SUSTAINING DISTRICT-LEVEL PRIMARY HEALTH CARE PERFORMANCE AND MANAGEMENT PRACTICES

Lessons Learned from the Primary Health Care Performance Management Activity

Sustainability: At a Glance

Despite investments in primary health care (PHC) performance management, a key question persists: to what extent can district-level gains and management practices be sustained beyond project funding, particularly in the absence of external funding that have enabled implementation? The PHC Performance Management (PHC-PM) Activity, funded by Gates Foundation, equipped district teams in Rwanda and Ghana with improved leadership and management behaviors while empowering them with autonomy and support to lead performance improvement using a customized PHC Leadership Development Program (PHC-LDP). An assessment conducted at the end of the PHC-PM Activity explored the extent to which the PHC-LDP process has institutionalized these tools and skills within routine systems and practices in Ghana and Rwanda. This brief details findings from district stakeholders in Ghana and Rwanda, including how financial constraints and limits on district autonomy affect the sustainability of this approach.

Data sources: Key informant interviews (KIIs) and focus group discussions (FGDs) were conducted with District Health Management Teams (DHMTs), facility leads, and health workers. Prior baseline and outcome harvesting assessments are also referenced to contextualize KII findings.

Key Questions	*Findings*	*Recommendations*
How did districts facilitate alignment of the activity selection with regional and national priorities?	▪ While desired measurable results (DMRs) aligned with national goals, Rwanda followed central guidance and Ghana used greater autonomy to address local gaps through data-driven decisions.	▪ Align PHC-LDP activities with national priorities to increase the likelihood of sustainability, as nationally-targeted activities are more readily integrated into routine planning and budget processes.
Which PHC-LDP practices are most likely to continue after the end of the Activity?	▪ Sustainability was strongest where PHC-LDP practices were embedded in routine systems, backed by district ownership, and reinforced by visible improvements in service delivery and community impact.	▪ Continue supporting outreach and transport, durable equipment procurement, and peer-led capacity building. ▪ Institutionalize and enhance supervision accountability mechanisms that showed success in driving local ownership.
What are some of the barriers to sustaining interventions beyond the end of the Activity?	▪ Funding (dependence on external funds), staffing (high turnover), and leadership continuity challenges threaten long-term sustainability despite demonstrated benefits.	▪ Prioritize embedding key PHC-LDP activities into routine district financing and planning cycles. ▪ Address staffing shortages by promoting cross training and designating a PHC focal person at the health center level to ensure continuity.
How do districts sustain the improvements made as a result of the PHC-LDP?	▪ While leadership, data use, and prioritization practices are likely to be sustained, activities dependent on catalytic grant funding remain at risk.	▪ Facilitate deliberate integration into district financing systems, strong DHMT advocacy in Rwanda, and community-driven financing strategies such as diaspora engagement and dedicated health development funds in Ghana.
Where is further exploration required?	▪ Further exploration is needed to understand which practices are sustained after Activity end, how they become embedded in routine operations and budgets, and which deliver the best value under resource constraints.	▪ Integrate supervision into routine budgets to sustain staff motivation and collaboration. ▪ Engage district leadership early to build the ownership needed for long-term sustainability.

INTRODUCTION

In many low- and middle-income countries, DHMTs are tasked with translating national policies into local action, often operating with limited data, decision-making authority, or financial resources.

Districts in both Ghana and Rwanda have faced persistent challenges in delivering primary care services, particularly in maternal, newborn and child health (MNCH) and vaccination services.

In October 2023, Bugesera district in Rwanda reported antenatal care (ANC) coverage as 33%, lagging the national average of 53%. Similarly, in Ghana's Akwapim South district, only 27% of births were attended by a skilled practitioner, missing the national target of 68%.[1] The PHC-PM Activity operated in these districts as well as North Tongu (Ghana) and Gicumbi (Rwanda) to support DHMTs in addressing these challenges.

Through the PHC-LDP Program, the Activity strengthened district leadership, management, and governance while introducing structured performance management practices, including data-driven prioritization, action planning, and engagement with communities and diverse stakeholders. To accelerate implementation, the PHC-PM Activity also deployed catalytic grant funding to support district action plans, enabling DHMTs to address critical system gaps such as outreach, supervision, transport, and essential equipment.

