THE ESTHER EUROPEAN ALLIANCE'S REGIONAL AFRICAN WORKSHOP

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The institutional health partnerships based approach

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I. General Context and objectives of the workshop

The European ESTHER Alliance (EEA) is an alliance of European countries that share the common goal of improving health in low and middle-income countries, by strengthening the capacities of health professionals through Institutional Health Partnerships (IHPs), including hospital institutions partnerships.

The African Regional Workshop of the European ESTHER Alliance, which was held in Mohammedia (Casablanca, MOROCCO) on October 14, 15 and 16 2014, brought together seventy-two participants from thirty countries (twenty-two African countries and eight European countries)[1]. It has been organized with the EEA support, and particularly financial contributions from ESTHER Germany and ESTHER France.

Since the creation by France of ESTHER (Ensemble pour une Solidarité Thérapeutique Hospitalière en Réseau / Together for a networked hospital Therapeutic Solidarity) in 2002 and, simultaneously of the EEA, the various EEA member states meet regularly. These European meetings have helped progressively define the EEA as it is today. In parallel and beyond these meetings, EEA member states also hold bilateral meetings with their technical partners from North and South.

However, this is the first time a multilateral meeting of this size is held, which includes both EEA members, and technical partner states from a large number of African countries. This encounter illustrates the outcome of a long period of investment, commitment, and mutual wills to build an innovative and specific approach in the field of development cooperation in health: the Institutional Health Partnership. It was therefore a great opportunity **to compare approaches, share results, conduct critical analyzes of partnerships, learn and think together on the African scale about ESTHER's operating mode.**

This workshop is also a starting point, thus it will decisively **influence the future of the EEA.**

The ESTHER initiative was created when the international community launched the Millennium Development Goals (MDGs). Three objectives specifically dedicated to health were part of the roadmap: MDG 4, 5 and 6.

Although initially, the EEA was dedicated especially to MDG 6, it has expanded its mandate to cover all the health MDGs. Today, at one year to the MDGs deadline, ESTHER partnerships go far beyond the MDG health agenda, and are part of actions intended to be sustainable and within a logic of

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[1] Burkina Faso, Burundi, Cameroon, Central African Republic, Côte d'Ivoire, Ethiopia, Ghana, Kenya, Madagascar, Malawi, Mali, Niger, Rwanda, Senegal, Sudan, Tanzania, Tchad, Togo, Uganda, Zanzibar, Zimbabwe, Morocco, France, Germany, Greece, Ireland, Italy, Norway, Switzerland, United Kingdom

devertalization. It is also for this reason that the workshop was mainly devoted to health systems strengthening.

This workshop is valuable for the whole ESTHER community **to prepare for Sustainable Development Goals (SDGs), which, starting from the end of 2015** will constitute the development agenda for the next 15 years.

Institutional Health Partnership has a role to play in contributing to the achievement of the SDGs for health and the targets attached to them. This workshop is a stage in its preparation.

A recent external evaluation[2] of the European ESTHER Alliance indicates that the benefits of partnerships go beyond the inputs of classic technical assistance. These partnerships support health professionals and strengthen services on aspects often overlooked by donors. Plus, this approach is particularly appreciated by Southern governments and partners in charge of implementation. This cooperation between peers also influences institutions and individuals in the way they work, and improves the quality of services. Finally, it is also a way to cushion the negative effects of the crisis in health human resources.

It is important to understand why and how these partnerships work, and to support these explanations with tangible evidence. This will synergize partnerships, better position ESTHER's approach for the international health agenda and qualify for more funding. The Regional Workshop in Mohammedia was the perfect opportunity to start this process of thinking and generating knowledge, by consulting a wide range of partners.

Furthermore, EEA member states have recently adopted **a strategic framework covering the period 2015-2020**. This framework is the result of the teachings transmitted by northern and southern EEA partners following the evaluation conducted in 2013, but it is not definitive. Its operational application is being defined. **Therefore, this workshop is an opportunity to better determine how, together, as south-to-south partners, we can implement it.**

The main purpose of the workshop consisted in capitalizing on our institutional partnerships approach, as an innovative and crucial instrument for development cooperation in the field of health, with as a backdrop the long-term outlooks: transition from MDGs to SDGs; implementation of the EEA 2015-2020 strategy, joint actions; fundraising.

African participants were mainly technical partners involved in ESTHER's partnerships. European participants were representatives of partner institutions, ESTHER's national secretariats, ESTHER's European secretariat and the WHO.

