Republic of Rwanda
Ministry of Health

USAID
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msh
Management Sciences for Health

In Partnership with CIIC-HIN

LANDSCAPING OF DISTRICT HEALTH MANAGEMENT TEAMS (DHMT) GOVERNANCE AND MECHANISMS

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List of Abbreviations

AOS: Africa Olleh Services

CHWs: Community Health Workers

CIIC-HIN: The Center for Impact, Innovation and Capacity building for Health Information System and Nutrition

CoK: City of Kigali

CSOs: Civil Society Organizations

DDEA: Deputy District Executive Administrator

DDMC: District Disaster Management Committee

DHMT: District Health Management Teams

DHU: District Health Unit

DPEM: District Plan for the Elimination of Malnutrition

FBO: Faith Based Organization

FGDs: Focus Group Discussions

GOR: Government of Rwanda

JADF: Joint Action Development Forum

KIIs: Key Informant Interviews

PBF: Performance-Based Financing

RMS: Rwanda Medical Supply

RSSB: Rwanda Social Security Board

UHC: Universal Health Coverage

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Definition of Key Terms

DHMT (District Health Management Teams): Teams established within the Rwandan health system framework to improve local health governance and ensure effective implementation of health policies at the administrative district level.

UHC (Universal Health Coverage): A health care concept where all individuals have access to quality health services without financial hardship.

CHWs (Community Health Workers): Individuals trained to provide promotional, preventive and curative basic health services and education within their communities.

FGDs (Focus Group Discussions): A qualitative research method tool used to gather diverse perspectives on a specific topic through group discussions.

KIIs (Key Informant Interviews): In-depth interviews conducted with individuals who are knowledgeable about a particular subject or theme or topic.

Key Administrative Bodies: refers to the primary leadership figures within the District Health Management Team (DHMT), including pivotal roles such as the Vice Mayor in charge of Social Affairs, the Director General of the District, and the Director of the Health Unit. These leaders are instrumental in setting strategic directions, overseeing health initiatives, and ensuring that public health policies are implemented effectively within the district.

Evidence-Based Decision Making: The process of making decisions based on the best available, current, valid, and relevant evidence.

Health Governance: refers to the frameworks and processes that oversee and manage a health system, including the coordination among stakeholders, strategic planning, standard setting, and ensuring accountability, all aimed at meeting the health needs of the population effectively and fairly. The composition of the health governance comprises members of District Health Units, DHMTs and JADFs

Service Delivery: involves the direct provision of health services to individuals, encompassing diagnosis, treatment, care, and health promotion, focused on patient-centered and timely, efficiently, and equitably delivered.

Background

The Government of Rwanda (GOR) has identified critical components for achieving Universal Health Coverage (UHC), highlighting the need for strengthening health system building blocks such as Leadership, management and Governance, health workforce, medical products and commodities, health information systems, and health financing. Rwanda has a decentralized and hierarchical health system structure that aims to provide accessible healthcare services to the population. The country is divided into provinces, districts, and sectors, with each level playing a key role in service delivery and policy implementation. Despite high social health insurance coverage in Rwanda (93.3% in 2022[1], Rwanda faces persistent challenges in ensuring equitable access and affordability of quality of healthcare services. These challenges are primarily due in inefficiencies in risk pooling, gaps in the health workforce, and sub-optimal mobilization and management of health system resources [2], [3].

In response to these challenges and to enhance the decentralization of health services, the District Health Management Teams (DHMTs) were established within the Rwandan health system framework in 2011. The DHMTs were created to improve local health governance, ensure the effective implementation of health policies, and address district-specific health needs. They play a pivotal role in coordinating health activities and improving service delivery at the district level [4], [5].

To further support these efforts, the Ministry of Health (MOH) in collaboration with USAID designed Ireme initiative to enhance leadership, planning, and management at all levels and with a particular focus at the district level, improve efficiency and effectiveness of district health governance. The initiative includes a detailed landscaping exercise that captures the district governance architecture and mechanisms, along with perceptions and understanding of the mandate, roles and responsibilities of the district health management team's (DHMT) and other health committees including performance-based financing steering committees.

This assessment is timely, considering that numerous studies and reports in the region, including Rwanda, have highlighted a lack of clarity on how discussions within district health-related bodies or committees are supported by policymakers and contribute to implementation and evidence-based policy-making decision processes. Key issues include insufficient policy support, limited financial and human resources, and challenges in integrating health data into decision-making processes
The effectiveness, complementarity, and efficiency of these processes remain inadequately understood and widely under documented [6], [7].

Structure

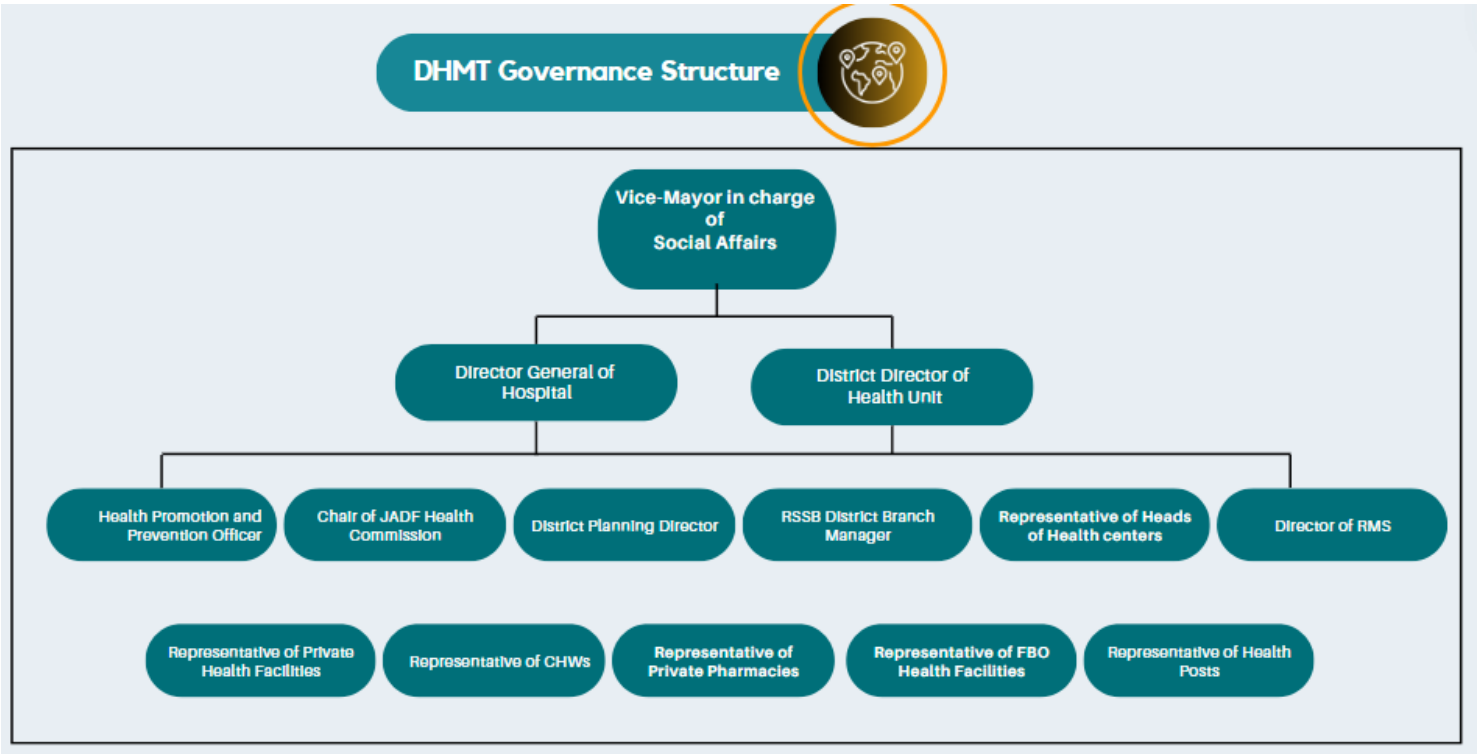

Figure 1: DHMT structure

DHMTs were established to strengthen health governance and service delivery at the district level. According to the district health system management guidelines, there are 14 members designed to operate within each DHMT. Figure 1 provides an illustration of the structure and essential members of DHMTs, which are overseen by district authorities [8]. At the heart of this structure is the District Health Management Team administration, led by the Vice-Mayor or the deputy district executive administrator (DDEA) in the City of Kigali districts, responsible for social affairs.

The DHMT comprises the following members who serve on different committees: (1) vice mayor in charge of social affairs, (2) the Director General of hospital, (3) the District Director of Health, (4) the District Planning Director, (5) the Health Promotion and Prevention Officer, and representatives from critical health system stakeholders such as (6) health centers, (7) pharmacies from RMS branches, (8) private pharmacies, (9) community health workers, (10) faith-based organizations, (11) JADFs and (12) the private health facilities, (13) health posts, (14) RSSB branch district branch manager and other participants can be invited as needed. This collaborative framework aims to enhance coordination, efficiency and effectiveness in district-level health governance and service provision.

