USAID, 2014). On the other hand, there is also a tendency for the national level to centralize the available resources and redistribute budgets on the basis of need, so that access to care is not linked to the contributing capacities of each region (MSAS, 2014).

Another issue to consider is the capacity of health providers to develop and implement budgets efficiently. This raises more generally the issue of the lack of financial management capabilities at the central and district levels (Toure, 2011).

An additional challenge involved in improving the health financing function has to do with the ability of the health system steward to coordinate activities and information flows among the relevant stakeholders and actors across sectors and administrative levels. It also relates to the coordination between regions, to ensure equal access to quality services throughout the national territory (Moussa and Ilboudo, 2012).

CHAPTER 3: METHODOLOGY

3.1 Introduction

This third chapter provides information regarding the methodological basis for this thesis. The choice of research design, the conceptual framework, and the data collection and analysis methods are presented. The chapter also includes information on the ethical implications, the delimitations, and limitations of this research.

3.2 Study design

This research was designed as an exploratory qualitative case study, focussing on strategies like contracting practices to reinforce the function of stewardship at a decentralized level. The qualitative approach was selected to provide insight into how the stewardship function was fulfilled and strengthened at a decentralized health system level. The methods used in this qualitative case study included a literature review and thematic content analysis.

The thematic content analysis, more precisely the thematic document analysis, was suitable for this study because, as stated by Hsieh and Shannon (2005), it helped to categorize texts to make data more manageable and to interpret the texts in pursuit of deeper levels of understanding, knowledge, and meaning of a given subject. The document analysis examined data from existing documents, without collection of primary data through interviews, observations or surveys (Bowen, 2009).

Also, this study had several characteristics of a case study, as described in the literature (Tellis, 1997; Yin, 2009): 1. a defined research question; 2. an explicit purpose of the study. 3. a unit of analysis; 4. several sources of data; 5. a logic that links the data, the findings and the recommendations. The unit of analysis for this research was the direct financing mechanism, developed and implemented by Abt. Associates in Senegal. It was investigated within its real-life context. A case study approach was valuable to the objective of study since health systems

issues are often context specific. However, a description of challenges and their potential solutions, as well as processes and drivers associated with health systems reforms, in a given setting can improve the utility of findings in another setting, and contribute to the overall body of evidence to support innovative approaches to health system efficiency.

3.3 Analytical Framework

At a global level, stewardship is considered a neglected topic in health systems research, and more particularly in Francophone African countries. Research on this topic, as on any issue related to health system research, involves conceptual, analytic and design challenges (Gilson and al, 2011). While this study examines, in the body of existing research, how the function of stewardship is implemented at a decentralized level, it also provides a theoretical framework as a tool to document the potential contribution of a given strategy to the improvement of stewardship at a decentralized level. The analytical framework that guided study of the direct financing mechanism (case study component of the study) is described in Figure 3, next page.

While it was important to assess the core functions of stewardship reinforced by the direct financing mechanism, this conceptual framework also covered the context in which these functions were assumed. Therefore, two levels of analysis were considered:

- The direct contributions of the program to the implementation of the stewardship functions, the capacity building of the stewards involved in this implementation and its effects on the level of governance where these functions are assumed.

- The indirect contributions in terms of contextual factors that influence the health system fulfillment of these functions, as well as its effect on the national health reform process of decentralization.

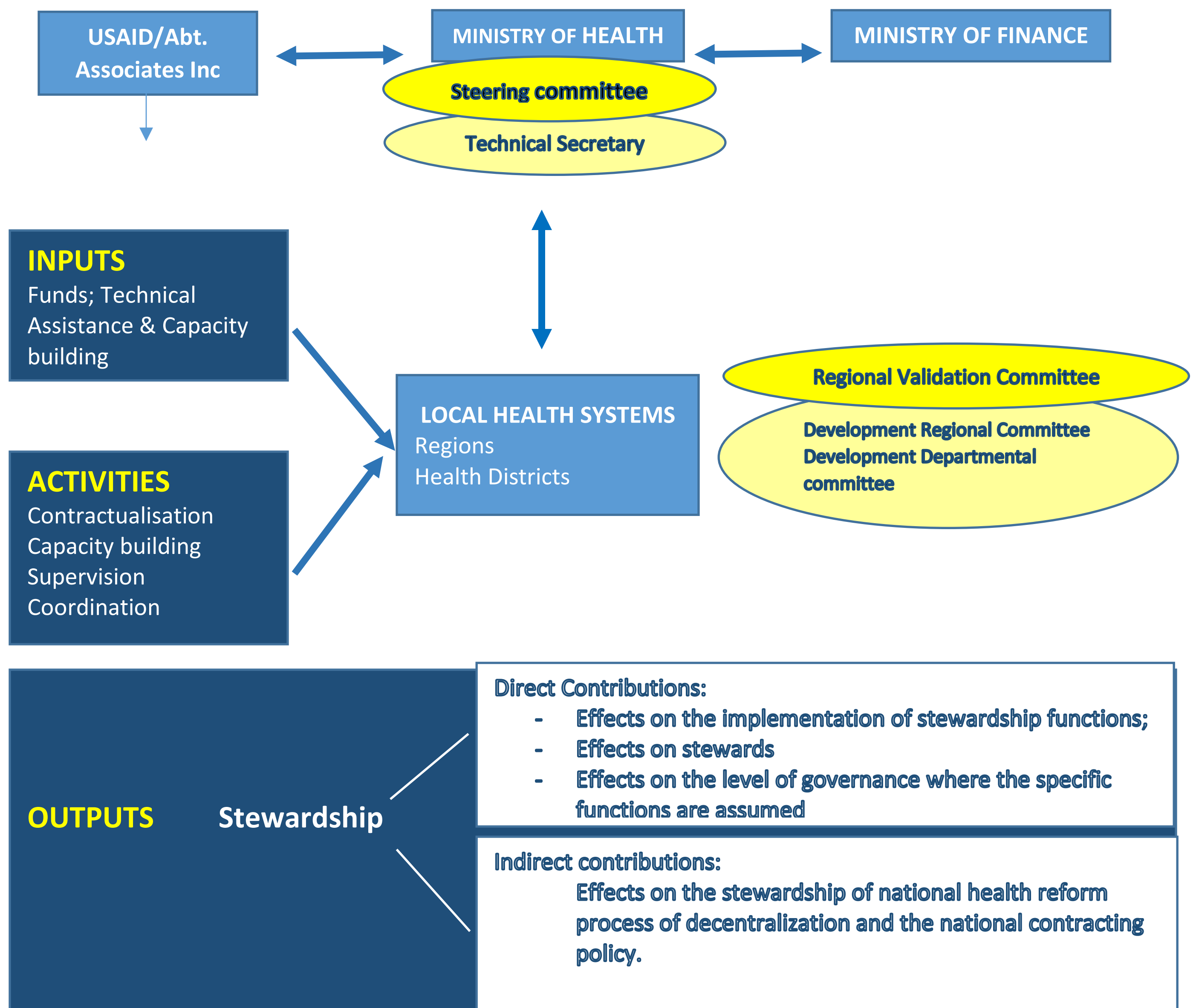

Figure 6: Case Study Analytical framework

Key questions to document the influence of the direct funding mechanism on the stewardship function of a local health system included:

- Do we observe a shift in stewardship after the introduction of the approach?
- Does the direct financing mechanism affect the autonomy of the stewards regarding decision making? Does it increase their autonomy or impose restrictions?
- Did the stewards feel deprived of their responsibilities or strengthened in their role?

- How does the direct financing mechanism change the stewards' perceptions of their own role and of the role of the local health system in improving the health status of the population for which are responsible?
- Does the direct financing mechanism affect the working environment of the stewards? Issues to be assessed include the effects on the provision of additional equipment, supplies, computers, and offices.
- Does the direct financing mechanism ensure adequate staffing, including hiring additional staff?

3.4 Different steps

The study has been developed through several phases described below:

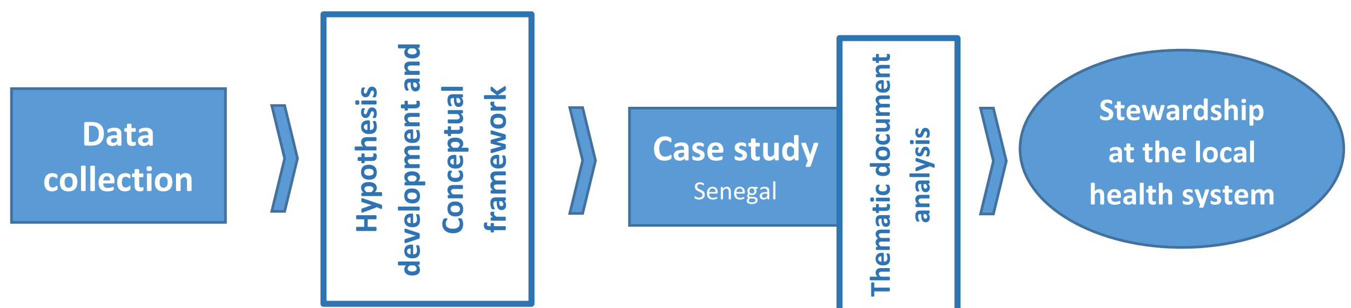

Figure 7: Steps

3.4.1 Data collection

The non-systematic literature review was done on the stewardship function and approaches to reinforce it at a local level in Africa, with a focus on Francophone African countries[4]. The review used multi-site search engines, namely: PubMed, Google Scholar, DATAD[5], Theses.fr, and AIM[6]. The research was conducted in English and in French using key

[4] Benin, Burkina Faso, Cote d'Ivoire, Guinea Conakry, Mali, Mauritania, Niger, Senegal and Togo.
[5] *Database of African Theses and Dissertations*
[6] African Index Medicus, developed by WHO and the Association for Health Information and Libraries in Africa (AHILA)

words – in particular stewardship (*pilotage, management, administration* générale), decentralization (*décentralisation*), direct financing (*financement direct*), health system (*système de* santé), health system strengthening (renforcement du système de santé), Africa (Afrique), francophone countries (*pays francophones*). The bibliography of selected articles was also reviewed to find related documents. Published research-based articles, theory-based papers, as well as national gray literature (official records of the Ministry of Health and Welfare, white papers…) were selected based primarily on their relevance to the subject area. Both Senegalese and international literature were analyzed.

