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KERALA SUPPLEMENT

# Re-engineering primary healthcare in Kerala

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**INTRODUCTION:** In the backdrop of the Sustainable Development Goals (SDGs), the state of Kerala, India, revamped its existing primary health centres (PHCs) into people-friendly family health centres (FHCs) in order to provide comprehensive primary care as part of a mission-based (*'Aardram'*) initiative. It was envisioned that the mission's implementation and operation would make use of decentralised governance. The present study explored how the decentralised governance influenced reorganisation of primary care.

**METHODS:** The study adopted an exploratory approach using qualitative methods: key informant interviews ($n$ = 8), in-depth interviews ($n$ = 20) and document reviews. Thematic analysis was done following deductive coding and the themes that emerged were organised under a schema.

**RESULTS:** The results could be summarised under five overarching themes. Strong political commitment, combined with bureaucratic competence, facilitated implementation and functioning of *'Aardram'* primary care. The insights developed through multi-sectoral training helped local governments (LGs) get involve and engage with the health system as a team in order to plan and implement interventions. The decentralised governance structures enabled re-engineering of PHCs by mobilisation of financial resources, provision of human resources, infrastructure modification, and enhanced community participation at various levels. Non-uniformity of commitment, sub-optimal engagement of urban LGs and issues of sustainability and monitoring were the shortcomings observed.

**CONCLUSION:** Decentralised governance played a positive role in the re-engineering of PHCs, which was utilised as a platform to demonstrate best practices in health governance through a participatory approach. The importance of empowering LGs through capacity building to address challenges in achieving primary care SDGs is highlighted in this study.

The UN Sustainable Development Goals (SDGs) 2030 are the driving forces of global health and development agendas.[1] The commitment of governments to achieving the SDGs was declared in the Astana Declaration of 2018, which focuses on Universal Health Coverage (UHC) through primary healthcare.[1,2] Primary healthcare aims to improve the health and well-being of people equitably through Comprehensive Primary Health Care (CPHC), addressing their needs and preferences in a neighbourhood setting.[3] The broader concept of primary care also addresses the social determinants of health that could be accomplished by multi-sectoral actions and community participation.[4,5] The role of governments in improving population health through the health sector, as well as other sectors, cannot be underestimated.[5,6] Collaborative governance, focused on local and decentralised governance with more civil society participation, has gained greater support following the Alma Ata Declaration.[7] In India, decentralised governance of health programmes received greater recognition with the launch of the National Rural Health Mission (NRHM) in 2005.[8] In addition to the NRHM initiatives, Ayushman Bharat was initiated as a strategy to achieve UHC in line with National Health Policy (NHP).[9]

Kerala is one of the most decentralised states in India, with improved access to healthcare services and better outreach activities based on 'wellness', attributable to contributions from local governments (LG).[10–14] Also, decentralisation plays a vital role in health sector planning and budgeting in the state.[15] Policy decisions linked to decentralisation such as deployment/management of human resources (HR), increased allocation of financial resources and better community participation has the potential to improve efficiency and quality of healthcare services.[16] However, Kerala had lately been experiencing a relative failure to cater to changing health needs of the population, along with increasing privatisation and high out-of-pocket (OOP) expenditure.[17] To address existing and emerging challenges in the health sector against a backdrop of global and national developmental paradigms focused on the SDGs, the state government opted to transform the public healthcare delivery system through based on '*Aardram Mission*'.* One of the main objectives of the 'Aardram' mission was the re-engineering of existing primary health centres (PHCs) into more comprehensive, people-friendly family health centres (FHCs).[18] As part of an ongoing broader study on decentralisation and health in Kerala, we attempted to document the experience of decentralised governance in Kerala with the implementation and functioning of 'Aardram' focused on reengineering PHCs into FHCs.

## METHODOLOGY

The study was undertaken from November 2020 to August 2021 adopting an exploratory approach using qualitative methods such as key informant interviews

*Meaning in English: 'compassion'.

