

Building resilient sub-national health systems – Strengthening Leadership and Management Capacity of District Health Management Teams

20-22 April, 2016, Freetown, Sierra Leone

Technical Workshop Report



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ABBREVIATIONS AND ACRONYMS

ANC	Antenatal care
AFRO	WHO Regional Office for Africa
CBO	Community-based organization
CEMONC	Clinical emergency maternal obstetric and neonatal care
CH	Community health
CFR	Case fatality rate
CHPS	Community health planning and services
CMAM	Community management of acute malnutrition
COP	Community of practice
CRS	Catholic Relief Organization
CSO	Civil society organization
DFID	Department Fund for International Development
DHMT	District health management team
DHO	District health officer
DHS	Demographic and Health Survey
DMO	District medical officer
DOO	District operation officer
DEHS	District environmental health superintendent
DHIMS	District health management and information system
EDP	Essential drugs programme
EMTCT	Elimination of mother-to-child-transmission
EPI	Expanded Programme of Immunization
ES	Epidemiological surveillance
EU	European Union
EVD	Ebola viral disease
FBO	Faith-based organization
FP	Family planning
FPHSM	The Fellowship Programme in Health Systems Management

GNI	Gross national income
GDP	Gross domestic product
GIZ	Gesellschaft für Internationale Zusammenarbei
HCD	Health care delivery
HR	Human resources
HSS	Health system strengthening
ICT	Information and communication technology
IDSR	Integrated disease surveillance and response
IPC	Infection prevention and control
ITM	Institute of Tropical Medicine
IYCF	Infant and young child feeding
JICA	Japan International Corporation Assistance
M&E	Monitoring and evaluation
MCH	Maternal and child health
MOH	Ministry of Health
NGO	Non-governmental organization
NHSP	National Health Strategic Plan
NID	National immunization days
OAP	Operational annual plan
OD	Organizational development
PCG	Central Pharmacy of Guinea
PHC	Primary health care
PHU	Primary health unit
QA	Quality assurance
RH	Reproductive health
SDG	Sustainable Development Goals
SOP	Standard operating procedure
THE	Total health expenditure
TICH	Tropical Institute of Community Health

UHC	Universal health coverage
UNDP	United Nations Development Programme
USAID	United States of America International Development
UWC	University of the Western Cape
WASH	Water, sanitation and hygiene
WHO	World Health Organization
WHR	WHO World Health Report

1 EXECUTIVE SUMMARY

Background

The 2014 Ebola virus disease (EVD) outbreak starkly reiterated the importance of having strong health systems and a systems approach to fighting infectious diseases. Leadership and management of the health system are critical elements for performance at all levels. With the end of the outbreak, the transition phase should take advantage of the improvements and innovations put in place in the health system, such as community structures, coordination mechanisms and resources and processes (human resources, information and communication) mobilized to build and maintain a resilient health system.

This technical workshop on building health systems was seen as an opportunity for experience sharing and discussion on how to strengthen the health system at the sub-national level.

The health systems in Sierra Leone are organized into different structures with two levels, while there are three levels in Guinea, and Liberia has two or sometimes three levels in some areas depending on population size. Thus, the degree of decentralization differs across the three countries. Elements variously decentralized are human resources management, financial management and decision authority. However, the impact on the health system of the disease was similar in the three countries.

It was noted, based on a multi-country study on perceptions and perspectives in the African Region, that although global and regional policy tools, frameworks and evidence are available, their application is far from adequate at national and sub-national levels. There is some discordance between the availability of policy tools and the realities on the ground. Policies requiring multi-sectoral collaboration and community engagement, for example, have increased leadership responsibilities in the health sector since the leadership role of the ministry of health (MOH) is paramount in steering collaborative initiatives with partners. However, this need for a more holistic approach is occurring at a time when the communities no longer have much trust in the national health system in each country.

Needs and key challenges

Key challenges were observed in all the health system pillars. Governance and management were noted to be inadequate, particularly the skills of those occupying district leadership positions. They tended to be stronger in clinical rather than management tasks. Hence, there was weakness in planning, budgeting, monitoring and evaluation, as well as building partnerships. District health management teams (DHMTs) lacked adequate human resources to fulfil some of their important functions. There was much demand on the time of DHMTs, leading to overload with tasks they were ill-prepared to undertake.

Weak engagement with communities, civil society and the private sector was also identified. The participants felt that the DHMTs needed authority commensurate with their responsibilities, autonomy in decision-making and building partnerships, for them to function better. DHMT planning capacities would allow adaptation of policies and strategies to local contexts. Participants expressed the need for DHMT reforms in light of the changing contexts. However, it was observed that reform should be informed by an assessment of the functionality of health districts, including the performance DHMTs. Weak coordination within the DHMT and between this team and partners was highlighted.

The participants mentioned the phenomenon of donor dependency leading to donor-driven programmes which did not match DHMT plans. In addition, the DHMTs experienced funding gaps and lateness in disbursements which affected the implementation of health activities. There was inadequate financial management and economic capacity. There was no budget for public health emergencies, so transfer of EVD assets to the DHMTs remained a challenge.

Other problems encountered concerned human resource management and development (such as training, career growth and remuneration). Other constraints highlighted involved human resources for health regarding numbers, capabilities, distribution, skills mix and motivation.

Best practices and opportunities

Examples of approaches that have proven effective were shared, such as the Continuing Leadership and Management Training in Tanzania, task-shifting and micro-research approaches. Studies have shown that community health workers are effective in their role of providing an important link with communities. However, they must be appropriately trained and incentivized and regularly supervised by nurses from health centers. Mentoring is an effective tool that should be well structured and continuous. Crisis events (such as a meningitis outbreak or mass violence) have provided opportunities to develop systems and build institutions and useful processes. Many civil society organizations (CSOs) are actively engaged in capacity-building in health systems strengthening. Countries can partner with such institutions to build capacity.

Country roadmaps

To address the challenges and bring about sustained continuous improvement, the workshop participants drafted frameworks aimed at improving their health systems. All three countries agreed to hold in-country discussions to refine their roadmaps and to ensure buy-in from key stakeholders before adoption and implementation. The key elements in the roadmaps were aimed at strengthening the leadership and management capacities of DHMTs. The goal of the roadmap is to enable DHMTs to develop, implement, monitor and evaluate the operational plans derived from the national health strategic plan (NHSP) with the involvement of all stakeholders at the local level. Recommendations put forth include:

1. Sustainable, continuous improvement in governance, leadership and management competencies to permit decentralization of authority, resources and a support system for all

districts. The automation of all management systems, namely human resources, financial, logistical and information systems was seen as vital. Coordination, community engagement and regulation of service delivery were considered important strategies to achieve the goals of a reformed DHMT.

2. Pursue strategies for an adequate and appropriate financing of the sector for universal access to quality health care, through advocacy and partnerships.

3. Sustained service delivery capacity, focusing on epidemiological surveillance and alert; delivering the essential health care package; focusing on accountability in performance.

4. Human resource capacity-building to gain competencies for all assigned roles, revision of guidelines, and collaborating with partners for capacity-building.

Participants made a commitment to follow up on roadmap implementation in their respective countries, while they expected WHO to follow up with all the three countries respectively.

2 INTRODUCTION AND BACKGROUND

1.1 Background

The outbreak of Ebola virus disease (EVD) in Guinea, Liberia, and Sierra Leone had a major impact on the health status of these countries' populations and on already fragile health systems. As the countries move from addressing Ebola to building resilient health systems, district health management teams (DHMTs) will play an important role in re-building the affected health systems (WHO, 2015). In April 2016, WHO held a three-day workshop in Freetown, Sierra Leone, which sought to gather best practices on how to best address leadership and management capacity gaps and challenges at the sub-national level in the three Ebola-affected countries.

The workshop was the first in a series of WHO country-focused meetings looking to improve district-based health systems. It is anticipated that follow-up mechanisms (field visits, teleconferences, operational progress reports, etc.) will be scheduled to monitor improvements, cross-fertilize thinking and to harness critical elements of the improvement process that would stimulate change at the frontlines.

The workshop brought together expertise to brainstorm on the current prevailing issues relating to management and capacity-building. The workshop was seen as an opportunity for experience-sharing and deliberations on how to strengthen the sub-national level. The notable experts were from WHO, nongovernmental organizations (NGOs), development partners, ministries of health, finance, and local government, and capacity-building advisors alongside DHMT representation, implementing partners and civil societies. Participants jointly developed practical approaches to designing and implementing effective capacity development programmes for DHMTs in post-disaster/disease outbreak countries. The emphasis was on bridging the knowledge gap,

recommending intervention packages and identifying delivery models that address leadership and management capacity at sub-national levels. Evidence-based experiences were drawn from experts around the table to input into effective implementation of national recovery plans at the frontline.

The EVD outbreak in the three countries of Sierra Leone, Liberia, and Guinea ‘echoed’ the importance of health systems and a systems approach to management, and highlighted the importance of strong leadership and management as key to progress, especially at decentralized levels. Participants noted that it was easier to identify ‘what to do’ and ‘what is needed’, yet much more challenging to determine ‘how to do things’ in order to achieve better results. In the transition phase from the EVD outbreak, the affected countries recognized the need to take advantage of the health systems strengthening (HSS) experiences and outcomes gained during the outbreak, for example, community structures that were built, coordination mechanisms that were established for the use of resources, processes that were used to strengthen human resources, and improved information-sharing and communication among the numerous stakeholders. It was noted that supporting global and regional policy tools, frameworks and evidence were available, such as the World Health Report (WHR) on PHC reforms of 2008; however, these tools were not readily available nor were they applied at the sub-national levels.

2.2 Workshop objectives

The workshop objectives were:

- to develop a collective understanding of the current needs in terms of policy, knowledge, leadership and management that would be critical to the attainment of effective health care delivery;
- to document what countries have done to address the challenges and with what results;
- to formulate possible intervention models and strategies to address the management and governance challenges and capacity needs of DHMTs, informed by best practices;
- to recommend general and country-specific actionable strategies;
- to map out available resources to address the capacity-building of DHMTs.

3 WORKSHOP METHODOLOGY AND PROCESS

A process methodology was used for the workshop which consisted of the following:

- Country case-study presentations
- Group work for in-depth analysis, deliberations and consensus of issues related to a functional district health management team

- Plenary presentations of group discussion outcomes
- Plenary presentations of technical guidance (DHMTs structures and missions), best practices, opportunities and resources available
- Stakeholder engagement through a panel discussion on partnerships and collaboration
- A concluding summary presentation of the main outcomes of the workshop.

Participants from WHO headquarters, from the WHO Regional Office for Africa and the Sierra Leone WHO Country Office opened the workshop by explaining the background and objectives, as well as the importance of the workshop. An introductory presentation was made by the Regional Office's health systems strengthening department, on DHMT roles and mission. The presentation provided background information on current issues, challenges, leadership and management in health systems and at the district health level. This was followed by presentations from each of the three countries, to share country experiences and promote peer learning from one another and to bring out both common and country-specific challenges. The country teams were asked to present experiences before the Ebola outbreak, during and after the Ebola outbreak, outlining what impact the outbreak had had on their country and the innovations that had emerged from the outbreak experience.