[2] Ema Kelly and Vicky Doyle, Evaluation Report, European ESTHER Alliance Study, Capacity Development International/EEA, May 2013 (Report available on EEA's website: www.esther.eu).

II. Institutional health partnerships and health systems strengthening

One of the main objectives of the EEA is to help strengthen health systems (see EEA Charter). However, the evaluation conducted in 2013 showed that there was no shared understanding about how institutional health partnerships can contribute to strengthen health systems. The different types of bilateral partnerships have many orientations and influences that may, in each case, have an impact at local, regional or national level. But it appears that, to this day, a large number of partnerships have not developed yet a real potential to significantly act on health systems. Therefore, an additional effort is needed to ensure that ESTHER bilateral partnerships increase their impact on health systems.

With this in mind, a large part of the seminar was dedicated to study the links between institutional health partnerships and health systems strengthening.

In order to do so, **the WHO concept of health system** and the main functions it covers, was presented (Ms. Apparicio Katthyana), especially **the six fundamental pillars of health systems** that are: health service delivery, health workforce, health information systems, access to essential medicines, financing, leadership and governance. Also, the quality and safety of health service delivery, which must be at the heart of universal health coverage, were especially focused on. The role of IHP in strengthening health systems is illustrated by the APPS program (African Partnerships for Patient Safety). This program has twelve areas of action, including the reduction of health-care associated infections which is a priority (reinforced by the current epidemic of Ebola virus disease). This hospital institution partnership program includes 22 countries (19 African and 3 European).

On the basis of the WHO overview, several concrete examples to current partnerships were presented. They aimed, from the speakers experience in IHPs to present the achievements and added value of partnerships, to develop a critical analysis of partnerships in connection with Health Systems Strengthening concept, and present teachings, challenges and recommendations on the subject to be treated.

They were part of the main pillars of health systems logic, defined by the WHO, in particular: 1 / health service delivery (Mariam Sylla, Mali, Pankaj Jani, Kenya, Cosesca Programme); 2 / health workforce (Emmanuel Teye Adjase, Ghana; Ide Moussa, Niger); 3 / health information systems (Sefonias Getachew Kalbore, Ethiopia, Eugene Messou, Côte d'Ivoire); 4 / supply chain management in hospital setting (Sam Phiri, Malawi; N'Guessan Kissiedou, Côte d'Ivoire); 5 / Health Policy (Idrissa Ba, Senegal; Marlin Fissha Asfha, Ethiopia).

A. Health service delivery

The IHP experience in Mali supported by ESTHER France shows that hospital twinning produced significant results that enabled an expansion of care supply. The main teachings are the added value of IHP for a better organization of services; skills transfer and local capacity building. Moreover, the IHP approach allowed, based on locally identified needs, to increase local expertise, to maintain lasting

relationships between North and South teams and to promote continuous exchange of experience. The example of the Nouygal study (on the early treatment of pregnant HIV-positive women and their children) shows that IHP can produce results in terms of health service delivery and health status that are similar to those obtained in the North, but they can also be a source of innovation in partner countries playing a pioneering role which leads to national policies (option B validation for PMTCT). The experience of Mali calls to develop SOUTH-SOUTH partnerships, in addition to maintaining IHPs with northern hospitals, which are a lever for health systems strengthening.

The example of COSESCA program (College Of Surgeons, East, Central, Southern Africa), supported by ESTHER Ireland, covers 10 countries (Ethiopia, Kenya, Uganda, Rwanda, Burundi, Tanzania, Zambia, Malawi, Mozambique and Zimbabwe). The program has existed for 11 years and promotes access and excellence in care, education and research in the field of surgery. Cosecsa is a **"university without walls**" that relies on national resources to strengthen the capacity of existing training institutions and health facilities. The shortage of surgeons in the region is critical, with a particularly increased deficit in rural areas. Within this framework, Cosecsa aims to train surgeons outside large cities. The program, led by African surgeons arises as a long-term solution that can provide more durable traineeships than if they were provided by international organizations. The program has trained hundreds of professionals and qualified more than 100 surgeons in the region, who perform more than 26,000 surgical acts per year. The program aims to produce 50,000 surgical acts in the region within the next three years. Furthermore, this partnership aims to expand to new countries, developing multiple approaches (exchange and inter-institutional trainings; distance learning; joint research).