Beyond these quantitative differences, a baseline assessment revealed important operational and quality gaps in both countries. Supportive supervision was inconsistent, particularly at lower levels of care, and systemic barriers limited service quality. In Rwanda, Bugesera reported specific challenges related to transportation constraints, inadequate equipment, and insufficient staff training, whereas Gicumbi showed more reliable access to electricity and water within facilities and relatively stronger performance in areas such as staff incentives.[2]

In Ghana, existing gaps in Akwapim South were compounded by poor facilities infrastructure and lack of essential commodities, medical supplies and equipment, making health facilities less attractive for client's patronage. Midwives lacked basic lifesaving equipment to function during nighttime deliveries, and health providers lacked transport to remote communities to provide essential services. In North Tongu, lack of tools at the facility or training on essential protocols hampered health care workers' capacity to provide maternal care, including basic emergency obstetric and newborn care. Health workers became more demotivated to deliver care, and health care facilities became less attractive for clients, leading to dips in PHC targets.

While the Activity's combined approaches contributed to improvements in PHC performance, many were supported by finite Activity inputs, raising important questions about the sustainability of gains and practices once external support—particularly catalytic grant funding—ends.

What does "sustainability" mean in the context of PHC-LDP?

Through adaptive performance improvement cycles, DHMTs continuously analyzed, monitored, learned, and adjusted to address key challenges within their

[1] Data from the Rwanda Health Analytics Platform and Ghana's District Health Information Management System in October 2023.

[2] Incentives include more frequent provision of accommodations as well as trainings facilitated by the Ministry of Health, district hospitals, or the Society for Family Health for career advancement.

districts. To facilitate this performance improvement, the PHC-PM Activity deployed catalytic grant funding to accelerate implementation of district action plans and address system gaps identified through data and planning. Funds supported a range of activities, including outreach, supervision, training, and essential equipment, while also strengthening district ownership and decision-making.

Together, these efforts resulted in both performance gains (improvements in PHC indicators) and strengthened management practices (including improved data use, prioritization through DMRs, and multi-stakeholder engagement).

Although effective in implementing action plans, the PHC-LDP and catalytic grant interventions are directly tied to the Activity's duration and raise important questions about the long-term ability to sustain these gains and practices once external support ends.

An outcome harvesting assessment conducted at the Activity's midline explicitly connected enhanced DHMT leadership, management, and governance behaviors with improved PHC outcomes and DHMT coordination.[3] However, sustaining these gains will require continued investment in core system functions, including training newly posted health workers, ensuring transport for routine outreach to geographically hard-to-reach communities, and maintaining reliable access to essential medical services and commodities in the context of unpredictable government funding and limited internally generated funds.

Management Sciences for Health (MSH), Three Stones International (TSI) in Rwanda, and Ubora Quality Institute in Ghana noted the need to explore opportunities and challenges in sustaining gains made in each district. This includes understanding which PHC-LDP practices are most likely to be institutionalized within routine district systems, which have depended on catalytic grant funding, and how districts plan to finance and maintain these approaches over time.

ASSESSMENT OVERVIEW

Data collection in Rwanda was led by TSI and in Ghana by Ubora Institute. In Ghana, FGDs were conducted separately for two categories of stakeholders to elicit divergence views regarding sustainability. Emerging themes were identified and validated by the group at the end of the sessions for better construct and precision. In Rwanda, KIIs were conducted with key stakeholders to capture an accurate understanding of the institutionalization of PHC-LDP behaviors within the DHMT. Details are shown in table 1.

[3] MSH. Outcome Harvesting Highlight: Primary Health Care Performance (PHC-PM) Activity, 2025. Available at: https://msh.org/resources/outcome-harvesting-highlight-primary-health-care-performance-phc-pm-activity/.

Table 1. Qualitative data collection by country, district, and stakeholder level

Stakeholder level	Data Collection Method and Participants	Selection Procedures
Rwanda[4]		
DHMT Members	**Bugesera (KIIs, N=7):** Community health worker (CHW) supervisor, Director of Administration and Finance, Director of Health, Director of Nursing, DHMT focal person, health center representative, CHW representative **Gicumbi (KIIs, N=4):** Director of Administration and Finance, health center representative, DHMT focal person, CHW representative	Selection focused on formal DHMT members actively involved in PHC-PM activities including workshops, meetings, trainings, and implementation. In Gicumbi, some respondents could not be reached due to limited availability.
Health Center Staff	**Bugesera (KIIs; N=3):** Head of Health Center of 3 health centers **Gicumbi (KIIs; N=2):** Head of Health Center of 2 health centers	Health centers were selected with the district focal person, prioritizing facilities with staff who worked closely with the DHMT and participated in project implementation activities. Purposive sampling was used to select participants directly involved in PHC-PM implementation with sufficient experience.
Ghana		
DHMT Members	**North Tongu (FGDs; N=8)** **Akwapim South (FGDs; N=9)**	All DHMT members in both districts were eligible to participate; discussions were facilitated with a note taker and supported by recordings. Key points were validated at the end of each session and shared in plenary for additional input/clarification. Other stakeholder groups were not included for this theme due to limited dashboard access/interaction.
Opinion Leaders	**North Tongu (FGDs; N=5)** **Akwapim South (FGDs; N=5)**	Opinion leaders were selected based on their role in health planning and resource allocation decisions and ability to influence how Activity interventions will be sustained within their communities.