For the case study, archival materials and existing data collected by Abt. Associates Inc from its national partners through their daily management information system, as well technical and financial documents developed for the direct financing mechanism, were analyzed. A very first step was the review of all documents received (baseline documents; technical and financial reports, minutes of workshops or sessions organized by the regional verification committee, contracts between the medical region and health districts, executive letters between Abt. Associates and medical regions…). A list of the type of documents finally included in the analysis is presented in the Appendix section. There were four sources of documents: 1. USAID/Abt. Associates; 2. Medical Regions; 3. Health Districts; 4. Regional validation committee; 5. External evaluation team (Cisse Sarr and al., 2016).

3.4.2 Hypothesis development and conceptual framework

Based on the literature review and the first exhaustive analysis of the direct financing mechanism, the proposed framework was designed using information from the literature review (frameworks, articles on stewardship assessment). It was based on the hypothesis that strategies like contracting practices have the potential to improve leadership at a decentralized level. The conceptual framework has provided a structure for organizing and analyzing the data available, and shaped the structure of the paper itself. This practical application, in turn, provided a good opportunity to validate and further refine the framework.

3.4.3 Data analysis and interpretation

The data collected, mainly qualitative, were analyzed using qualitative document analysis, through a process of coding, categorization of patterns and themes, and interpretation. The coding of a text's meaning into categories makes it possible to quantify how often specific themes are addressed. Hsieh & Shannon have defined qualitative content analysis as *"a research method for the subjective interpretation of the content of text data through the systematic classification process of coding and identifying themes and patterns"* (Hsieh & Shannon; 2005; p. 1278).

Quotes that most accurately illustrated the categories under each subtheme are then determined. Microsoft Word and X-mind, a mapping software, were used to develop, deductively, the code tree (cf. Appendix), based on three sources: the data, previous related studies, and the conceptual framework. The MAXQDA software, using a code-and-retrieve process and including data management features such as the ability to create memos and retrieve coded segments (Nie, 2017), was used to conduct the analysis.

The thematic content analysis contributed to a better focus on the topics of interest and managed the data around these topics and in relation to them. The process was iterative. The categories emerging from the analysis helped define the code tree and refined the analytical framework. Recommendations were formulated from the findings.

3.5 Data quality and integrity

This thesis focuses on the secondary analysis of existing data. To optimize the quality of the data and the level of reliability in their interpretation, the use of different sources of data, the choice of the methods (content analysis with Maxqda), the design of the analytical framework and the consistency in the coding process, allowed an exhaustive cross-analysis of the direct financing mechanism.

3.6 Ethical considerations

Ethics approval was unnecessary for this research since it is based on literature review and the secondary analysis of existing data on the Abt. Associates' direct financing mechanism. Even though this study has no specific sensitivity with regards to ethical implications and does not require a review by the IRB, it honors the following ethical considerations: authorization from Abt. Associates Senegal to access their archives, proper acknowledgment of authors, accurate data extraction, and interpretation.

3.7 Limitations and Delimitations

There are several limitations related to this study.

Firstly, studies based on document analysis are constrained by what data is available and its quality (Bowen, 2009). This case-study is based on information that was not collected for the purpose of this study. Even though the documents were useful in providing abundant information on the direct financing mechanism, a question that remains is the correspondence between the documents (developed primarily for reporting or evaluation purposes) and the objective reality.

Secondly, there is no universally accepted way to assess the stewardship function and the potential contribution of a given strategy to its implementation. As a result, interpretations based on the proposed conceptual framework might not be generalizable to other contexts.

Thirdly, as the focus of the thesis is on the stewardship function, other factors within the health sector or local initiatives that influence health systems performance and health outcomes, might be neglected.

Finally, a limitation to consider is the reliance upon a single researcher for the data analysis and interpretation. However, this situation has contributed to the consistency in the coding process.

CHAPTER 4: RESULTS

This study examined approaches to improving the stewardship function at a decentralized level, in the context of health reform. It was also designed to answer the following question: Could the direct financing approach be relevant for reinforcing stewardship at the decentralized level in Francophone African countries? As a reminder, this chapter provides a detailed description of research findings from a content analysis of relevant documents (cf. Appendix).

This chapter begins by presenting background information on the direct financing mechanism as it relates to the research question. Then, using the analytic framework, the following sections present findings pertinent to the direct contributions of the Senegalese funding approach to the sub-functions of stewardship, the effects on the stewards as well as its impact on each level of governance in the health pyramid.

In this study, a steward is any professional carrying out responsibilities or in a supervisor position within the local health system, or acting for the benefit of the health system. And later, the potential indirect contributions are analyzed.

4. 1 Overview of the direct financing mechanism

4.1.1 Background and rationale

As reported in the concept note of the direct financing mechanism, its design in Senegal has been based on the characteristics of two primary health sources of funding: government funding and funding from development partners. Government health funding, part of the Senegalese national budget, depends on credits: decentralized health structures do not manage cash resources. Financing mechanisms are centralized. Budgets are in general prepared at the national level, based on previous expenditures and not on targeted objectives and indicators. Regions and districts hardly have flexibility in the allocation and use of resources. The

consequences are a lack of effectiveness of public expenditures, as well as an unequal distribution of resources, which primarily benefit referral hospitals and the wealthiest population that have access to those hospitals. On the other hand, development partners use two financing mechanisms: the transfer of funds after the planning of activities and the direct funding of implementing organizations (mostly international non-governmental organizations). However, funding for decentralized services is a fiscal responsibility of central and local government units. Development partners only provide additional resources to support the government's objectives. Both partners and public funding mechanisms do not encourage performance-based management and skills building of the local health system.

Once again as stated in the concept note, the direct financing mechanism, experimented with since 2013 by USAID Senegal and its implementing agencies, addresses these two impediments to adequate health financing in the regions of Senegal. It also relies on the principles of the 2005 Paris Declaration on Aid Effectiveness, the 2008 Accra Agenda for Action, the new modalities of USAID's assistance[7], as well as the Senegalese National Health Development Plan (PNDS 2009-2018). It is built on management practices, for instance, participatory business planning, results-based management, and external control to ensure that the health system provides quality services in the most efficient way. Before the designation of Abt. Associates as responsible for the implementation of the direct funding mechanism, USAID's five implementing agencies[8] worked in collaboration to design and implement the first year of the project.

[7] Better alignment of USAID assistance to national priorities, reduction of transaction costs, increased accountability and empowerment, and sustainability of results.

[8] 1. Abt. Associates, Health Systems Strengthening; 2. ADEMAS, Health Communication and Promotion; 3. Child fund, Community Health; 4. Intra Health, Improvement of Health Services; 5. FHI360, HIV/AIDS and Tuberculosis;

4.1.2 Description and Implementation

Developed under the USAID/Senegal 2011-2016 Health Program, the direct financing is described in the concept note of the project a mechanism through which financial resources are placed under the direct responsibility of local health structures, to support the implementation of eligible activities, given on condition that a contract is signed between the donor and the beneficiary. Thus, the USAID implementing agencies can provide direct support to the operational level of the Ministry of Health.

The external evaluation report explains that the direct financing approach has been implemented over two phases. The pilot phase was executed during the 2013 fiscal year and covered the regions of Kaolack, Kolda, and Thies, where the USAID Health Program has regional offices in place. The extension phase concerns the regions of Diourbel, Sedhiou, and Ziguinchor.

The concept note presents the five pillars of the direct financing mechanism, aligned with the planning and monitoring of the implementation of health interventions at regional and local level. The five pillars are: i) Package of eligible activities; ii) Planning; iii) Contracting; iv) Payment modalities; v) Reporting and monitoring. Medical regions, health districts, and health workers are the final beneficiaries of the direct financing mechanism. It should be noted that, in some regions, other structures attached to the Ministry of Health were also beneficiaries of the funding because their activities were integrated into the action plan of the medical region. For instance, the Regional Hygiene service, the Regional Welfare Service, the Regional health training center and the local Hygiene Brigade benefited in this way.

4.1.3 Goal, objectives, and principles

The content analysis reveals that the purpose of the direct financing mechanism is to promote a culture of results-based management and accountability in medical regions and health districts. This goal is translated into four objectives described in the founding documents of the direct funding mechanism:

- Contribute to strengthening the decentralization of health services;
- Improve the planning, budgeting and implementation of health interventions at all levels of the public health system;
- Increase transparency and accountability;
- Strengthen the management capacities of medical regions, health districts, and locally-based health stakeholders.

The approach focuses on contributing essentially to the improvement of the quality and coverage of maternal health services, family planning, child health, disease control.

In addition, the direct financing mechanism relies on six principles presented in the direct financing mechanism concept note: transparency, accountability, flexibility, efficiency, additivity and predictability.

*Transparency**:** to promote information sharing among stakeholders, avoid duplication among development partners and meet accountability requirements.*

*Accountability**:** to ensure that actors are responsible for their achievements and commitments.*

*Flexibility**:** to make sure that the local health system has the possibility of adapting management rules and resources allocation in case of an emergency, a newly found gap or need to expand an activity.*

Efficiency: to streamline and adapt procedures to the capacities of the local health system, align to the objectives and procedures of the Ministry of Health, and maximize inputs at the operational level.

*Additivity**:** to reaffirm the fact that the contracting mechanism does not replace government funding.*

*Predictability**:** to guarantee that the funding mechanism is based on a multi-year commitment to support the capacity-building and skills development process at the decentralized level.*

4.2 Direct contributions to the stewardship function

This section answers more specifically the following sub-questions:

- Do we observe a shift in the stewardship sub-functions after the introduction of the approach?
- Does the direct funding mechanism strengthen the stewards at the local health system level (including autonomy of decision-making space, leadership, responsibility and skills) and

positively affect their working environments (provision of additional equipment, supplies, computers, adequate staffing, including hiring additional staff)?

- How does this approach affect the stewardship function at the different levels of governance?

4.2.1 Effects on the implementation of the stewardship sub-functions

As described earlier in the literature review, the different sub-functions included in the analytic framework are i) Intelligence and Information, ii) Vision and Strategy, iii) Tools and Systems, iv) Organizational Development, v) Partnership and Networking, vi) Accountability, vii) Customer's Protection.