B. The Health Human Resources

The Kintampo project is a pilot experiment implemented in Ghana through a partnership with the United Kingdom (THET) regarding mental health. The project aims to create new positions in professional mental health: clinicians in psychiatry and community mental health workers. The results are significant over the past four years. They mark a very significant increase (123%) of the number of community staff trained across the country (400 community mental health workers trained and deployed nationally), and availing of a continuous training apparatus. The project aims for 2018 to increase by 60% the amount of health professionals and to increase by 500% a year the number of patients treated. The project being carried by the national health authorities, and the alignment of education and training modules of health workers with national referential, are clearly an asset to the success and impact of the project.

The pilot project on task shifting from doctors to nurses and midwives and ongoing training, implemented in Niger with the support of ESTHER France and the French Development Agency, aims to address the crucial problem of health human resources crisis. This partnership has provided support for national authorities to define a public policy on task shifting (which resulted in a national guideline); to adapt the initial training of nurses and midwifes, to develop and organize ongoing trainings within a context of decentralization (training guide to be used by nurses and midwifes, referential documents of qualification and integrated training, ongoing training plan). Such a partnership directly impacts the health system strengthening and provides substantial support to the decentralization of management. It revolutionizes training practices and reinforces multidisciplinary actors.

C. Health Information Systems

The health information systems (HIS) are a key to improve clinical programs and procedures. The term "HIS" means processing data network (clinical, socio-demographic, biological ...), which are converted into usable information and thus can correct and enhance programs or ongoing procedures. In the case of Cepref (*Centre de Prise en Charge de Recherche et de Formation* in Abidjan) HIS represents a significant contribution to scientific arguments in the improvement of procedures and protocols for clinical care. ESTHER France has assisted Cepref teams in the three stages of data processing, which are the raw data input, storage and processing, and finally the output information. ESTHER France has formed teams, funded computer equipment purchase, and helped data collection in the community.

The Cepref HIS by now is an efficient system which guarantees good quality information (in accuracy, frequency, coverage but also their delivery), which allows continuous use. For example, in the context of Temprano ANRS 12136 clinical research, a cohort of 430 patients have been followed for 4 years, compared to 998 patients whom were followed up for 8 years routinely for the VRE ANRS research. The Cepref has more than 200 scientific publications and communications to its credit.

An ESTHER Germany partnership between Addis Ababa University and Halle Saale University allowed a substantial strengthening of the health system, including information systems. This partnership focuses on cancer treatment in Addis Ababa, particularly cervix cancers and cancer caused by HPV. Through internships organized on site, many researches have been conducted, which has documented the incidence and prevalence of different types of cancer. In two years of partnerships, 20% additional women were followed, and researches on risk factors have been conducted. To continue to improve the information systems at the University of Addis Ababa,
it would be necessary to acquire more data.

D. Strategic management of the supply chain in the hospital

The example of Malawi shows the complexity of supply. There are two main supply systems at the Lighthouse Hospital (partnership with ESTHER Germany). The "push system" and the "pull system." The first mainly covers ARVs and HIV testing; it consists in direct supply of sites. On the other hand, the "pull system" is based on a central store that distributes orders to hospitals. In the case of Lighthouse Hospital, this system is used for treatment of opportunistic infections. The supply chain of Lighthouse Hospital underwent numerous challenges: insufficient resources for the purchase of medicines, logistical problems (storage and distribution) and human resources (staff shortages and poorly qualified staff) and lack of tools in terms of quantification and measurement of access.

In the case of Côte d'Ivoire, and the Sassandra Hospital Center (supported by ESTHER France), the drug supply is accomplished through the hospital pharmacy in different steps: 1 / Assessment of hospital needs and order by hospital structure 2 / Acquisition of products 3/ Reception and storage 4/

dispensing products 5 / managing physical, administrative and accounting flows. IHPs play a role in the drug supply circuit, particularly by intervening simultaneously and in a coordinated manner at the level of central purchasing companies (wholesale), country's Public Health pharmacy and hospital pharmacies. Specific IHPs in prison settings played a key role in the drug circuit, from the issuance of ordinance to dispensing the patient, including the order at the pharmacy district (or private pharmacy if order is issued externally).