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(KIIs), in-depth interviews (IDIs) and document reviews. Research articles related to decentralisation and primary healthcare, publications, policy/concept documents, government orders and reports were reviewed. Eight state-level senior technical and administrative officers were interviewed (KIIs) to explore the concept of re-engineering of PHCs into FHCs and the role of LGs in this process. Medical Officers (MOs) and elected representatives of selected FHCs were interviewed in-depth to examine the role of LGs in the implementation and functioning of FHCs. Three rural, three urban, two tribal and two coastal FHCs were selected purposively to ensure geographic representation from three randomly selected districts –Thiruvananthapuram, Palakkad and Malappuram, one each from southern, central and northern zones, respectively. Altogether 28 interviews were conducted (8 KIIs and 20 IDIs) following structured KII and IDI guidelines (Table 1). The interviews were then transcribed verbatim and translated into English. Deductive coding was done, followed by thematic analysis, focusing on the implementation of FHCs to contextualise the decentralised governance mechanism operational in the state. We organised emerging themes using a schema adapted from the theory of change for the extension of the primary healthcare development programme in Tanzania.[19]

Due to COVID-19 related restrictions, informed consent was obtained electronically. Ethical clearance was obtained from the Institutional Ethics Committee of Health Action by People, Thiruvananthapuram, India (No. EC2/P1/Sep2020/HAP;10/12/2020)

## RESULTS

Five overarching themes on the context and impetus that led to the launch of the 'Aardram' mission and the role of decentralised governance in its functioning at the primary level emerged from the study (see Table 2 for quotations)

### *Evolution of the Aardram mission*

#### *Historical antecedents*

The concepts informing 'Aardram' date back to the primary healthcare movement of the late 1970s, the 1983 NHP, "Health for All by 2000" movement, the Millennium Development Goals of 2000 and the 2017 NHP. Since decentralisation in 1996, there were several attempts at strengthening primary healthcare in Kerala. NRHM provided a platform for easier interaction of the health system with decentralised governance structures. The concept of re-engineering emerged from a pilot project for UHC focusing on revamping primary healthcare that putatively drew inspiration from the UK National Health Service. This was carried out in three LGs in Thiruvananthapuram District from 2012 to 2015. Experiences from this project informed deliberations on the CPHC Programme in the state. Several expert committees were simultaneously formed at the state level to set state specific targets in line with the SDGs. These groups consistently recommended strengthening of primary healthcare in the state.

#### *Political commitment*

According to KII-3, the Left Democratic Front, an alliance of left-wing political parties, which came into power in 2016, had declared their manifesto intention to reduce OOP expenditure for health by strengthening the public healthcare services in the run-up to the elections. This commitment was operationalised by the state government through the 'Aardram' declaration, the health component in

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**TABLE 1** Details of study participants and documents reviewed

| Participant profile | Number interviewed | Roles |
|---|---|---|
| Key informants ($n$ = 8) | | |
| Additional Chief Secretary, Department of Health and Family Welfare | 1 | Main stakeholder involved in policy formulation, concept development, implementation process and monitoring |
| State Aardram Consultant | 1 | Involved in concept development, implementation process, development of government orders and conduct of training in connection with Aardram mission |
| Honarary Consultant for Aardram | 1 | |
| State Nodal Officer for Aardram | 1 | |
| State Nodal Officer Training | 1 | |
| State Aardram resource persons | 3 | |
| In-depth interviews ($n$ = 20) | | |
| Medical officers in selected Family Health Centres | 10 | Involved in the implementation process at field level, in liaison with local government elected representatives |
| Elected representatives (panchayat presidents and municipal ward counsellors) of selected Family Health Centres | 10 | Involved in the implementation process at field level, integrating the different line departments |
| Document review | | |
| Handbook on Sustainable Development Goals 2030 | Detailed description of concept, operationalisation and implementation of Aardram mission in primary health care, role of stakeholders, in implementation and sustenance, changes envisaged in primary health care after Aardram mission | |
| Handbook on Aardram mission | | |
| Handbook on planning of project preparation for local self-government department | | |
| Family Health Centre concept document | | |
| Douthyarekha - Handbook | | |
| All government orders related to Aardram mission | | |