4.2.1.1. Intelligence and Information

The content analysis shows that the direct financing mechanism provides an informational system designed to assist in its management and planning. The manual of procedures of this mechanism defines the data collection and reporting tools, as well as the procedures for data processing, the timing and the flow of information. The type of information shared with the stakeholders involved at a different level in this project is substantially related to its implementation. It includes a concept note, contracts, and letters of execution, plans (and their level of execution), a list of milestones, indicator performance tracking table, minutes of the meetings, technical and financial reports, workshop reports. The information is also related to available resources and reinforces the principle of predictability, critical for this project.

This information is shared between the health management team at the district and regional levels, the Ministry of Health, the NGO Abt. Associates, the USAID regional offices[9], and all actors participating in the Regional Validation Committee. The political authority (the

[9] In three regions in Senegal: Kaolack, Thies and Ziguinchor

governor) and the regional development agency is also informed on the terms of contracts and the level of execution of the direct funding mechanism.

The external evaluation report of the direct financing mechanism (Cisse Dia and al., 2016) confirmed that this system contributes to the good governance and the transparency of this project. It also highlighted the limitations of this information system when reporting that some interlocutors interviewed by the evaluation team (Cisse Sarr and al., 2016), criticized the compartmentalization of financial information between the Chief Medical Officer and his or her manager. Furthermore, as stated in this report, each member of the executive teams is concerned only with carrying out activities for which he or she is responsible.

In addition, the documents analyzed in this study did not mention if the project's data management information system is integrated into the existing local health structure's information systems. It also did not refer to the completeness, accuracy and the utilization of these data beyond this project.

4.2.1.2 Vision and Strategy

As stated in the concept note, the USAID Program and the direct financing mechanism are based on the strategic orientation of the 2009 -2018 National Health Development Plan (NHDP), that defines the priorities to improve the capacity of the Senegalese health system to deliver quality, equitable, efficient and sustainable healthcare to the population. This NHDP contains several goals and objectives that serve as a basis for mutual accountability by all stakeholders. The direct funding mechanism uses one of its implementation tools: the annual and quarterly work plans developed at the regional and district levels. Any activity financed by the project should be comprised of these plans. The documents examined also mention the advent of the multi-annual expenditure programming documents by the reform of public financial management in the *UEMOA* (West African Economic and Monetary Union) region.

Furthermore, the data analysis shows that the direct financing mechanism is presented in reference to the orientation and reforms of USAID's assistance modalities and the principles of the Paris Declaration on Aid Effectiveness. There is no indication of the national contracting policy.

Finally, the documents did not mention the existence of regional contextual strategic vision and plans, which could have served as the foundation for ownership by local health systems.

4.2.1.3 Tools and Systems

The third sub-function assessed is related to the establishment, by the direct financing mechanism, of support systems and regulatory frameworks, both tools described in the literature as a critical dimension of stewardship (Travis and al., 2002).

Support system development

The content analysis of documents reveals two components of the projects associated with the elaboration of a support system: the conceptualization and implementation of technical and financial data management systems, as well as the availability of resources for capacity building. The purpose of the support system is to reinforce the functionality and capability of the local health system.

As described earlier, the information data management system in place in each region is a decision management system with the goal of producing information on the level of execution of the performance contracts, the effects of the project, as well as challenges faced. It contributes to enhancing the functionality of the system.

As reported by the external report (Cisse Sarr and al., 2016), the second approach used by the project to strengthen the capability of the local health system is the availability of

resources for the acquisition of equipment, the recruitment of staff and their training. The goal is that, as stewards, members of local health systems have the powers to do their job. Firstly, both the 2014 annual report of the project and the evaluation report (Cisse Sarr and al., 2016), describe the type of material purchased by the project. This fundamentally comprises IT management tools (laptops, external hard drives, printers and copy machines) for the district and regional health structures. Resources have also been used to pay for the subscriptions of the districts in the Thies Region to a billing software designed for the management of health centers. Secondly, resources have been made available to recruit in some regions (e.g. Thies) a focal point for this project. Finally, training sessions for health agents were mostly organized on different topics related to the administration of the health system (e.g. skills building regarding planning, advocacy, accounting and financial management, informatics) or relevant health issues. Health agents have been trained on specific subjects including family planning counseling, recording of maternal and fetal measures and events on a partograph, norms, protocols, humanized childbirth, as well as prevention and care of post-partum hemorrhage. The following table illustrates the results of training activities funded in 2014 by the project.

Table 2: Results of training activities supported by direct funding in 2014 in the six regions.

A number of health providers in health centers and health posts trained by domain:	Total
Child Health	162
Maternal Health	380
Family Planning	309
Other priority areas (Nutrition, Malaria, HIV/AIDS, etc.)	937
Number of trained community health workers	
Child Health	331
Maternal Health	148
Family Planning	471
Other priority areas (Nutrition, Malaria, HIV/AIDS, etc.)	850

The table 3 presents the total number of health providers that have been trained in the south of Senegal and the Kaolack region.

Table 3: Total trained health providers in all areas combined in the South regions of Senegal.

REGIONS	**2013**	**2014**	**2015**	**TOTAL**
KOLDA	0	523	229	752
SEDHIOU	0	100	257	357
ZIGUINCHOR	418	22	76	516
TOTAL South Regions	418	645	562	1625

Moreover, between 2014 and 2015, the increase in community health workers and community workers trained in Child Health (from 24 to 331), Maternal Health, Family Planning (from 163 to 228) shows a willingness to train more officers than initially anticipated. in order to achieve service improvement objectives in subsequent years. Training sessions and formative supervisions were organized, facilitated and supported by members of the USAID regional offices and the USAID's implementing partners (including the Abt Associates team, in partnership with ACA, a national NGO specialized in the capacity building). These sessions were also facilitated by the regional and district health management teams. The following table illustrates the number of community health workers trained in 2014 by thematic area.

Table 4: Number of Community Health Workers trained in 2014, in the six target regions

Child Health	331
Maternal Health	148
Family Planning	471
Other health priorities (Nutrition, Malaria, HIV/AIDS)	850

Source: Direct funding annual report, 2014

In sum, as stated in the evaluation report of the project (Cisse Sarr and al., 2016), the implementation of the direct funding approach is focused on the capacity building of the health personal in these six regions and the decentralization of priority health services at the local and community levels.

Regulatory framework

In this study, regulatory framework refers to every principle, procedure, standard, incentive, sanction or structure established in the direct financing project that could contribute to strengthening the regulative role of health system stewards. One central principle behind the design of the direct financing approach is "accountability" (Cisse Sarr and al., 2016). To ensure a complete application of this principle, the project has developed a manual of procedures providing the guiding principles and standards for instance with regard to accounting, reporting, audit, and procurement. In compliance with procedures, contracts and letters of execution were signed, with articles specifically addressing the sanctions that would apply should one party not fulfill the contracting agreement. Moreover, the project has established in each region a Regional Verification Committee that serves as a regulatory body. Within each regional entity, a subgroup has been created, in charge of financial risk management. This unit is composed of the Regional Controller or its representative, a representative of the medical region, the Director of the Regional Development Agency, and one member of the Abt. Associates team. This group is responsible for the implementation of the quarterly internal audit, in partnership with the regional financial advisors. Members of this unit could also participate in the financial controls organized by the central level. Transparency is expected of districts who should inform members of this sub-committee on a regular basis. If following a mission, reservations are made concerning the regularity, trustworthiness and fairness of the financial situation of the Health District, any additional payment for any other phase of the project will be withheld until a favorable opinion has been issued. In the event of fraud, misuse, and mismanagement of funds, the contract could be terminated. An investigation will be opened to identify those responsible. If payments are made for activities, results or milestones that have not been implemented, Abt. Associates reserves the right to require a reimbursement of all payments made for such activities, milestones or results.

In accordance with the concept note, the annual reports and the manual of procedures, USAID and its regional offices, but also Abt. Associates, have a supervisory capacity. They shall have the right at all reasonable times, with prior notification to the beneficiary of the project, to

inspect activities, documents, and receipts pertinent to their agreement, to assess implementation progress and to conduct tests. It is important to highlight that the external evaluation report of the direct financing mechanism (Cisse Sarr and al., 2016) did not question the effectiveness and efficacity of these regulatory bodies.

4.2.1.4 Alignment between objectives, culture and organizational structure

For this sub-function of stewardship related to the alignment between objectives, culture and organizational culture, the content analysis did not produce sufficient relevant data to study. However, the culture of accountability, designated as a goal, in itself, in this project, is reflected throughout the different reports examined. Also, the project has defined the lines of communication and reporting, to ensure transparency and information sharing.

4.2.1.5 Partnership and coalition building

The implementation of the direct funding mechanism involved several types of actors at all levels of the health pyramid, participating in the facilitation and the functionality of coordination entities. Even though the latter were initially established for accountability and coordination purposes, they have been described in the archival documents of the project as reinforcing the partnership between actors and stakeholders, a partnership centered on health interventions at the decentralized level. To examine this sub-function in the data available, three aspects were analyzed:

- The creation and functionality of coordination entities[10];
- The collaboration with existing coordination entities;
- The typology of actors and stakeholders.

[10] All committees put into place, for instance the Regional Verification Committee, are considered as coordination entities.

At the national level, the evaluation report states that two entities were created by internal memo within the Ministry of Health in August 2014: A Steering Committee and an Executive Secretariat. The committee is chaired by the Secretary General of the Ministry of Health and consists of representatives of central services of this ministry (Internal Inspection; General Division of Health; Planning, Research, and Statistics Division; and General Administration and Equipment Division – also in charge of health finance). Representatives of USAID and its partners, WHO lead of the technical and financial partners, the Regional Medical Head officer, the focal points of all units at the central level that benefit from the USAID program, the University of Cheikh Anta Diop[11] (represented by the Parasitology and Microbiology Laboratory) were also members of this committee. Once again, as reported by the evaluation report of the pilot phase of this project (Cisse Sarr and al., 2016), the cooperation expected from the Ministry of Health could not be achieved due to the slow implementation and the weak functioning of both the Steering Committee and the Executive Secretariat. One of the consequences has been the frequent scheduling conflicts due to the lack of coordination between the vertical activities (coming from the central level) and those envisaged in the annual regional work plans. Moreover, it was also expected that the Steering Committee would propose a framework for continuous documentation of good practices, lessons learned, constraints, bottlenecks, and solutions during implementation.