E. How IHPs influence national health policies?

The example of Senegal shows the direct impact of IHPs on public policies. The intravenous drug users (IDUs) are particularly vulnerable to HIV. 5-10% of new HIV infections worldwide are due to injecting drugs, because of the use of syringes but also because of risk behaviors led by drug use. A study by the Inter-ministerial Committee for the Fight against Drugs (CILD), which confirmed the use of injectable drugs in many parts of Senegal, was the starting point of UDSEN project (Drug Users in Senegal), initiated in 2008. This project is primarily based on IHPs between Senegal, Morocco and France. It is to provide a public health response to the vulnerability of the IDUs group. The strength of this project lies in its inscription in a national and international normative framework. Whereas initially, the legal and social context was quite repressive, the advocacy conducted under the project made the risk reduction programs for IDUs quite acceptable. The Senegalese government is actively involved in the program through its various agencies: CILD, involved in field work and the opening of CEPIAD the care center, the CNLS (*National Committee of Fight against AIDS*) contributes to training programs. At the level of the sub-region, the UDSEN program was built in parallel to the harmonization of intravenous drug use legalization, following the Dakar Initiative (January 2010).

III. Institutional Health Partnerships and preventing health crises: the case of Ebola virus disease

The epidemic of Ebola virus disease outbreak in West Africa is a major concern for the international community because of its unprecedented scale. The violence of this epidemic is due to the weakness of health systems, and we asked about the role that could play ESTHER in the response. Indeed, the European ESTHER Alliance is established in many African hospitals, and ESTHER IHPs approach would be an answer to this problem, ***especially in the preparation of countries*** that are not yet affected by the virus. In these countries, the specific technical preparation for the management of possible cases could be accompanied by capacity building, particularly on the issue of hospital hygiene and caregivers safety.

WHO (represented by Ms. Joyce Hightower) evoked the link between Ebola outbreak management and improved hospital hygiene. The APPS (African Partnership for Patient Safety) program was introduced as an example of intervention that can help countries prevent sanitary crises such as Ebola. It is about IHPs whose purpose is to strengthen capacities for the prevention and control of infections. The APPS

emergency declination program is called RAPPS (Early Intervention Partnerships); it lies on the basis of existing partnerships, to offer remote assistance but also on the ground. It is also possible to create *ad hoc* partnerships for emergencies only. The emphasis is on peer learning and the development of local capacity. Hand hygiene is an essential part of the IHPs.

After this overview of the WHO Representative, more concrete illustrations, country by country, have been proposed. Their goal was to initiate a debate on the role of institutional partnerships in health to prevent health crises of Ebola type but also explore options for future collaborations. The idea was first to see how the outbreak was handled at the hospital level in three countries with different contexts: 1) Zimbabwe (Cleophas Chimbetete), 2) in Burundi (Jean Bosco Nduwarugira) and 3) in Burkina Faso (Paul Ouedraogo). In a second time, thinking has focused on the role of Esther in supporting these partners for the implementation of their national response to the epidemic, with 1) the example of ESTHER France (Christophe Michon) 2) the example of ESTHER France in Cameroon (Olivier Terzolo) and 3) the case of Ireland and reflection on European ESTHER Alliance (David Weakliam).

A. How is Ebola virus disease being managed at the hospital level?

Zimbabwe – Newlands Clinic: Given the geographic location of the country, there is little chance that the health centers in Zimbabwe would have to manage cases of Ebola. However, the health authorities are prepared for this eventuality. The country has enough personal protective kits as well as human resources. Its monitoring system is reliable, and isolation rooms are ready. The literacy rate allows effective communication campaigns within communities. For now, meetings on the subject were organized, ongoing monitoring is underway, press releases have been published and quick response teams already trained. From a more technical point of view, arrivals in the country are monitored, and travelers from the affected regions are followed up for 21 days. Nevertheless, many challenges remain: lack of resources, difficulties in setting up procedures for infection control in hospitals and weaknesses of analysis laboratories.

Burundi - Prince Regent Charles Hospital: The Organization of the Management of Epidemics and Disasters has a role of oversight, alert and mobilization. It published a specific plan for the management of Ebola virus disease, to coordinate response actions (communication and social mobilization, monitoring and early warning, capacity building of laboratories, care and control of infection, advocacy and resource mobilization). Actions have already been taken at a national level, such as taking temperatures at airports, border surveillance, and missions to raise awareness among health professionals. At the hospital level, the measures vary depending on the structures, but some elements remain the same: a reminder of hospital hygiene, identification of isolation ward, advocacy at the health department to obtain protection outfits etc.

The problems are generally the shortage of equipment, lack of motivation of human resources and lack of resources. The recommendation that could be applied to hospitals in Burundi would be to build capacity at the hospital level, and therefore the autonomy of health centers for integrated management of epidemics. IHPs with Burundi would allow a strengthening of health systems in general, motivational enhancement of staff and technical capacity.