Invited “resource people” from a number of regional and international institutions (see List of Participants - Appendix 1) gave presentations which outlined best practices from experiences beyond the three Ebola-affected countries of Sierra Leone, Liberia and Guinea. Following these presentations, the workshop participants were divided into country-based groups to develop consensus on issues and challenges affecting their own countries, to determine ways of addressing these, gleaned from workshop presentations and learning resources. The three-group work discussions led to the development of a roadmap for initiatives to strengthen the leadership and management capacity of DHMTs. In the first session of group work by countries, participants defined the key country-specific challenges, enablers and barriers, recommendations and follow-up actions at the country level to address the issues. In the second group work session, participants reflected on what they could do to improve the performance of their DHMTs. In the third and final group work session, participants developed frameworks or roadmaps that would guide their implementation of recommendations from the workshop.

4 COUNTRY CASE STUDIES

4.1 Liberia country presentation

Liberia has a population of approximately 4 million, with 56% of its people living in poverty; the adult literacy rate is 60% (DHS 2013); life expectancy is 59 years (UNDP 2010); access to improved source of drinking water is 73% (DHS 2013). The health system is organized into three levels: national, county and district, but the three levels are not equally functional throughout the

country. The national and the district levels are functional but where population levels are low, the sub-county level tend to be less-functional.

EVD impact

A large number of health workers (184/372) died from EVD. Out of the 372 cases, 3.4% of health workers developed EVD and 1.6% died from the disease. The recommended four antenatal care (ANC) throughout the course of one's pregnancy, dropped by 8%, while deliveries by skilled birth attendants declined by 7% from 2013 to 2014. Measles immunization coverage declined by 21% from 2013 to 2014, while outpatient visits reduced by 61% . Economic growth declined, schools were closed for protracted periods and a state of emergency was imposed for three months.

Post-Ebola recovery and investment plan

The goal of the national recovery plan is to improve the health status of the Liberian population through building a resilient health system. The plan was formulated to address health system vulnerabilities exposed by Ebola which included health facility design, weak public health laboratories, poor infection, prevention and control (IPC) practices, a de-motivated health workforce, lack of a bio-bank and bio-safety, among other constraints. Weak epidemic preparedness and response including poor quality of care (i.e., inadequate IPC, diagnosis, etc) and low community engagement (Source: Key priority areas for Recovery/Investment Fiscal Gap Analysis: Scenarios *Liberia Health Sector Investment Plan Q4 FY 14/15 – FY 21/22, Data as of 18 May 2015.*) were emphasized

4.2 Guinea country presentation

Guinea has a three-tiered health system at national, regional and district levels. The district is managed by the DHMT.

Central Level: the central health system of the Ministry of Health has four directors of national programmes.

Intermediate Level: the regional health system has eight regional care facilities with seven regional hospitals.

Third level: this level consists of health posts, private health care facilities and faith-based health centres.

Health human resources: all categories of health workers are available including health technical agents, laboratory technicians, nurses, midwives, general practitioners and specialists.

District health system (pre- and early Ebola outbreak): financing of the health sector was low, given that only 1.7% of state funding was allocated to the health sector in 2013, with a slight increase to 3.8% in 2014. There is low capacity in epidemiological surveillance, clinical and laboratory diagnostic technology, and density of health workers in the health districts, e.g., 0.45

doctors per 10 000 inhabitants, 0.69 nurses per 10 000 population and 0.25 midwives per 10 000 inhabitants. The country also has limited epidemiologists, laboratory technicians and managers. Thus, leading to an overall lack of a quick response mechanisms for emergencies.

Impact of Ebola: reductions occurred in revenue and grants for health services. A negative impact in health care was evidenced in the use of health services, for example, low immunization rates were recorded from 2013 and 2014. Most health districts had low levels of functionality during the outbreak. Personnel management systems were weak and few qualified health staff were available to provide services. The services most affected were laboratories, medical imaging and blood transfusion units. This resulted in the closure of 94 health centres and one district hospital. Health facilities were not easily accessible within five kilometres. Inadequate supplies of drugs, biomedical materials and equipment were also recorded. The health information system was inadequate (lack of promptness and completeness) resulting in a lack of real-time information for results-based planning and service delivery.

Post-Ebola: infrastructure standards were changed, depending on the level of the health facility. Other changes implemented were:

- a sorting centre at health centre level was constructed;
- a treatment centre for epidemic-prone diseases at hospital level was established;
- rehabilitation / extension and equipment for existing infrastructure, e.g., construction of four regional hospitals and construction of new infrastructures in disadvantaged areas;
- rehabilitation, modernization and extension of three national hospitals; strengthening the hospital network of laboratories at all levels;
- training of personnel specialized in the management of epidemiological emergencies in all districts;
- drugs provided for all programmes and supported the Central Pharmacy of Guinea (PCG) in the implementation of its drug programme;
- health logistics were strengthened, especially the provision of vehicles;
- improvements in health services delivery
- biomedical laboratory network for diagnosis, monitoring and research was developed;
- governance and leadership of the Ministry of Health improvements;
- coordinated alignment and synergy of interventions at the county, district and community levels;
- developed and computerized the information system at all health system levels.

There is need to implement Guinea's Health Sector Investment Plan (2016-2021) in order to

build a resilient health system. Furthermore, there is need to implement the health sector policy, to implement the technical guidelines and protocols and to ensure that health indicators improve and targets are met for the sustainable development goals.

4.3 Sierra Leone country presentation

Sierra Leone, on the West Coast of Africa, is divided into four regions: Western Area (two districts), Southern Region (four districts), Eastern Region (three districts) and the Northern Region (five districts). The Gross National Income (GNI) per capita (current US Dollar, Purchasing Power Parity is \$1690). The GDP growth rate was 6% in 2013; 43% of the population are older than 15 and literate. Life expectancy at birth is just 45 years (World Bank, 2015).

The Human Development Index rank for Sierra Leone is 177 out of 187 countries (UNDP, 2014). There have been notable coverage gains in access to essential services between DHS 2008 and 2013, including modern contraception (7% to 16%), skilled birth attendance (42% to 62%), malaria bed net use (26% to 49%), malaria treatment (6% to 77%), diarrhoea management (68% to 88%), and basic immunization (DPT3 54% to 78%). Sierra Leone's child mortality rate is 156 per 1000 live births, while the maternal mortality rate is 1165 per 100 000 live births (Measure DHS and Statistics, Sierra Leone, 2008 and 2013).

The country has a decentralised three-tier health care delivery (HCD) system consisting of primary, secondary and tertiary health care. The system is dependent on donor funding, while the public health structure has many weaknesses. HCD was badly affected by the double barrel catastrophe of the civil war between 1991 and 2002 and the Ebola outbreak in 2014 and 2015. There are several health training institutions in the country. The MOH has several policies such as health sector policies, directorate policies, programme policies, service delivery policies (e.g., Free Health Care Policy), but these are not widely implemented.

Impact of Ebola: as at December 2015, there were 14 324 Ebola cases in Sierra Leone, with a 41.2% case fatality rate.

Health workforce: a total of 296 EVD infections occurred among health care workers with 221 deaths, including 11 specialized physicians. Several institutions closed including the medical school and the nursing and midwifery training institutions. Many private medical practitioners fled the country during the outbreak.

Infection prevention and control (IPC): Lack of IPC capacity led to high infection rates among health staff. Patients/visitors/family members were also often infected with Ebola due to poor IPC practices.

Health service use: community confidence in the health sector fell as a result of the Ebola outbreak, which in turn negatively affected health service utilization. Four percent 48/1185) of primary health units (PHUs) closed; there was a 23% decrease in institutional deliveries; an

increase in still birth rate and maternal mortality. There was also a 39% decrease in children /treated for malaria; a 21% decrease in childhood immunization (penta3); and a decrease in the proportion of women reporting pregnancy-related care. There was a 90% drop in family planning visits (*Government of Sierra Leone, 2014*).

Health programmes and interventions: at the onset of the epidemic, many implementing partners and international aid workers ceased operations in the districts. Essential health programme management staff were re-assigned to help control the outbreak. This move led to the delayed implementation of key health programmes (MCH, EPI). Delivery of essential interventions was halted, routine health management and coordination meetings ceased.

Social and economic impact of Ebola: various negative socio-economic occurrences resulted from the Ebola outbreak which included orphaned children (over 16 000 children lost one or both parents to Ebola in the three affected countries); negative psychological impact and stigmatization of survivors; closure of schools for about a year during which students lost 784 school hours; considerable loss of GDP (6-8%); and a rise in poverty incidence to 14% during 2014-2015.

DHMTs post-Ebola: There was greater focus on district health management and leadership as DHMTs resumed normal functions. Operational plans were developed at the district level(0 to 9 month plans, 10 to 24 month plans) with greater emphasis on disease prevention and control, surveillance, integrated disease surveillance response (IDSR), IPC measures and supportive supervision.

Current leadership strategies at the national level: The following actions are being supported at national level:

- Policy formulation;
- Technical, administrative and oversight functions, strategic and operational planning for health care delivery;
- Human resource management issues;
- Coordination mechanisms at national and district levels, including partnership expansion and strengthening;
- Capacity-building and leadership strategies at DHMT level; district health administration and health systems strengthening; consultative meetings; and community engagement;
- Supportive supervision to districts and to PHU;
- Inventory control;
- Expansion of DHMT administrative bases and service delivery points.

Lessons Learned:

- Outbreaks are best controlled in the early stages;
- Delays in emergency funding can have increased consequences;
- Strengthening public health care delivery system is essential for effective disease prevention and control;
- DHMTs are more effective when supported with a full range of resources and logistics;
- District health issues are best managed by competent DHMTs with expertise in clinical and management issues;
- Effective partnerships can enhance the delivery of health services at all levels;
- Effective collaboration with community structures is a useful strategy for outbreak response and service delivery.

In summary, the three countries had similar systems design and structure of their health systems. While Guinea has all the three levels of national, regional and district, these levels have limited capacities. It is noteworthy that the impact of EVD on health systems in the three countries was similar.

5 FUNCTIONS OF DHMTs AND REQUIRED COMPETENCIES

An introductory presentation by AFRO's health systems department highlighted issues of leadership and management at the health district level, including current issues and challenges in health systems. This presentation was complemented by contributions from country representations and experts attending the workshop. Additionally, useful information on the structure and organization of the work of DHMTs were shared by the 3-EVD countries as well as the two countries (Democratic Republic of Congo and Ghana), invited to share their experiences on PHC at the local level with a focus on DHMTs.

5.1 Roles and functions

The DHMT takes responsibility for the planning, organizing and monitoring of the whole district health service.

Planning and management: DHMTs meet at regular intervals (preferably monthly) to plan, manage and administer the delivery of health care services; it organizes the number and distribution of peripheral health units within the district to make PHC universally accessible; the team works to improve capacity and services of district hospitals to enable better management of increased referrals.

Noted functions of the DHMT include:

Service delivery: administer health services at the district level and undertake supportive supervisory visits;

Human resources: posting all categories of staff within the district;

Training: train, deploy, equip and supervise PHU staff;

Supplies: revitalize the existing network of health units by providing equipment, drugs;

Information: collect, collate and analyse information relating to health and health services within the district; and use data to monitor, evaluate and plan;

Coordination: coordinate health care delivery at district level including the coordination of all health-related NGOs in the district;

Surveillance: ensure surveillance and prompt notification of all epidemic prone diseases and other notifiable diseases and take prompt action to control the outbreaks (identify, notify, prevent and control epidemic prone diseases). Monitor the health situation and health services of the district. Plan, organize and monitor intervention strategies against other priority diseases;

Community participation: encourage community participation and the development of village/area development committees;

Funds: solicit funds and carry out general advocacy.