The Internal Monitoring Committee for direct financing is, as stated in the 2014 annual report, an important mechanism instituted to provide guidance, monitor, and document the implementation of the direct financing mechanism. It is chaired by Abt. Associates. It is composed of the Abt. Associates team and sub-contractors and the regional office coordinators. The committee meets quarterly and has five main missions:

- Review the regional reports appended to the requests for payment or any other report related to the Direct Funding Mechanism and feedback to be submitted to Abt. Associates;
- Follow progress towards the achievement of milestones;

[11] Main university located in Dakar, capital of Senegal

- Monitor the payment claims process and analyze the absorption rates of direct funding resources,
- Identify bottlenecks in a timely fashion and make recommendations for improving the management of the Direct Funding Mechanism;
- Pilot the process of documentation.

This committee has compensated for the non-functionality of the coordination mechanisms mentioned above.

In the concept note of the direct funding mechanism, an independent advisory committee was envisaged, to provide a technical appreciation of the quality of documents produced, the relevance of decisions made, and the functioning of committees at the central and regional levels. This advisory group would comprise a representative of technical and financial partners, of the Ministry of Finance and the Ministry in charge of decentralization and local government units. The content analysis did not show any other mention of this committee.

At the regional level, the project has requested the establishment of Regional Verification Committees (RVC) to provide technical and operational support to the direct financing mechanism, as explained by the manual of Procedures. A cross analysis of the different letters of execution and contracts, as well as the letters sent to the governors by the project, the composition varied slightly from region to region, but the different types of members was often the same. The president of this committee has been consistently the Governor of the region or his representative. Other members include the director of the Regional Development Agency (RDA)[12], the president of the association of mayors, the president of the association of presidents of departments[13] in a given region; the regional controller of Finance or his representative; the head of the Regional Planning Division; the head of the Regional Social Welfare Division. The following are also members: the representative of

[12] A mechanism for assistance, support and cooperation to local Government authorities
[13] In Senegal, regions are subdivided into departments, strictly administrative entities.

Civil Society Organizations (CONGAD regional unity); the representatives of the USAID regional office; a representative of Abt Associates; a representative of other partners in the region; and the regional medical head officer (or his representative) who will participate in an advisory capacity. In some regions, the participation of local authorities was not planned in the bylaws. As stated in the manual of procedures Regional Validation Committee met once every quarter at the invitation of its Chair to review reimbursement requests submitted by the Chief regional medical officer. Meetings of the Regional Validation Committee were planned to convene within one month following the receipt of reimbursement requests from the Chief regional medical officer.

It is important to note that initially these regional committees should have been created only in regions where such entities did not exist, to prevent duplication. The principle was to use existing regional frameworks, for instance, regional committees for regions benefitting already from another project called performance-based financing, supported by the World Bank and USAID. Some regional annuals report, as well as the external evaluation (Cisse Sarr and al., 2016), mentioned meetings involving both the medical region and the health districts. Also, the region took advantage of existing coordination mechanisms, for instance, the Regional Development Committee, to present the project, the planned milestones and inform local stakeholders on the level of progress.

At the local level, bi-monthly coordination meetings with community health workers were organized in some regions at the health post level to capitalize on information from community health activities and plan and monitor the implementation of integrated advanced strategies.

To sum up this sub-section, the choice of the project has always been to put in place participatory processes and mechanisms to reinforce the collaboration, communication and coordination of interventions. These outputs constitute critical elements of partnership and coalition building.

4.2.1.6 Accountability

Unlike building partnership and alliances, “Accountability” was an announced objective and a cornerstone principle of this contracting mechanism. In this sub-section, accountability has been examined considering the three forms proposed by Brinkerhorff (Brinkerhoff, 2004): financial accountability, performance accountability, and political accountability. According to this author, financial accountability is related to the tracking and reporting on financial resources allocation, disbursement, and utilization. Performance accountability concerns the demonstration of the attainment of the planned targets. And finally, the political accountability refers to any procedure or mechanism that ensure that commitments are fulfilled and public trust and interest are considered in the process (Brinkerhoff, 2004).

Firstly, the financial accountability was obvious from the analysis of the data. Accountability is mentioned and described in every founding document of the direct financing Mechanism (Concept note, Manual of Procedures, Model of contract, Model of the letter of execution – cf. Appendix). The project established different tools and mechanisms to ensure financial accountability. The beneficiaries were requested to develop a detailed budget corresponding to all eligible and planned activities. They also had to open a dedicated bank account to facilitate transparency in the management of these funds. The manual of procedures provides detailed information and guidance on the administration of the bank account, the petty cash funds, bookkeeping and the management of the necessary supporting documents. It also described the standards and procedures for funding of the activities, the calculation of the real cost of services, requirements regarding the mode and process of contracting as well as the audit. It is necessary to highlight the fact that the manual of procedures of the direct financing project refers, among other documents, to the National Health Development Plan (PNDS 2009-2018), the Multiannual Expenditure Programming Document (DPPD) and the Grant Agreement signed between USAID / Senegal and the Government of Senegal. Payments were made by milestones completed and authenticated by a Regional Verification Committee; the request for payment was verified by the head of the

medical Region. According to the evaluation report (Cisse Sarr and al., 2016), a necessary improvement at this level was to broaden the level of control beyond the deliverables given to the Regional Validation Committee by the medical region. Then, each medical region allocated the funds to its districts each quarter after receipt of payment requests. Each district received reimbursement for its activities during the quarter and an advance for the next quarter based on available resources. For all districts, these funds were transferred from the region's bank account to the district bank account. Another critical aspect was the financial monitoring and reporting component of the project. Technical and financial follow-up was provided by the Regional Medical Team supported by the Regional Office teams during the missions of supervision. The frequency of financial follow-up was determined by when deliverables were expected. The subcontracting mechanism between Abt. Associates and the NGO ACA, with the provision of financial advisors in the USAID regional offices, has improved financial accountability through the traceability of the transactions of the various sources of financing and the respect for administrative, financial procedures and accounting. Each quarter, the adviser and a representative of the medical region will conduct a financial follow-up. This includes, among other things, the maintenance of accounting documents, the management of funds, the validity, filing and archiving of supporting documents. Good record keeping and material inventory enhance transparency and good governance in the health sector. As stated in the evaluation report (Cisse Sarr and al., 2016), despite the difficulties encountered, mainly at the start of implementation of the direct funding, significant advances were made in the archiving of supporting and accounting documents but also in the regularity of financial reporting in medical regions and health districts. The evaluators also suggested that, since the Direct Funding Mechanism was based on a government-to-government partnership, there was a missing step, namely the verification that the Ministry of Health should have taken to guarantee the reliability of the data and the information provided. Indeed, because this Ministry is the recipient of funding through its services at the decentralized level, it must guarantee this reliability through an appropriate control system.

Secondly, the content analysis shows that the direct financing mechanism had put a high emphasis on performance accountability of its beneficiaries, through a culture of transparency, participatory planning and consensual definition of indicators and milestones, contractual commitments (letters of execution, performance contracts) and the validation of deliverables by oversight committees. The project also contributed to an improved reporting and verification system, a better filing and archiving system and more regular and integrated supervisions. Each quarter, the medical region produced a technical report on the level of implementation of their plans. The report described the activities carried out, the targets achieved and the results accomplished and presented the beneficiary's performance in relation to the objectives and expected results. Performance criteria are used to determine which products trigger disbursements to finance the direct financing package. These criteria are of two types: availability of working annual plans and performance reports and execution rate of planned activities. These annual plans, which constitute the basis for contracting, were translated into quarterly plans, which were broken down into milestones (key intermediate results.) The means for verification are defined when identifying the milestones. To facilitate the verification of the deliverables, beneficiaries and stakeholders agreed to limit the number of milestones. Thus, three milestones were chosen on a consensual basis to be applied to the beneficiary regions:

a) Completed regional annual plans and signed performance contracts;

b) Previous quarterly report executed at 80% and plan for the current quarter developed;

c) Financial and accounting management system that meets the requirements of an audit

> ***"The three consensual standard milestones applied to all beneficiary regions are a subset of the milestones in each beneficiary region. In addition to these standard milestones, there are others specific to each beneficiary region defined according to local priorities and specificities. Standard milestones are necessary for the implementation and follow-up of the direct financing mechanism: the two milestones on the annual and quarterly work plans serve to minimize the programmatic risks associated with the direct funding approach; and the milestone related to the financial and accounting management system serve to reduce the fiduciary risks". Abt. Associates representative, Evaluation Report,*** (Cisse Sarr and al., 2016).

The manual of procedures described the performance criteria. Subsequently, letters of execution and contracts defined the commitments made by the regions and the health districts. A table of required deliverables is appended to these documents. When the medical region receives deliverables from the districts, it undertakes quality and completeness checks using all the means of verification at its disposal. It summarizes the results and forms a folder that it submits to the Regional Verification Committee for review and validation. This latter verifies and validates the milestones on the basis of a checklist. The delay of one health district in the production of its deliverables often penalizes a whole region as regards the validation of a milestone. Another essential contribution of the project is the strengthening of the supervision component, in particular at the most decentralized level of the health pyramid. Actors from a higher level are involved in the monitoring of a lower level. Moreover, evaluation exercises are planned during the project's cycle. The results of the external evaluation of the pilot phase (Cisse Sarr and al., 2016) were shared with the different stakeholders.

Finally, the accountability of this mechanism is also political, with the establishment of committees with an oversight power (described in the sub-section related to partnership), and the existence of a watchdog unit within the Regional Verification Committee outlined in the subsection related to tools and systems.

4.2.1.7 Consumers' Protection

As for the sub-function associated with the "alignment between objectives, culture and organizational structure," the content analysis did not produce sufficient explicit data to study how the direct financing mechanism contributes to the protection of consumers. However, the whole focus of this USAID project and the package of eligible activities are intended to improve maternal and child health (health benefit of the project). As an illustration, the implementation of the direct financing mechanism contributes to an increased number of modern contraceptive users, boosts the number of pregnant women having received prenatal counseling along with an HIV test, augments the number of women beneficiaries of assisted delivery, etc. The project

also increased the number of children vaccinated and who got vitamin A. Moreover, members of civil society organizations and communities were involved in the committees at the regional and district levels, but also were beneficiaries of training. Meetings with local representatives were also organized in the context of decentralized and integrated missions of supervision. Finally, the evaluators of the project have reported that some district management committees, composed in part of members of the local communities, have accepted to pre-finance the implementation of activities. This is a testimony to their level of trust in the direct funding mechanism.

The content analysis did not mention any mechanism, procedure or activity intended to promote responsiveness to consumers' right or guarantee that they could be entitled to appeal in any way or claim any form of compensation.

