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HEALTH SYSTEMS STRENGTHENING
PRACTICE SPOTLIGHT

PROMOTING INCLUSIVITY IN HEALTH SYSTEM DECISION-MAKING

HEALTH EQUITY SERIES

Health equity is a cornerstone of effective and sustainable health system strengthening (HSS). An equitable health system ensures that every individual has a fair chance to achieve their optimal health, irrespective of social or demographic factors. There is a critical need for integrated, systems-based approaches to enhance health equity to accelerate the achievement of Universal Health Coverage. This series of Health Equity HSS Practice Spotlight briefs documents effective approaches to improving health equity within HSS programming. This brief focuses on promoting inclusivity in health system decision-making through the involvement of underrepresented groups, including those from subnational levels of the health and political systems. Case studies from Guinea and Mali demonstrate how inclusive, co-creative processes for action planning can influence health system decisions related to policies, programs, and resource allocation. The case studies are followed by considerations for implementation based on lessons learned from practice and literature.

INTRODUCTION

Inclusive decision-making, bolstered by localization and good governance, helps health systems meet the needs of their populations. This entails engaging underrepresented groups, including those from subnational levels of the health and political systems, and sharing power, resources, and opportunities. More inclusive health policy and program decisions promote health equity and universal health coverage.

Inclusivity is important throughout the policy or program cycle, from defining the problem to designing and implementing a solution, and assessing its effects. Potential benefits include context-specific solutions, enhanced transparency, improved community ownership, and increased accountability. A diverse group of stakeholders can address challenges more comprehensively and generate wider support and commitment to solutions that benefit local and vulnerable populations.

The U.S. Agency for International Development (USAID) defines localization as "transferring leadership in priority setting, design, implementation, and measuring results to local actors" who possess the "capabilities and credibility to drive change in their own countries and communities."[1] Localization makes development and humanitarian responses more effective by managing resources closer to the communities.[2] How to ensure more local-level resource management and engagement is one focus[a] of USAID's Health System Strengthening Learning Agenda.[3]

Inclusive approaches, aligned with good governance, enable diverse voices to be heard and build trust with the health system. They can shape priority setting, program design, and resource allocation. The structure of political and administrative systems, including the extent to which power is decentralized and emphasis is placed on transparency and accountability, affects who makes decisions and how they are made.

[a] Question 4 of the USAID Learning Agenda reads: "What are effective and sustainable mechanisms or processes to integrate local, community, sub-national, national, and regional voices, priorities, and contributions into USAID's health system strengthening efforts?"

Factors that affect inclusivity often overlap with those affecting health equity, such as place of residence, race, ethnicity, culture, language, occupation, age, sex, gender, religion, education, socioeconomic status, disability, and social capital, among others.[4] These factors are often interrelated and can compound disadvantage.

Improving inclusivity in decision-making is an important way to enhance health equity, which is "based on the principle that all people should have a fair opportunity to achieve their health potential."[5] Health equity is a central focus of USAID's health system strengthening approach, along with quality and resource optimization.[6] "Health care is equitable when people who need it can access it in trusted ways that are available to all, including to poor, underserved, and vulnerable populations." [7]

CASE STUDIES

The following case studies from Guinea and Mali illustrate how inclusivity can influence health system decisions on policies, programs, and resources at various stages of planning and implementation.

Guinea: A co-creation process to develop community health action plans with civil society organizations (CSOs) leads to policy advocacy and passage of a new law

This case study describes how stakeholders in Guinea, with support from the USAID-funded Health Systems Strengthening Accelerator project (the Accelerator), co-created and implemented action plans to operationalize the country's national community health policy. The co-creation process with CSOs began with a situation and root cause analysis of bottlenecks, followed by prioritization of these root causes and learning from other country experiences. Findings from this analysis and learning informed the development of three country-owned action plans and built momentum for sustained collaboration between the Ministry of Health, CSOs, and other stakeholders. These stakeholder partnerships and joint advocacy efforts contributed to the passage of a new national law mandating the use of local budgets to fund community health workers (CHWs), as well as to the generation of new local evidence from associated learning activities.

Context

Guinea continues to experience poor health indicators, including high rates of maternal and child mortality, high numbers of zero-dose and under-immunized children, health system challenges, and multiple concurrent infectious disease outbreaks. There are stark disparities in health service access and outcomes within Guinea, such as between rural and urban areas, by maternal educational status, and by household wealth.[8]

Guinea developed its first national community health policy in 2017[9] as a key strategy to increase high-quality, affordable, and accessible health care. The policy also emphasized rebuilding community trust, engagement, and participation in the health system as a critical pathway toward achieving Guinea's universal health coverage goals. The cornerstone of this policy is training, recruiting, and funding two cadres of health workers: CHWs and *relais communautaire* (known as RECOs or community mobilizers).[b] The national community health policy was rolled out beginning in 2018 and has been brought to scale across most of the country.