Burkina Faso - Hospital St Camille Nanoro: Unlike the previous two examples where the possibility of a case in the territory remains low, Burkina Faso is considered a country at risk by WHO, mainly because of migration in the region. For now, there have been six suspected cases in Burkina Faso, and no confirmed case. The response is organized by the National Committee of Epidemics Management, lined by regional committees. It is based on partnerships with WHO and with laboratories for tests confirmation. For now, the Management cascade trainings were conducted (general information on the disease, definition of suspected cases, mapping sites of isolation, communication ...). Immediate action was taken within the St Camille hospital. First, training of hospital staff as well as staff from 20 health centers in the district were conducted (generality, case definition, alert, reminder of the infection prevention routine, demonstration for specific measures - wearing combination and mask). Respect for routine Infection prevention measures was verified in all services. Isolation wards have been identified. Finally, the specific equipment has been ordered thanks to an ESTHER partner, the Italian NGO Medicus Mundi (personal protective equipment as well as laser thermometers). Various problems have been encountered by St Camille teams: lack of technical assistance by experienced personnel in the management of an Ebola epidemic, the denial of the problem by some practitioners, the latent risk of desertion from the hospital by both patients and caregivers, and finally the lack of resources to provide hospital gowns, gloves and disinfectant.

These three examples show us that whatever the differences due to various national contexts are, problems often remain the same. The implementation of IHPs in response to the epidemic could help overcome some challenges, including those related to the lack of technical expertise. In addition, IHPs are a long term solution to improve the overall level of hospital hygiene in health facilities

B. The role of ESTHER France in the response to the outbreak

ESTHER France is very active in West Africa, including Liberia. We can therefore distinguish three fields of intervention in helping the national responses to the epidemic of Ebola. First, ESTHER France can contribute to the response to Ebola in Liberia, severely affected by the epidemic, by sending personal protective equipment, and possibly diagnostic platforms if requested by the authorities, and by mobilizing expertise of its partners to provide technical support. The second is technical support from border countries in the sub-region in preparation for response to a potential outbreak, by holding a workshop, training (in Senegal, Cameroon, Côte d'Ivoire and in Mali), and work with the network of ESTHER partners community. Finally, it seems essential to strengthen the capacity of health human resources in hospital hygiene and safety of care, especially through current and future APPS partnerships. Through these three axes, ESTHER France's position is clear: while the partnership

model can only provide a superficial response in an emergency, it can build a truly effective response plan in the long term.

ESTHER France action in Cameroon is an implementation of ESTHER's response second axis. In fact, there have not been cases in Cameroon yet, despite internal risk (populations of bats carring the virus, same hunting practices shared with the affected countries) and external (geographic location). The ESTHER France intervention follows a request from the Government of Cameroon and is flanked by the Ministry of Health's "Response Plan". The specific objectives of this action are the early detection of possible cases, minimization of contact cases, and a general increase in the level of hospital hygiene in targeted sites. The procedure is done under existing partnerships. It involves developing protocols for management of proven cases, training human resources, and rehabilitation of isolation rooms identified by the government to buy / provide equipment, and finally perform simulations on site. This intervention is limited: it focuses on five sites. The hospital hygiene level is low at the moment. It will take time to integrate protocols in place.

The example of Ireland and the role of the Alliance: Ireland follows international recommendations regarding preparation for Ebola. Broader preparation plans for possible outbreaks of hemorrhagic fever disease were already in place. Various actions have been launched: the documentation has been distributed to the persons concerned at various levels (staff of ports and airports, paramedical and medical staff, laboratory staff, and finally funeral services), adapted individual protection kits have been distributed, technical teams trained, and an information campaign is underway in the media. The situation of North partners is not particularly advantageous because they lack knowledge about the virus and how to approach it in the field. North-South IHPs would therefore represent an opportunity to exchange and share experiences to determine what are the best practices in the case of Ebola virus.

The role of ESTHER Alliance joins the ESTHER France intervention perspectives. The Alliance could help hospitals prepare, assist with fundraising, and support national actors in their preparation.

Discussion points

The hospital hygiene issue: the caregivers' safety concept is central to the response to Ebola epidemic. In affected countries, medical and paramedical staffs represent a significant proportion of new cases due to lack of adequate protection measures. WHO has published a specific guide to this subject in October. Similarly, the problem of nosocomial infections is related to the spread of the virus: they are one of the leading causes of death in hospital environment. Promote good practice in this area plays a large part in stopping the race of the virus.