4.2.2 Effects on stewards

The direct funding project is conceived as a capacity building mechanism, with planned workshops, training sessions, and technical support from Abt. Associates, its sub-grantees, and the USAID regional teams. The content analysis also looked at data related to the positive changes in the attitudes, behaviors and skills of the stewards.

4.2.2.1 Attitudes and Behaviors

The document review revealed several key terms used in the regional annual reports and the evaluation report (Cisse Sarr and al., 2016), to describe the benefits of the direct financing project: "Responsibility," "Leadership," "Commitment," "Transparency," "Accountability" and "Rigor."

First, the French word "*Responsabilisation*" has frequently been mentionned in the different regional reports and the evaluation report (Cisse Sarr and al., 2016). It shares in

French the same root as "*responsibilité*" (in English "responsibility"). It is translated into English as "empowerment." However, in French, the term is related to a process where one is "taking or given more responsibilities." In the sense of taking responsibility, the reports from the regions were referring to the growing responsibility of local health teams at the regional and district levels, in the planning and management of financial resources and the resolution of health issues. It was also touching on their willingness to enter a contracting relationship making it mandatory to be accountable and transparent. On the other hand, reports from the evaluator and Abt. Associates referred to the opportunity given to these stewards to increase their responsibilities. They were given the choice of activities and the management of resources. Medical regions and health districts had resources in their own account and all the sovereignty required to choose their activities, manage their resources, acquire inputs and services to support interventions, and decide the timing for the implementation of the planned activities. They had thus acquired the responsibility of justifying funds and committing themselves to managing for results. They also had the responsibility to manage these resources in complementarity with other funds and planned activities.

Moreover, with the implementation and the essential functions of the Regional Verification Committee, the administrative authorities (governors for instance) found themselves in a stronger leadership position, with strong responsibilities and increased levels of information on health sector interventions. Finally, the involvement of administrative authorities and civil society representatives in the validation of deliverables through this regional committee contributes to strengthening the accountability of regional and local health authorities. The positive effect, in accordance with the evaluation report (Cisse Sarr and al., 2016), was a greater degree of commitment, at all levels of the health pyramid, including local committees.

Lastly, "rigor," "accountability" and "transparency" have been cited in line with the financial reporting and the management of supportive documents and accounting entries.

4.2.2.2 Skills

The direct financing mechanism seemed to have contributed to providing health stewards with opportunities to experiment and reinforce their technical and financial management skills. The availability of a manual of Administrative, Financial and Accounting Procedures was crucial in this skills-building process. It guaranteed that managers knew what the lines and levels of responsibility were and how to correctly record technical and financial operations in the amount of detail required. It also contributed to fostering a culture of transparency and accountability.

The financial management skills consisted of negotiation and resource allocation, budgeting, accounting, financial reporting, equipment, and supplies inventory, financial data management and internal audit. Resource allocation was negotiated during participatory workshops, using predefined criteria. Following the external evaluation (Cisse Sarr and al., 2016), the regions had proposed additional criteria (Health statistics, geographic constraints, and levels of poverty) for increased equity in the distribution of resources within a given region, and among the regions. Budgeting has also improved compared to previous years' assessments, due to resources being known in advance and better management capacities. In fact, the project had developed the working capabilities and environment of managers, with the acquisition of supplies, equipment inventories, and financial data management. For instance, bookkeeping entries and charges, production of financial reports, budgetary monitoring, archiving of supporting documents and evaluation of the level of execution of activities have been improved in four regions (among 6) with the availability of an Excel version of a financial management system or an accounting software. This software has also increased the traceability of transactions from different funding sources and the respect for administrative, financial and accounting procedures.

Project documents have reported that the annual inventory of equipment and supplies by the beneficiaries was now generalized in the six regions of intervention. Moreover, the project has been described as also an opportunity to develop the level of knowledge about

contracting practices within the decentralized public sector. Finally, Abt. Associates had planned to develop a financial management self-assessment tool to help medical regions and district health teams to develop capacity building plans, which could be funded later.

From a technical point of view, the reports have revealed numerous opportunities to improve health stewards' skills regarding planning, programming, priority setting, data management, supervision, coordination, and control. The improvement of the quality of the supporting documents produced by the medical region and the Health districts has been mentioned, as well as the progress made regarding data quality, completeness and readiness. Moreover, members of the Regional Verification Committee were trained on their mission (the approach and tools for validating plans and reports) and the management of the Financing Mechanism.

4.2.3 Effects on the level of governance

This section presents the contribution of the funding mechanism to the stewardship of the different levels of governance in the Senegalese Health System.

4.2.3.1 At the central level

The content analysis of documents related to the project did not show how the Direct Funding Project was contributing to reinforce the stewardship at the national level. Even if in the evaluation report (Cisse Sarr and al., 2016) this was qualified as innovative and motivating by the national representative, what has emerged from the analysis is the non-functionality of the coordination entities and a limited involvement of central services in the monitoring, evaluation, and control of the implementation of this project.

4.2.3.2 At the regional level

The analysis of the documents has demonstrated the positive effect of the project on the capacity for action of the local health systems involved. The direct funding mechanism had indeed provided additional resources to complement existing budgets, and increase their ability to manage a substantial amount of money. The direct funding mechanism had also supported specific activities which, in general, are not considered by other partners, including a reference system based on mobile phone, computer solutions to improve the financial management system, and the reinforcement and coordination of community health insurance schemes at local or departmental level. Also, the capacity for intervention was improved by more skilled health human resources, allowing more outreach programs on a regular basis at all levels of the health pyramid. The following table illustrates the evolution in terms of the number of outreach strategies by year and by region, in the south of Senegal.

Table 5: Integrated Outreach Strategies by region and by year of implementation (South regions)

REGIONS	*2012*	*2013*	*2014*	*2015*	*TOTAL*
Kolda	81	303	942	1 884	3 210
Sedhiou	0	72	489	800	1 361
Ziguinchor	74	255	211	308	848
TOTAL	155	630	1 642	2 992	5 419

Source: Direct funding evaluation report (Cisse Sarr and al., 2016).

The health performances have then substantially improved, as illustrated by the table presented next page (Table 6).

Table 6: Achievements made in 2014 by the six regions

Indicators	Target achieved
Number of children vaccinated during these outreach strategies (0 - 11 months of age)	99,064
Number of children fully immunized	16,948
Number of pregnant women that performed four correct prenatal visits	886
Number of pregnant women beneficiaries of TPI2 (Malaria)	13,583
Number of pregnant women that have benefited from HIV Testing	13,574
Number of children supplemented with Vitamin A	23,548
Number of new users of Family Planning Methods	8,761

Source: Direct funding mechanism evaluation report (Cisse Sarr and al., 2016).

According to the 2014 annual report, a total of 3,776 Integrated Outreach Strategies were implemented in the six target regions with the support of direct funding resources in 2014. As a further example and along similar lines, table 9 describes the evolution of the number of children immunized, in the south regions of Senegal.

Table 7: Children (0-11 months of age) immunized

Years REGIONS	2012	2013	2014	2015	TOTAL
Kolda	3 311	9 050	23 462	51 771	87 594
Sedhiou	0	2 481	10 147	21 978	34 606
Ziguinchor	521	3 462	1 411	6 300	11 694
TOTAL	3 832	14 993	35 020	80 049	133 894
Growth Rate		391%	234%	229%	

Source: Direct funding mechanism evaluation report (Cisse Sarr and al., 2016). Regions of the South of Senegal 2015

The analysis of the documentary data has made it possible to identify multiple types of results at the regional level:

- Increase in the achievements of the regional targets;
- Quantification of population reached through outreach activities (immunization, prenatal visits, vulnerable children, family planning);

- Performance appraisal through results-based management;
- Consolidation of the technical and financial capacities of local health teams;
- Increased field presence of districts health teams and nurses in charge of health posts;
- Improved coverage of the demand for care;
- Diversification of the contents of activities;
- Greater acknowledgment of community needs.

Moreover, as reported, the existence of coordination entities composed of various actors at the regional level has increased their degree of communication and the culture of transparency. Also, the commitment of the local authority strengthened the mechanism of direct financing and improved the quality of deliverables.

Furthermore, the contracting links between medical regions and health districts teams have reinforced the coordination of the interventions, as well as the quality of their relationships. Also, the relationships have improved significantly and been strengthened with other actors including the local authorities, civil society, and community agents. The latter were greatly empowered through training and formative supervision.

However, the evaluation report stated that, while the quality of the annual plans was aligned with national priorities, their linkage to the Ministry of Health planning was strongly lacking, causing significant unforeseen challenges. This lack of articulation between local and central planning caused frequent overlaps between the activities of the regional plans and those requested by the hierarchy. These situations usually led to delays in the implementation of activities and the production of deliverables.

4.2.3.1 At the district level

In addition to the progress made in terms of health performance, especially in the context of integrated outreach strategies, it is important to note the acknowledgment by the medical regions of a better quality of work plans developed at the district level. As stated in the

evaluation report, health districts plans submitted to the regional and central levels were indeed increasingly realistic, and their validation was easier and went faster. Planning has become truly more objective since it is based on the situational analysis of the previous year, which makes it possible to know the starting indicators to set realistic targets to be achieved for the annual work plan. Knowledge of the amount of projected funding brings significant improvements in the quality of planning. Moreover, these plans have been integrated with the health activities designed by the local Government development committees. The health districts of the regions of Thiès, Kaolack, and Kolda, enrolled in the direct funding project in 2013, have improved the level of execution of their Annual plans from 68% in 2012 to 77% in 2013 and 84% in 2014. The health districts of the regions of Diourbel, Sédhiou, and Ziguinchor, enrolled in 2014, have also increased their execution rate from an average of 67% in 2012, 70% in 2013 to 73% in 2014.

Moreover, the direct funding mechanism has allowed the districts to support the following beneficiaries at the local level: health posts; rural health units ("*Cases de santé*"), local Health Committees and CBOs involved in health promotion activities.

4.3 Indirect contributions to the stewardship function

To complete this case study, we provide an analysis of how the direct funding mechanism is positively affecting the Senegalese Health System is provided. This sub-section examines, in particular, the factors that could contribute to enabling the fulfillment of the stewardship function at a decentralized level. A cross analysis of the documents related to the Senegalese direct funding project shows three themes to be considered: the regional coordination of the health system, the national contracting policy and the current organizational reform agenda within the Senegalese Health System.