5.2 Composition of the DHMT

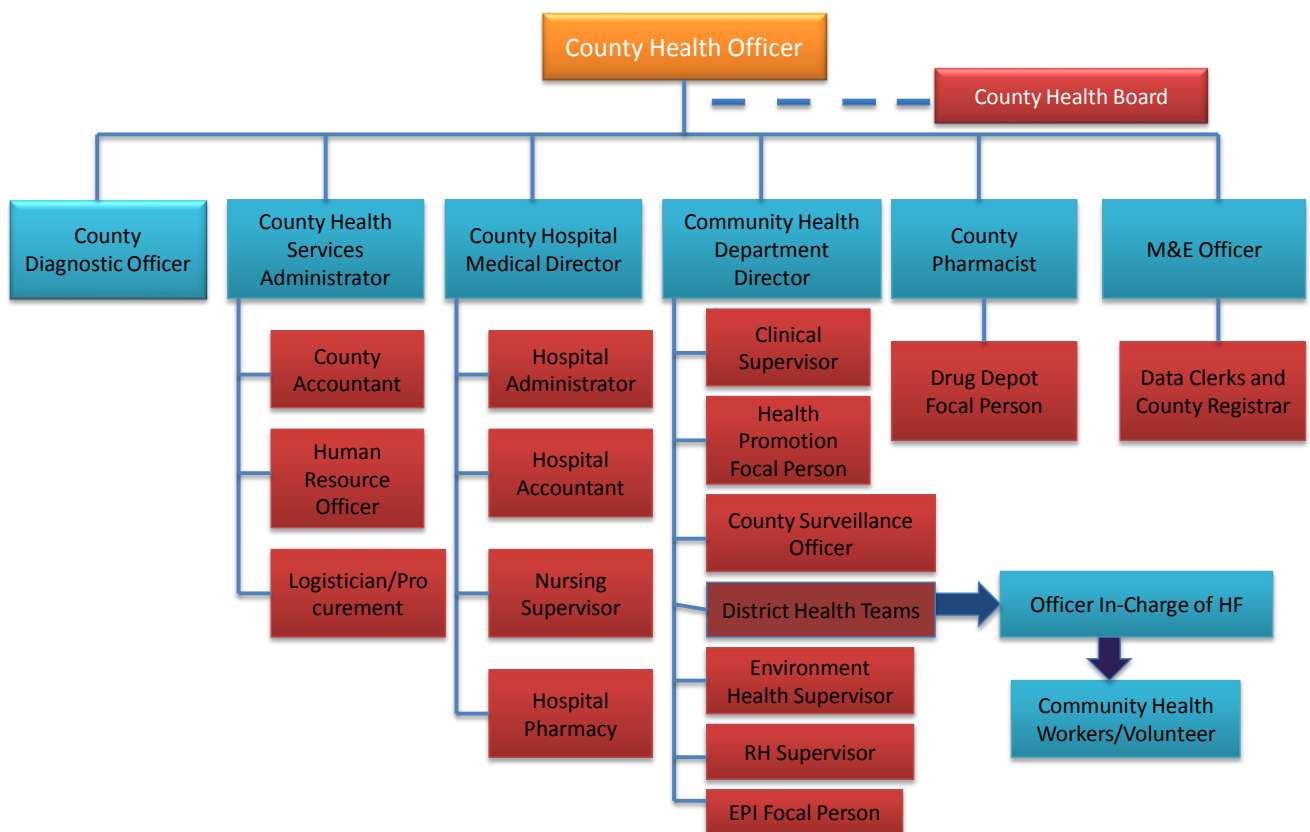
The district medical officer is the administrative head and is responsible for convening regular meetings of the team that comprises the following: the medical officer or medical superintendent or specialist in charge of the district hospital; district health sister (DHS), district environmental health superintendent (DHES); hospital matron; monitoring and evaluation officer; health education officer; district pharmacist; health administrator or hospital secretary; WASH coordinator; representative of community health officers; finance officer; district operation officer (DOO); district social mobilization officer; birth and deaths registrar; MCH aides, training coordinators; the disease surveillance officer amongst others.

The role of the district team is as follows: coordinate and administer health services at the district level; plan and manage the delivery of health care services; train, deploy, equip and supervise PHU staff; ensure surveillance of priority diseases and intervene appropriately; identify, notify, prevent and control epidemic prone diseases; monitor the health situation and the health services of the district; solicit funds and carry out general advocacy.

5.3 Structure of the DHMT

The DHMT is a decentralized health service system. Figure 1 shows an example of a DHMT structure depicting key roles, functions and composition. The DHMT is supervised by the District Council or equivalent body district council.

Figure 1: An Example of a DHMT Structure



5.4 Required competencies in the DHMT

Management and administrative skills: strategic planning and development; DHMT coordination; human resources management; supervisory skills; crisis management; basic financial management, accounting and budgeting skills; procurement; resource management; asset allocation and distribution; gender-inclusive programming.

Technical skills: knowledge management, analytical skills (i.e., monitoring and evaluation of health system, performance measurement, data use for decision-making, etc.); programme planning and implementation; clinical skills and knowledge (i.e., surgical skills and public health background for doctors).

Leadership skills: stakeholder engagement and partner coordination; advocacy.

6 NEEDS AND KEY CHALLENGES

6.1 Policy

Some emerging issues not reflected in existing policies included the following:

- Weak support for research
- Obsolete health standards
- Lack of national policy and structures for thematic issues (IPC, community engagement/participation),
- Low capacity for epidemiological surveillance
- A need for '*DHMT reforms*' in the context of changing environments. The degree of decentralization varies in the three countries in terms of human resources management, financial management; and authority to take responsibility.

6.2 Resources

Resources remain the cornerstone of a functioning district health system, meaning that adequate financing, human resources and logistical support are needed. Furthermore, there is weak support for knowledge management to address district challenges.

Finances: donor dependency and some resulting donor-driven programmes which are not always aligned with DHMT plans were cited. Some DHMTs do not participate in budgeting processes, resulting in low health financing from the national level for sub-sector financing. Low prioritization of district health funding by national budget leads, lead to inadequate funding to implement health activities.

Human resources: DHMTs work in very strenuous environments with poor internet, electricity supply, maintenance and security facilities. Many demands on the time of DHMTs and inadequate personnel to complete multiple tasks leads to overworked employees. Additional constraints on human resources are inadequate numbers of workers and their poor distribution in districts. Low staff motivation; in some cases, there is restriction on placement of staff on incentive or on government payroll.

Health worker skill mix is lacking, with few health financing professionals, health economists and epidemiological surveillance officers. Human resource development such as training, absorption, career growth and remuneration were noted as areas for improvement. Health training institutions have multiple challenges (e.g., numbers, tutors, infrastructure and training materials).

Logistical Support: DHMTs do not have adequate logistical support to conduct effective administrative, oversight and coordination functions (district scenarios are variable):

- Lack of regular repairs, maintenance of facilities/equipment and inadequate waste management due to low budgetary allocations;
- Inadequate drugs and medical supplies due to insufficient budgetary allocation and distribution system;
- Transfer of EVD assets to DHMTs remains challenging in many districts.

6.3 Leadership, management, coordination and governance

The *leadership role* of the MOH is paramount in steering the health sector to collaborate with key partners, and more so in post-Ebola contexts. Examples exist of successful '*delegated*' leadership roles by NGOs and the private sector. A major leadership role is the coordination of stakeholders and interventions in the health sector. However, while clinical skills exist, there are low management and leadership skills of those occupying the position of a DMO. The weak management skills of those occupying DMO positions lead to situations where administrators make health systems-related decisions. Leadership challenges for the district include the following:

- Performance management systems;
- Quality management units;
- Weak planning, budgeting, monitoring and evaluation processes (poor data management and use);
- Weak coordination mechanisms.
- Weak culture of accountability.

Coordination is a major function across the different levels of the health system. Constraints to be addressed include uncoordinated activities by national level programmes and poor feedback and communication systems. This leads to both weak external coordination between the DHMT and other partners in the district (the 'partner-overload' syndrome), and weak internal coordination between different DHMT units. Coordination activities have cost implications that require support such as legislation, conference rooms, power supply and refreshments. DHMTs do not have adequate logistic support to conduct effective administrative oversight and

coordination functions (district scenarios are variable). There is need to assess DHMT functionality.

6.4 Knowledge and skills

Overall, knowledge management was noted as an area needing improvement. There is a need to build the planning capacities of the DHMT to allow adaptation of solutions to the local context and monitor these activities over time. Additionally, health information is not available in real time for decision-making and for management of the health services sector.

6.5 Community engagement

There are increasing responsibilities in health even in the context of multi-sectoral approaches and this requires community engagement and behaviour change. In 2012, a multi-country study on community perceptions revealed discordance between the availability of policy and tools with realities on the ground. Weak community engagement continues to persist, and DHMTs are not adequately trained on how to engage with communities. Civil society and the private sector have roles in the districts, although the private sector is weak in Guinea; it offers 30% of services in Liberia, but mainly in Montserrado county.

5.6 Addressing the DHMT challenges

Focus should be on how to rebuild an efficient and responsive health system to prevent a repetition of the disastrous initial delays in management of the EVD outbreak. All stakeholders should be aligned with national priorities to effectively provide support in a spirit of fruitful partnership. Under the responsibility of the development committee at health district, the DHMT is responsible for translating national policies/strategies into concrete action by ensuring the meaningful participation of beneficiaries as actors.

For DHMTs to fulfil their leadership and management roles and to function better, they require authority that is commensurate with their responsibilities and autonomy for decisions and building relations (e.g. as outlined in the Ouagadougou PHC framework). There are currently no guidelines regarding leadership and governance. Above all, more resources are needed. The DHMTs need empowerment to think outside the box and to build their capacities in the following areas:

- Technical and managerial skills;
- Resources planning and implementation skills;
- Monitoring and evaluation skills.

7 BEST PRACTICES, OPPORTUNITIES AND RESOURCES AVAILABLE

The session on best practices, opportunities and available resources consisted of presentations by various speakers as outlined below.

7.1 Burkina Faso meningitis outbreak (1996)

The organization of the health system in Burkina Faso: 11 health regions, 53 health districts with district health management teams responsible for planning and implementation of programmes, including epidemiological surveillance and staff training. During the meningitis outbreak in 1996, 42 129 were recorded, while the number of deaths was 4226, representing a case fatality rate of 10.03%. The health system was disorganized with a resulting loss of credibility of the actors in the health system. Support of the regional and central levels towards the districts was not fully operational.

Lessons learned concluded that a significant epidemiological surveillance failure was the cause of the spread of the epidemic, which was exaggerated by the lack of a response plan. The DHMTs did not include sufficient epidemiological surveillance and data were transmitted every 3 to 4 months. In the basic training of health personnel (doctors and paramedics) epidemiological surveillance was undeveloped. Further, the district management training focused on resource management, although the technical capacities of district management teams were weak.

A meeting of health ministers of the sub-region was convened to reflect on management of the epidemic. Burkina Faso adopted a response plan to the epidemic, approved by its Council of Ministers. This was followed by a cascade of training of health teams in epidemiological surveillance and strengthening of the laboratory network and vaccine stocks. The course on epidemiology was introduced at the National School of Public Health for paramedics, while the university introduced epidemiology and disease surveillance for medical students. Master's courses were offered on quality of care, management of health services and in leadership management and governance for countries in the WHO African Region. Short courses were available in partnership with USAID. Other degree programmes were introduced to address epidemics in health systems in West Africa.