Border closure: it is a double-edged solution that prohibits access to foreign aid. Generally, transport should not be suspended because it would require the mobilization of more resources than those needed in the operational response. The border evaluation should be mandatory accompanied by technical means of evacuation and hospitalization. This would require, in addition to the action plan already established in the country, a preparation plan that varies according to the capacities of each country. These decisions are subjected to the measures taken by each state and its readiness in case of crisis.

Sites of isolation: the Burkinabe experience teaches us that the isolation sites are a serious risk of

spreading. Centralizing patients in hospitals or regional treatment centers is a better way to contain the risk of contamination, given their degree of readiness and technical means at their disposal.

The psychological aspect of the epidemic: it is clear from the discussions that the panic generated by Ebola is a key element to consider in the response to the epidemic. First, we must support the medical staff, like it has been done at the beginning of the HIV / AIDS epidemic. Then we'll have to take into account the community and soothe people to avoid panic.

C. Exploring the role of ESTHER Alliance in response to the epidemic

Working groups formed during the workshop discussed the role that the Alliance should take in response to the epidemic. Various tracks have been suggested, in line with the different presentations. All the Alliance partners suggested the creation of tools (protocols, data sheets) that could help the decision of caregivers, and the creation of a common database containing information about the virus and allowing the sharing of experience.

From a more technical point of view, it is recommended to assist partner agencies in their response to the epidemic, and that by classifying countries into three categories: countries affected by the epidemic which are in an urgent need for human resources; risk countries that need help to prepare especially through training and material assistance, and finally non-affected countries, where the general level of hospital hygiene should be raised.

Different ideas have emerged to assist at-risk countries in their preparation: the creation of a pool of trainers for cascade trainings, communication and community information (e.g. through national media such as radio broadcast). From the discussions, it emerged that ESTHER should propose projects that go along with national plans, which were discussed in the previous three examples, as it is the case of ESTHER France project in Cameroon.

IV. The quality of partnerships and aid effectiveness

The main EEA mode of intervention is the institutional health partnership between hospitals, universities, colleges, national laboratories, research institutions, NGOs in Europe and their counterparts in the partner countries. Thus, the Alliance supports North / South and South / South partnerships to build institutional and individual capacities, reduce inequalities in health and improve the quality of care in countries with limited resources. To attain these objectives, the quality of partnerships is a key factor.

It is in this spirit that the members of the EEA adopted in 2012, a Charter on the quality of partnerships. This Charter is a document for all stakeholders likely to be involved in institutional health partnerships and who are concerned about implementing quality interventions. These partnerships goal is to contribute to health systems strengthening, to define and deploy public health policies but also sustainable development of human resources in health.

Furthermore, following the adoption of the Charter in 2012, the EEA has developed a self-assessment tool to measure the quality of institutional health partnerships managed by the EEA. This tool is based on the principles established in the Charter. It aims to assist the EEA's national secretariats and its partners to bring the best partnerships upon the principles of quality. In other words, their annual self-evaluation should enable partnership impact optimization.

The workshop, which brought together a large number of experienced technical partners in institutional partnerships, helped leading the collective works as a working team.

The mandate of the group was to include 1 / Revisiting the Charter for Quality Partnerships in the European ESTHER Alliance and 2 / review and further define the methodology to use for the self-assessment tool and measuring partnerships quality.

Partnerships quality Charter: Working groups have proposed amendments (see document in annex). A general discussion yielded a consensus on a revised version in English. This version will be presented to the Board of EEA Directors for a final adoption before its French translation and dissemination throughout the network of the EEA.

Partnerships Quality Measurement: Working groups have finalized the self-assessment form of partnerships and have defined the methodology for the collection of information. Group results were presented and discussed in plenary. They proposed, in particular, adding a "comment" column to the form, which offers the opportunity to explain the degree of judgment and analyze qualitatively the evaluations mentioned. As for data collection method, the groups specified the options and opted predominantly for a multi-step: forms shall be completed separately by the north and south team. A joint work session is dedicated to compare the mutual results and produce a final version (which can take into account disagreements, should these persist), this version will be transmitted to the EEA national secretariats. National secretariats will exchange with partners involved and report collected results to the European Secretariat of the Alliance for consolidation and general report. The form and the final methodology will be aired during the year 2015.

V. Specificity, added value and partnerships impacts

A. The example of mother and child health

A year remains to the end of the Millennium Development Goals, the balance sheets of MDG 4 (child health) and 5 (maternal health) is not so glorious. Although significant progress has been achieved over the period 1990-2012, the latest figures available indicate that we are still far from the targets set by the international community in this regard.