4.3.1 Regional coordination

The content analysis revealed, besides the creation and facilitation of committees, several opportunities offered by the direct financing mechanism to reinforce the coordination of health actors, health interventions, and processes at the regional level integration of plans, integration of services and functions, and donor coordination.

4.3.1.1 Integration of plans

At the district level, the document analysis supports the finding that real gains have been achieved with the systematic integration of Local Government Health Operational Plans (LGHOPs) into the Annual Works Plans (AWP) of the health districts. The process was participatory, allowing:

- A better focus on priority geographic areas and needs;
- Coherence (articulation/integration) and complementarity of actions/strategies of the public, private and civil society sectors;
- The mobilization of local financial resources;
- A better definition and operationalization of the multisectoral approach;
- An improved clarity of financial flows and interventions;
- Greater ownership and accountability at the regional level;
- Strengthening of decentralized institutions.
-

4.3.1.2 Integration of services and functions

According to the evaluation report (Cisse Sarr and al., 2016) and the 2014 annual report, the direct funding mechanism has contributed to the development, at a regional and local level, of integrated delivery of health services during outreach strategies. Outreach strategies were used to deliver services (including immunization, Vitamin A supplementation, prenatal consultations, malaria, HIV testing) and reinforce the health promotion strategy (family planning) in areas where access to sanitary facilities is low. Service integration is also a strategy

for increasing the equity and efficiency of critical health interventions and coordinating the response to the health needs of a given community.

Moreover, monitoring and evaluation are primary activities financed by the direct funding mechanism. The evaluation report (Cisse Sarr and al., 2016) also stated that real progress had been made, notably with the supervision of rural health units every two months. Monitoring is integrated at the regional level in the coordination and quarterly monitoring activities of the Annual Workplans.

4.3.1.3 Donor coordination

The content analysis showed that the design of coordination mechanisms put in place in the context of this project has permitted the coordination of interventions between the sub-grantees of USAID, and between the technical and financial partners present in a given local health district or region. Also, this project was designed with respect to the Paris Declaration.

4.3.2 National contracting policy

As part of its stewardship function, the Ministry of Health of Senegal has introduced a tool needed for the regulation of contracting practices: a contracting policy linked to the overall health policy (MSMP, 2004). Although the documents provided by Abt. Associates did not explicitly mention this policy, the implementation of the direct funding mechanism, according to the evaluation report (Cisse Sarr and al., 2016) is based on cooperative agreements and subcontracts:

- Between USAID and Abt. Associates ("cooperative agreement") for the implementation of the Health System Strengthening component (HSS);
- Between Abt. Associates and FHI in charge of the HIV / Tuberculosis component (planning, monitoring, support for the development of annual work plans, contracting, and counselors in USAID's regional offices);

- Between Abt. Associates and ACA (design of management tools, contribution to the development of the manual of procedures, advisers, training of managers and accountants, organization of exchange and peer review meetings, monthly monitoring, and management support);
- Between Abt. Associates and the medical regions (through letters of execution);
- Between medical regions and health districts (performance contract).

USAID and Abt considered the last two forms. Associates as innovative and contributing to strengthening local health systems. These implementing contracting models are different from practices developed with incentive mechanisms. A comparative analysis of these two models developed in Senegal could contribute to improving the regulative tools put in place by Senegal.

4.3.3 Organizational Reforms Agenda

In the evaluation report of the direct financing mechanism (Cisse Sarr and al., 2016), one recommendation addressed to the Ministry of Health is the effectiveness of the organizational reform related to the establishment of Regional Management Units (*Directions régionales de la Santé*) in place of existing medical regions. The intent is to devolve the functions of planning, allocation of resources, management, and regulation of the district health system. This recommendation from the regional level reflects the level of frustration of regional teams in the context of the direct financing mechanism, linked to the limited involvement of the central level and the overlap of planned activities. The content analysis of technical reports of the medical region highlights the fact that the direct funding mechanism contributes to the reinforcement of the responsibility of local health teams, the clarification of roles and tasks, the consolidation or the creation of the regulatory system, as well as their financial skills development. In their opinion, it also contributes in addition to capacity building regarding planning, programming, allocation of resources, monitoring and evaluation. In that respect, it participates in the strengthening of the stewardship function at a decentralized level.

4.4 Summary of the main findings

- The literature review has shown that the concept of stewardship remains little understood and under-documented, especially in Francophone West African countries. Attempts to translate this term do not provide a conceptual significance of stewardship.

- The analysis of the direct financing mechanism highlights several strengths to be considered when intended to reinforce the stewardship function at a decentralized level. The potential to impact positively three pillars of the health system - health governance, health financing and human resources for health - in an integrative manner, is an asset of this initiative. Providing additional resources directly to local health teams, through contracting practices, increase their autonomy in decision-making processes, as well as their accountability in the implementation of planned activities. Furthermore, this mechanism reinforces their managerial, financial, administrative and technical skills, using various approaches (contract learning, mentoring, training and experience sharing). Moreover, it contributes to strengthening their leadership and coordination functions. All in all, the direct financing mechanism addresses the main challenges observed in all health system pillars in a context of decentralization.

- The direct funding mechanism could be considered as an appropriate approach to implementing stewardship at a decentralized level, only if the following dimensions are reinforced: degree of commitment of the central divisions of the ministry of health, better engagement with communities and involvement of the private sector; special attention to the behaviors and attitudes of the health stewards.

CHAPTER 5: DISCUSSIONS

The findings from the literature review and the case study were set out in the previous chapters. This section analyses those results and develops conclusions as to sense-making around the concept of stewardship in a francophone context. It also describes the potential of stewardship for West African Francophone countries, as well as the significance of the findings regarding stewardship capacity building at the decentralized level.

5.1 Making sense of the concept of stewardship in a francophone context

English is considered as the *lingua franca* of scientists in general, including public health specialists. The linguistic disconnect between English and other languages has always been a challenge, and francophone countries are affected by this situation (Adams and Fleck, 2015). The primary focus of this section is to establish, based on the literature review, the use of the stewardship concept and its meaning in a French-speaking environment. Several terms have been found in the literature to translate the concept of stewardship: "*intendance,*" "*pilotage stratégique,*" "*fonction de pilotage,*" "*administration générale,*" "*fonction de direction.*"

The French word "intendance" is a literal translation of the concept of stewardship. "*Intendance*" commonly refers to the function of management of resources and purchases. It is used in French in a military or educational environment, to describe the function fulfilled by a "*intendant*" (steward) or the office of this "*intendant*". As far as we are aware, this word has not often been used in articles related to health systems.

"*Pilotage*" is translated into English by "Steering" and, in French, this word defines an act whereby someone takes charge of or is in control of a process. The formulation "*pilotage stratégique*" is used in management to describe a function that involves strategic vision, planning and risk management (Daniel, 2010). The use of this term is very much in line with the application of management concepts and tools to reinforce health systems' performance.

However, it could be misleading to use this term that could be understood as “taking control” of the health system, instead of “taking responsibility” for it (Alvarez-Rosete and al., 2013).

Finally, “*administration générale*” is a terminology adopted by WHO and its partners in French versions of key reports and guiding documents. The word “*Administration*” in French is similar to the English word, and usually, describes all functions necessary to administrative actions. The term “fonction de direction” (“*direction*” for guidance) is also used by the European Office of WHO in its reports (WHO, 2008).

None of these formulations reflect the essence of the word “Stewardship” nor its nuances. They are focusing mostly on the management dimension of the concept, instead of underlying values like responsibility, trustworthiness, fairness. This observation is not surprising, as this term covers a variety of concepts and practices that are difficult to synthesize. Even in English, this umbrella concept is challenging to envision fully and difficult to apply in practice (Travis and al., 2002). Experts in a technical consultation on stewardship in 2001 in Geneva (Murray & Evans, 2003) and participants at the WHO Regional Committee for Africa 52nd session (WHO, 2002) highlighted the fact that the term stewardship did not translate well into other languages. Translations by WHO did not precisely reflect the concept.

In 2002, the Institute of Tropical Medicine (ITM) in Antwerp, Belgium, coordinated a multicenter research study in seven francophone countries[14], including two Francophone West African countries (Boffin, 2002). The first step, in the launching meeting with the seven research teams in Rabat in Morocco, was the drafting of a consensual definition of stewardship in French:

> *Le « stewardship» du système de santé est la direction et la gestion avisée, éclairée, consciencieuse et compétente du système de santé afin que celui-ci soit capable de remplir au mieux les autres fonctions que sont la prestation des services de santé, le financement de la santé et la création des ressources qui, ensemble, servent l’objectif premier du système de santé qui est l’amélioration de la santé des populations. Cet*

[14] Burkina Faso, Haiti, Mali, Morocco, Central African Republic, Democratic Republic of Congo, Tunisia

objectif premier ne peut être pleinement atteint que si le système assure l'équité dans la contribution financière des bénéficiaires et répond aux attentes autres que celles concernant les soins » (Meda & Sondo, 2003, p. 9).

"The "stewardship" of the health system is the guidance and the wise, informed, conscientious and competent management of a health system, so that this latter could better fulfil other functions such as health service delivery, health financing, and resources creation, which, together, serve the primary objective of the Health system which is the improvement of the health of the populations. This primary objective could only be fully achieved if the system ensures fairness in the financial contribution of beneficiaries and meets expectations other than care".

An analysis of the content of this proposed definition shows an attempt to consider both the managerial dimension of the stewardship function, as well as values and principles associated with it.

Furthermore, we did not find in the literature review any specific definition applied to the local health system. This refined and more practical definition was a request from the delegates to the 52nd session of the WHO Regional Committee for Africa. Stewardship needs to be defined in the light of decentralization and on-going health sector reforms in Africa.

5.2 Strengthening the stewardship function at a decentralized level: significance of the findings and lessons from the direct financing mechanism

For ease of comprehension, the research questions which drove and shaped the findings are repeated as follows:

- What approaches towards strengthening the stewardship of regional, provincial and district health systems, and more specifically in Francophone African countries are described in the literature?
- Does the direct financing mechanism improve the stewardship of local health systems?
- Is it consistent with the district-level reform strategies?
- Could this approach be relevant for reinforcing stewardship at the decentralized level in Francophone African countries?

This chapter will provide some responses to fuel further reflection on the function of stewardship of local health systems. It will also discuss the analytical framework used for this case study.