**TABLE 2** Difference between a PHC and FHC as envisioned in Aardram mission

| Services | PHC | FHC |
|---|---|---|
| Operating hours | 9 am–2 pm | Extended: 9 am–6 pm |
| Nurse's role | Limited to clinical services | Active role in triaging, post consultation counselling |
| Referral and follow-up | Limited compliance | Forward and backward referral and follow up based on CPHC guidelines |
| Laboratory services | Only in few centres | Available at all centres |
| SWAAS programme (COPD/asthma) | Not in place | Available at all centres |
| *Aswasam* programme (depression) | Not in place | Available at all centres |
| Sub-centre clinics | Limited services only | Clinics on 6 days/week |
| Institution outreach programme | Limited | Becomes regular with staff nurse |
| Human resources | 1–2 doctors<br>0–1 staff nurse<br>0–1 laboratory technician | Minimum 3 doctors<br>4 staff nurses,<br>1–2 pharmacists,<br>1 laboratory technician |
| Infrastructure | Not standardised | People friendly; standardised with token system, waiting areas with improved amenities, display boards and signages |
| Quality of care | Insufficient | Improved with guidelines |
| Community participation | Inadequate | Through *Arogyasena*, *Kudumbasree*, ASHA, AWW, WHSNC |
| Addressing social determinants | Inadequate convergence | Through better intersectoral coordination |
| Health and medical records | Maintained manually with limited accessibility | Through e-Health; accessible at all levels |
| Social security services | Not always | Integration of services ensured |
| Vulnerable and marginalised | Inadequate attention | Special attention ensured |
| Field-level activities | Restricted to reproductive and child health services and prevention of communicable diseases | Extended field activities covering non-communicable diseases and mental health |

PHC = primary health centre; FHC = family health centre; CPHC = Comprehensive Primary Health Care; SWAAS = Stepwise Approach to Airway Diseases; COPD = chronic obstructive pulmonary disease; ASHA = Accredited Social Health Activist; AWW = Anganwadi Worker; WHSNC = Ward Health Sanitation and Nutrition Committee.

*Navakeralakarmapadhadhi adhahdhi*',† an agglomeration of four missions in four development areas. 'Aardram' was launched in February 2017, with the main focus on transforming PHCs to FHCs.

## *Administrative inputs at the state level for Aardram roll-out*

### *Bureaucratic assistance at the state level*

The administrative efficiency of bureaucrats complemented the political will. These efforts were characterised by the formation of expert committees at several levels, including a state-level committee with the Chief Minister as the Chairperson, a core committee with the Secretary of Health and Family Welfare as Chairperson and a task force with the NRHM State Mission Director as Chairperson. State Health Systems Resource Centre–Kerala (SHSRC–K), an agency that provides technical support for the health department, was entrusted with the responsibility of developing the concept of re-engineering PHCs into FHCs and providing training. PHCs were upgraded in a phased manner, converting 170, 504 and 212 centres in the first, second and third phases, respectively. A facility survey was conducted in the first phase to assess the baseline of 170 PHCs in terms of existing infrastructure, HR and equipment to develop institution-specific proposals. The duties and responsibilities of each category of staff were revised and government orders were issued. The workflow was standardised, standard operating manuals were drafted, and consensus was reached with health worker associations, and sensitisation of elected representatives and raising awareness through the media were encouraged to facilitate the implementation process. Due to financial constraints, it was not possible in the past to hire enough new employees to complete the increased tasks. The committees formed continued to monitor the progress of 'Aardram' at each level.

†English equivalent: action plan for a new Kerala.

### *Financing for infrastructure modification and HR deployment*

The main source of funding for public healthcare institutions in Kerala included budgetary allocations from the state treasury, funds from LG institutions and NRHM. Internally generated funds included a heavily subsidised fee paid by patients for out-patient/in-patient registration, collected as part of the Hospital Management Committee Fund, and donation from the public and organisations. Funds from the state treasury were used to finance additional HR, part of up-gradation of buildings, equipment and drugs and consumables. However, significant portions of the funding for up gradation of each FHC were locally generated.

According to KII-1, funds from the treasury for FHC transformation in 2018 has increased over the years: Indian rupees (INR) 5,997 million in 2018–2019; INR6,690 million in 2019–2020 and INR 9,625.5 million in 2020–2021. NHM sanctioned a fund of INR 600 million in 2018–2019 and INR 440 million in 2019–2020. For the first and second phase FHCs, respectively 830 posts (170 doctors, 340 nurses, 150 pharmacists and 170 laboratory technicians) and 1,000 posts (400 doctors, 400 nurses and 200 laboratory technicians) were recruited. During 2018–2021, a total of INR22,310 million was sanctioned through LGs to implement FHC transformation.