How did districts facilitate alignment of the activity selection with regional and national priorities?

Across the four districts, DHMTs consistently aligned their selected activities and targets with national health priorities, though with varying approaches.

In Rwanda, activity selection aligned with typical decision space at the district level, with strong central level oversight dictating district priorities. In Gicumbi, many respondents mentioned that the selection of DMRs was largely driven by the National Strategy for Transformation (2024-2029). However, although DMRs (specifically, neonatal mortality and ANC coverage) were mandated to align with national priorities, respondents reported

[4] TSI undertook an internal validation process: two coders undertook the coding process, meeting on several occasions to discuss and agree on key themes and sub-themes. High-level findings were validated internally by Activity team members and were shared with MSH and Ubora for feedback.

that DHMT members made more deliberate decisions about the selection of targets and activities through the PHC-LDP process:

> *"I was there during the selection process, and I felt like a deputy in parliament. We voted for every single indicator and described why we were choosing it. For example, if someone said, 'Let us test hemoglobin,' we had to explain why…Every decision was deliberate, discussed, and backed by evidence to make sure the indicators truly reflected the gaps and priorities at both the district and national levels." Head of Health Center, Gicumbi*

Bugesera district demonstrated the same adherence to national priorities, with respondents choosing to *"identify gaps where we were not meeting (national) goals" (DHMT member, Bugesera).* These findings indicate that the PHC-LDP process still improved decision-making even as mandated priorities stayed constant; given longstanding central government involvement in setting national and district targets, this approach represents potential for long-term DHMT strengthening within existing district constraints.

In Ghana, DMR selection also aligned with national priorities; however, given additional autonomy at the district level, DHMTs were able to further contextualize the PHC-LDP approach to their own longstanding challenges. In Akwapim South, services such as skilled delivery support, community clinics, child welfare clinics, ANC outreach, and use of diagnostic equipment align with national priorities on maternal, newborn, child, and adolescent health.[5] This indicates strong potential for sustaining these practices, especially where services respond directly to persistent access barriers, such as transport and distance. In North Tongu, facility leads clearly linked PHC-LDP practices to national priorities, particularly data use for planning, teenage pregnancy reduction, ANC attendance, and skilled delivery. Respondents emphasized that strategies were selected based on analyzed data rather than external direction, strengthening institutional ownership.

Alignment with national priorities could increase the likelihood that PHC-LDP practices are sustained, as activities that reflect national targets are more likely to be integrated into routine planning and budget processes.

Which PHC-LDP practices are most likely to continue after the end of the Activity?

Across districts, stakeholders highlighted a range of factors that have helped sustain momentum around PHC-LDP practices. Practices most likely to be sustained were those embedded in routine systems, supported by existing resources, or reinforced through strong district ownership.

Respondents reported improved PHC services and stronger teams and leadership as key enablers to the sustainability of the approach.

Visible improvements in service delivery and community level impact have reinforced local buy-in, while consistent outreach and transport support have expanded access to care. For example, in North Tongu, strengthened staff capacities in problem analysis, prioritization, and planning – and the integration of these approaches into routine meetings and annual workplans – have also boosted confidence and ownership. In some settings, training

[5] Relevant strategies for alignment include the WHO Every Newborn Action Plan (https://www.who.int/initiatives/every-newborn-action-plan) or Ending Preventable Maternal Mortality (https://platform.who.int/docs/default-source/mca-documents/qoc/quality-of-care/strategies-toward-ending-preventable-maternal-mortality-(epmm).pdf?sfvrsn=a31dedb6_4)

was supported by protocols, supervision, and accountability mechanisms embedded into routine practice. Overall, the PHC-LDP process was received well within the districts and described as *"our eye-opener – it taught us to use what we have to solve our own problems"* (*District Director of Health, North Tongu*).