Furthermore, practical information on epidemiological surveillance and leadership were conducted. This included a regional course which was launched on how to fight viral hemorrhagic fever outbreaks. For skills training to work, there is a need for effective leaders in the district health management teams who are capable of mobilizing and leading teams. At the district level, there is a need to strengthen district level planning and to establish performance indicators which take into account analysis of epidemiological surveillance data at local levels. The DHMTs should receive all the necessary support.

7.2 DRC experience with Ebola outbreaks

The Democratic Republic of the Congo (DRC) is a vast country covering an area of 2 345 409 km², with a population of approximately 75 million, spread across 26 provinces, which are divided into 516 health zones. There is a network of 454 health care structures, 40% of which are faith-based. GDP was 514 US\$ in 2014; per capita expenditure on health is 26 US\$ per year with out-of-pocket expenditure being 38% of total health expenditure. Life expectancy at birth is 51 years for men and 54 for women. Maternal mortality rate is 846 per 100 000 births; and 104 infant deaths occur per 1000 births.

The history of primary health care (PHC) in the DRC dates back to 1970, starting with experiments in the first health zones of Bwamanda, Kisantu Kasongo and Vanga. In 1975, there was a national reflection on community health care followed by the Alma-Ata Declaration in 1978. In 1983-84 there was sub-division of DRC into 306 health zones. Nearly 60% were functional in 1990 and were managed by a zonal health team. By 2003, there were 516 health zones. There have been sector reforms since 2006 in line with the World Health Report of 2008 (on renewal of PHC) and the Ouagadougou Declaration. The health zones were built around the national network of hospitals and the population within the catchment areas were engaged and consulted prior to the zoning.

Lessons learned on Ebola crisis and health systems: quarantine measures were immediately imposed, along with temporary suppression of hunting activities throughout the districts of Tshuapa and Djera. A mobile laboratory was installed in Lokolia, the epicentre of EVD and the home of the international committee of technical coordination against EVD. Free drugs were provided for patient care in all health facilities and IPC skills of health providers were strengthened. Awareness and health promotion for the general population to undertake prevention and hygiene measures were also instituted.

A functioning health district is an asset for effective management of health information and relationships between the community and health staff. The availability of diagnostic capacity at the national level, government leadership and community participation in the fight against EVD is essential.

Use of the Ebola outbreak to strengthen the health district:

- Review and harmonize the tools and methodology of in-service training for executives from the operational level;
- Provide close supervision by the provincial level to strengthen DHMTs post-Ebola;
- Develop an adequate funding strategy for universal health coverage for quality health care and to offer an essential care package;
- Reduce direct payment;

- Facilitate referrals;
- Provide incentives for the retention of trained staff;
- Continue to work on patient safety and that of health personnel in health facilities;
- Promote the use of universal precautions in health facilities (single use devices, hand sanitizer, disinfection and sterilization of drinking water and management of bio-medical waste).

7.3 Ifakara health training institute experience and available opportunities

Introduction

Despite an increase in health spending in Africa, many people still have limited access to good quality health care. The burden of diseases such as HIV, Ebola, TB and malaria, lack of health workers as well as management and organizational failures are all attributed to weak health systems in the region.

Due to weak health systems, the achievement of proven cost-effective interventions is still often not possible. Health system strengthening is complex due to the multiple dimensions. There is therefore need for organisational capacity-building measures. Capacity-building is a process of establishing or strengthening organizations (DHMTs) to perform key functions, improve the vision of leadership in respect of those functions and strengthen the commitment of leaders/managers towards their achievement.

Some best practices and successful approaches:

- Continuing leadership and management training for DHMTs. This should be integrated with postgraduate training and mentorship to ensure that learning, adaptation and implementation takes place (there is evidence from Tanzania on this approach of training).
- Scaling up the use of professionalized, paid and mobile-enabled community health workers to provide maternal, neonatal and child health services (evidence is available to demonstrate that this works).
- Scaling up the use of a task sharing/shifting approach to train and deploy associate clinicians to provide CEMONC services (evidence is available that this works).
- Use of micro-research approaches to identify local solutions for local problems (evidence is available).
- Use of micro research approaches to identify local solutions for local problems (evidence is available).

7.4 AMREF experience and training opportunities

. AMREF Health Africa is a civil society organization which is actively engaged in capacity-building in health systems strengthening (HSS). Countries can use such institutions for capacity-building in leadership and management.

Strategic Health Priorities: Maternal, reproductive and child health, noncommunicable diseases, infectious diseases (HIV/AIDS, TB, malaria, cholera and others), WASH, medical and diagnostic services.

Leadership, management and governance (LMG) training: the overall aim is to enhance the competence of leaders and managers of health systems and programmes. In June 2011, the Japan International Corporation Agency (JICA), the Ministry of Health, Kenya and AMREF Health Africa entered into a tripartite agreement for the delivery of the AMREF Health Africa Partnership for Health Systems Strengthening in Africa (PHSSA) programme. In November 2011, the programme brought together experts from Anglophone, Lusophone and Francophone countries to develop training curricula and manuals.

The HSS curriculum has 10 modules which cut across the six blocks of functional health systems: overview and context of a health system; governance in health; leadership and management; human resources for health; health management information systems; health financing and financial management; service delivery, supply chain management, monitoring and evaluation.

Key programme outputs: development of training materials and dissemination of various health systems strengthening materials in English, French and Portuguese. These include a curriculum and manuals covering 10 modules, case studies, training monitoring and evaluation tools.

AMREF produced a monitoring and evaluation package for assessing HSS training programmes; conducted a tracer study and mid-term review to assess the continued relevance of PHSSA, and documented lessons learned and best practices; dissemination of programme outcomes to stakeholders across Africa.

Acceptability: 93% of respondents indicated that the PHSSA programme responded to African countries' needs for health workforce strengthening.

Accessibility: the curriculum is widely adopted across the African Region on the basis of needs of each institution or country.

Sustainability: Replication is evident in Botswana, Cote d'Ivoire, DRC, Ghana, Kenya, Senegal and Uganda. The curriculum is adapted in the training of undergraduate or postgraduate students in various health-related professional training programmes.

Discussions are ongoing with programme partners on the implementation of a second phase. Reviewing the curriculum in line with lessons learned and delivering the revised curriculum

using an ICT-enabled platform to increase reach and access. The new module will include capacity-building in the management of middle-level health facilities across African health systems.

7.5 Kenyan post-election violence experience (2007/2008) and ongoing opportunities

Post-election violence led to the division of the Ministry of Health into two, and the creation of many new districts. The result was a large number of management positions that were staffed by individuals with no training or experience in management. This was in the context of huge disparities in the health status of populations and displacement of populations and health personnel. Front-line health providers moved upward to management positions with neither skills nor experience. The management crisis was worse at the district level.

The roles and responsibilities of the DHMTs was management of health services, which included the following: Planning, Budgeting, Implementation, Supervision, Logistic support, Performance management, Monitoring, Evaluation, Feedback, and Regulation to ensure an environment in which people could be healthy.

Response to the situation

Training needs assessment was conducted which highlighted weaknesses in the ability to manage health services. There were varying management skills amongst managers who were expected to translate health investments into desired health outcomes. There was no strategic approach at the implementation levels and national strategies were not translated at implementation levels. Numerous management training activities were undertaken by partners, with curricula that were neither harmonized nor aligned to actual training needs.

The Tropical Institution of Community Health (TICH) at Great Lakes University of Kisumu was contracted by MOH/WHO to develop a training programme to build the capacity of DHMTs in management. TICH developed a standardized and comprehensive package to train sub-national level managers in health system/services. The objective of the training was to promote standardized management practices to address gaps at sub-national levels. Other training institutions were invited to take responsibility for training in various regions in the country. Lesson plans and presentations were developed jointly and a four-week course was conducted in two phases. Participants developed investment/business plans for their respective planning units.

The following were the aims of capacity-building of the DHMTs:

- Understand and address contextual issues that shape the health situation of populations, in a sustainable manner, improving the resilience of the system;
- Promote the development and use of transferable knowledge, skills, systems and resources;

- Promote system-wide increases in capacity to meet stated objectives through improved management and strategies;
- Improve performance at the level of individuals, groups, teams and the system to increase their ability to perform core functions, solve problems and achieve objectives,
- Establish a continual process of improvement within individuals, teams, and the system;
- Enhance the capacity of institutions in resource management;
- Enable managers to gain better control over their context of service;
- Develop sustainable skills, structures, resources and commitment to health improvement in areas of responsibility.

Course content: context influencing health system performance; organization of the health system/services; health care delivery principles: access, quality, coverage, safety, efficiency, effectiveness, equity, ethics, sustainability, resilience; health services leadership and management; health services planning, costing and budgeting; health services regulation, health law; supportive supervision, communication, relationships in the health system; health services monitoring and evaluation; health sector reforms, major international and regional commitments and their role in improving health systems.

These courses are available as part of formal and informal learning activities offered by the institute, in Kenya, but can also be offered in other countries interested in governance and management capacity-building.

7.6 Antwerp Institute of Tropical Medicine, Belgium

The Institute shared three training experiences:

- University of the Western Cape, Cape Town: modular courses: e-learning and winter school.
- Masters of Public Health (MPH) and short courses at Institute of Tropical Medicine (ITM), Antwerp. MPH Core competencies. Assess the performance of local and national health organizations, systems and policies. Formulate evidence-based and context-specific strategies for health systems strengthening. Communicate and negotiate with relevant stakeholders.
- Strategic management of health systems: health systems and health organizations as complex social system; strategic management framework; health policy with that overarching theme of “Health systems strengthening for universal health coverage.”

Institute of Tropical Medicine, Antwerp: Technical, financial support for The Fellowship Programme in Health Systems Management (FPHSM). Rationale: Gaps identified in management and leadership skills and competencies for senior health systems managers (mainly

District Health Officers); Health systems managers have received a Master's training in various institutions with different emphasis on health systems and management. Limited appreciation by many stakeholders of health systems management as a specialty within public health compared with clinical sciences. District Health Officers feel isolated, unrecognized, with unclear career paths.

7.7 Community of practice health service delivery: knowledge management at the district level

Community of practice for health service delivery fosters exchange on health service delivery at the district level. It brings different knowledge holders/profiles together in one place and facilitates interaction, builds trust and develops a common knowledge agenda through an online discussion forum (<https://hhacops.org/cop-hsd-pss-bilingual/discussions>), newsletter in French (www.santemondiale.org), a blog (www.health4africa.net) and face-to-face events such as Dakar regional conference on district health (2013). Since Harare (1987), there have been numerous changes in Africa's local health systems. However their performance is still low. The health district remains a valid strategy, but needs a renewed vision to improve primary health care.

The network reflects on the priorities for well-performing health districts in Africa. It convenes face-to-face events, research and publications. A key strength of the network is to mobilize DHMTs during outbreak and apply a *bottoms-up* approach for a more effective response to outbreaks.

A number of relevant were cited to improve the functionality of DHMTs: context-relevant data collection, analysis and visualization system to improve motivation of DHMTs to use data for action; a benchmarking of performance to improve priority setting and decision-making. A national discussion forum to empower local actors in taking action.

Key questions to address for DHMT preparedness for outbreaks:

1. Is my district ready?
2. What more is needed?
3. How do peers deal with the same challenges?
4. How are top-down recommendations adapted to local contexts?

Key questions to address to engagement communities and DHMT:

1. Do people have quality and up-to-date information about diseases and outbreaks?
2. Are they empowered to defend their right to health and leverage an effective bottom-up pressure?
3. How to mobilize DHMTs in evaluating their own performance and improving their response to health challenges?