### *Cross-departmental capacity building*

All respondents lauded the training component provided as part of Aardram. With the help of experts from within the system and outside, SHSRC–K conducted training courses using adult learning methods. Three types of training: 'team building', 'concepts' and 'skills' were provided. Team training was attended by a team of 12 (health officials in FHC and elected representatives) from each LG. Changes in the attitude of staff and elected representatives were an important outcome of this training. Training in con-

cept was carried out to orient the duties and responsibilities of staff in the altered scenario. The staff nurses and laboratory technicians were given hands-on experience through skill training provided at the district/zonal level.

### *Supportive role of local governments*

The multiple roles of LGs as steward, provider and convergent body for the different departments were described in detail by informants.

#### *Local government as provider and steward*

LGs contributed to rolling out 'Aardram' by using the discretionary funds available to them or by mobilising resources for improved infrastructure and additional HR. In addition to line items from the budget, which are used to finance routine expenditure of institutions, LGs have control over devolved funds transferred to them from the Treasury, which they can allocate, subject to a few guidelines from the state. The allocation is done through projects proposed for funding in the LG plan reflecting the local needs and their perception of the political utility of the proposed projects. LGs also expended project funds and community donations for construction/renovation. Our IDIs indicate that the belief of LGs about the better ambience in FHC in their area reflected the quality of the services provided and excellence of their governance, adding to their political utility. This was facilitated by improved rapport between health officials, especially physicians and elected representatives. The recruitment of HR (202 doctors, 129 nurses, 62 laboratory technicians and 178 pharmacists as of May 2021) with LG funds, sometimes at the request of the state government, was path breaking.

#### *Local government as convergent body*

The role of the LG in recruiting and training *'Arogyasena'*, a newly conceptualised community-based voluntary workforce for health, was also noteworthy according to our study respondents. LGs were able to align with other sectoral departments, particularly during the pandemic. They were more or less convinced about the importance of addressing social determinants of health for better health outcomes, and at least some of them took it up as important agenda.

### *Output*

The output categories were grouped under remodelled infrastructure, more HR, wider range of services and focus on better service performance and quality. The major changes envisaged through reengineering of PHCs is given in Table 3.

#### *Improvement in service delivery*

The package of additional services available in FHCs included additional hours of consultation, more laboratory services and 'SWAAS' (Stepwise Approach to Airway Diseases) for chronic obstructive pulmonary disease and 'Aswaasam' for the control of depression. Respondents indicated that extended out-patient hours conducted by LG-appointed doctors has improved accessibility and availability of healthcare services to vulnerable groups, including women, older persons, and the tribal, coastal and internal migrant worker populace. Introduction of laboratory services for all basic investigations, ranging from haematology to glycated haemoglobin for nominal charges, were reported as particularly beneficial. This was made possible by the decision of LGs to recruit additional HR with their own funds.

#### *Improvement in service quality*

Augmentation of infrastructure/equipment, additional staff and improved capacity to provide better services incentivised efforts to obtain quality accreditation. Introduction of clinical guidelines, standardisation of services and team training contributed to an improvement in technical quality. The re-engineered process flow, especially initial clinical workup and post-consultation counselling by nurses who were able to devote more time, resulted in greater community identification and improved patient satisfaction. Improved workplace environment and the perceived success of the transformation led to higher staff morale, which further improved patient satisfaction and fostered a positive attitude towards public institutions.

#### *Innovations*

We also came across certain innovations with increased community participation that redefined primary care services. Informants mentioned the creation of gymnasiums and physical rehabilitation units, and the use of electric vehicles for older persons through LG funds.

### *Challenges*

#### *Sustainability*

Sustainability of the mission was a concern raised by different stake holders. Some of the core achievements were person-dependent—either the Medical Officer or the Panchayat President‡. Improved services led to increased demand, which led to increased workload and a tendency to focus on clinical services to the detriment of outreach activities and community mobilisation. Involvement of urban local bodies was found to be sub-optimal in the implementation of 'Aardram'.