Investments in durable equipment were seen as particularly beneficial, with one district team member noting, *"We made efforts to fully utilize the allocated funds, prioritizing the procurement of durable equipment… we were able to acquire the items we needed" (DHMT member, Bugesera).* Broader stakeholder involvement, including leadership engagement, was repeatedly emphasized as critical for sustainability. Respondents in Rwanda noted that the district has taken over some of the responsibility of paying for cashiers at the health centers. In a similar vein, another respondent highlighted the benefit of continued district and hospital support for essential equipment:

"We received oxygen equipment that helps babies when they are born weak or tired… Without that support, we couldn't afford it alone. So these things really make it easier to sustain services beyond the project" (Head of Health Center, Gicumbi).

What are some of the barriers to sustaining interventions beyond the end of the Activity?

Sustainability is most constrained by reliance on catalytic grant funding and persistent health system resource gaps including staffing challenges.

Despite enabling factors, several constraints continue to limit the long-term institutionalization of PHC-LDP practices. In Ghana, sustainability remains challenged by ongoing dependence on external funding to cover essential logistics and equipment maintenance, alongside the limited integration of certain PHC-LDP practices into routine district budgets.

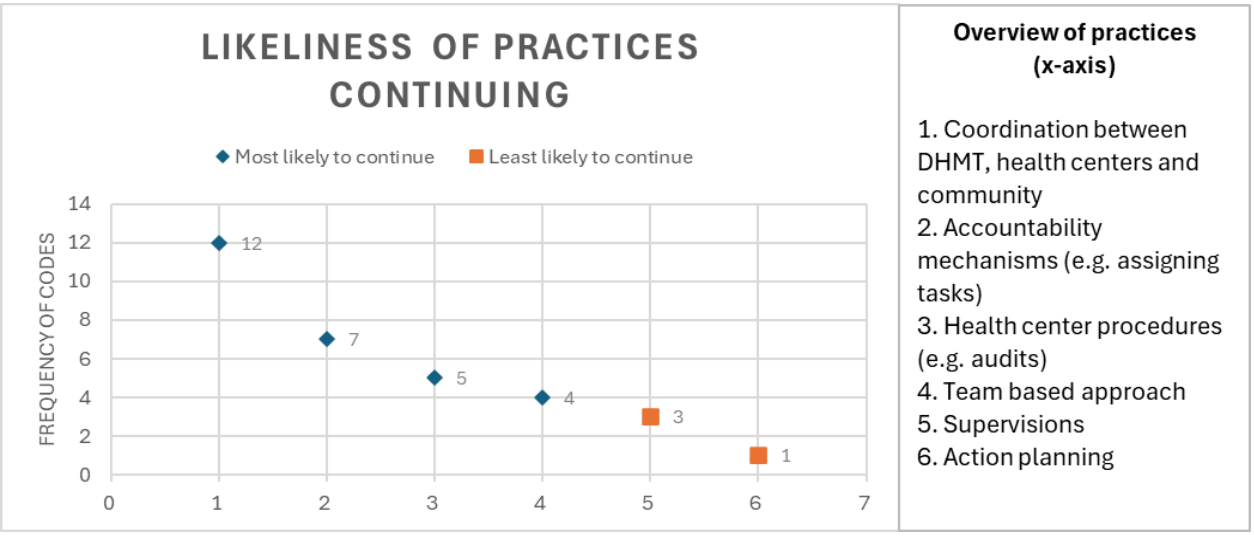

Figure 1: Representation of practices most likely to continue in Rwanda. Coding conducted in Dedoose identified practices related to coordination, accountability, and procedures as most likely to continue, while action planning and supervision were the least likely to be sustained. For practices most likely to continue we coded responses under these two questions: "Do the changes you identified represent a longer-term change or a temporary shift due to the project?" and "Which practices are most likely to continue?" For practices least likely to continue, we coded responses under this question: "Which practices are least likely to continue?" Coders agreed on the major subthemes.

As one district lead noted regarding sustainability proposals, *"We have not implemented (them) yet, but if we organize ourselves well, our people abroad can help" (KII, District Director of Health, North Tongu).*

In Rwanda, staff shortages, turnover, and fluctuating motivation were commonly cited challenges to continuity, alongside difficulties convening regular review meetings due to limited operating funds. Budget constraints were a recurring theme, with particular concern that activities like supervision, refresher training, and participation in DHMT meetings may decline once supplemental funding ends. As one CHW representative explained:

> *"I live near the Burundi border, and attending these (DHMT) meetings regularly without transport reimbursement is very difficult. While the achievements can be maintained, sustaining high performance will require consistent effort and support from district-level officials" (CHW representative, Bugesera).*

Some respondents also worried that leadership engagement could wane after Activity completion, potentially diminishing the momentum currently observed. Together, these barriers create uncertainty around long-term implementation despite clear community-level benefits.