Conclusion: Improving DHMT performance requires a number of action areas. This includes but not limited to vertical and peer-to-peer strategies, steering pluralistic health systems, accountability for results, empowerment of communities and individuals, quality of care, multisectoral action, public private partnership, equity, decentralization and innovative ICT tools

7.8 Ghana's experience: evidence and best practices on district health system

Background:

Kassena-Nankana West District is one of the 13 districts in the Upper East Region of Ghana. It lies within the Savannah zone of Ghana. The district covers a land surface area of 1658 km². It has a projected population of 75 910 which gives a population density of 46 people per km².

The Health Sector Strategic Objectives 2014 -2017 objectives include bridge equity gaps in geographical access to health care; ensure sustainable financing for health care delivery and financial protection for the poor; improve efficiency in governance and management of the health system; improve quality of health services including mental health; intensify prevention and control of noncommunicable diseases and other communicable diseases.

Health system in Ghana

Ghana's health service is organized at three levels: national (teaching hospitals); regional (regional hospitals), and district level (district health administration, district hospitals). The district level is organized into sub-districts.

Several mechanisms exist at the district-level for financing of health care: the National Health Insurance Scheme; fee for service programmes (initiated by the Global Fund); district and support from partners (e.g. UNFPA, UNICEF), exist to support financing of health services. The district has 80% registration in the national insurance scheme in Ghana. This guarantees access to care for the population, including vulnerable populations such as pregnant women and children under five.

Human resources: Kassena-Nankana West District has one medical officer, 12 midwives, 58 Community Health Nurses and 54 other staff. The district has not been able to meet the staffing norms. This has thus resulted in task shifting and integration of services to meet the health needs of the people. Motivational drivers for staff have included : reward to staff for hard work and retention, facilitate acquisition of accommodation for newly posted staff; sponsor in-service development training for staff in critical areas e.g. midwifery, intensive care nursing and anaesthesia, and respond promptly to staff welfare issues.

Access to health care through community health planning and services (CHPS) concept: CHPS is a strategy to improve geographical access to health care especially in rural areas. The district is divided into zones which match the local government electoral areas. The district has 29 zones in

which a trained health worker is deployed to stay, with the support of volunteers to provide basic health services to the people.

Health information is generated through the use of registers and tally sheets and entered into a web-based software (DHIMS 2) on a monthly basis. Epidemic-prone diseases and maternal deaths are reported within 24 hours of occurrence to a higher-level and also at the end of the week. All other conditions and services provided are reported at the end of every month. Health information data is also gathered through surveys i.e. multiple indicator cluster surveys. Monthly validation is carried out; quarterly feedback is then given to facilities. All reports are validated and authorized by the district director every month.

Health commodities: Vaccines are supplied from the national level on demand. Drugs and essential commodities are supplied on a door-to-door basis directly to the facilities from the regional medical stores. Partnerships for health commodities are through: UNICEF, UNFPA and the Catholic Relief Services are the main partners in service delivery in the district.

A number of community-based organizations act as accountability watchdogs regarding the provision of health services. The local government set-up is the prime overseer of health services in the district.

Interventions for children: strategies and innovations to improve child health have included: provision of integrated services, both at static and outreach sessions; quarterly mop-up exercises where health workers are assigned to electoral areas for clinical improvement; follow-up of defaulting clients and postnatal mothers by Community Health Officers (CHOs); community management of acute malnutrition; child health promotion week activities; food demonstration at community level; implementation of targeted supplementary feeding; home visiting; use of model mothers to counsel other mothers on infant and young child feeding, Deworming of children, both in schools and at child welfare clinics; food demonstration session with mother-to-mother support groups.

Maternal health interventions: a number of interventions areas were highlighted: intermittent preventive treatment for malaria; elimination of mother-to-child transmission of HIV (EMTCT); promotion of ITN use; antenatal care and skilled delivery; post-natal care; family planning; adolescent health; innovations to improve maternal health; provision of outreach ANC sessions in CHPS compounds without midwives; TBAs trained to serve as link providers; orientation of community members as council of champions; use of three-cylced (motor king) ambulance to facilitate referral of emergency cases in hard to reach communities; establishment of pregnancy schools i.e. pregnant women and midwives meet mostly weekend where they discuss on persisting conditions; use of organized groups to educate community members; mobile technology for community health (MoTECH); and trained peer educators

Disease control: strategies highlighted: screening for both communicable and noncommunicable diseases; follow-up of discharged patients; mass drug administration for neglected tropical

diseases, e.g., Onchocerciasis and Elephantiasis; integrated disease surveillance and response (IDSR), innovations to improve disease prevention; monitoring of thresholds of epidemic-prone diseases for notification and taking action; prompt case investigation and reporting, updating of district integrated epidemic preparedness plan; holding quarterly epidemic preparedness committee meetings; building capacity of staff on the various case definitions of the diseases and treatment protocols; use of community-based volunteers to detect and report unusual events for further investigation.

Health promotion: proven interventions have included: media discussions on topical health issues; health talks at static and outreach sessions; use of the communication for development (C4D) approach i.e. dialogue, songs, video shows and drama to educate people on key interventions; use of volunteers and key stakeholders to pass on health messages. Organization of durbars to create awareness on prevention of priority disease and other health issues.

Clinical care: Interventions include: consultation and treatment using standard treatment guidelines; maternal death audit; 24hr emergency services in all facilities; client and staff satisfaction surveys; customer care training; key areas for building an effective district health system; strong leadership; strategic plan from which annual plans are extracted; regular monitoring and supervision of various units and facilities; regular meetings i.e. weekly, monthly and quarterly health family meetings; Regular briefing of political heads and other collaborators on the health situation of the district; efficient financial management and an internal audit unit; strong collaboration with community members from planning to implementation of health programmes for effective service delivery and an emphasis on public-private partnerships.

Challenges and recommendations of district health systems in Ghana:

Though the district health system in Ghana is deemed as a model of success, a number of challenges are presented: dwindling resources making it difficult for sustainability of projects; poor infrastructure i.e. inadequate WASH infrastructure, residential and office accommodation; inadequate means of transport to facilitate regular outreach visits, to developed and remote areas; inadequate critical staff i.e. midwives and doctors; poor internet connectivity; volunteer fatigue, weak capacity of some managers especially at the sub-district level.

Recommendations put forth to improve district health system include: regular funding to district health directorates from the government of Ghana; strengthen integration of programmes; regular technical support visits to provide on-the-job coaching and training; improve supply of essential commodities, including transportation; provide adequate infrastructure and human resources; strengthen community involvement from planning to implementation.

An innovative strategy pioneered within the Ghana sub-national health system is the use of ‘motorking:’ motorized tricycle charged with providing care for those in route areas and transporting critical patients to health facilities.

8 RECOMMENDATIONS FOR THE ROADMAPS

8.1 General recommendations for the roadmaps

Approaches to acquire DHMT competencies

Concerted efforts must be undertaken to define approaches to acquire these competencies. Initially, start with training needs assessment (TNA) based on clear job descriptions for district staff, accompanied with orientation. Develop or identify appropriate curricula and learning materials or resources to train personnel. Carry out research including bottleneck analysis and implementation research; establish a mentoring programme and complement these approaches to training the DHMT with exchange visits either at the sub-national level or cross-country.

The required competencies include: technical, managerial, resources mobilization, planning, implementation, monitoring and evaluation, implementation of appropriate reforms in a changing environment, and assessing DHMT functionality in order to set up performance management systems. Competencies can then be enhanced through in-service trainings, short- and long-term training courses, technical support, mentorship and coaching. This should be accompanied by strengthening administrative structures and the development of guidelines to support workplace practice. Support continuing capacity-building programmes for DHMTs. A low-lying fruit option is to partner with training institutions (in-country, regionally) for capacity-building initiatives. Strengthen pre-service training institutions by hiring and deploying technical staff, to enable them to increase their intakes and to participate in service delivery. It is useful to keep a diary of what is being learnt, and what else needs to be learnt towards effective solutions. Explore other modes of learning such as blended learning, e-learning, short courses, competency-based modular delivery of a large variety of topics; linking course work with field practice and mentorship for greater effectiveness.

Countries can establish effective structures to support coordination, ensuring harmonization and alignment of all stakeholders with MOH strategies through joint planning and meetings. For in-service level agreements (SLA), the MOH should include the DHMT in the conversation. Partners need to speak to DHMTs at the outset of partner projects. Advocate for effective decentralization of responsibility, authority and resources. Advocate for effective engagement at all levels in planning & budgeting. For the DHMTs to function well, they require authority commensurate with responsibilities, autonomy for decisions and building relationships; and empowerment to think outside the box. Revise management guidelines and develop guidelines where they do not exist, e.g., for community participation.

Countries should organize in-country sessions to follow up on roadmap implementation, while WHO should organize sessions between countries to share information on progress, build consensus, and learn from one another.

8.2 Stakeholder panel discussion on coordination mechanisms

A panel discussion on coordination mechanisms was held for stakeholders, comprised of non-governmental organizations (NGOs); development partners; ministries of health, finance, and local government; capacity-building advisors; implementing partners and civil society. The panellists deliberated on the need for coordination to ensure that district plans and priorities were agreed upon and that realistic roadmaps were developed for implementation.

It was evident, from the Ebola experience, that coordination was essential for the effective participation of actors and for accountability. Coordination was achieved mainly through classic coordination mechanisms, such as meetings, which required resources. Coordination meetings were held at each sub-level health facility to contribute to district and national health plans and to harmonize the activities of all actors. Coordination took place both vertically and horizontally, resulting in synergies of activities and preventing duplication. Establishing working groups and having transparent information flow contributed to effective partnerships. Partner mapping (for example, area of coverage, period of work) was essential for an effective management of resources for delivery of better health outcomes. Partners aimed to work with national structures to support the development of national plans and activities.

9 COUNTRY-SPECIFIC ROADMAPS

9.1 Country-specific roadmaps

The methodological approach used was largely based on the report from an international consultation on how to improve leadership and governance in the health sector by switching on the cardinal "dimensions":

- Dimension 1: number required
- Dimension 2: skills and versatility
- Dimension 3: functional support systems
- Dimension 4: work environment.

Activities derived from the 3-country roadmaps have been summarized below applying the four cardinal dimensions. Detailed elements of the 3-country roadmaps are found in the annexes.