Objectives

The overall objective of this assessment was to evaluate the functionality of District Health Management Teams (DHMTs) in driving the implementation of health policies and achieving strategic health objectives, thereby enhancing the overall governance and performance of health services at the district level.

The specific objectives of this study were to:

Figure 2: DHMT objectives

Methodology

Study Context

The study was conducted within the framework of DHMT, identified and documented existing governance structures, evaluated decision-making processes, and their efficiency and synergies. Additionally, the study assessed DHMTs technical committee members capacity to use data in making policy decisions and sought recommendations to improve governance. Findings from this assessment will inform the district and central level leadership and stakeholders to strengthen the existing DHMTs and explore areas of collaboration and coordination across various health system actors and structures at the district level, enabling them to better respond to local health needs and priorities, including emerging health threats.

Study Design

A cross-sectional study design using a descriptive qualitative-method approach was employed to gather comprehensive data on DHMT operations. This approach combined Key Informant Interviews (KIIs) and Focus Group Discussion (FGD) consultations to provide a holistic understanding of DHMT dynamics and their interactions with other district-level health system structures and stakeholders.

Study Setting

The landscaping of DHMT study was designed to cover 8 districts across Rwanda, each contributing valuable insights into district health management. The study concentrated on Huye and Muhanga districts in Southern Province, Gatsibo and Ngoma districts in Eastern Province, and Ngororero and Rubavu in Western Province. In the Northern Province, Gakenke district was included. However, due to the busy schedules of the target group and the limited study timeline, the selected Kigali City district was not covered in the assessment, reducing the number of districts studied from 8 to 7.

Target Population

Figure 3: DHMT Target Population

Figure 3 outlines two groups of participants for the qualitative study on District Health Management Teams: Key informant interviews and focus group discussion members

The "Key Informant Interviews" included leadership of DHMTs such as Vice-Mayor in charge of Social Affairs, Director General of District Hospital, and various directors and officers like the District Director of Health Unit and Health Promotion and Prevention Officer. The "Focus Group Discussion" included RSSB District Branch Manager, Representative of Heads of Health Centers, Director of District Pharmacy, and other representatives from private health facilities, Community Health Workers (CHWs), Faith-Based Organization (FBO) Health Facilities, and Civil Society Organizations (CSOs). These groups were purposely selected to provide varied and in-depth perspectives on the dynamics within DHMTs.

Sampling and Sample Size

A random sampling strategy was employed to select a total of 8 districts out of 30 districts in Rwanda, ensuring an unbiased representation of the country's diverse geographical and socio-economic landscapes. This approach aimed at providing a representative sample of districts, allowing for a comprehensive analysis of DHMT functionality and effectiveness across various settings.

Within each randomly selected district, all 14 members of the District Health Management Team (DHMT)were purposively included in the study along with other participants who are typically invited to DHMT meetings as needed. This comprehensive inclusion of DHMT members sought to capture the full range of roles, responsibilities, and perspectives within the team, ensuring a holistic understanding of their operations and interactions with other health system actors at the district level.

Data Collection

Key Informant Interviews (KIIs) and Focus Group Discussions (FGDs) were conducted in person by research teams, each comprising a skilled moderator and a note-taker, supported by one supervisor with extensive experience in qualitative research.

Participants provided signed consent before the audio-recording of the interviews and FGDs, which were subsequently transcribed in Kinyarwanda and then translated into English. KIIs and FGD guides/tools were developed in English, translated and administered to the participants in Kinyarwanda and back translated in English. For the FGDs, the target was to have approximately 10 participants per group to facilitate in-depth discussions and gather diverse perspectives. The interviews and FGDs were recorded anonymously with the consent of the participants to ensure that all insights were thoroughly captured.

Data Management and Analysis

The translated interviews from the Key Informant Interviews (KIIs) and Focus Group Discussions (FGDs), along with the preliminary fieldwork results, were used to create a comprehensive codebook that reflected the key themes emerging from the data. This codebook was then used to systematically code a subset of the transcripts.

The research team convened subsequently to discuss and exchange their preliminary findings and experiences. This collaborative process enabled the team to refine the list of codes based on the collective insights gained. The refined codebook was then employed for an in-depth analysis within Atlas.ti, following the thematic analysis, allowing for the identification, categorization, and interpretation of patterns and themes within the collected data. Relevant quotes corresponding to each of the primary codes were extracted, and the emerging themes were summarized into concise texts.

To ensure the security and integrity of the data, all collected information was stored on a secured server at the CIIC-HIN, which is located at AOS. This measure was taken to protect the confidentiality of the participants and the data they provided during the research process.

Ethical considerations

Prior to enrolling participants in the study, ethical considerations were important to ensure and safeguard participants' rights and privacy. All participants in this study provided their informed consent prior to their involvement in the study. All ethical measures were implemented to protect participants' confidentiality through anonymization and securing of the data storage and protocols.

Study Results

1. Respondents Demographic Information

Variable	Frequency (No).	Percentage (%)
Age Category		
30-34	4	5
35-39	23	29.1
40-44	20	25.3
45-49	9	11.4
50-54	10	12.7
55-59	10	12.7
60-64	3	3.8
Districts		
Gakenke	11	13.9
Gatsibo	11	13.9
Huye	12	15.2
Muhanga	9	11.4
Ngoma	11	13.9
Ngororero	13	16.5
Rubavu	12	15.2
Sex		
Male	29	36.7
Female	50	63.3
Working experience		
0-5 years	20	25.3
6-10 years	16	20.3
11-15 years	24	30.4
16-20 years	17	21.5
20 and above	2	2.5

Table 1: Demographic characteristics of the study respondents (N=79)

The study respondents as shown in descriptive Table 1 consisted of 79 individuals from seven districts in Rwanda: Gakenke, Gatsibo, Huye, Muhanga, Ngoma, Ngororero, and Rubavu.

Most of the respondents were female (63.3%), while males accounted for 36.7%. The age distribution of the respondents ranged from 30 to 64 years, with the highest proportion falling in the 35-39 age category (29.5%), followed by the 40-44 age group (25.6%). The respondents' working experience varied, with the largest group having 11-15 years of experience (30.4%), followed by those with 0-5 years (25.3%), 16-20 years (21.5%), and 6-10 years (20.3%). Only 2.5% of the respondents had working experience of 20 years or more.

2. Health District Governance Structure

The findings from the DHMT interviews revealed a variety of relationships and interconnections among different administrative bodies of district health management teams and other technical health committees in the district health sector. Furthermore, there are notable discrepancies in the composition and operational frameworks of DHMTs across the districts visited in Rwanda. Figure 4 provides an overview of the district health governance structure and the interconnections among technical committees explored in these interviews.

The analysis revealed the organizational structure and functions of District Health Management Teams (DHMTs) and associated technical committees across different districts in Rwanda (Fig 4). It highlights a central focus of DHMT governance in overseeing and managing the implementation of health services, with strategic mechanisms in place for adjustments based on performance outcomes. Leadership within these teams often includes high-level officials like Vice Mayors in charge of Social Affairs, and encompasses a broad range of health officials and sector representatives. Multiple technical committees operate in synergy within these teams, including health, management, and performance-based finance committees, disaster management and malnutrition underscoring a comprehensive approach to health governance. Membership across these committees typically ranges between 15 and 56 members (e.g: DPEM), reflecting a robust participation in district-level health management efforts.