Notwithstanding this important progress, implementation of the policy has been marked by several challenges. These include gaps in sustainable financing and funding flows, ineffective decentralization of roles and responsibilities among those charged with implementing community health programs, a lack of citizen engagement and accountability, and the absence of a learning agenda to promote an iterative process for program improvement and decision-making. In addition, the majority of CHWs and RECOs have been supported by partners and donors, rather than by domestic government sources, making local sustainability of these positions challenging. The policy itself involves complex health system reform that requires changes in governance, financing, and institutional arrangements to be successful.[10]

[b] CHWs (or ASCs in French) are paid Ministry of Health staff who deliver basic maternal and child health services (including provision of essential commodities), carry out community-based surveillance of epidemic-prone diseases, implement health promotion and education, and supervise RECOs. RECOs are volunteers who receive a monthly stipend and reside in the communities they serve. Their focus is to provide community-based health promotion and prevention services and to conduct disease surveillance.

Using a Co-Creation Process to Address System Challenges in Community Health Policy Implementation

Guinea's Department of Community Health and Traditional Medicine (DNSCMT) of the Ministry of Health and Public Hygiene partnered with the Accelerator beginning in 2019 to take an inclusive systems approach to addressing community health policy implementation challenges. This partnership was premised on using a co-creation process to propose solutions to these complex systems issues.

Co-creation is defined as: "a collaborative approach to developing solutions ensuring that these solutions align with the needs and preferences of stakeholders and the target population. It involves engaging with diverse stakeholders to co-create effective and sustainable solutions."[11] The co-creation approach was intentionally selected by stakeholders to address community health implementation challenges, because it "has been shown to be a promising approach to increase the impact of health interventions, especially in vulnerable populations."[12]

From 2020 to 2021, under the leadership of the DNSCMT, the Accelerator convened and facilitated co-creation workshops focused on strengthening sustainable financing, decentralization and local governance, and learning and operational research for the national community health policy. These workshops were held virtually due to the ongoing COVID-19 pandemic during that period. The co-creation process was designed to be inclusive and multisectoral to represent a diverse range of perspectives and voices. For example, participants included government stakeholders at the national and regional levels, CSOs, including women and youth-led organizations, implementing partners, humanitarian organizations, and multilateral partners and donors.

To prepare for the co-creation process, the Accelerator completed a **situation analysis,** which included review of key documents, such as country strategies, reports, and published literature, and interviews with key stakeholders. This exercise provided an in-depth overview of the policy environment, bottlenecks, available resources, and opportunities, grounded in contextual realities (Figure 1). The findings were shared during the co-creation process and incorporated into a **root cause analysis** of identified bottlenecks. The co-creation process also integrated peer learning from other countries' experiences. Through collaboration with Exemplars in Global Health, Liberia's Director of the National Community Health Assistant Program, and Last Mile Health Ethiopia, shared their experiences in developing an advocacy case for investment in community health, and how they integrated data utilization and learning for program improvement initiatives, respectively.

Information gained from the root cause analysis and peer learning exchanges was used as the basis for developing three country-owned **action plans** pertaining to:

1) Sustainable financing (domestic resource mobilization)
2) Decentralization (a. clarification of roles associated with strengthening CSOs and citizen engagement, and b. transfer of resources and decision-making to subnational levels)
3) Learning (a. improving recruitment, training and supervision, b. promoting community participation, and c. institutionalizing CHWs)

The co-creation process was characterized by strong Ministry of Health ownership, extensive stakeholder consultations and engagement, cross-sectoral and civil society participation, and local buy-in. The involvement of CSOs fostered more open and collaborative relationships with Ministry of Health counterparts and built trust, as reported by respondents in semi-structured qualitative interviews carried out after the co-creation.