Guinea	Liberia	Sierra Leone
1. Deploying the required managers		
Recruit & deploy managers	Recruit & deploy managers	Recruit & deploy managers
	Recruit & deploy economists	Revise and populate DHMT organigram in line with the updated PHC Handbook based on assessed needs
	Build capacity of training institutions for leadership and management	
2. Building competencies around "knowledge, skills & behaviours"		
	Assess DHMT competencies	Assess DHMT competencies
Develop national competence framework of district managers	Develop training materials	Operationalize DHMT competency framework
National workshop to train the trainers	Develop a continuous skills development programme	Mapping of training needs and profiles at all levels (national and sub-national)
National training workshop on policy dialogue towards UHC		Continue performance development programme
	Develop a leadership mentoring programme	Structured on-the-job training for managers
	Provide technical assistance on continuous support for managers	Organize customized trainings on key competences
		Establish better collaborations with partners on training programmes
3. Strengthening "management support systems"		
Institute automated health information systems at the district levels (DHIS2)	Strengthen health information management (HMIS & LMIS)	
	Strengthen human resource management	
	Strengthen financial management	Strengthen financial management systems
Institute computerized supply systems for managing drugs and other medical products		
	Strengthen planning & budgeting capacities	Support the DHMT in conducting monthly/quarterly integrated supportive supervision visits activity at district level
Organize bi-annual supervision visits	Provide logistics for monitoring & supervision	Support Data/HMIS reports in the DHIS 2.0
Establish coordination structures at operational levels (prefectural and communal committee)		
Produce monthly situation reports as recommended for accountability of the implementation of the recovery plan		
4. Fostering an enabling "working environment"		
Update norms and standards	Review of DHMT profiles and job	Review DHMT profiles and job

(national and district), national guidelines for integrated supervision and other management tools	descriptions	descriptions
	Review DHMT organigram to ensure it reflects reality	Operationalize DHMT organigram
Implement regulation texts on decentralization for effective autonomy of district	Advocacy for greater autonomy/authority	Revise PHC Handbook regarding roles & responsibilities
	Institutionalize functional coordination mechanisms	Define roles & responsibilities of staff at all levels
	Establish appraisal and reward mechanisms	Establish a performance management system
		Strengthen MOHS/Partner coordination - -- SLA model (establish donor/partner coordinating unit within DHMT)
Establish incentives (accommodation, internet connectivity, equipment and cash bonuses)	Provide accommodation & utilities for managers	Explore different staff motivation approaches
	Conduct regular stakeholder meetings	

Liberia roadmap

The country team outlined the need to work with training institutions to increase production of the health workforce (numbers, quality, variety of courses/topics) which is a long-term approach to solving the problem. Other recommendations put forth were: working with professional bodies to accelerate the process of recognition (accreditation, registration); automation of HR data; facilitate communication; provision of housing for personnel (institutional, mortgage schemes, community); advocating for 15% health funding allocation (aligned with the Abuja Declaration); develop a National Health Financing Policy and Strategy; and the creation of an emergency contingency fund.

As a short-term intervention, ensure that DHMTs learn planning skills through training in order to promote adaptation to local contexts. Quality management units were emphasized as being essential. Other strategies proposed include: reduction of bureaucracy on accessing funds for health services. Innovative funding mechanisms for health are needed. There is a need to strengthen accountability structures and mechanisms.

For DHMTs to function better they require autonomy with decision-making and building relations and empowerment to think outside the traditional box. Required DHMT capacities: technical and managerial; resources and planning; implementation skills; M&E skills. Assessing DHMT functionality is required, including the setting up of performance management.

Challenges and mitigation strategies: reactivate and strengthen the training unit at MOH; harmonize trainings provided by partners and the MOH; scale up the integrated human resource information system (iHRIS).

Proposal to revise the DHMT structure and integration: review county health team organigram, health team organigram or structure, to reflect actual situation. Establish functional support systems and ensure there is an adequate number of managers in the DHMTs. Also ensure that managers have the necessary skills and competencies required to create a positive work environment for colleagues.

Guinea roadmap

The Guinean delegation at the workshop felt that the major challenge to their health system was the need to expand health coverage to the entire population by strengthening the delivery of health services; and the development of community-based health care to achieve universal health coverage (UHC). They recognized that to address these challenges, they would need to improve health sector governance, the availability of human resources for health, to ensure the quality of services, strengthen infrastructure and equipment, establish sustainable financing of the health system, and ensure adequate availability of essential medicines and other quality health products and medical technologies, based on an efficient health information and research system to provide timely evidence for decision-making.

The Guinean team identified three main strategic directions for their roadmap:

Strategic direction 1: Strengthen the prevention and management of diseases and emergencies;

Strategic direction 2: Promote the health of mothers, children, adolescents and the elderly;

Strategic direction 3: Strengthen the national health system.

The national recovery plan for Guinea mentions the need to improve the functionality of the district health system, and to strengthen the national health system. The need to re-define the district health profile, effectively integrate IPC into routine service delivery, support EVD survivors and maintain epidemiological surveillance and alerts, were specifically emphasized. Participants from Guinea noted that they were aware of the need to focus on the essential package for health care, including mental health, as they strive to strengthen the sub-district health systems.

Participants from Guinea intend to implement the National Health Observatory: single platform of the National Health Information System (NHIS), as well as the district health information system (DHIS) assisted by CDC Guinea, eHealth, and IntraHealth. Guinea noted the need to improve decentralization of the health policy dialogue to the regional, district and community levels and to convene discussions with donors at these decentralized levels.

In order to improve the performance of the health system in terms of quality of care, it is necessary to strengthen the management of health services as well as the management of human, material and financial resources; and of health information, including epidemiological surveillance. Strengthening leadership, governance, and management at all three levels of the health system (central, regional and district) is also vital. Of importance is management and governance of the district health system, emphasizing coordination, accountability, community engagement and the regulation of service delivery.

Priorities in the health care package will continue to be the prevention and control of infections, the promotion of mental health care, management of the supply of essential medicines, vaccines, blood and other medical products. These must be supported by the improved management of infrastructure, equipment and health technologies.

The team will pursue strategies for adequate funding of the sector for universal access to health care, human resources development, development of health information systems and health research; strengthened leadership and health governance, planning and management; coordination, monitoring and evaluation; partnership and multi-sectoral participation in health legislation, regulation and control.

Financing should promote decentralization aimed at strengthening district health systems based on primary health care. At the same time, there is a need to strengthen health sector coordination structures at all levels of the health system (central, regional, district or municipal). This should ensure the integration of all stakeholders

The country team wished to explore the idea of reforming the district health management team. New functions proposed include: epidemic surveillance, IPC, mental health, development of annual operational action plans (OAPs); update and implement coordination mechanisms, and political dialogue. These functions will require new competencies that the current DHMT may not have. The reformed DHMT will require epidemiologists, laboratory technicians, IPC specialists, social workers, mental health workers, and skills in monitoring and evaluating health; and information systems specialists to establish a monitoring and early warning system.

This change in the DHMT will require that the essential package of services be re-defined. The package should be integrated with community, health centre and district hospitals to ensure a continuum of care for patients. The annual operational plans should be linked to the financing system that permits the allocation of resources at every level of the health system, and is linked to a procurement system for drugs and equipment.

The country team favours integrated and people-centred activities. For the roadmap to be adopted, there will be a need for a national awareness workshop on the new framework for implementation, in terms of scaling up. Re-orientation of staff to equip them with the required competency-strengthening provider's capacity. For sustainability of implementation, training curricula and implementation, materials will be required, taking into account the overall

framework of implementation in developing training plans. There will be a need to ensure standards for IPC; WASH standards and procedures for prevention and control of infections for institutions of care.

There will be a need to carefully monitor and evaluate the infection prevention and control standard operational procedures (SOPs) and the rapid response team which should be activated during emergencies. It may be necessary to construct triage facilities in health facilities alongside capacity-building in IPC & WASH for service providers and supervisors, trainers and health workers. The components of the district health system should cover specific geographical areas, have an accurate idea of the population it serves, health structures and structures for community participation, which should include traditional medicine and related sectors.

This process should lead to sustainable district health technical autonomy – autonomy in the ability to deliver quality services to meet the expectations of the population it serves. In particular, there is a need for greater economic autonomy which is the ability of the district health system to cover all costs, individually and collectively, with its own revenues and complementary financing. It should also lead to institutional autonomy which is the ability of stakeholders to manage the district health system as a viable enterprise with financing, essential care packages, community involvement, and all the core activities necessary for performance improvements.

Sierra Leone roadmap

The following is the framework for country-specific roadmaps for leadership/management and capacity-building of DHMTs:

Logistics and maintenance - The country team will maintain effective internet access and communication facilities at the district level; improve maintenance of facilities for office equipment at the district level; improve maintenance infrastructure at the district level. The country will ensure the provision of a reliable power source for DMHTs, establish an effective mechanism for waste management at DHMT hospitals and PHUs. The team noted that the Ministry of Health and Sanitation (MOHS) will provide adequate logistical support for DHMTs to conduct effective administrative, oversight and coordination functions, support DHMTs to achieve effective and continuous community engagement. It was also mentioned to organize in-country sessions to share information and build consensus with all stakeholders.

Capacity-building approaches - The country will review competencies and roles (job descriptions) of staff; conduct a training needs assessment of staff; improve the MOHS, Ministry of Education and private institutions. They will map training needs and profiles at all levels (national and sub-national) and partner with training institutions (in-country and regionally) for capacity-building initiatives. Participants noted to establish a postgraduate medical training college. Sierra Leone noted to hold structured on-the-job trainings for health staff, and organize customized training on key competencies for managerial/administrative staff. The MOHS will

maximize partner-led capacity-building initiatives and collaborate with partners to prioritize the identified training needs of staff. They will develop training plans and budget and share with partners. Seek to influence and standardize the content of training that will be agreed upon by MOH and partners, and explore models of learning (blended learning, e-learning, short courses, competency-based modular delivery of a large variety of topics, linking course work with field practice and mentorship for greater effectiveness). They also aim to support regulatory bodies for health cadres, and institute effective performance-based incentive mechanisms.

Management and administration - Ensure clear job descriptions for district staff, accompanied by orientation; advocate for effective decentralization (responsibility, authority and resources). Sierra Leone will revise its management guidelines and develop guidelines in areas where these do not exist, e.g. for community participation; Facilitate harmonization and alignment of all stakeholders with MOH strategies through joint planning and meetings; Advocate for effective engagement at all levels in planning and budgeting; Focus on results as a measure of effective change, to promote an accountability culture by strengthening accountability structures and mechanisms.

The team stressed that they would develop clear structures (including roles) on the relationship between MOHS and local councils and communities. They will also revise the PHC Handbook and strengthen MOH/partner coordination by establishing a donor/partner coordinating unit within the DHMT. Finally, the team noted to implement a roadmap that is justified and supported by a costed plan.

9.2 Issues requiring further discussion

There is a need for continued joint working on the roadmaps, namely follow-up by WHO to facilitate networking and in-country follow-up is also essential.

Linkage of the health system to the community as part of building a resilient district is yet to be fully embraced. The Ebola response in the affected countries resulted in improved capacity, systems and practice, all of which require a strategy to sustain them. Therefore, follow-up activities need to be specific on how each country will sustain these gains to maintain and carry on with the improvements to the health system.

District leadership needs to be nurtured and empowered to take decisions that are informed by evidence. This will facilitate decision-making and enable DHMTs to customize strategies to their contexts. Decentralization needs to be comprehensive, involving services and responsibilities but also authority, power and resources.

District leadership capacity-building will assist DHMTs to manage human, financial and logistical resources such as procurement and supply chain management (drugs, equipment), and also information systems. Management capacity-building should include facilitating good

governance, community linkages, accountability and to ensure that principles of service are adhered to such as striving for better access, efficiency, effectiveness, equity, quality, safety, and last but not least that they are ethical. District management should address effective communication and relationships. Leadership needs to address loss of credibility and trust in the health sector by the populations they serve, using appropriate strategies. For example, the dialogue model that engages communities in discussion, consensus and action is one such strategy.

Inadequate capacity of the regulatory bodies to function effectively and to regulate health practice should be addressed through contextualized strategies to deal with local realities such as limited capability and inadequate staffing.