#### *Monitoring*

Some LGs reportedly accepted less responsibility in monitoring mission activities at their level. This led to delays in taking timely corrective action.

## DISCUSSION

This study tried to understand the role of decentralised governance in re-engineering PHCs into FHCs as part of the 'Aardram' project in Kerala. The findings suggest that the LGs had multiple roles to play in this experiment. This was not a knee-jerk reaction by the government but rather the consequence of prolonged efforts that gained momentum when conditions became favourable. Strong political commitment, as evidenced by the study findings, was a major contributor to the success of 'Aardram'. Primary healthcare is often defined as an expected political corollary of systems that give priority to equity and social justice requiring long-term commitment against several counter-forces.[20,21] Strengthening primary health services is crucial to making the health systems more resilient, in alignment with previous reports.[20–24] The introduction of *'Ayushman Bharat'* and recruitment of mid-level service providers have the potential to complement the 'Aardram'efforts.

Bureaucratic support was key in Aardram implementation; this complemented the political commitment and facilitated implementation by taking into account technical and systemic factors. Allan et al. highlights the importance of integrating emotional, technocratic and system factors while implementing change.[25]

Health financing is an important health system function, whereby resources are raised, pooled and allocated judiciously, such that all people have access to good-quality health service without financial hardship.[26] LGs are expected to budget, implement, manage, monitor and evaluate primary care services to ensure affordability using people-centred methods and technolo-

‡Elected head of the local government.

**TABLE 3** Quotes illustrating selected themes of the study

| Themes | Sub-themes | Quotes |
|---|---|---|
| Evolution of Aardram mission | • Historical antecedents<br>• Political commitment | "Election manifesto of LDF government assured provision of quality health care services especially primary care to all citizens at lesser cost …they won the election…came into power… implemented what they promised" (KII-3)<br>"Chief minister himself was monitoring the missions directly" (KII-7) |
| Administrative inputs at state level for rolling out | • Bureaucratic activity at state level<br>• Financing for infrastructure modification and deployment of human resources<br>• Cross-departmental capacity building | "Situational analysis was conducted to explore why people are reluctant to seek care from government hospitals….initially we planned OPD transformation…. based on Chief Secretary's advice ……we decided to integrate our plan with Aardram mission" (KII-1)<br>"As years progressed, fund allocation from LSGD increased …..2018–2019 – 5997 million; 2019–2020: 6690.3 million; 2020–2021: 9625 million"…….. (KII-6)<br>"…member of legislative assembly / parliament (MLA/MP) fund were also utilized" (IDI-12)<br>"My LG appointed a doctor through a project to conduct afternoon clinics….and he promised that next year a lab technician will be appointed through LG fund" (IDI-21)<br>"Initially several meetings/discussions were held in SHSRC-K to develop Aardram concept, action plans training modules… discussions went on for hours and days… resource persons stayed as a family." (KII-4)<br>"This was the first time in history…, a training like this…happened. Elected representatives along with health care officials attended… as a team…like a festival… left the participants teaming up with enthusiasm …" (KII-6)<br>"At present there are no conflicts or ego related issues between myself (medical officer) and my panchayat president. Thanks to Aardram mission and team training". (IDI-12) |
| Supportive role of LG | • LG as provider and steward<br>• LG as convergent body | "Our panchayat….in spite of its low-income status… mobilized an amount of 28 lakhs for infrastructure modification……credit goes to them ……for these changes… proud of being part of the team" (INR2.8 million~USD36,634) (Panchayat – a unit of the three-tier local government system in Kerala)" (IDI-18)<br>"Interdepartmental coordination attained and volunteer group (Aarogyasena) constituted through Aardram mission benefitted …….even during this pandemic COVID-19……" (IDI-17) |
| Output | • Improvement in service delivery<br>• Improvement in service quality<br>• Innovations | "Lab services in FHCs is a boon for people in our LG…earlier they used to go to a private lab far away…for checking blood sugar …had to spend a fortune for the transport…but now its available right here… walkable distance" (1DI-6)<br>"In my FHC, LG has installed a gym from their own fund…men are doing their workouts here during morning hours and for women… it's evenings" (IDI-23) |
| Challenges | • Sustainability<br>• Monitoring | "…If there is a change in the elected representatives in power at present…I don't know how these activities are going to continue……. honourship from state (KII-6) |