Results and Decisions Influenced

Following the development of the community health action plans, Guinea's DNSCMT prioritized specific activities from each action plan to implement, with support and technical assistance from the Accelerator and other partners. These activities included the following:

FIGURE 1. CO-CREATION PROCESS FOR STRENGTHENING THE NATIONAL COMMUNITY HEALTH POLICY IN GUINEA

Civil society advocacy for sustainable community health financing: The Accelerator provided coaching and capacity building support to CSOs to strengthen social accountability, citizen engagement, and sustainable financing for community health. CSO umbrella organizations, networks comprising smaller CSOs and community-based organizations, nominated 10 individuals, 5 women and 5 men, including youth, to participate in capacity strengthening workshops and to represent their respective constituencies in meetings and events. During the workshops, participants developed an advocacy plan and messaging, urging the government to recruit more CHWs to meet the population's health service needs. Advocacy and messaging also highlighted the need to pay CHW salaries and RECO stipends from sustainable domestic funding sources, instead of relying on external donor support, which was declining. The CSOs organized press conferences to increase awareness and visibility of their advocacy efforts and met with high-level government decision-makers to present their case. These advocacy efforts contributed to the passage of a new law in December 2022, mandating that the national government recruit and pay CHWs and that municipal level governments recruit and pay RECO stipends. CSOs are continuing their efforts to ensure effective implementation of the law.

Generating evidence on CHWs through district-level learning cycles: The Accelerator partnered with researchers from the Africa Centre of Excellence for the Prevention and Control of Communicable Diseases at the University of Gamal Abdel Nasser in the capital Conakry[c] to strengthen capacity among health actors to generate and use evidence for decision-making to improve community health implementation and outcomes. The project supported two districts in designing learning activities to answer their own learning questions related to CHW and RECO capacities.

The first learning activity assessed the role of CHWs and RECOs in identifying, treating, and referring children under five years of age and pregnant women for malaria. Findings from this assessment demonstrated that implementation of the community health policy significantly increased the number of suspected malaria cases reported and the percentage that were treated and referred in Dubréka and Forécariah health districts. The second learning activity evaluated the capacity of CHWs to carry out community-based surveillance of epidemic-prone diseases. This evaluation found that CHWs and RECOs contributed to a significant increase in the number of suspected cases reported and referred for treatment in the two districts.

Challenges and Sustainability

The co-creation process led to the identification of sustainable financing, governance, and learning challenges and opportunities for the implementation of Guinea's community health policy. This country-owned process laid the groundwork and built momentum for sustained collaboration between the Ministry of Health, civil society, and other stakeholders, as described.

While the co-creation process fostered more inclusive, multisectoral dialogue and the development of country-owned action plans to address challenges associated with the rollout of the national community health policy, ongoing social accountability and oversight efforts are needed to ensure that CHW salaries and RECO stipends are covered by domestic sources as stipulated in legislation. This shift depends on government funds being allocated to community health and their effective transfer to local authorities. It requires not only continued bottom-up social accountability efforts from civil society actors to continue holding government entities accountable, but also top-down social accountability efforts by high-level government leaders and decision-makers to ensure the continued prioritization of community health and its financing, and the operationalization of decentralized roles and responsibilities. Continued monitoring and evaluation, research, and learning at the district level is also needed to generate evidence to assess the effectiveness of CHWs, as well us to use findings to strengthen buy-in for the importance of their role and sustain commitment for their funding. Similar efforts must be ongoing to identify and address context-specific challenges CHWs face in their day-to-day work.

[c] The Accelerator also partnered with the University of Gamal Abdel Nasser on an implementation research study of the community health policy, described in a separate HSS Spotlight brief, *Enhancing Equity in Health Systems: The Critical Role of Implementation Research*.

Mali: Inclusive adaptation of a self-assessment tool for health zone management committees drives action planning and measurement of performance improvement

In this case study,[d] the USAID-funded Keneya Sinsi Wale Project supported national, regional, and local stakeholders in Mali to shape a self-assessment and planning tool for health zone management committees. What began as a first step in helping local leaders and health care providers analyze their strengths and weaknesses and create action plans, led to longer-term quantifiable improvements in governance, service delivery, and health equity. Adaptation of the tool for health zone management committees to be more inclusive enabled participating stakeholders to monitor and evaluate management of community health programs, identify root causes of health zone governance challenges, and take appropriate action. Following success with the approach locally, the Ministry of Health linked it to the formal health information system, giving visibility to local data and informing resource needs for community health.