Indeed, while the infant mortality rate was divided by 2 in the world from 1990 to 2012 (12.6 million children under 5 years in 1990 to 6.6 million in 2012), large regional disparities persist (no reduction in children under 5 mortality in sub-Saharan Africa and Oceania over the entire period). In addition, the proportion of neonatal mortality in the world (0-27 days), increased from 37% in 1990 to 44% in 2012, in less than 5 years.

Moreover, even if the rate of maternal mortality dropped by 45% between 1990 and 2013, 300,000 women die each year worldwide during pregnancy and childbirth. And nearly 8 million women a year suffer serious complications. 99% of these cases occur in developing countries where 40 million births unassisted by qualified personnel took place in 2012.

From their experience and expertise in the field of maternal and child health, the speakers presented and discussed the key role of institutional health partnerships in this field in order to reflect on how to maximize sustainably the contribution of institutional health partnerships to the mother and child health. This discussion was connected to the Millennium Development Goals (MDGs) transition into the Sustainable Development Objectives (SDO).

Several examples were presented at a roundtable by: Mariam Sylla (Mali), Haby Signate Sy (Senegal); Samuel Kabota (Malawi) and Murwan Omer (Sudan).

The main observations and speakers experiences:

- Persistent resources deficit in the health sector (noncompliance with Abuja undertakings to allocate 15% of the national budget to the health sector);
- A significant lack of qualified human resources (HHR);
- Strong geographic disparity in HHR (between rural and urban areas in particular);
- The problem of care supply which hampers access to early care (free care is not achieved everywhere, nor any acts);
- The absence of early screening among pregnant women;
- Insufficient integration of mother to child transmission prevention (PMTCT) in maternal, newborn and child health
- A lack of knowledge and data on care provided at a community level;
- Lack of decentralization of regional training institutes;
- Still very shy task shifting to General practitioners, midwives and nurses.

In general, speakers notice the added-value brought by institutional health partnerships, as they help strengthen the capacity of health human resources available and to improve the quality of care. In addition, the IHPs are important assets to support national authorities in the definition and implementation of public policies, in particular through their proximity to professionals, patients and the practical realities of care supply. IHPs provide a favorable framework for operational research development and pilot programs, and their results feed the national authorities reflection. They are large scale tools that particularly support national programs of care supply decentralization, and thus play a role in areas where human health resources are very limited.

Hospital partnerships play a very specific role compared to other approaches or instruments of health cooperation. Generally, the classic development partners focus their interventions especially on

national strategic development plans and resource mobilization. But hospital partnerships like Esther have an immediate impact on care supply and population's health, while being positive to national policies that benefit from these experiences.

North/South IHPs model has in fact evolved and is increasingly echoed by public authorities for implementation of joint programs between South-South partners, focused on partnerships between hospitals and regional districts.

In general, participants recommend using IHPs to assist countries increase the number of specialists in maternal, newborn and child health areas, and insist on the importance, to achieve MDGs 4 and 5, of developing new policies, taking into account HRH crisis and the initial and ongoing health professionals training.

B. The hospital management

Hospital management and care organization both remain insufficiently covered areas in the IHPs approach. The "medical" part, which aims to strengthen the capacity of caregivers is often highlighted. IHPs also include the broader dimension of hospital management, which is crucial for the viability, sustainability and quality of care in a health facility, but also for its outreach and influence in the country to help reflection makers in terms of public health.

Likewise, from their experience and expertise in the field of Hospital Management, speakers presented and discussed the key role of IHPs in this area.

Several examples were presented by Salama Khamis (Zanzibar); Thomson Kinge Njie (Cameroon); Berihu Kiros (Ethiopia); Isaac Langat (Kenya); Adam Walter Lyatuu (Tanzania); Jean Bosco Nduwarugira (Burundi); John Rubaihayo (Uganda).

Several findings were identified by speakers:

- One of the great challenges of the partners lies in financial management, from the funds reception by the hospital to patient treatment. For example, in Zanzibar, there is neither central management system nor control of the funds.
    - IHPs can help establish such a system in hospitals.

- Another challenge is the access to funds. For example, in Kenya, the new constitution established the Commodities Supply Agency. In this device, health care facilities have no access to funds. As a result, access to care is paralyzed, hospital staff demoralized, wages unpaid, which ultimately penalizes the patients. Kenya also suffers from the terrible lack of health infrastructure.
    - IHPs with the United States have been established and yet allow technical supply.