LDF = Left Democratic Front; KII = Key Informant Interview; OPD = OutPatient Department; LSGD = Local Self Government Department; IDI = In-Depth Interview; SHSRC-K = State Health Systems Resource Centre Kerala INR = Indian rupee; USD = US dollar; FHC = Family Health Centre.

gies.[27,28] The performance of primary care is assessed based on fair financial contributions, one of the performance objectives of health systems, as well as the distribution and optimal use of these financial contributions by different agencies.[4] In our analysis, the opportunities and obstacles presented by LGs for doing this were made clear. The 1997 fiscal decentralisation initiative in Kerala resulted in the transfer of funding for the maintenance of healthcare facility assets to LGs.[27] Since then, there have been numerous reports of significant contributions to the public health infrastructure made by the decentralised government.[29] It is also plausible that LGs had a special interest in creating physical infrastructure and publicising it in order to expand their voter bases. Given the challenge created by the heterogeneity of LGs, quality services at FHCs and sub-centres were pursued by standardising services, staff pattern, infrastructure, including equipment, medicines and consumables, in order to achieve the objectives of the mission. Better physical infrastructure, technologies, and availability of essential medicines and equipment are important to deliver quality primary care services.[30] Similar to our findings, clinical guidelines for quality of care and adequate infrastructure for capacity building were also reported as important.[31] Capacity-building programmes for all elected representatives are crucial to provide information regarding their role in primary care, as evident from our study; this improved the morale of the staff and that of the LGs.[31,32] Similarly, laboratory and pharmacy facilities in the PHCs have improved access to better and timely services, leading to better health outcomes and creating a positive feedback loop.[33]

The multiple roles of LGs as conceived through FHCs were reinforced by our findings.[17,18] The integration of policy makers, technocrats, funders, implementers and supervisors of the ground initiatives at multiple levels is crucial for identifying problems and finding solutions for achieving the objectives of primary healthcare. The system had taken proactive steps to improve the

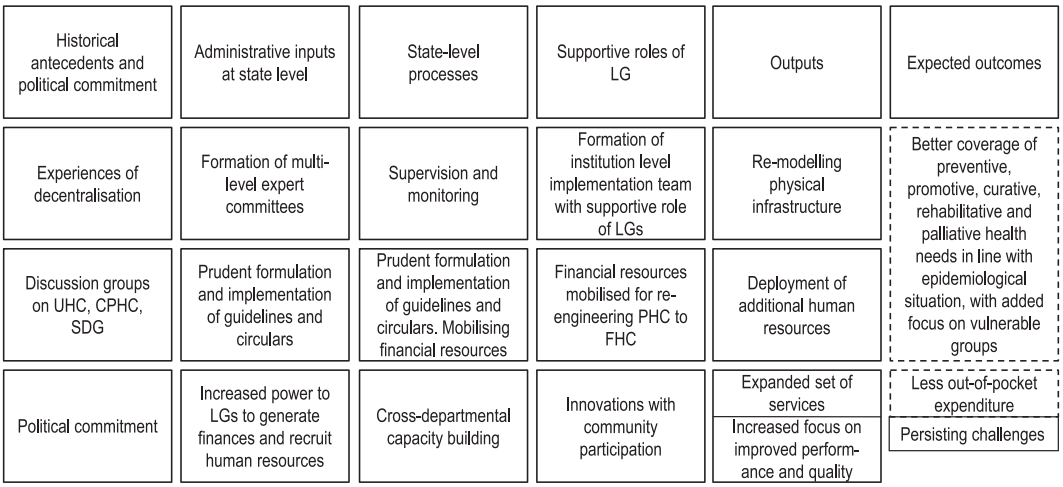


**FIGURE** Schema representing broad themes and sub-themes of the study. LG = local government; UHC = Universal Health Coverage; CPHC = Comprehensive Primary Health Care; SDG = Sustainable Development Goal; PHC = Primary Health Centre; FHC = family health centre.

scope and quality of services while addressing the social determinants of health through intersectoral coordination, which is a prerequisite.[21] Autonomy and discretion in local level HR management have potential positive implications on recruitment, retention, development and distribution of health personnel, as evident from an earlier report.[34,35]