Context

In Mali's decentralized health system, primary health care policy mandates that residents of each health zone (comprising on average of seven to nine villages) elect a health zone management committee, referred to locally as an ASACO, to govern the zone's health services and activities. This includes community health centers (known as CSCOMs), outreach initiatives, and links to services provided by private maternity care providers, clinics, and pharmacies. In 2020, although most management committees were functional, they faced challenges in the areas of health planning and budgeting. Many community health centers lacked essential medicines and could not raise sufficient funds to recruit qualified staff. Membership of the management committees largely excluded women, the principal users of health services. Local health providers and other stakeholders needed to strengthen their governance capacity to improve the availability and accessibility of quality health services. Compounding these challenges, significant and recurring security risks impeded coaching and supervision visits by the project lead, Palladium. Instead, a local sub-grantee trained and supported by Palladium supervised the committees and health facilities with an experienced security team. The security risks underscored the importance of having functional community health systems to make health care more accessible closer to where clients reside.

Theory of Change

The USAID Keneya Sinsi Wale Project was designed around a theory of change emphasizing locally led approaches to strengthen the local health system. The activity aimed to enhance health outcomes and performance data of health centers; improve district-level capacity in planning, monitoring, and evaluation; and strengthen overall management, communication, and accountability at the health zone level in Mali.

Tool Development and Use

The Keneya Sinsi Wale Project collaborated closely with stakeholders across various levels of government to adapt, digitize, and deploy a self-assessment and planning tool to help improve overall health center clinical services and outreach activities. The project coordinated refinement of this tool at national, regional, and local levels, incorporating feedback to ensure that it was user friendly and contextually relevant.

The Ministry of Health at the national level ensured that the revised tool included key health priority areas, such as governance, leadership, management, and gender equality. District health management teams, health centers, and their management committees ensured alignment between the self-assessment tool and stakeholders' respective roles and responsibilities.

Health center staff and members of the management committees led the implementation of the self-assessment and developed improvement plans with local stakeholders, including health care providers, townhall representatives, community leaders, and clients. Overall results were presented for feedback to communities and local non-governmental organization (NGO) staff responsible for monitoring action plan implementation.

The self-assessment tool was tailored for management committees and health centers. It included numerous components, such as review and reporting on gender representation in decision-making bodies, coordination of planning and implementation of committee and health center activities, review of quality of services, including

[d] Content adapted from the Case Competition poster Mali Health Committee Self-Assessment and Oversight Tool by Joseph Limange, Paula Wood, and Issiaka Dembele (https://www.acceleratehss.org/wp-content/uploads/2023/11/Mali-Health-Committee-Self-Assessment-and-Oversight-Tool.pdf) and complemented by more recent information provided by the project.

the availability and management capacity of technical staff, health facility client satisfaction, management of equipment, compliance, and monitoring of subsidies and financial resources transferred by the state to the committee. Between 2020 and 2023, 86 percent (584) of 683 health management committees completed the self-assessments with project support at least once. Over half (312) repeated the process during that period to monitor progress and guide subsequent rounds of action planning.

Results and Decisions Influenced

The self-assessment tool measured quantifiable improvements from 2020 to 2023 in health management committee composition and function, and its use is credited for sustainable improvements in governance and services. During that time, the total number of management committees more than doubled, from 333 to 683, and the percentage of committees using the self-assessment tool increased from 53 percent to 91 percent.

Benefits realized: What began as a collaborative self-assessment and action planning tool evolved to support ongoing implementation and monitoring. Committees have used action plans developed from the assessments to make sustainable improvements in governance and provide oversight of health services, medicines, programs, and budgets, as evidenced by repeat yearly assessments. Community leaders have expressed positive feedback on the value of the tool as they witness real-time improvements in coordination and motivation in delivering services at the health facility and community levels. The micro plans that resulted from the self-assessment process have helped clinic staff and community leaders prioritize interventions, leading to more trust in the health system and increased participation in newly instituted local health insurance schemes (*mutuelles*). In addition, the tool has improved leadership and governance at the health centers, supporting better planning and implementation of outreach activities.

An additional benefit has come from digitizing the self-assessment data collection tool and linking it to Mali's national-level health management information system. Health center and committee data from across Mali are now provided directly to the Ministry of Health, allowing the Ministry to strategically allocate technical assistance and resources to regions, districts, and health areas. Using collected data, the project and health district staff address identified needs at health centers and for health management committees through tailored interventions, and health centers can use the data to apply for national accreditation programs. In Mopti, Ségou, and Sikasso regions, 64 percent (435) of the 683 management committees used results from the self-assessments to help mobilize funding from local sources, such as women's associations, cotton growers' associations, contributions from mining and other companies, dam management committees, and other national donations.

Meeting frequency increased: The percentage of committees organizing annual general assembly meetings increased from 54 percent (180/333) to 78 percent (530/683) from 2020 to 2023. Committees meeting quarterly increased from 42 percent (140/333) to 72 percent (490/683), and committees with monthly meetings remained constant at 38 percent (28/333 and 258/683) as the total number of committees increased.