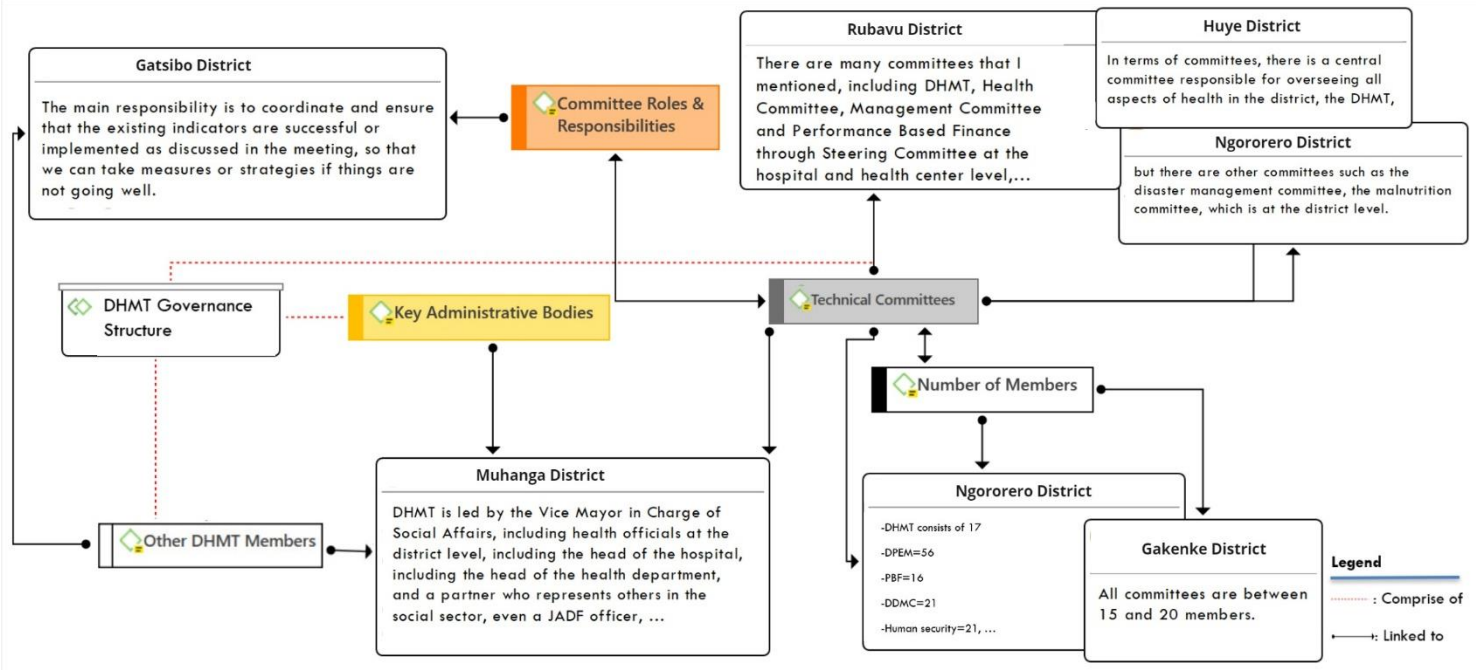

Figure 4: Overview of District Health Management Team Structures and Key Committees Across Different Districts in Rwanda: Roles, Responsibilities, and Membership Composition.

2.1 DHMT Operational Guidelines

This section explored existence of and adherence to guidelines within DHMT organizational structure or governance. Their challenges or facilitation as perceived by participants were assessed. The majority of participants reported the availability of guidelines but their understanding and application in their daily work was perceived as challenge impeding the functioning of the DHMT in general. One of the main challenges is the lack of oversight of the administrative leadership as well as legal tools or instruments for the reinforcement of its application.

Most respondents emphasized the presence of guidelines for DHMTs, which is essential for ensuring organized and effective health governance. A participant noted,

> *"…The DHMT guidelines are in place, but another crucial aspect is to understand how its application can be embedded within health unit ".*

Similarly, the majority of officials highlighted the specificity of these frameworks and the importance of adherence to guidelines and ministerial orders.

> *"The DHMT guidelines specify when we have to meet and the responsibilities of the committees, complementing the guidelines and current ministerial orders".*
> *"We adhere to the guidelines set forth by the Minister of Health regarding roles and responsibilities".*

Despite the widespread recognition of DHMT guidelines, some participants reported challenges related to its awareness, accessibility and their application into their daily activities.

> *"…. I haven't encountered a specific guideline, but we adhere to the principle 'intore yishakira ibisubizo' (meaning we find our solutions). When you adopt this approach, you don't receive all the information during the handover……."*

Additionally, key informants indicated the absence of a comprehensive understanding of legal frameworks that led to operational challenges.

> *"…. Technically, it might exist in the health sector, but it should have been communicated to the committee members to ensure they are aware of it…."*

> *"…. I haven't read those instructions to fully understand them, but there are regulations governing them…."*

Moreover, members recognized the lack of oversight and governance empowerment in the existing legal documents or instruments. Most participants reflected on the availability of DHMT guidelines set by the Ministry of Health for missing key points that are essential for health district governance operations which in turn limited the DHMT committee from performing necessary interventions to support decision-making process. Others also considered that it should allow the inclusion of other members who specifically have special skills in law.
Consequently, while some participants acknowledged the existence of DHTM guidelines, they admitted not having seen or fully understood them; hindering their application.

> *"…. The DHMT primarily addresses smaller-scale issues because of a gap in the legal framework that fails to recognize it within district structures…."*

> *"…. The DHMT does not make legal decisions; instead, it focuses on advocacy and relays concerns to higher authorities who have the power to act. For example, if there is an issue at the hospital level, the DHMT advocates for change and forwards the issue to those who can address it…."*

"…. The main challenge is the absence of certain individuals who ought to be involved, such as lawyers. It would have been beneficial to have someone with professional expertise in areas like law. I believe it is important that at least one person with relevant skills should join the committee…."

2.2 Key administrative bodies

The vital role of DHMTs in ensuring effective healthcare services became evident as stated by DHMT members. In each district, the Vice Mayor in charge of Social Affairs emerged as a central figure, consistently chairing district health governance meetings and coordinating healthcare services. They revealed that this comprehensive governance structure also extends to community health workers who have their own committees. Additionally, Participants emphasized the inclusion of representatives from the hospital, health community workers, the Director General (DG), and other staff responsible for monitoring the activities of health community workers within the DHMT.

"…The district health administration is headed by the vice mayor in charge of social affairs and the director of the health unit; for the CoK, it is DDEA, and the Director of Health and Social Development Unit. It comprises various personnel including health insurance fund managers and campaign managers. Supporting committees, such as the DPEM, bolster the administration. The health structure spans from the district level to the sector level, reaching down to health centers staffed with personnel responsible for facility management. Key committees include the health committee (COSA) and the resource management committee (COGE)…."

In addition, the participant demonstrated that although the governance structure adapts to address specific health issues through additional committees, such as those focusing on malnutrition and disaster response, the DHMT is involved in the coordination of a wide range of health sector stakeholders, including representatives from private clinics, faith-based organizations, and national bodies like the Rwanda Social Security Board (RSSB) and Rwanda Medical Supply (RMS).

"…The members of the DHMT include representatives from private clinics and pharmacies, as well as individuals from institutions like the Rwanda Social Security Board (RSSB) and Rwanda Medical Supply (RMS). Additionally, key figures such as the chief of planning, the Joint District Action Forum (JDAF), and a representative of community health workers are part of the team. This diverse composition ensures a range of perspectives and expertise contribute to the decision-making process within the DHMT…."

2.3 Variety in District Health Technical Committees: Structure and Function.

The data findings from interviews indicated that the structure of District health technical committees varies across different health districts, each designed to address specific aspects of healthcare delivery and administration. At the core of this structure is the DHMT, identified as the primary body responsible for the overarching coordination and management of health activities within the district. As described by one respondent:

"…. In terms of committees, we have a central committee tasked with overseeing all health-related aspects in the district, and the DHMT, which coordinates and manages all health issues and activities within the district…."

In addition to the DHMT, most participants reported that the health governance structure comprises several specialized technical committees, each addressing specific operational and strategic requirements. One notable example is the Performance-Based Financing (PBF) committee, which plays a crucial role in assessing the performance of health facilities. This committee is responsible for evaluating the quality and quantity of services provided by each facility and allocating bonuses accordingly. By tying financial incentives to the standard of care delivered, the PBF committee effectively promotes and maintains high-quality healthcare services throughout the district.

"…. In terms of committees, we have several layers including district health technical committees and the DHMT. We also have a steering committee that focuses on Performance-Based Financing (PBF) and assesses the quality of medical services delivered. Additionally, we address nutritional needs through a specific technical committee known as 'DPEM'. Within the hospital, there are numerous committees including hospital health committees, management committees, medical quality committees, hygiene committees, hospital staff safety committees, and others. At the health center level, we have a health committee and a management committee. These are the committees I wanted to highlight…."

Additionally, there are reported thematic committees at the district level that address specific health issues such as malnutrition through the District Plan for the Elimination of Malnutrition (DPEM), DDMC, Human Security Committee, epidemic prevention and disaster management committee, and drug control as stated by the participants:

"…. There are also special technical meetings or committees that are thematic and focus on specific indicators. For example, those responsible for combating malnutrition are part of what we call the DPEM (District Plan for the Elimination of Malnutrition) …"

"…. There are other technical committees at the district level, such as the Disaster Management Committee, , PBF, and DPEM…."

2.4 DHMT Committee Membership

The responses from participants stipulated significant insights into the actual structure and membership of health committees involved in district health governance. Most participants highlighted that DHMT plays a pivotal role, with its membership varying across districts. For instance, in most of the districts, the DHMT is said to include the Vice Mayor, directors of hospitals, health unit directors, representatives from health centers and community health workers, however, participants from this committee reported that the membership generally ranges from 13 to 20 individuals.