5.2.1 Approaches to strengthening the stewardship function of local health systems

The multicenter study[15] (Boffin, 2002) described earlier was focused on strategies intended to reinforce the stewardship function in health systems. The following are a list of capacity building strategies identified as contributing to the stewardship function: Needs assessments of health information systems; Consultative meetings between diverse actors and sectors; health system research; projects, programs and pilot experiments; capacity building on planning; structural and organizational development. The list also considered approaches to reinforce the skills of health stewards: professional education; study abroad; continuing medical education (CME); mentorship, coaching and networking. In Burkina Faso, three initiatives have been examined, all contributing to reinforce one or several sub-functions of stewardship: the annual Ministry of Health's partners conference, a study on the cost recovery of health services in a province of Burkina Faso, and the creation of a support unit for the decentralization of the health system. However, the research team questioned the real impact of these activities, not initially intended to reinforce the stewardship function.

Another important initiative in the West African region is a research development program implemented between 2009 and 2013 by the West African Health Organization (WAHO), based in Burkina Faso (Aidam & Sombie, 2016). This program was based on a framework designed by Pang and al. (2003): the *knowledge for better health research capacity development framework*. A lesson learned from this program is that collaboration among countries, and a mutual learning process, with adequate resources, can reinforce health system research capacities. This initiative had also considered in each country the decentralized level.

[15] coordinated by the Institute of Tropical Medicine, Belgium, in 7 countries of the South.

These approaches to strengthening the stewardship function in Africa are very different in nature, time-frame, and processes. The question of whether these strategies can be sustained without external funding remains to be answered.

5.2.2 Analyzing the direct financing mechanism in a perspective of stewardship capacity building at a decentralized level

5.2.2.1 Contribution to the reinforcement of the sub-functions of stewardship

The study case's findings show that the direct financing mechanism has positive effects on at least five sub-functions of stewardship: vision and strategy, intelligence and information, tools and systems, partnership and networking, and accountability. The two other sub-functions: protection of consumers and alignment with the culture.

Even though there is no regional strategic vision and plans, which could have served as the basis for ownership by local health systems, the direct financing mechanism has defined as a conditionality the correlation between the activities financed and the annual works plans developed at a decentralized level. These plans are linked to the National Health Development Plan, which constitutes the strategic vision of the Ministry of Health of Senegal. We believe however that regional strategic plans should be considered as stewardship tools that articulate a vision grounded in population needs. This vision could reinforce a commitment to increased accountability for the implementation of positive changes.

The direct financing mechanism had led to the creation of data management information systems with the objective of improving collection and monitoring of routine data. This action enhances the production of evidence, as well as evidence-based planning, and decision-making processes. However, a question remains: Is this data management information system integrated into existing ones? If this were the case, it would have contributed to strengthening the system already in place. Moreover, data available for this case study did not mention the use of this data management system beyond the project.

This mechanism also seems to contribute to the sharing of information between health management teams at different levels, between them and representatives of administrative authorities, civil society, and donors. The establishment of committees at the national (Monitoring Committee), and regional (Regional Validation Committee) levels and coordination meetings held by health agents with community workers at a local level contribute to a better coordination of health activities and the reinforcement of partnerships between different groups of health actors. The external evaluation of this mechanism (Cisse Sarr and al., 2016) did not analyze the functionality of these committees, as well as the impact of the inactivity of the national committee. The development of working partnerships at the district and community level is essential in a context of decentralization of health services delivery (Munthali, 2016). To be efficient and exert the appropriate degree of influence, otherwise than by regulation, building and maintaining relationships with civil society, the private sector and other administrative authorities are critical tools for better stewardship (Travis and al., 2002). The stewardship responsibility of the Ministry of Health is in question, as well as the positive effect of this mechanism when it comes to reinforcing the relationship between the central level and the regions. Finally, with sustainability in mind, would it not have been better if existing committees had been strengthened?

The findings show also that the direct financing mechanism has contributed to reinforcing the level of accountability of the local health teams using different tools and systems. They include contracting agreements, a manual of procedures, financial supervision, the establishment of a regional verification committee, a control unit, peer pressure between districts in case of delay in the transmission of reports to the medical region. The accountability was financial, political and related to the local health systems performances in the context of this project. In any event, a concern is the scope of accountability: should each level of the local health systems be narrowly accountable for actions within the direct financing mechanism, or more broadly for the health system? Also, what about the accountability to the populations, in addition to the accountability to the donors and the regional authorities? The direct financing did not seem to consider ways of involving or protecting the communities in the

implementation process. The private sector has also not been cited at all. The sub-function "Consumers' protection" is not addressed. Responsiveness of a health system to the legitimate expectations of the population and fairness in the financing of the system are two essentials components of a performing health system and good stewardship (Murray & Frenk, 2000; Murray & Evans, 2006). Finally, the regulation in place is mostly designed to invite local health teams to respect their commitments. A question remains concerning their capacity to implement the regulations and their enforcement.

More generally, from a stewardship perspective, we believe that to play their role of stewards, local health teams should consider their performance in this project, their performance as a local health system and the overall attainment of health system goals simultaneously. This latter requires that the socio-determinants of health are taken into account, to improve health, reduce health inequalities, enhance the level of responsiveness of local health systems and ensure fairness in the allocation of resources.

5.2.2.2 Contribution to the capacity building of the stewards

The findings of this case study suggest that the direct financing mechanism has participated in reinforcing positive attitudes and skills of the local health teams. In addition to the training sessions and the coaching provided by Abt. Associates Inc. and its partners, the direct financing mechanism has offered to local health teams opportunities to practice their skills and learn from experience, a form of on-the-job training (Daines and al., 2014).

Contractual arrangements between Abt. Associates Inc and the medical regions, and between the medical regions and the health districts ("learning networks"), constitute a driving and binding power. In this situation, a steward must be self-directed and learn to respect his commitments. The approach has some similarities with the idea of a *learning contract*, developed by Knowles (1980). Based on a psycho-socio-pedagogical approach, the learning contract provides an accompaniment to self-training, in a well-suited system-environment

interface . The direct financing mechanism values, therefore, a culture of competence, responsibility, accountability and knowledge sharing.

However, this mechanism has not been designed initially with the intent to strengthen the stewardship capacities of the stewards, but rather their governance skills. An effective steward is supposed to be accountable for the well-being of the population and serves its best interest. He or she should be trustworthy and operate in fairness and transparency (Saltman & Ferroussier-Davis, 2000), capacities difficult to strengthen. In fact, this is more about mindsets than capacities. Stewardship implies *value management*, a management approach that, when applied to the field of health, involves, for example, listening to the population (information and participation in decision-making) and mutually beneficial relationships with stakeholders (dialogue between professionals, institutions, and public authorities) (Stocker 2006). All these dimensions of stewardship need to be taken into account by a more steward-centered capacity building strategy.

Furthermore, the direct financing mechanism has provided local health teams with financial resources, equipment, and supplies, on the hypothesis that, besides the immediate benefits, they will produce long-term effects, for instance on the accounting and financial capacities. The sustainability of this mechanism should be discussed strategically with the Ministry of Health, to find the most sustainable and cost-effective alternatives.

5.2.2.3 Effects of the direct financing mechanism on the different levels of governance

The direct financing mechanism has reinforced, at the medical region level, core components of the stewardship function (integrated plans, accountability, production of information, the establishment of regulation tools and systems). It has resulted, according to the evaluation report of the mechanism (Cisse Sarr and al., 2016), in a greater capacity of action and more responsibilities from local health system teams. Another finding is the improvement

of the relationships between the local health systems and the administrative authorities, and the necessary articulation regarding the flow of stewardship from a central to a district level.

From the perspective of health reform, the Ministry of Health should better accomplish its role of oversight and support of local health systems (WHO, 2002). The literature review stressed, in particular, the critical role of the department within ministries of health that is in charge of planning, policy formulation, strategic plans development and multisectoral coordination and the necessity to strengthen their stewardship role (Munthali, 2014). This is also true for the department in charge of finances, within ministries of health.

5.2.2.4 Analyzing the direct financing mechanism from the dual perspective of stewardship and health reform at a decentralized level

In the concept note on the direct financing mechanism, it is clearly stated that this approach will contribute to improve the planning and budgeting process at all levels of the public health system, increase transparency and accountability and strengthen management capacities of medical regions, health districts, and local health partners. There is enough evidence from the content analysis of the different reports that suggests that real progress has been made, particularly regarding the improvement of the accounting and financial management system, the teamwork between the medical region and the health districts, and the capacity for action of the local health system.

However, this case study shows the difference between reinforcing governance of the local health system and the improvement of their stewardship role. The stewardship perspective of health reforms, in addition to sub-functions related to governance, could restore a sense of social purpose among local health teams and renew a sense of trust and legitimacy to their role.

Even if central-level stewards still need to oversee and give feedback to local health systems, from a stewardship viewpoint, health reforms should empower local health authorities and ensure that they have the resources and regulatory tools to exercise broader responsibilities, in alignment with national policies and orientations. Unfortunately, the content analysis of documents shows the limited involvement of the central divisions of the Ministry of Health in the implementation of this direct financing mechanism: inactivity of the National Steering Committee, insufficient financial control by the central service in charge of finances. Moreover, the Senegalese Ministry of Health and Social Welfare has limited powers, in a situation where public health funds are directly sent from the national treasury to the local authorities, and the Ministry of the Public Function, in charge of human resources, is the one that recruits health staff.

5.2.3 Potential for West African French-speaking countries

WHO started the third millennium with a new emphasis on health system performance (WHO, 2000). This concern, which is increasingly taking the form of a global program, is underpinned by the reform movements. Contracting practices are on the agenda in several African countries committed to reforming their health sector (Kadai and al., 2006). With the exception of the Republic of Guinea, all countries addressed by our study[16] have national contracting policies formulated by their Ministry of Health. Contracting is becoming a tool to reshape the relationships between the public health sector and its partners (civil society, the private sector, donors, local health systems) (Kadai and al., 2006). Contracting is also used internally, within the public health system, to instill a new mindset and more responsible practices.

Morocco, in particular, has defined a national strategy based on internal contracting practices. This contracting model has similarities with the direct financing mechanism: performance-based approach, contracting agreement within the different levels of the health pyramid. The real difference is that the budget comes from the government and not from a

[16] As a reminder: Benin, Burkina Faso, Cote d'Ivoire, Guinea Conakry, Mali, Mauritania, Niger, Senegal, Togo

partner. This contracting model is not described for instance in the national contracting policy of Senegal. Nevertheless, the fact that contracting is now an integral part of the national health policies of these francophone West African countries is an opportunity to exploit in efforts to improve the stewardship function at a decentralized level.