The commitments and gaps in the decentralised health governance model in Kerala required alternative strategies to channel LGs for health, and the 'Aardram' experience offers some optimism. The state government leveraged the existing structures of decentralised governance in support of the centrally designed and orchestrated transformation with positive outcomes for the mission. LGs who identified with and supported the programme reaped political benefits from the success of the programme. Similar to the study by Baru et al.,[36] the monitoring of progress towards equitable services, feedback mechanisms to resolve gaps and barriers, and strengthening of democracy in the running of public health delivery systems identified similar inadequacies.

We could draw parallels between the Tanzanian infrastructure improvement programme and 'Aardram' mission (Figure).[19] Both experiences reflect the need to balance resource constraints with needs while assuring value for the money invested. As the 'Aardram' initiative was undertaken in a mission mode, there is a need to integrate the learnings into the mainstream. The main limitation of our study was that the supply side perspective predominated. Further research is needed on perspectives of end users, especially of those who need the services the most. Nevertheless, the study has revealed aspects that are important in the participatory re-engineering and potential financing solutions for primary healthcare, which could be further validated in future.

## CONCLUSION

The decentralised governance system played a positive role in re-engineering PHCs in terms of infrastructure modification and in HR recruitment. The changes in HR management, financial resource mobilisation and greater involvement of the community in decision-making need further strengthening and evaluation to ensure sustainability. Re-orientation training for both healthcare professionals and elected representatives should be planned at regular intervals, with special focus on outreach activities, community participation and interdepartmental coordination. The governance potential of appropriately empowered local bodies continues to hold promise for achieving local and regional SDGs.

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**INTRODUCTION :** Dans le contexte des Objectifs de développement durable (SDG), l'État du Kérala, Inde, a transformé ses centres de soins primaires (PHC) existants en centres de santé familiale (FHC) conviviaux afin de fournir des soins primaires complets dans le cadre d'une initiative mandatée en mission ('*Aardram*'). Il était prévu que la mise en œuvre et le fonctionnement de cette mission fassent appel à la gouvernance décentralisée. Cette étude a examiné l'influence de la gouvernance décentralisée sur la réorganisation des soins primaires.

**MÉTHODES :** L'étude a eu recours à une approche exploratoire, en utilisant des méthodes qualitatives : entretiens avec des informateurs clés (*n*=8), entretiens approfondis (*n*=20) et analyses documentaires. Une analyse thématique a été réalisée selon un codage déductif et les thèmes identifiés ont été structurés sous forme de schéma.

**RÉSULTATS :** Les résultats peuvent être résumés en cinq thèmes principaux. Un engagement politique fort, associé à des compétences bureaucratiques, ont facilité la mise en œuvre et le fonctionnement des soins primaires de la mission *'Aardram'*. Les connaissances acquises grâce à la formation multisectorielle ont aidé les gouvernements locaux (LG) à s'impliquer et à s'engager dans le système de santé en tant qu'équipe afin de planifier et de mettre en place des interventions. Les structures de gouvernance décentralisées ont permis de réorganiser les PHC en mobilisant des ressources financières, en fournissant des ressources humaines, en modifiant les infrastructures et en renforçant la participation communautaire à différents niveaux. Parmi les lacunes observées figurent le manque d'uniformité de l'engagement, l'engagement sous-optimal des LG urbains et les questions de durabilité et de suivi.

**CONCLUSION :** La gouvernance décentralisée a joué un rôle positif dans la réorganisation des PHC, qui a été utilisée comme une plateforme pour illustrer les bonnes pratiques en matière de gouvernance sanitaire par le biais d'une approche participative. Cette étude met en évidence l'importance de l'autonomisation des LG au travers du renforcement des capacités afin de relever les défis liés à la réalisation des SDG en matière de soins primaires.

Public Health Action (PHA) welcomes the submission of articles on all aspects of operational research, including quality improvements, cost-benefit analysis, ethics, equity, access to services and capacity building, with a focus on relevant areas of public health (e.g. infection control, nutrition, TB, HIV, vaccines, smoking, COVID-19, microbial resistance, outbreaks etc).