"…. It comprises at least 15 individuals, which allows us to include key officials such as the Heads of Health Centers and the Heads of Health Posts, while keeping the group to a manageable size…."

Similarly, in some other districts, several participants noted that while the DHMT has a base membership of 14, it can expand as needed. Furthermore, many participants revealed that other specialized committees within the health sector also show variability in their composition.

"… The DHMT has 17 members, the DPEM has 56, the PBF comprises 16 members, and both the DDMC (District Disaster Management Committee) and the human security committee each have 21 members…."

Discrepancies emerge when comparing participant responses with the official District Health Systems Guidelines of 2019, which prescribe a core membership of 14 for the DHMTs. While some districts adhere to this guideline by maintaining a base membership of 14, they also possess the flexibility to expand the committee as necessary to address specific needs. This foundational group of 14 can be augmented on demand, which allows the DHMT to incorporate expertise from various sectors effectively, enhancing its ability to manage diverse health governance challenges within the district. However, these findings indicate a significant gap in awareness or adherence to the guidelines among DHMT members. Not all members are fully aware of or consistently follow the stipulated membership norms. This gap underscores the need for enhanced training and communication to ensure that all members understand and adhere to the guidelines set forth for effective health governance at the district level.

3. DHMT Roles and Responsibilities

Most participants reported that DHMTs in Rwanda plays a coordinating role and overseeing health activities within their respective districts during the planning process. They highlighted the collaborative efforts to analyze health situations and develop practical plans, ensuring diverse perspectives are integrated into the decision-making planning processes. Notably, the participants underscored the advisory role of DHMTs, emphasizing their capacity to provide guidance and recommendations for enhancing healthcare services at the district level.

> *"……Through collaborative efforts, we analyze the current situation and develop actionable plans. We also encourage contributions from individuals with valuable insights, inviting them to participate in our discussions…."*

Moreover, several participants emphasized the role of conducting regular monitoring of health indicators, where the DHMTs track various health metrics to identify areas needing improvement. Furthermore, many participants revealed that DHMTs address specific health issues such as maternal and child health, malnutrition, and infectious diseases. This involves a thorough analysis of health indicators to develop targeted interventions.

> *"DHMT meets with us to review health indicators, and if they are not performing well, we discuss and implement necessary measures or strategies."*
>
> *"…. We conduct a comprehensive analysis of various health indicators within the district, including malnutrition rates, maternal and child health statistics, malaria prevalence, and the rate of deliveries occurring at health centers…."*

Additionally, several participants reported that oversight and supervision of health services are integral to DHMTs' responsibilities to ensure the quality of care, sanitation, and address healthcare provider shortages.

> *"Our responsibility is to enhance the quality of life by monitoring healthcare provision in the district and taking actions to improve it."*

Moreover, participants explained that the DHMTs are deeply involved in planning health activities and mobilizing resources. Many participants highlighted their collaboration with health centers on planning, budgeting, and resource mobilization to sustain health programs.

"DHMT's role includes going to the health center for planning, budgeting, monitoring, and mobilizing resources. Additionally, several participants mentioned that DHMTs address challenges and implement solutions through regular meetings that serve as forums for discussing problems and devising strategies. Finally, engaging with the community is another crucial aspect, ensuring that community needs, and feedback are incorporated into health plans.

> "*In these meetings, they serve as a forum to discuss problems within health institutions and to devise strategies to address them."*

> *"As a member of the DHMT committee, we collectively tackle critical issues affecting our community.*

In addition to these responsibilities, the DHMTs also play a vital role in fostering partnerships with various stakeholders, including local government entities, non-governmental organizations and community groups. By building these relationships, DHMTs can leverage additional resources and expertise to enhance health service delivery. Participants noted that such collaborations often lead to joint initiatives that address pressing health challenges.

4. DHMT Operations

4.1 DHMT Meetings

4.1.a Importance

Based on respondents' insights, the necessity of schedule, participation and frequency of DHMT meetings emerge as crucial components of effective healthcare governance. The respondents emphasized that these meetings serve as platforms for decision-making, progress review, and task delegation. Additionally, they get the opportunity to review the progress of implementation by consulting these designated individuals in the next meeting. Furthermore, the meetings facilitate collaboration and coordination among various stakeholders within the district's healthcare system.

> *"……. Another positive aspect is that we make decisions during the meeting and assign responsibilities to various individuals for executing these decisions. At the next meeting, we assess the progress of implementation by consulting these designated individuals……"*

4.1.b Frequency

Multiple respondents confirmed that DHMT meetings are typically held every three months or quarterly. This regular schedule allows the DHMTs to effectively oversee and guide the district's healthcare operations, address important issues, and make informed decisions periodically throughout the year. However, some noted that the meeting frequency often depends on the partner's budget. Additionally, a few participants indicated that DHMT meetings are sometimes convened on a needed basis, exceeding the regular schedule, suggesting flexibility based on urgency or specific issues requiring attention.

> *"…. The DHMT committee meets quarterly, typically once every three months, unless there are extraordinary circumstances that necessitate additional meetings…"*

While the standard practice is to convene DHMT meetings quarterly, the respondents acknowledged the flexibility to hold additional meetings as needed.

4.2 DHMT Staffing

The interviews conducted across various districts consistently reveal significant challenges related to staffing within the DHMTs. Participants from several districts frequently highlighted the lack of dedicated employees for DHMT functions. This scarcity of staff affects the implementation and monitoring of health initiatives, with some participants emphasizing the absence of specific roles within the DHMTs. For instance, there are no designated employees responsible for executing or evaluating DHMT plans and activities. Instead, these duties are generally added to the existing responsibilities of current health staff, leading to overburdened employees who cannot focus solely on DHMT-related tasks. In some instances, members of the DHMT themselves take on additional roles to cover these gaps, but this is seen as insufficient for effective health service delivery. Moreover, the lack of facilitation and motivation for staff working in these difficult conditions exacerbates the staffing issues.

> *"…There are no permanent employees specifically tasked with monitoring DHMT's plans and programs, as most are members with additional roles. However, we have appointed one of our members to be responsible for reminding us of our planned activities…."*

Despite participants consistently raising concerns about the absence of dedicated staff for the DHMT, the guidelines specify that the District Health Unit (DHU) serves as the principal organ responsible for implementing administrative activities. Additionally, the feedback from DHMT members indicates a need for clearer role delineation and possibly enhanced support to ensure effective health service delivery without overburdening existing staff.

4.3 DHMT Budget

Focus group discussions conducted by the current study revealed a critical issue regarding the financial resources available to DHMTs within all the visited district health governance bodies. A majority of participants highlighted the absence of a dedicated budget allocated specifically to the DHMT. Furthermore, many participants pointed to challenges in securing funding at the district level. They mentioned navigating the processes for implementing priority health-related activities but facing significant roadblocks due to the lack of allocated budgets, suggesting substantial difficulties in obtaining necessary resources.

Moreover, the data often showed a reliance on external sources to support DHMT activities. Participants mentioned seeking support from partners and donors and reported a heavy dependence on external funding. Several respondents also highlighted various interventions and health indicators that remained unaccomplished due to budget constraints.

> *"… DHMT lacks a dedicated budget, but we still maintain an action plan with associated budgeting, which is funded by our partners. It is the partners who decide which projects to support from our action plans in the district. If no partner is available to support our budget, we develop projects that do not require financial resources…."*

This situation necessitates a proactive approach to resource mobilization, where the DHMT actively seeks alternative funding sources and explores innovative solutions to address health challenges. Engaging with local businesses, community organizations, and government agencies can create a more diversified funding landscape. Additionally, fostering a culture of collaboration and transparency with partners can enhance trust and encourage more consistent support for health initiatives, ultimately leading to improved health outcomes for the community.

4.4 DHMT Governance Monitoring and Evaluation

The key respondents revealed that monitoring and evaluation (M&E) plans are integral to the operations of DHMT across various districts. Most participants reported that their districts have action plans and M&E frameworks to guide their activities and priority decision-making processes, emphasizing that meetings always begin by reviewing the implementation status of previous decisions, thus ensuring accountability and continuous improvement. Additionally, participants also highlighted the importance of regularly discussing health indicators to assess performance and implement of corrective measures based on these evaluations. They also extend the invitations to other health partners working on similar issues to join in the accountability process.

> *"…. When we hold a meeting and make decisions, we monitor their implementation. The next meeting begins by ensuring that the decisions from the previous meeting have been executed. This is when we conduct our assessments…"*

> *"……In the meetings, we review and discuss the health indicators of the district. After evaluating the indicators and identifying any issues, we take necessary actions to address areas where improvements are needed…."*

Furthermore, the majority of the respondents confirmed the presence of annual action plans and the importance of joint planning, evaluation, and reporting with partners, which enhanced the overall effectiveness of the health system:

> *"Yes, we are implementing it because you cannot operate without guidelines. We follow an action plan that includes these guidelines."*

"When discussing the district, we refer to a long-term plan known as the district health strategy, which is part of the broader sustainable health development strategy."