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APPENDIX 1: PARTICIPANT LIST

**WORKSHOP ON BUILDING RESILIENT SUB-NATIONAL HEALTH SYSTEMS-STRENGTHENING
LEADERSHIP AND MANAGEMENT
CAPACITY OF DISTRICT HEALTH MANAGEMENT TEAM 20-22 APRIL,2016, Freetown, Sierra Leone**

	NAME	COUNTRY	DESIGNATION	ORGANISATION
1.	Abdoulaye Djakite	Guinea	Médecin Chargé des Maladies	MOH/Guinea
2.	Aboubacar Sylla	Guinea	Président Plateforme ONG santé	Société civile
3.	Addoulaye Kaba	Guinea	Directeur National du Bureau de la Stratégie et du Développement	MOH/Guinea
4.	Adewale Akinjeji	Sierra Leone	Technical Officer	WHO/Sierra Leone
5.	Adolphus T. Yeiah	Liberia	County Health Officer	MOH/Liberia
6.	Adzodo Mawuli Rene	Guinea	Expert HSS	WHO/Guinea
7.	Alhassan Joseph Kanu	Sierra Leone	Planning specialist	MOHS
8.	Ali Badara Cisse	Guinea	DPS District Kissidougou	MOH/Guinea
9.	Amara Nana Camara	Guinea	DPS District LOLA	MOH/Guinea
10.	Amara Sumaila	Sierra Leone	Reporter	88.7 FM—MEdia
11.	Anders Nordstrom	Sierra Leone	Country Representative	WHO/Sierra Leone
12.	Archana Shah	Geneva	Health Systems Adviser	WHO/Geneva
13.	Bokar Dem	Guinea	Conseiller Senior RSS	JHPIEGO
14.	C. Stanford Wesseh	Liberia	Asst. Minister/Statistics	MOH/Liberia
15.	Cuallau Jebbeh-Howe	Liberia	Director-County Health	MOH/Liberia
16.	Dan Kaseje	Geneva	Professor	Great Lakes University Kenya
17.	Dirk Horemans	Geneva	Programme Officer, Service Delivery & Safety	WHO
18.	Elongo Tarcisse	Brazzaville	Regional Advisor	WHO/ AFRO
19.	Eric D. Johnson	Liberia	Health Economist	WHO/Liberia
20.	Falikou Loua	Guinea	MCM	MOH/Guinea

21.	Foday Sam	Sierra Leone	District Medical Officer- Kambia	WHO/Sierra Leone
22.	Fodé cissé	Guinea	Directeur Préfectoral de la Santé (DPS), District DUBREKA	MOH/Guinea
23.	Francis Moses	Sierra Leone	District Medical Officer: Koinadugu	DHMT Koinadugu
24.	Francis S. Namisi	Kenya	Training specialist	AMREF Health Africa
25.	Gorbee Logan	Liberia	County health officer	MOH/Liberia
26.	Ibrahima Kouyate	Guinea	Médecin Chargé des Maladies	MOH/Guinea
27.	Isaac Boateng	Sierra Leone	District Team Lead-Western Area	WHO/Sierra Leone
28.	J. N Kandeh	Sierra Leone	Director of Primary Healthcare Services	MOHS/Sierra Leone
29.	Jean Pierre Lokonga	DRC	National Professional Officer	WHO
30.	John Marrah	Sierra Leone	Reporter	News Watch—Media
31.	John Mosima	Sierra Leone	Admin. Programme Assistant	WHO/Sierra Leone
32.	John Ndyahikayo	Sierra Leone	Field Coordinator- Kambia	WHO/Sierra Leone
33.	John S. Doedeh	Liberia	Country Health Officer	MOH/Liberia
34.	Kamadi Balla Conde	Guinea	Recr APS Faranah	OMS
35.	Karolina Lagiewka	Guinea	Projects Officer	European Union
36.	Kassie Fangamou	Guinea	Coordonnateur Régisseur PASA UE N'Zerekore	European Union
37.	Katharina Wietler	Guinea	Counsellor Technique	GIZ
38.	Kemoko Malick Conde	Guinea	Medecin chargé de la prévention et lutte contre les maladies - MCM	MOH/Guinea
39.	Keugong Basile	Cameroon	Moderator	Community of Practice: Health Service Delivery
40.	Kiyoma H. Koroma	Sierra Leone	In- House Consultant	JICA
41.	Laurent Ouedraogo	Benin	Professeur	Institut Régional de Santé Publique (IRSP)
42.	Lavela B. Kortimai	Liberia	Medical Director	MOH/Liberia
43.	Mamadi Balla Conde	Guinea	Médecin Chargé des Maladies District Faranah	MOH/Guinea
44.	Mara Karifa	Guinea	National Professional Officer: Health systems	WHO/Guinea

45.	Margaret Kaseje	Geneva	Public Health Specialist	Great Lakes University Kenya
46.	Maria Dominika A. Meo	Sierra Leone	District Team lead Pujehun	WHO/Sierra Leone
47.	Mark A. Abugri	Ghana	District Director & Health Service	Ghana Health Service
48.	Mary Stella Adapesa	Ghana	District Director & Health Service	Ghana Health Service
49.	Mauricio Calderon	Sierra Leone	Health Security	WHO
50.	Mohamed A.S Kamara	Sierra Leone	Western Area	MOHS/Sierra Leone
51.	Mohamed Y. Turay	Sierra Leone	Reporter	Parliament—Media
52.	Monica Musenero	Sierra Leone	District Team lead	WHO/Liberia
53.	Moustapha Grovogui	Guinea	Coordonnateur National PASSP	Catholic Relief Services
54.	Mukesh Prajapati	Sierra Leone	District team lead	WHO/Sierra Leone/Kenema
55.	Nana Mensah Abrampah	Geneva	Technical Officer- Service Delivery & Safety	WHO/Geneva
56.	Ngozi Kennedy	Sierra Leone	Health Specialist	UNICEF
57.	Niouma Nestor Leno	Guinea	Health Systems Strengthening	UNICEF
58.	Nuzhat Rafique	Sierra Leone	UNICEF	Health manager
59.	Oliver Behn	Sierra Leone	Districts Coordinator	WHO/Sierra Leone
60.	Omar Sam	IST- West Africa	Health Systems	WHO
61.	Osaio Kamara	Sierra Leone	District Medical Officer Bombali	MOHS/Sierra Leone
62.	T. T Samba	Sierra Leone	District Medical Officer: Western Area	MOHS/Sierra Leone/Western Area
63.	Robert Marten	Sierra Leone	Technical Officer	WHO/Sierra Leone
64.	Salifou Soumah	Guinea	DPS District PITA	MOH/Guinea
65.	SAS Kargbo	Sierra Leone	Director of health systems, Policy, Planning and Information	MOHS/Sierra Leone
66.	Satoshi Otani	Sierra Leone	Health Systems	Specialist MOHS/JICA
67.	Senga K Pemba	Tanzania	Professor	IFAKARA Health Institute
68.	Shunsuki Suzuki	Japan	Chief Advisor	MOHS/JICA
69.	Sowmya Kandandle	Sierra Leone	Technical Officer	WHO/Sierra Leone
70.	Stanley Ifeanyi	Sierra Leone	District team lead	WHO/Sierra

				Leone/Koinadugu
71.	Thérèse Soropogui	Guinea	Médecin Chargé des Maladies: District Kissidougou	MOH/Guinea
72.	Wim Van Damme	Belgium	Professor: Public Health	Institute of Tropical Medicine
73.	Younoussa Ballo	Guinea	Secrétaire Général	MOH/Guinea

APPENDIX 2: PRELIMINARY COUNTRY ROADMAPS

10.1 LIBERIA

GROUP WORK 3:
ROADMAP FOR STRENGTHENING
DHMTS

LIBERIA

DIMENSION 1 : ESTABLISH FUNCTIONAL SUPPORT SYSTEMS

#	Key Actions	Expected Results	Indicators	Timeline		
1.1	Assess DHMTs Leadership and Management capacities	Leadership and management gap identified	Proportion of DHMTs assessed		Q3	
1.2	Develop Leadership and Management Training Course	L&M Training Curriculum developed	Availability of L&M Curriculum			Q4
1.3	Train DHMTs in leadership and management	Enhanced L&M capacity	Proportion of DHMTs members trained in L&M			Q4
1.4	Partner with national and regional training institutions for leadership and management capacity development		Number of partnership agreements signed with national and international training institutions		Q3	
1.5	Train and deploy health economists	Improvement in costing and budgeting	Number of health economists trained and deployed			Q4

DIMENSION 1 : ESTABLISH FUNCTIONAL SUPPORT SYSTEMS

#	Key Actions	Expected Results	Indicators	Timeline		
1.6	Provide scholarships for staff in epidemiology	Improved early warning and surveillance system	Number of staff trained in epidemiology			Q4
1.7	Establish budget line for construction and maintenance in national budget	Increased access to health facilities	Availability of construction and maintenance budget line in MOH National Budget		Q3	
1.8	Construct or establish county and regional drug depots	Improved drugs storage capacity	Number of regional and county drugs depot constructed		Q3	
1.9	Train staff in M&E and HMIS	90% reporting coverage and timeliness	Proportion of M&E Officers trained in M&E & HMIS		Q3	
1.10	Train staff in financial management and procurement	Improved financial and procurement management system	Number of staff trained in financial management and procurement			Q4
1.11	Increase budgetary allocation for drugs and medical supplies	Lack of drugs stock out	Percent of increased in drugs and medical supplies budget			Q4

DIMENSION 2 : MAKE SURE TO HAVE AN ADEQUATE NUMBER OF MANAGERS/DHMTs

#	Key Actions	Expected Results	Indicators	Timeline		
2.1	Strengthen health training institutions to increase their production level of selected cadres (ie: Midwives, Lab Tech, Pharmacists, etc)	Increased capacities of health training institutions	Number of health training institutions capacity enhanced			Q4
2.2	Hire and deploy required managers	Strengthened DHMT capacity	Number of managers recruited			Q4
2.3	Place managers on Government payroll	Sufficient number of staff placed on Government payroll	Number of managers placed on Government payroll	Q2	Q3	Q4
2.4	Implement the MOH two housing schemes: facility based housing Units and mortgage scheme	Motivated health workers	Number of housing units constructed	Q2	Q3	Q4
2.5	Review DHMTs structure to reflect current reality	Increased DHMTs productivity	Availability of revised DHMTs Structure	Q2		

DIMENSION 3 : ENSURE THAT MANAGERS HAVE THE NECESSARY SKILLS/COMPETENCIES REQUIRED

#	Key Actions	Expected Results	Indicators	Timeline		
3.1	Develop and implement national skills development program	Enhanced DHMTs performance				Q4
3.2	Request Technical Assistant for skills transfer and coaching	Strengthened DHMTs	Number of TA recruited and deployed		Q3	
3.3	Develop and implement leadership & mentorship program	Improved leadership and management Skills				Q4

DIMENSION 4 : CREATE A POSITIVE WORK ENVIRONMENT FOR MANAGERS

#	Key Actions	Expected Results	Indicators	Timeline		
4.1	Provide logistics for monitoring and supervision	Improved data quality and health service delivery	Number of supportive supervision conducted		Q3	
4.2	Establish and implement appraisal and reward mechanisms	Increased in staff performance	Number of staff appraised and rewarded each year		Q3	
4.3	Establish periodic feedback mechanisms	Motivated health workforce	Number of feedback sessions held	Q2		
4.4	Conduct regular stakeholders and leadership meetings	Enhanced information sharing and stakeholders coordination	Number of stakeholders meetings held	Q2		

Thank you!!!!