Female participation increased: The percentage of committees with at least 30 percent female membership increased by 8 percentage points, from 30 percent (22/333) to 38 percent (258/683). Overall membership among women increased from 25 percent to 29 percent, despite inequitable gender norms.

Community health center staffing and stockouts of essential medicines improved: Full staffing at community health centers increased dramatically, from 36 percent (26/73) to 91 percent (619/683), an increase of 55 percentage points. Stockouts of chlorhexidine, used for newborn cord care to prevent infections and associated mortality, decreased by 27 percentage points (from 34 percent [25/73] to 7 percent [48/683]), and stockouts of magnesium sulfate, used for women suffering from pre-eclampsia and pre-term labor, were all but eliminated, decreasing from 20 percent to 1 percent.

Challenges and Sustainability

This approach has not been without challenges. Low levels of literacy have impeded utilization of the self-assessment tool in some areas. Involvement of women in leadership roles, a best practice of this approach and key to including them in decisions, is not commonly accepted and necessitates education and awareness around potential benefits to the management committees. Despite these challenges, the tool and approach have proven to be sustainable, given that it is largely driven by staff from local health centers and community-level management committees and monitoring of the action plans is conducted by local NGO staff.

IMPLEMENTATION CONSIDERATIONS

Based on lessons learned from practice and literature, the following implementation considerations are proposed for policy and program decision-makers and partners:

Plan for inclusivity at each phase in the program or policy cycle, as part of an ongoing, long-term process to enhance equity. Inclusivity is not a box to be checked in a one-off workshop. Local stakeholders are important contributors to problem identification, development of the theory of change, selection of implementation approaches, monitoring and evaluation, and continuous learning and adaptation.[13] Inclusivity requires ongoing commitment and action.

Track measurable indicators of success, such as pertinent policy and strategy changes, group composition, trust in the health system, and equitable resource allocation. Disaggregate data where possible by characteristics such as wealth, gender, education, religion, race, ethnicity, age, and location, as applicable and feasible. As noted in Mali, tracking women's representation in local health committees helped keep a focus on the inclusion of women. This is especially important where women are not typically in leadership roles.

Carefully identify which CSOs, local leaders, and community members get a seat at the table. CSOs are strong potential representatives and advocates for special populations, as seen with the active engagement of youth organizations in Guinea to appropriately tailor community health policy implementation. In addition to identifying which organizations to include based on the groups they speak for, critically examine the social positions and roles of people functioning as representatives and look for missing voices to help balance perspectives.[14] Literature on community-engaged research cautions against a tendency for key informants to represent privileged positions and to inadvertently reinforce local inequalities.[15] Consultation with diverse members of the communities of interest, aided by focus group discussions and interviews, can help diversify perspectives.

Provide regular opportunities for bottom-up input into key decisions and processes. Although actors at the "the top" of the health system should create opportunities for lower-level engagement, managers in districts should be recognized as important intermediaries who can lead an inclusive process within their district while helping secure national buy-in and support from above for local approaches.[16]

An example of national leaders creating opportunity for subnational input into national discourse comes from Ghana, with the assistance of technology and a push from the COVID-19 pandemic. Stakeholder coordination was needed to continue national policy dialogues and support data management for health sector assessments. A new virtual hybrid format for Ghana's annual Health Sector Summit, with technical and organizational support from the Accelerator, facilitated subnational and health worker participation for the first time in 2021. Summit inputs informed the development of a comprehensive set of indicators and a data collection template for the country's Annual Health Sector Assessment. The new set of indicators and related tools were developed through extensive engagement with a broad group of stakeholders.

Emphasize local organizations over international partners in local activities. As described in Mali, a domestic NGO monitors locally developed improvement plans. This arrangement reinforces local ownership and sustainability of the process, although in this case it was also driven by the security situation. While international partners may promote knowledge exchange across countries, their presence should not dominate conversations or decisions to be made and governed locally. Fundamentally, inclusivity in decision-making requires a shift in individual behaviors, social norms, and power dynamics.[17]

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The Health Systems Strengthening Practice Spotlight series is an initiative of USAID's Office of Health Systems. Practice Spotlight briefs contribute to the global knowledge base in health systems strengthening and support implementation of USAID's Vision for Health System Strengthening 2030 and the accompanying Health System Strengthening Learning Agenda. Learn more about how USAID is promoting evidence-based programming for Health Systems Strengthening:

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