Therefore, several participants noted specific challenges and strengths in the execution of these M&E plans. They admitted that while they plan numerous activities, not all are fully executed or reviewed, indicating a gap in consistent follow-up:

"It is in its weakness; As DHMT, we plan activities to work on, but I cannot guarantee 100% that we perform all of them and make a review and evaluation, but it does not mean that we do not have plans."

5. DHMT Recommendations and Decision-Making Process and Mechanisms

5.1 Process Flow

Many Participants describe a collaborative framework at the district level, where expertise from the DHMT and the executive committee, along with cooperative institutions, meet to produce results. They said that during meetings, issues from health facilities (hospitals, health centers, health posts, community, private health sector) (are discussed, resolutions are made, and outcomes are communicated back to the relevant parties for the enforcement of the implementation. They also elaborate that decision-making typically originates from the DHMT level, where existing problems are identified, and solutions are sought. They mentioned a case where PBF delays required DHMT advocacy, demonstrating the importance of proactive decision-making. Participants also emphasized the value of open discussions and collective decision-making, with documented outcomes and designated implementers. Additionally, participants communicated that sector-level approval is crucial for workforce needs, highlighting the procedural flow from health centers to sector and district council meetings.

"…At the district level, the DHMT and an executive committee, along with cooperative institutions, collaborate to yield results. During these meetings, for instance, if an issue arises at a specific health center, decisions are made, and then they communicate these decisions to us. This way, we are informed and understand the outcomes of those meetings…"

5.2 Information Gathering

The participants from focus group discussions across various districts revealed diverse channels and methods that DHMTs use for information collection, which is crucial for informed decision-making in district health governance. They revealed that the data collection process is comprehensive, involving contributions from multiple sources including hospitals, health centers, health posts, and the community. They also pointed out that each health center assigns a data manager to oversee data-related activities, ensuring collaboration and data quality. Moreover, local authorities including district officials also utilize field trips to other institutions to gather comparative data, which aids in policy formulation. Additionally, donors play a significant role by performing data analysis to identify areas needing support. These combined efforts highlight a robust framework for data-driven decision-making within district health governance.

"…At DHMT level, we follow specific guidelines, when formulating a plan. We gather data from hospitals, health centers, health posts, and within the community. Additionally, we align with the country's broader vision, for example, during an epidemic, by visiting the affected areas to collect information directly…."

5.3 Decision/Choice Selection

Most of the participants highlight that decision-making often depends on the severity of the problem, with a focus on addressing issues that pose a threat to individuals or healthcare facilities. They compare problems across different health centers to determine which issues require urgent intervention. Decisions are typically made during meetings where all problems and challenges are presented and discussed collectively, with majority opinions guiding the final decision.

> "…. *The decision-making or choices depend on the severity of the issue at hand. Often, these decisions prioritize addressing problems that pose threats to the public or jeopardize the functioning of health centers at the start of service provision…*"

5.4 Decision Making Bodies

Many participants revealed that decision-making within the DHMT and related health entities is inherently collective rather than individual. They emphasized that decisions are made by all members of the DHMT, highlighting its collaborative nature. Additionally, it was noted that the DHMT functions as a decision-making body, while the DPEM and coordination meetings are responsible for implementing these decisions. The involvement of multiple stakeholders, including health unit directors, regional councils, and partners such as Ministry of Healthand MINECOFIN, ensures that decisions are comprehensive and address needs at various levels of governance.

> "*At the district level, DHMT and an executive committee collaborate with cooperative institutions to deliver results. When we hold meetings, for instance, if a problem arises at a certain health center, decisions are made collectively and then communicated to us. We are informed and understand the outcomes of those meetings.*"
> "*…In DHMT meetings, all members participate in decision-making. Although there might be a chairperson for each meeting, we ensure that we first listen to everyone's opinion. Then, the vice mayor assists us in finalizing the decision.…*"

5.5 Decision-Making Process and Influencing Factors

Participants revealed that while there is a chairperson for each meeting, everyone's opinion is heard first, and the vice mayor assists in finalizing decisions. They affirmed that decisions are made collectively by all members, emphasizing that no single member can claim to make decisions independently. Instead, there is a consensus on all matters during the meetings, and responsibilities are assigned based on specific roles. For instance, if the issue pertains to a hospital, the Director General (DG) handles it, while issues related to the RSSB or health posts are delegated accordingly.

The discussions further highlighted the collective and regulated nature of decision-making within the DHMT. Most participants noted that decisions are guided by established regulations and priorities, ensuring that no individual has the authority to make unilateral decisions. Current issues, such as missing or non-existent medicines at the RMS or building-related problems, are identified and escalated to the appropriate level for action. The seriousness of the problem determines its consideration by the whole committee, but the final decision is made at the district level without any individual influence.

"*…All members have a say in the meeting, and no one makes individual decisions. I would emphasize to my colleagues that we agree on everything during the meeting, and everyone is given responsibilities based on their area. If it's a hospital*

issue, the DG handles it; if the problem involves RSSB, they address it; and if it's about a health post or CHWs, the relevant person takes charge. That's how we operate…"

> *"…All DHMT members make the decision together. Although there is a chairperson for every meeting, we first hear everyone's opinion, and then the vice mayor helps us finalize the decision…"*

5.6 Collaboration and transparency

Most participants emphasized the importance of collaboration and transparency in the decision-making process. They highlighted that during decision-making, every member has equal rights, and once actions are decided, a responsible individual is designated for execution with clear timelines. Subsequent meetings focus on evaluating the implementation of these actions. A key challenge noted was the lack of follow-up due to budget constraints. Additionally, they also added that every level is represented, and decisions are made based on consensus. The health committee complements the trustees' committee by ensuring decisions are transparent, providing feedback, and advocating at higher levels. This structure extends to the hospital level, where the steering committee should evaluate district activities. The Steering Committee also handles remuneration and incentives through the PBF system, rewarding those who perform well. Finally, they noted the collaboration between committees, emphasizing that problems can be cross-cutting and may need to be addressed by multiple committees, thus prioritizing their resolution.

> *"…There is an inclusiveness while taking decision during the meeting of DHMT. All members give their opinions in a clean and clear atmosphere. The problem comes when implementing planned actions."*

5.7 Obstacles & Barriers

The participants revealed several obstacles and barriers impacting the DHMT's decision-making process. Participants said that health committees at the district level lack budgets, hindering their ability to execute action plans effectively. Meetings often depend on personal contributions or occasional support from hospitals, leading to inconsistent functioning of committees. They added that while the PBF steering committee has a budget, DHMT lacks a fixed budget, resulting in temporary financial coverage by different partners during meetings. The absence of dedicated employees on these committees further complicates the execution of action plans, as highlighted by participants. Also highlighted challenges such as the lack of a formal timeline for following up on action plans and decisions, as well as insufficient coordination among partners, were mentioned by several participants. They also pointed out that decisions made by DHMT sometimes exceed their competence and lack subsequent feedback, which undermines the effectiveness of their initiatives. Additionally, the shortage of staff and inadequate formal documentation of regulations were cited as significant gaps. Despite these challenges, participants emphasized the necessity of having a dedicated budget for DHMT and other health committees to ensure sustainable and effective health service delivery. Finally, they said that the absence of specific DHMT partners and the limited capacity of existing partners further exacerbate these issues.

> *"…Health committees at the district level struggle with a lack of dedicated budgets, which affects their ability to execute action plans and coordinate effectively. Meetings often face delays, or members must cover costs themselves, sometimes with financial support from hospitals. Moreover, the absence of formal documentation and not enough staff make it challenging to tackle issues related to accessibility and staffing. We suggest that the Ministry of Health should enhance support by providing timely feedback and routinely sending representatives for evaluations..."*

6. DHMT Interaction and Collaboration among Health Committees

The participants noted that all district health technical committees are coordinated through the DHMT, which serves as the central and advisory body to ensure cohesive decision-making and communication across various levels. Moreover, the council meetings, where decisions from different committees are shared and discussed, were reported to foster significant collaboration and enforce the implementation. Additionally, many participants revealed that issues that cannot be resolved at the lower committee levels are escalated to the DHMT, promoting peer learning and collective problem-solving. As summarized in Figure 5, the interaction and collaboration among committees and stakeholders were revealed as coordination pathways toward addressing health issues at the district level, even though different coordination challenges still exist.

The findings revealed strong collaboration and interaction between DHMT and other district health technical committees.

The visualization provided an illustration of the network of the interdependencies among committees related to collaboration, coordination, and information flow across the health management system. It highlighted both successes and challenges encountered during the analysis, particularly the issue of overlapping responsibilities, which significantly hindered the effectiveness of collaborative efforts. This nuanced perspective offered valuable insights into the complex dynamics that characterized Rwanda's district health governance, revealing how these interrelated factors influenced overall success of collaboration and interaction.