The potential of the direct financing mechanism to strengthen the stewardship of local health systems is in its innovative and disruptive characteristic. Based on the case study, there is a strong possibility for this mechanism to channel information on the importance of stewardship. Moreover, this mechanism could be considered, from the perspective of a learning health system, as having the potential to leverage on-going efforts to accelerate health system reform at a decentralized level.

Of great importance in this respect are four characteristics of this mechanism: predictability and control in budget execution; accounting, registration, and reporting; audit and external scrutiny; flexibility in the implementation of the mechanism.

Predictability and control in budget implementation

Health budgets in African countries are still defined and managed at a central level (WHO, 2013). The direct financing mechanism allows local health systems to gain a greater budgetary control and more responsibility in the decision-making process. The decentralization of decision making to district level is considered a positive factor in the effective planning, grounded in the needs of the populations, and the delivery of health care services.

Accounting, registration, and reporting

With the direct financing mechanism, local health teams improve their financial management system, but also produce, register and report financial information to facilitate decision-making processes and monitoring of the transparency and the accountability of the system.

Audit and external scrutiny

To prevent the development of parallel programs by donors perceiving governmental services as corrupted and underperforming, the establishment of an inner and outer system of control in the direct financing mechanism has the potential to increase transparency and trust. As a matter of fact, trusting the local health system could from a long-term perspective facilitate the planning and delivery of adequate services in an integrated way. In the direct financing mechanism, this control is exercised by coordination entities, which increase a culture of accountability among the actors represented in these structures.

Flexibility in the implementation of the mechanism

Flexibility is a principle of the direct financing mechanism, in the allocation of resources as well as the implementing process. It leaves room for experimentation, allowing the mechanism to evaluate the progress made and to evolve over time with inputs from all categories of stakeholders. The problem-solving, 'learning by doing' approach is appropriate in facilitating profound changes in a given system (McLaughlin & Mitra, 2001.)

5.3 Questioning the analytical framework of this case-study and its potential to scale

This research has found that there are no standard, universally accepted tools for assessing the stewardship function at a decentralized level. However, the core six (even seven) sub-functions are used by several scholars to examine how the stewardship function is applied in a health system.

As a reminder, the six sub-functions as presented by Murray and Evans (2003) are:

- Generation of information and intelligence;
- Formulation of a vision and strategic policy;
- Alignment between policy objectives, organizational structure, and culture;
- Accountability;
- Tools and systems for implementation: powers, incentives, and sanctions;

- Coalitions/ partnerships building.

The seventh sub-function is the protection of consumers against unfair health practices (Wiysonge and al., 2016). In this study, these seven sub-functions were used to guide the analysis. This axis of analysis was important in order to allow comparison of this research to other studies that have to use a similar approach.

To triangulate the findings using this axis of analysis, the data available has also been analyzed in three other ways: the direct contribution of the direct financing mechanism on the stewards and the level of governance, as well as the indirect effects on the national health reform process.

With multiple angles for assessing the stewardship function, the application of this analytical framework aimed to provide a thorough analysis, as well as a more broad and pragmatic perspective. It seemed flexible enough to help assess the stewardship function at a decentralized level. However, it remains a work in progress. It should be improved to reduce overlap and further tested in practice.

Of interest is the use of a stewardship perspective to examine the potential of the direct financing mechanism to promote stewardship and efficient local health sector reforms. The limitation of this case study derives from the research design, the type of data that has served as a basis for this investigation, as well as the generalizability of the findings. Future research should include an emphasis on how to optimize and adapt this framework to a particular context.

CHAPTER 6: CONCLUDING REMARKS

Stewardship is recognized as a critical function in improving health systems. However, its meaning and unique contributions to health reforms – including how to best improve it at every level of a health system – remain to be established.

This research illustrates that applying a stewardship lens to the analysis of health systems strengthening strategies can provide useful insights into what essential aspects are ignored or insufficiently considered. For instance, from a health governance perspective, the population is still seen as an external beneficiary. The stewardship function gives more attention to the necessary involvement of the community in ensuring equitable and accountable health systems than the governance function. A significant tendency of the literature on decentralization studies the extent to which it facilitates efficient service delivery and enables responsiveness to citizens (Brinkerhoff and al., 2004). Initiatives intended to build the capacity of local health systems must offer a space for communities to exercise their voice, and strengthen local leadership to build trust and expand participation (Bossert and al. *2003).*

Moreover, when seen from a stewardship perspective, capacity building strategies will focus more on the values, principles, and attitudes that a good steward, willing to serve the community, needs to develop to fully fulfill his or her roles and responsibilities. This will complement several initiatives intended to reinforce at a sub-national level, the leadership and management capacities of health managers (Conn and al., 1996; Tetui and al., 2016; WHO, 2016.)

The findings from the case study on the direct financing mechanism confirm that an active application of the function of stewardship at a decentralized level is critical for well-performing, people-centered local health systems. Our analysis also corroborates that challenges in the implementation of stewardship are related to limitations of the role of ministries of health (Veillard and al., 2011).

Stewardship and health financing reforms constitute a winning duo when it comes to transition to a more efficient decentralization of the health system. In that respect, the direct financing mechanism can be credited as an innovative approach that can build ownership and contribute to a reinforcement of the stewardship function in a local health system. An essential issue is the extent to which such interventions can lead to broader and sustained health system changes.

Remaining challenges include the following: the need for ongoing research on strategies to reinforce the stewardship function at a decentralized level, particularly in French-speaking West African countries; the need for a widespread adoption of a stewardship perspective in health system strengthening initiatives; and an adapted framework to assess the stewardship function.

CHAPTER 7: PRACTICAL IMPLICATIONS AND RECOMMENDATIONS

At regional and national levels, the first implication of this research is to adapt the definition of stewardship, its sub-functions, and the available frameworks to their context of implementation. In the present case, it is about a francophone context with particular challenges (for instance, language divide, conflicts, weak health systems), and on-going decentralization processes of health systems. Instead of translating the concept into terms that do not accurately reflect the broad meaning of stewardship, each country should develop a consensual operational definition, with an adaptation at any level of a health system and to the model of decentralization. This participatory process will lead to a collective understanding of this concept and its value for a health system, as well as its appropriation by different actors.

A significant finding of the evaluation of the direct financing mechanism developed in a French speaking country was, despite the benefits regarding leadership and management capacities building, that several areas of improving were left aside. These include the importance of putting emphasis on the communities, not only as beneficiaries but as major players in the process of health system strengthening. Another essential aspect is the necessity to use capacity building approaches inspired from the transformational training techniques to help health stewards cultivate personal virtues and meet their social obligations. Furthermore, health systems strengthening initiatives focusing on the decentralized level should include strategies to reinforce the national level and reduce the resistance to the changes being implemented. For the direct funding mechanism to succeed as a model for strengthening the stewardship of local health systems, a clear and consistent strategic direction is required from the National level, linked with a system-wide transformation approach. The reflection must take into consideration ways to sustain this mechanism.

Finally, this thesis showed that the stewardship perspective is pivotal to health system strengthening at a decentralized level. Ministries of health in Francophone African countries should be encouraged to evaluate health system strengthening initiatives focused on three critical pillars of health systems: health financing, health governance and human resources for health. The purpose is to assess their strengths in improving health system stewardship at different levels of the health pyramid, identify the factors of success and draw out the lessons learned. Based on this evaluation, a regional strategy can be developed to optimize the potential of these initiatives to improve the stewardship function. Over and above, these assessments will contribute to the development of the health system research in West Africa and experiences sharing between countries.

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9. APPENDIX

9.1 List of analyzed documents

Annual Work Plans
Appendix for the technical implementation letter
Conceptual Document on Direct Financing
Contracts
Executive letters
Manual of Procedures
National Contracting Policy
National Health Development Plan (PNDS)
Performance Monitoring Plan and indicators
Quarterly financial reports
Quarterly work plans
Regional annual technical reports
Regional quarterly technical reports
Regional Validation Committee Minutes
Report of the meeting on bottlenecks and corrective actions
Training Reports
Workshop reports on milestones and deliverables

9.2 Code tree

Direct contributions				
	1. Stewardship sub-functions			
		Intelligence/Information	Typology of information	Plans and level of execution
				Available resources/Previsibility
			Level of information	
		Vision/Strategy	Letters of execution	
			Work plans	
			Budgets	
			Performance measurement strategy	
		Tools/systems	Harmonized tools	
			Recruitment of staff	
			Training	
			Equipment	
			Data Management System	
		Organizational development	Integration of functions	
			Lines of communication/reporting	
		Partnership/coalitions	Typology actors/stakeholders	
			Coordination entities	
		Accountability	Financial	Budgets
				Dedicated financial account
				Monitoring/supervision/audit
				Filling/archiving

			Performances	Contracts
				Plans/Milestones/Indicators
				Monitoring/supervision
				Filling/archiving
			Political	Existence of a watchdog unit
				Committee with oversight power
		Consumers' protection	Appeal system and procedures	
			Trust	

	2. **Stewards**			
		Attitudes/behaviors	Responsibility/empowerment	
			Leadership	
			Autonomy/self-governance	
			Transparency	
			Flexibility/Adaptation	
		Skills	Financial management skills	Negotiation/resources allocation
				Budgeting
				Financial reporting
			Accountability capacities	Supplies/equipment inventories
				Use of management tools
				Self-assessment
				Self-training
			Technical skills	Data management
				Supervision
				Coordination
				Implementation
			Planning, programming, priority setting	
		Practices	Contracting practices	
		Position		

	3. Level of governance			
		Central level	Coordination entities	
		Regional level	Capacity action	Resources/budget
				Human resources
				Outreach programs
				Regularity of supervision
			Coordination entities	
			Contracting practices between medical region/health districts	
			Quality of relationship between regions and districts	
			Health performances	
		District level	Quality of work plans	
			Work plans' level of implementation/execution rates	

Indirect contributions	**1. Contextual factors**	Integration of services		
		Integration of plans		
		Donors coordination		
		Response to local needs		
	2. Stewardship/Health reforms	Decentralization	Responsibility	
			Clarification of roles and tasks	
			Process	
			Management capacities/capabilities	
		National contracting policy		