10.2 Guinea

Feuille de route de mise en œuvre des priorités du Ministre de la Santé 2016

Leadership et Gouvernance sanitaire

Guinée, Conakry , 06 Mai 2016

Résultat attendu	Indicateur de résultat	Actions	Activité	Responsable	Chronogramme				Coût (USD)			Source de financement
					T2	T3	T4		Total	Disponible	GAP	
Dimension 1 : Veiller à avoir un nombre adéquat de gestionnaires (nombre, distribution,...)												
D'ici la fin d'année 2016, 40 % de district disposent de nombre de gestionnaires adéquats selon les normes requises	Taux de disponibilité Nombre de districts ayant une ECD avec le nombre requis de gestionnaires	Disponibilité des gestionnaires (number, distribution,...)	Redeployer le personnel de district	MS	X	X	X		0.00		0.00	
			Recruter le personnel additionnel	MS, MFP	X	X	X		0.00		0.00	
			Recruter à la fonction publique le personnel employé dans le cadre de la riposte de la MVE (salaire 2000 agents de santé)	MS, MEF		X	X				0.00	
Dimension 2 : Veiller à ce que les gestionnaires aient les compétences nécessaires (gestion ressources humaines pour la santé, finances, information, suivi évaluation, infrastructures, médicaments, équipements, logistiques,)												

D'ici la fin d'année 2016, 40% d'ECD disposent de compétences manageriales requises.	Taux de disponibilité Nombre de districts ayant une ECD avec le nombre requis de compétences gestionnaires	Compétences manageriales des gestionnaires (gestion ressources humaines pour la santé, finances, information, suivi évaluation, infrastructures, médicaments, équipements, logistiques,...)	Elaborer le cadre national de comptence des gestionnaires de district	MS (DRH)		X	X		10000.00		10000.00	OMS, UE-AFD, GIZ, UNICEF, BM, etc
			Reviser le manuel de formation des ECD	MS (DRH)		X	X		20000.00		20000.00	OMS, UE-AFD, GIZ, UNICEF, BM, etc
			Organiser un atelier national de formation des formateurs des ECD sur le modele OMS (1 Atelier CLP)	MS (SG, BSD, DRH)			X		50000.00	30000.00	20000.00	OMS, UE-AFD, GIZ, UNICEF, BM, etc
			Organiser 8 ateliers regionaux de formation des ECD				X				0.00	OMS, UE-AFD, GIZ, UNICEF, BM, etc
			Organiser un atelier national de formation des Equipes cadres de régions et districts sanitaires en dialogue politique en santé vers la couverture sanitaire universelle	MS (BSD)	X				25000.00	20000.00	5000.00	OMS, UE-AFD, GIZ, UNICEF, BM, etc
Dimension 3 : Mettre en place des systèmes d'appui fonctionnels												

(connaissances, qualifications, attitudes,comportements...capacité opérationnelle - être capable de)												
D'ici la fin d'année 2016, 40 % de districts sanitaires disposent d'un système d'appui gestionnaire fonctionnel	Taux de disponibilité Nombre de districts ayant un système d'appui gestionnaire fonctionnel	Disponibilité des systèmes d'appui fonctionnels (connaissances, qualifications, attitudes,comportements...capacité opérationnelle - être capable de)	Mettre en place un système automatisé de gestion comptable et financiere	MS (DAF), MEF		X	X				0.00	UNICEF, UE, OMS
			Mettre en place un système automatisé de gestion des ressources humaines	MS (DRH)		X	X				0.00	INTRAHEALTH
			Mettre en place le système automatisé de l'information sanitaire du district (DHIS2)	MS (BSD/SNIS)	X	X	X				0.00	USAID, OMS, parties prenantes
			Mettre un système informatisé d'approvisionnement en medicaments et autres intrants	PCG, MS (DAF, DNPL)	X	X	X				0.00	OMS-MUSKOKA, parties prenantes
			Produire le Sitrep mensuel de redevabilité de la mise en œuvre du Plan de relance	MS (BSD/SNIS)	X	X	X		6000.00	3000.00	3000.00	OMS, UE, BM, GIZ, UNICEF, autres PTF

			Poursuivre l'enregistrement des statistiques de l'etat civil (deces, naissance)	MATD, MS (DNSF, BSD/SNIS), MASFP, INS	X	X	X				0.00	OMS-MUSKOKA, parties prenantes
			Produire les rapports d'activité programmatique et financiers, bulletins, articles , rapport de documentation de bonne pratique et de surveillance epidemiologique	MS (BSD/SNIS), INS, MPC	X	X	X		10000.00	4000.00	6000.00	OMS, UE, GIZ, UNICEF, BM, USAID, etc.
			Organiser 2 visites semestrielles de monitorrages		X		X				0.00	parties prenantes
			Organiser la revue semestrielle et la revue annuelle		X		X		20000.00	3000.00	17000.00	OMS, UE, BM, GIZ, UNICEF, autres PTF
			Organsier une supervision mensuelle integree		X	X	X					
			Mettre en place du comite prefectoral de coordination de sante, comite sous-prefectoral de coordination de sante et comite communal de coordination de sante	MS	X	X	X		12000.00	5000.00	7000.00	OMS, UE, BM, GIZ, UNICEF, autres PTF

			Organiser une recherche action sur la performance du système de sante de district (Dubreka, Pita, Siguiri, Lola, Kissidougou)	MS (BSD)	X	X	X		20000.00	7000.00	13000.00	OMS, UE, BM, GIZ, UNICEF, autres PTF
			Organiser les reunions mensuelles du comite de coordination au niveau prefectoral, sous-prefectoral et communal			X	X		30000.00	20000.00	10000.00	OMS, UE, BM, GIZ, UNICEF, autres PTF
			Organiser l'audit institutionnel du Ministère de la santé	MS (BSD)	X	X	X					OMS, UE, USAID, BM, GIZ, UNICEF, autres PTF
			Organiser la cérémonie solennelle de signature du Compact national	MS (BSD)					20000.00	15000.00	5000.00	OMS, UE, USAID, BM, GIZ, UNICEF, autres PTF
Dimension 4 : Créer un environnement de travail favorable aux gestionnaires (rôles et responsabilités, réglementation, cadre institutionnel, supervision, mesures de motivation, relations avec les autres acteurs)												
D'ici la fin d'année 2016, 40 % des districts sanitaires disposent d'un environnement de travail favorables aux ECD	Taux de disponibilité Nombre de districts ayant un environnement de travail satisfaisant selon les normes requises	Environnement de travail favorable aux gestionnaires (rôles et responsabilités, réglementation, cadre institutionnel, supervision, mesures de motivation, relations avec les autres acteurs)	Organiser la revision de normes sanitaires (nationales et districts), de directives nationales de supervision integree et des autres outils de gestion	MS (BSD, conseil juridique)		X	X				0.00	

			Mettre en œuvre les textes réglementaires de decentralisation pour une autonomie effective de districts			X	X		0.00		0.00	UE, AFD, USAID,
			Organiser la revision de manuels de procedures de gestion administrative, financiere, de comptable	MS (DAF, BSD), MEF		X	X		0.00		0.00	UE, GIZ, AFD, BM, USAID, etc
			Mettre en place les mesures incitatives d'ECD (logement, outils informatiques, electricite, connexion internet, des primes)	MS (SG, BSD, DRH)	X	X	X				0.00	
TOTAL									223000.00	107000.00	116000.00	

10.3 Sierra Leone

ROADMAP FOR THE STRENGTHNING DHMTs

Expected results	Indicators	Keys actions	Actors			Chronogramme			Comments/ observations	
Major conditions			Nat.	Local	Part.	Trim				
						2	3	4		
Dimension 1 : Establish functional support systems (management of HR, financial ressources, health information-monitoring, infrastructures, drugs, equipments, logistic,...)										
1.1	Increased health funding allocation to at least 15%	Number of advocacy workshop conducted	Advocacy workshop with Stakeholders (Government, Partners)	MOHS, Parliament, GoSL	District Council	World Bank, DFID, China AID, USAID, WHO	x			
		Availability of costed plan and budget	Prepare a costed plan and justification	MOHS	DHMT	WHO, UNICEF	x			
		Number of fund raising activities conducted	Conduct innovative fund raising activities for health	MOHS, Parliament, GoSL	DHMT	UNICEF	x	x	x	
1.2	National health financing policy developed	Number of workshops conducted	Conduct a workshop with key ministries and stakeholders	x	x	x	x	x		
		Team in place	Set up a team to develop the health financing policy	x	x	x	x			

		Roadmap developed	Develop a roadmap and implement	x	x	x	x	x		
1.3	Emergency standby fund available	Availability of costed plan and budget	Prepare a costed plan and justification	x	x		x			
		Release SOP available	Develop release procedures for emergency fund	x	x			x		
1.4	Proper financial management systems at District level	Accounting manual available	Establish clearly defined accounting procedures	x				x		
		TOR developed	Develop the TOR for the financial officer	x				x		
1.5	CME/CPD monitoring created within DHMT	Curriculum for CME/CPD available	Support CME/CPD	x	x	x	x	x	x	
Dimension 2 : Make sure to have an adequate number of managers/DHMTs (number, distribution,...)										
2.1	DHMT organogram operationalised	Number of DHMT roles filled in	Revise and populate DHMT organogram	x	x		x			
2.2	Adequate number of units exist within DHMT	Number of assessments done	Conduct numeric assessment of units in DHMT		x	x	x	x	x	
2.3	Adequate functional units exist within DHMT	Number of DHMT roles filled in	Redistribution/Posting of staff to other identified units		x			x		

		Number of DHMT roles filled in	Fill the identified vacant position by recruitment		x			x	x	
Dimension 3 : Ensure that managers have the necessary skills/Competencies required (knowledge, qualifications, attitudes, behaviors...to be able)										
3.1	DHMT competency framework operationalized	DHMT competency framework available	Adapt the WHO competency framework for DHMT competency framework	x	x	x	x	x		
3.2	Staff adequately informed	Orientation/training package available	Develop orientation/training package for unit head and unit staff		x	x	x	x		
3.3	Training needs identified	Number of training needs assessment conducted	Conduct regular training need assessments for staff		x	x		x	x	
3.4	Qualified staff available	Number of pre-service and in-service training conducted	Conduct pre-service and in-service training		x	x	x	x	x	
3.5	Improved professional skills of health workers	Number of health workers meeting CME/CPD target	Support CME/CPD		x	x	x	x	x	
Dimension 4 : Create a positive work environment for managers (roles and responsibilities, rules and context institutional context, supervision, incentives measures, relationships other actors)										

4.4	Roles and Responsibilities assigned to all staff	Reviewed TOR available	Review TOR for all staff	x	x		x	x		
4.5	Staff adequately informed	Number of Staff oriented	Provide orientation on revised TOR		x	x		x		
4.1	Staff adequately supervised	Number of mentoring and supervision sessions conducted	Conduct Mentoring and Supervision of Staff	x	x			x	x	
4.2	Performance management system established	Performance targets available	Develop performance management system		x		x	x		
4.3	Improved staff performance	Number of staff appraised	Conduct periodic(quarterly) performance review		x			x	x	
4.6	Enhanced team work	Number of workshops conducted	Conduct workshop on team-building		x	x	x	x	x	
4.7	Improved coordination and collaboration	Number of coordination meetings conducted	Conduct scheduled regularly internal and external coordination meeting		x	x	x	x	x	
4.8	Staff motivation improved	Incentive package available	Introduce performance-based incentives for staff		x	x	x	x	x	
4.9			Provide incentive for supervision							