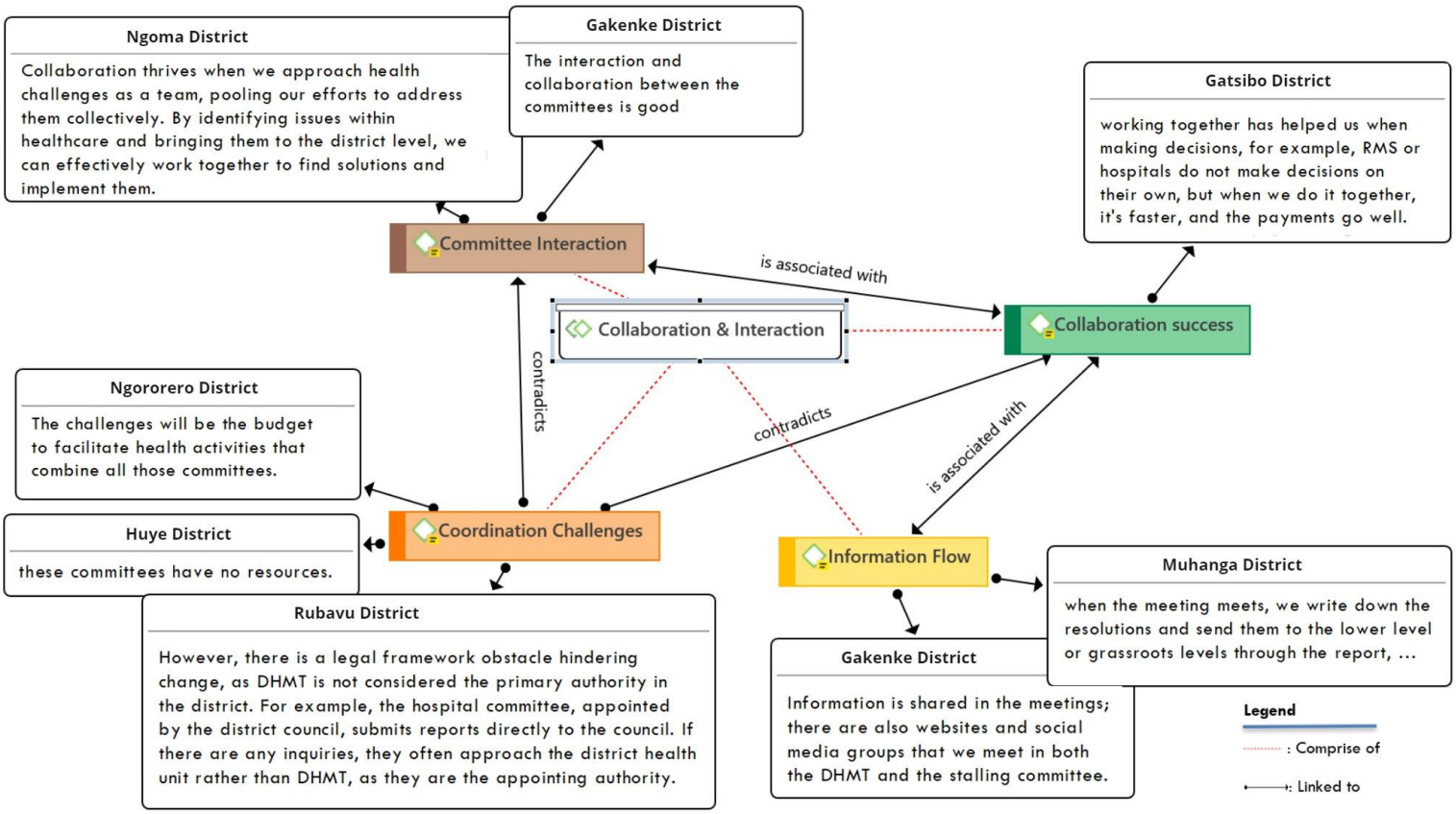

Figure 5: Collaboration and interaction among health committees of the district health governance system.

Legend

- **Boxes** with district names represent the input or feedback from specific districts about health committee interactions, coordination challenges, or information flow.
- **Arrow types** show associations between different factors.
- **Connecting lines** represents a positive connection between elements.

6.1 DHMT Information Flow

Most participants reported that the information flow among health institutions and partners is primarily facilitated through meetings, WhatsApp groups, and reports. Many key informants highlighted the use of selective information dissemination, ensuring that only relevant details reach those directly involved, thereby enhancing the efficiency of decision implementation. Moreover, the integration of various stakeholders through forums such as JADF and DHMT meetings promotes comprehensive collaboration, with partners often contributing to joint activities and resource pooling.

> *"…In addition to the legally mandated meetings that allow stakeholders to convene and discuss issues, various institutions have adopted different technological methods to enhance our communication. We use WhatsApp*

groups, group emails, and hold meetings that include our partners in the JADF. Within JADF, there is a social commission that facilitates connections among all the sub-commissions related to health…"

However, few participants highlighted issues related to the communication channels and collaboration within the DHMT. Several participants reported that while DHMT provides feedback at the sector level, there is a gap between DHMT meetings and the dissemination of feedback decisions. They emphasized the need for a timeline to follow up on all actions planned from the district level to the village level.

"…However, you may find that the health committees in some areas lack direct communication channels that would enable them to collaborate effectively with the DHMT. From what I have observed, this absence of collaboration does not support the integration of efforts in health care. For instance, there is a separate committee responsible for approving Performance-Based Financing (PBF), even though the DHMT oversees these operations. Ideally, the DHMT should be the entity approving PBF…"

6.2 Committee Interaction

Several participants highlighted the strong committee interaction within the health district governance structure. Furthermore, respondents emphasized that the DHMT's role in coordinating multiple committees, including those involving private parties and public health authorities, ensures that all stakeholders are represented and engaged in the decision-making process. Also, the interaction among committees was described as effective, with routine meetings allowing for the exchange of information and collective action toward common goals. Finally, participants noted that the DHMT's integration with the district council and other health-related institutions enhances the overall synergy and functionality of the health governance system.

"…Perhaps the interaction is reflected in the decisions we make, In the steering committee, we evaluate the performance contract of a particular health center focusing on its leadership, such as the Head of the health center who is directly involved in executing their plans. If we discover that this leader is not fulfilling their duties, we would then consult with the DHMT to determine whether transferring them to another location or making another corrective decision would be appropriate, and we proceed accordingly…"

6.3 DHMT committee collaboration success

Many participants reported that this interaction ensures smooth transactions and effective problem-solving, as all levels contribute to a common goal. Moreover, the collaboration extends to regular meetings where decisions are made collectively, ensuring all stakeholders, including independent clinics and health centers, are aligned.
Additionally, participants revealed that specific initiatives, such as donating resources to Early Childhood Development (ECD) programs and organizing community outreach services, exemplify the practical outcomes of this collaborative approach. Furthermore, the inclusion of diverse committees and forums, such as the Joint Action Development Forum (JADF), fosters continuous communication and partnership with external entities, leading to comprehensive planning and resource pooling. Many participants emphasized that the interaction between various health committees and the DHMT is characterized by complementarity and shared objectives. This multi-level collaboration is designed to maximize performance, as each level brings specific expertise and responsibilities. Additionally, the participatory method of preparing budgets and making decisions ensures representation and inclusivity at every stage. Moreover, the interaction involves regular feedback loops and problem-solving mechanisms, such as transferring health facility heads when necessary and addressing malnutrition through coordinated efforts. Furthermore, the presence of numerous committees monitoring different health aspects, including the National Child Development Agency (NCDA)

and others, ensures that decisions are made collectively rather than unilaterally. Participants also noted that peer learning and immediate replacement of committee members help maintain the effectiveness of these interactions. Finally, the district's role in overseeing and regulating stakeholder activities, ensuring no duplication of efforts, fosters a unified approach to health management.

> *"…The strength of interaction and collaboration is evident because if we plan a field visit to health centers, the Vice Mayor, the partner, and others will join, demonstrating effective interaction and collaboration. Whether it is right or not, we have advice to share because we work together…"*
>
> *"…As the DHMT, we can invite the staff member concerned with a particular issue to join us in the next meeting to find a solution together. Additionally, we might invite, for example, the five heads of health centers facing problems. This approach of inviting relevant individuals to DHMT meetings fosters collaboration and helps resolve significant health issues…"*

6.4 DHMT Committee Coordination Challenges

Many participants revealed coordination challenges within health district governance. Some reported poor communication across various health committees, highlighting a lack of effective reporting techniques to the DHMT. Additionally, several participants pointed out that the legal framework does not prioritize the DHMT as the primary authority, resulting in direct reporting to the district council rather than through DHMT. Moreover, the absence of a cohesive coordination mechanism or information flow connecting institutions was emphasized, with information often being confined to the vice mayor's office. Furthermore, some participants noted that the management behavior, especially of the vice mayor and health department directors, significantly impacts cooperation, sometimes leading to meetings being unattended. Finally, participants highlighted the necessity for capacity building and budget allocation to support better collaboration and interaction among health committees. Despite these challenges, many highlighted the positive role of the government's health policy and strategic plan in striving towards improved governance and accountability.