RECOMMENDATIONS

How do districts sustain the improvements made as a result of the PHC-LDP?

Both countries noted the utility of the PHC-LDP approach while also noting challenges to sustaining its impact without the additional buffer of the catalytic grants within the PHC-PM Activity. Strengthening sustainability will require a combination of institutionalization, financing, and stakeholder engagement strategies. In Rwanda, this challenge is exacerbated by limited financial autonomy; DHMTs do not determine budget allocations but instead play an advisory and advocacy role during the budgeting process. A key sustainability challenge moving forward is ensuring that existing resources can be strategically reallocated to continue covering these priority areas, which will require strong and sustained advocacy from DHMTs and health facility leadership.

In Ghana, budgetary constraints were similarly noted as a barrier to sustainability of PHC-LDP practices. The key sustainability proposals discussed in both districts reflected a strong commitment to fostering long-term community ownership and resilience, including several community-generated proposals for continuing practices. Participants emphasized the value of establishing quarterly support mechanisms from the Council of Churches, recognizing faith-based organizations as consistent and trusted partners in local development. In addition, they highlighted the need to create dedicated community health development funds that would allow villages to gradually pool resources for essential health initiatives, reducing dependency on external financing. Another important proposal involved mobilizing diaspora members through existing WhatsApp platforms, tapping into their interest and capacity to contribute financially, technically, and socially to their home communities. Finally, the districts underscored the potential of organizing homecoming events as a way to strengthen emotional ties with the diaspora, showcase local progress, and generate renewed support for community health priorities.

In North Tongu, efforts to continue the PHC-LDP past the end of Activity are already ongoing. North Tongu intends to apply the PHC approach going forward by using the DMR thinking rather than trying to address every challenge in the district. They found prioritization of PHC challenges more beneficial rather than a wholesale approach to solving problems. These strategies were viewed as

practical, community-driven approaches to sustaining health system improvements over time.

Where is further exploration required?

Across Rwanda and Ghana, findings highlight a shared need to understand and strengthen the institutionalization of leadership and performance-management practices within district health systems. Further exploration should explore the following research questions:

- Which PHC leadership and performance-management practices are sustained one year after Activity completion, and what enables or hinders their continuation?
- To what extent are project-introduced activities absorbed into national and district budgets, and what facilitates this process?
- What mechanisms most effectively embed PHC leadership and performance-management practices into routine DHMT and facility operations?
- How can peer-led orientation approaches be structured to effectively build capacity among staff not included in the original program?
- When resources are limited, which leadership and management practices deliver the greatest value at the district level?

CONCLUSION

Overall, The PHC-LDP demonstrated meaningful progress in strengthening primary health care systems across Rwanda and Ghana, with sustainability most evident where activities were embedded in routine systems, supported by district ownership, and linked to visible improvements in service delivery. While practices such as leadership development, data use, and health prioritization show strong potential for continuation, activities reliant on external catalytic funding remain vulnerable. Key challenges — including high staff turnover, leadership discontinuity, and dependence on donor financing — must be addressed through cross-training, designation of PHC focal persons, and deliberate integration of PHC activities into routine district planning and budget cycles. Strong DHMT advocacy, community-driven financing strategies, and early engagement of district leadership will be essential to sustaining momentum beyond the Activity period. Further investigation is needed to identify which practices endure after Activity completion, how they become institutionalized within routine operations, and which offer the greatest impact under resource constraints — findings that will be critical to informing future investments in sustainable primary health care strengthening.

ABOUT THE ACTIVITY

PHC is the foundation of resilient and equitable health systems. Strong local leadership is essential to ensuring accessible, high-quality care that responds to community needs. In Ghana and Rwanda, national and district health authorities are strengthening health system performance through the PHC-PM Activity, an initiative led by government partners and implemented with local institutions, with support from Gates Foundation and technical partners including MSH. At the heart of the model are four interlinked components, each designed to reinforce district leadership, evidence-based decision-making, and sustained PHC system improvement:

1. Leadership development
2. Operational data & integrated dashboards
3. Ongoing monitoring, evaluation, and learning
4. Catalytic grant funding

Through adaptive performance management cycles, district health authorities continuously analyze, monitor, learn, and adapt—maturing over time into effective stewards of district health systems. The PHC-PM Activity is a collaboration between MSH, Ubora Institute (Ghana), Building Systems for Health (Rwanda), Three Stones International (Rwanda), HISP Ghana, Zenysis, and district and national health authorities.

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