> *"…Communication is generally poor. As a hospital director, I make significant decisions within a health committee, but for DHMT, even during audits, we are not required to demonstrate the execution of DHMT decisions, despite being a high-level committee. Since DHMT comprises a large assembly, we need to gather information from various health committees. However, there is a lack of a proper reporting technique to DHMT, which presents a major challenge…."*

7. Synergy & Duplication

7.1 Synergy Opportunities

Many participants highlighted the potential for synergy and the reduction of duplication through better coordination within the DHMT. Several participants reported that the DHMT acts as an umbrella for various district health technical committees, addressing diverse issues such as Child and Pregnancy Nutrition and malnutrition. It was revealed that consolidating these separate health committees into the DHMT would likely enhance efficiency and collaboration in addressing health concerns. Many participants highlighted the importance of enhancing cooperation and maintaining consistency within the committee, ensuring each member understands their role. Furthermore, several respondents emphasized the need for a clear explanation of responsibilities and effective communication among health institutions to prevent duplication of activities. Additionally, it was reported that working with the JADF office could significantly improve coordination and reduce redundancies. Moreover, participants revealed that having a clear list of decision-

makers could mitigate conflicts of interest and promote fairness and transparency in decision-making. Ensuring accountability and utilizing a centralized information system were suggested as critical steps to achieve better synergy and prevent repeated efforts.

> *"…. We have JDAF (social commission) and we meet with health partners and conduct exchanges. forums are established and members make decisions together…"*

7.2 Duplication Issues

Several participants reported that there is minimal duplication of efforts within the district's health governance system. Most highlighted that mechanisms such as joint planning, coordination meetings, and strict regulatory frameworks effectively prevent redundant activities. Furthermore, many respondents emphasized that the JDAF has significantly contributed to reducing duplicative actions by ensuring partners coordinate and share responsibilities. Additionally, it was revealed that any potential overlap is addressed promptly through discussions and adjustments in planning. Moreover, some informants noted that while occasional duplicative efforts, such as similar evaluations by the DHMT and coordination meetings, do occur, these are viewed as opportunities for increased oversight and review rather than wastage.

Finally, the systematic monitoring and auditing processes were noted as crucial in maintaining accountability and preventing resource misuse.

> *"…No, it wouldn't happen because here we know that JADF is working well, not only is it commended but it is a good achievement for the JADF so that there are no repetitive actions/ activities. The partners help us to see where they can place their actions/ activities differently, whereas normally, you might find that they place them in areas where similar activities already exist…"*

7.3 Optimizing Efficiency and Minimizing Duplication

Several participants highlighted various efficiency measures within the district governance system, emphasizing the importance of collaboration with the JADF office to prevent duplication of activities and ensure coordinated efforts. Many informants revealed that having a clear list of decision-makers would enhance accountability and transparency, while more frequent DHMT meetings with higher-skilled technicians would improve the implementation of recommendations. Furthermore, better organization within the DHMT, including distinct reporting structures, was suggested to enhance efficiency. Additionally, respondents stressed the importance of joint planning and systematic monitoring to maintain synergy and prevent resource wastage. Finally, ongoing communication among stakeholders was highlighted as vital for ensuring complementary efforts and avoiding duplication.

> *"…Where we can improve cooperation is by working with the JADF office, as it oversees partners. Everyone who comes in first goes through them, preventing the occurrence of repetitive activities. You understand that this eliminates the possibility of duplication and enhances efficiency, ensuring that each activity planned at the district level interacts with JDAF to avoid overlapping activities in the same location…"*

8. Committee Members Capacity and Capabilities

8.1 Evidence-Based Decisions

Based on the information collected through participants, several participants highlighted the essential role of data in guiding evidence-based decision-making processes within the district. Many informants revealed that data serves as a crucial tool not only in identifying health-related problems, such as malnutrition, but also in monitoring fluctuations in diseases like malaria. Furthermore, participants reported that data informs the training provided to healthcare providers and supports the organization of mobilization efforts. Moreover, the lack of advanced data analysis

expertise and skilled technicians was a common challenge noted by many respondents, emphasizing a significant knowledge gap in data usage and interpretation. Additionally, it was highlighted that collaboration with various stakeholders, including partners with their own data analysts, helps fill these gaps and enhances decision-making.

> *"…Data plays an essential role in identifying challenges like malnutrition and guiding decision-making processes. It helps us identify successful areas and those needing improvement. For example, in regions where malaria is prevalent, data enables us to track case fluctuations, allowing for timely responses such as organizing mobilization efforts and distributing medications. Additionally, data informs the training of healthcare providers, ensuring they are well-prepared to tackle prevalent health issues effectively. Ultimately, data serves multiple functions, assisting us in understanding, responding to, and enhancing health outcomes in our communities…."*

8.2 Data & research use among committee members

Participants revealed that data and research use are integral to their operations, particularly in monitoring health indicators such as stunting and child mortality rates. Most stakeholders emphasized the necessity of accurate and timely data for effective decision-making and policy formulation. They reported that collaboration with partners, such as DHMT and various NGOs, is crucial for providing the resources and expertise needed for data analysis and implementation. Moreover, it was highlighted that while several stakeholders have proficient data analysis skills, there is a notable gap in advanced data analysis and policy assessment capacity at the district level. Furthermore, participants indicated that the existing collaborations ensure that decisions are data-driven and resources are appropriately allocated, benefiting community health outcomes. Additionally, they noted that partners often provide essential training to local health workers, thereby enhancing data management capabilities. Finally, many participants pointed out the need for continued capacity building to bridge the knowledge gap in data usage, analysis, and interpretation, ensuring that health interventions are effectively implemented and monitored.

> *"…Let's consider the stunting data from DHS: if our district's rate stands at 33% or 39%, we immediately develop measures or strategies to combat stunting and identify partners to assist us. This data guides us in addressing the issue. Similarly, when we examine the rate of childbirth at healthcare facilities, it informs us whether people prefer delivering at a facility or at home. This insight helps us understand what is required from us at the district level, from local authorities to Community Health Workers. Seeing the results of such research assists us in making informed decisions…."*

8.3 Monitoring & Supervision Tools

Many participants expressed concerns about the lack of specific tools to guide DHMT members in field monitoring and supervision. Currently, no standardized tools or protocols exist, making the supervision process particularly challenging, especially in hospital settings. This difficulty is further exacerbated when supervising individuals with greater skills or expertise. Participants noted that some projects or partners use their own monitoring tools tailored to their specific initiatives, each focusing on different aspects of health services.

Additionally, software systems like HMIS and ELMIS are available at the district level. These systems contain comprehensive data on health service delivery, disease incidence, and other critical indicators. Supervisors can leverage this data to monitor the performance of health facilities, assess the quality of care, and identify areas in need of improvement.

"…Unfortunately, there are currently no such tools and protocols available. While the HMIS exists, I'll attempt to access its data to proceed with our analysis within DHMT. It can become complex when you are supposed to supervise someone in the hospital, especially if the person you are supervising is more skilled than you are…"

"…The last tools used were for the INGOBYI project, where we checked the action plan, meeting frequency, whether DHMT members were appointed, if regular supervision and advocacy were conducted, and the challenges faced in the supervision process…"

9. DHMT Governance Effectiveness and Challenges

9.1 Effectiveness Success

Many participants highlighted the effectiveness and success of the DHMT, emphasizing their collaborative efforts and structured approach. Several participants revealed that the implementation of innovative practices, such as the use of ambulances, has significantly reduced mortality rates among parents and children. Additionally, the integration of technology and the establishment of health committees have been crucial in improving health service delivery and governance. Moreover, the involvement of key members, including the Vice Mayor in charge of social affairs, ensures that district-level decisions are effectively implemented. Finally, good governance, characterized by clear national health policies and strategic plans, was highlighted as a critical factor contributing to the sector's overall performance, although financial constraints and resource allocation remain ongoing challenges.

"…I would like to highlight that there is clear evidence of progress. Following the guidance, we received on ambulance use during our DHMT meeting, we have implemented this information effectively. As a result, we have observed a significant reduction in maternal and child mortality rates".

9.2 Contributing Factors

Many participants highlighted the diversity of skills and expertise within the DHMT, which encompasses individuals from various domains, facilitating overall performance. Participants also revealed that discussing health indicators across health centers allows for identifying trends and allocating efforts to address gaps, which positively impacts health units. Moreover, collaboration with district authorities, particularly the involvement of the Vice Mayor in charge of social affairs and the Director of Health Unit, was highlighted as enhancing DHMT's effectiveness. Furthermore, it was revealed that effective collaboration and agreement within the DHMT and between the district and health facilities are crucial for smooth operations. Additionally, participants reported that being in the same region enhances teamwork, information exchange, and problem-solving capabilities. Technology, evidence-based data use, and a culture of cooperation were also mentioned as significant factors that improved performance. Moreover, the strategic level's role in setting priorities and goals was appreciated, with volunteerism and the Ministry of Health's efforts to enhance health sector capacity also cited as important. Finally, the presence of partners and coordinated planning were seen as vital in addressing issues like malnutrition, though concerns were raised about budgetary constraints and the need for ongoing follow-up to ensure activities' effectiveness.

"…The factors that contribute to the effectiveness of the governance structure are numerous, including diverse skills from different individuals. for example, the composition of DHMT include individuals from various domain which enhance the performance because no domain becomes a limiting factor. However, challenges such as the low number of workers and their turnover rates posed significant obstacles…"

9.3 Obstacles and Challenges

Several participants reported that the effectiveness of governance within the DHMT is hindered by numerous obstacles and challenges. A prevailing concern among many was the lack of detailed guidance in the existing frameworks and guidelines, as well as the inconsistency in the tools used for supervision, monitoring. Moreover, financial constraints were a recurring theme, with many participants emphasizing the lack of a dedicated budget for DHMT activities. This financial limitation often leads to delays in implementing decisions and conducting essential activities such as field visits and data verification. Furthermore, participants revealed that dependency on external partners for support creates vulnerability, particularly when these partners withdraw. Also, committee members' limited proficiency in data analysis and interpretation hinders their ability to make informed decisions. These skills' gap prevents them from effectively utilizing available healthcare data, leading to suboptimal decision-making and inadequate monitoring of outcomes. Finally, the infrequent meetings and overburdening of DHMT members with multiple responsibilities further limit the timely execution of DHMT initiatives.

> "…*We observe a disparity in partner presence among districts; some have many partners, making their DHMT activities more effective due to the availability of financial resources, while others lack such support. I recommend that the central level take this into consideration…*"

10. Recommendations

Based on the findings from the assessment of the District Health Management Teams (DHMT), the following recommendations are proposed to enhance governance, decision-making processes, and overall efficiency within the health district:

1. **Strengthen Governance Framework:** It is essential to review and update the existing DHMT guidelines governing DHMT operations, establishing frameworks and their legal implications. This should include clear definitions of roles and responsibilities.

2. **Enhance Capacity Building:** Regular training and capacity-building initiatives should be implemented for DHMT members to improve their ability to utilize evidence-based data in policy-recommendations. This will empower them to make informed decisions that address local health needs effectively.

3. **Improve Communication and Collaboration:** Establishing a robust communication strategy among stakeholders is vital to enhancing the effectiveness of health initiatives. This strategy should include fostering collaboration with the Joint Action Development Forum (JADF) to prevent duplication of efforts and ensure that actions are well-coordinated across various health initiatives. Equally important is ensuring that feedback from both the District Council and the Ministry of Health on any DHMT recommendations is effectively communicated back to the DHMTs. Timely and detailed feedback is crucial, providing the DHMTs with clear guidance on the feasibility and implementation of their recommendations, and enabling them to adjust their strategies or approaches based on higher-level insights or directives.

4. **Implement Systematic Monitoring and Evaluation:** A structured monitoring and evaluation (M&E) framework and platform should be developed to the overall performance of the DHMT. This framework should include regular reviews of recommendations related to health indicators and the establishment of annual action plans that align with the district health strategy. Additionally, incorporate periodic evaluations of DHMT functionality, including a ranking system to facilitate benchmarking. This will help to identify top-performing

teams, thereby enhancing operational effectiveness and encouraging a competitive spirit to drive continuous improvement.

5. **Foster Joint Planning and Reporting:** Encourage the development of joint action plans with partners, ensuring that all stakeholders are involved in the planning, evaluation, and reporting processes. This collaborative approach will enhance the effectiveness of health system operations and ensure that resources are utilized efficiently.

6. **Facilitate Annual Inter-District DHMT Meetings:** Organize yearly meetings for DHMTs from various districts to discuss challenges, share lessons learned, and brainstorm improvements. These meetings will provide a platform for cross-district collaboration and knowledge exchange, fostering a community of practice among DHMTs. This initiative will not only enhance problem-solving capabilities but also promote the implementation of best practices across districts, ultimately improving health service delivery.

7. **Securing Dedicated Budgets for DHMTs:** To ensure that District Health Management Teams (DHMTs) can effectively perform their oversight roles and conduct comprehensive monitoring and evaluation of health services, it is crucial to allocate dedicated budgets. These funds should be specifically earmarked for activities related to the assessment of service performance, including regular data collection, analysis, and reporting. A dedicated budget will enable DHMTs to function autonomously and more efficiently, ensuring they have the necessary resources to fulfill their mandates without relying on inconsistent external funding. This financial empowerment will also facilitate timely interventions and improvements in health service delivery at the district level.

By implementing these recommendations, the DHMT will improve its governance structures, enhance recommendations-formulation processes, and ultimately respond more effectively to the health needs of the community.

11. Conclusion

The assessment of the District Health Management Teams (DHMT) has provided valuable insights into the governance structures, recommendations-formulation processes, and operational efficiencies within the health districts. The findings highlight the critical role that DHMTs play in enhancing health service delivery and addressing local health needs. The comprehensive inclusion of diverse members within the DHMT structure has been instrumental in fostering collaboration and ensuring that a wide range of perspectives is considered in health governance. This diversity not only enriches the recommendations-formulation process but also enhances the overall performance of the health system by leveraging the unique skills and experiences of its members.

However, the study also identified several challenges that hinder the effectiveness of the DHMTs. Key obstacles include insufficient financial resources, and a lack of detailed guidelines and frameworks for supervision. These challenges often lead to delays in implementing decisions and conducting essential activities, such as field visits and data verification. Furthermore, the dependency on external partners for support creates vulnerabilities, particularly when these partners withdraw, which can disrupt the continuity of health services.

To address these challenges, the report recommends several strategies aimed at enhancing the governance and operational efficiency of DHMTs. These include the establishment of a dedicated budget for DHMT activities, improved

training in evidence-based data use, and the integration of healthcare data systems to facilitate better recommendations-formulation and monitoring.

All in all, while the DHMTs have made significant strides in improving health governance at the district level, ongoing efforts are needed to strengthen their capacity and resilience. By addressing the identified challenges and implementing the recommended strategies, DHMTs can better respond to local health priorities and emerging health threats, ultimately leading to improved health outcomes for the communities they serve. The findings from this assessment will serve as a foundation for future initiatives aimed at enhancing the effectiveness of DHMTs and fostering a more integrated health system.

12. References

[1] Rwanda Ministry of Health (MoH), “Annual Health Sector Performance Report 2021-2022,” 2022.

[2] World Health Organization., “District Health Management Team Training Modules Planning and Implementation of District Health Services,” 2004.

[3] World Health Organization., *Monitoring the building blocks of health systems : a handbook of indicators and their measurement strategies*. World Health Organization, 2010.

[4] A. C. S. Heerdegen, M. Aikins, S. Amon, S. A. Agyemang, and K. Wyss, “Managerial capacity among district health managers and its association with district performance: A comparative descriptive study of six districts in the Eastern Region of Ghana,” *PLoS One*, vol. 15, no. 1, Jan. 2020, doi: 10.1371/journal.pone.0227974.

[5] S. Bosongo, Z. Belrhiti, F. Chenge, B. Criel, and B. Marchal, “Capacity building of district health management teams in the era of provincial health administration reform in the Democratic Republic of Congo: A realist evaluation protocol,” *BMJ Open*, vol. 13, no. 7, Jul. 2023, doi: 10.1136/bmjopen-2023-073508.

[6] D. K. Henriksson, S. S. Peterson, P. Waiswa, and M. Fredriksson, “Decision-making in district health planning in Uganda: Does use of district-specific evidence matter?,” *Health Res Policy Syst*, vol. 17, no. 1, Jun. 2019, doi: 10.1186/s12961-019-0458-6.

[7] E. C. Clark, T. Burnett, R. Blair, R. L. Traynor, L. Hagerman, and M. Dobbins, “Strategies to implement evidence-informed decision making at the organizational level: a rapid systematic review,” *BMC Health Serv Res*, vol. 24, no. 1, Dec. 2024, doi: 10.1186/s12913-024-10841-3.

[8] Ministry of Health (MoH), “District Health System Guidelines,” *Ministry Report* , 2019.