- The issues of HR management and working conditions are also a major challenge. The lack of HR supervision as well as the poor working conditions led to dramatic effects in terms of motivation, discipline and quality.
    - The example of IHPs developed by ESTHER in Cameroon in ten health facilities (rehabilitation, strengthening technical capacity, health care organization) shows the impact on staff involvement, now more motivated to work. In the Cameroonian context, projects that benefit from ESTHER IHPs draw the authorities' attention. A certain degree of commitment and consistency is maintained by professionals thanks to this.
    - IHPs allow more collaborative approaches. Partners in the North play both the roles of mentors, donors and technical assistants.
    - Advocacy with policy makers is crucial for improving the national long-term commitments.

- Lack of staff and specialties are also a major problem for hospital administrators.
    - In the case of Tanzania, the South / South IHP allowed an ad hoc collaboration that addresses the needs in a qualitative way. Medical staff is oriented multidisciplinary to tackle human lack. Teamwork has paid off and allowed more optimal needs assessment.

- The geographic location of health facilities is also a factor of inequality. Landlocked and poor regions do not have access to care, and health centers have neither adequate funds nor technical, not to mention the considerable lack of infrastructures. Despite the very low cost of care, the population does not have access to it, and NGOs are not sufficient to meet the financial needs.
    - In the case of Uganda, ESTHER IHP, in addition to financial resources supply, have allowed building technical capacity, exchange of expertise and programs (HIV, MCH, Malaria) as well as the construction of new infrastructures. Based on this, the country turned towards South-South partnerships to expand collaborations with neighboring regions.

- Local solutions exist. For example, Burundi opted for participative management to solve problems related to the failure of public service (Absence of quality standards, leadership, lack of infrastructure, equipment ...).
    - Financial support by the IHP takes time to motivate health workers. It is therefore necessary to highlight the capacities and skills of human resources to bring them the psychological support necessary to overcome long-term health crises.

In general, all interventions demonstrate that the health sector is underfunded, but the human factor is essential for a proper managerial approach. The role of government is to support people and manage their own institutions, ideally without any aid from IHPs. But that goal remains inaccessible. The discussions raise the question of IHPs sustainability and conclude on the need to conduct a plea to policy makers in partner countries in order to make them accountable for their role.

VI. EEA governance and role in networking and collaboration between technical partners

The EEA adopted a new strategy 2015-2020 in April 2014. Working groups who are in charge of defining the operational implementation of the strategy have been established. The new strategy also affected the EEA governance which features an Interim Administration Board in charge of leading the preparatory phase to launch the strategy planned for the 1st of January 2015. Each Member State of the EEA designated a representative (and his substitute) and members elected a chairman and interim vice president. The terms of reference of the various members of the Administration Board were finalized and adopted unanimously. January 1st, 2015, the EEA Administration Board will become permanent and the President and Vice President shall be elected for a term of 2 years. Although the definition of the EEA strategy was driven by its members, it should be noted that the outline of the strategy is based on the results of the independent evaluation conducted on the EEA in 2013. Also, many North and South partners involved in the approach of IHPs had participated in its development. On the contrary, the governance review has, to date, not been made with South partners. The EEA African regional workshop in Mohammedia was a unique opportunity to involve southern partners in the EEA reflection on the evolution of its governance, and in particular their representation within this governance, but also on reinforcing the network of technical partners.

How to best represent northern and southern partners in decision-making bodies (Board) and during EEA ESTHER meetings?

Partners unanimously suggest electing representatives, whose number varies according to the working groups (some groups have suggested two representatives, one English and one French speaker, while other groups suggest more representatives, depending on African geographical areas and language). These representatives should be given a term of two years.

In order to do so, the EEA Board should develop and distribute the terms of reference. Potential candidates could then be presented to the EEA Board by teleconference. Then an electronic vote would occur. The groups also proposed to create a discussion platform among partners, so they can decide all issues to report to the Board.

How the European Alliance can help its partners to collaborate / create a network of partners?

The partners recognize the importance of south-south network and therefore want the Alliance to focus an amount of its efforts to establish this network. The first action would be to create a common space on the internet to share information and contacts. Meetings such as Casablanca's Workshop should be organized more regularly (at least once per year). Regular videoconferences can also facilitate the

exchange between partners. ESTHER secretariats could also coordinate calls for proposals between different institutions.

VII. Annex

ANNEX

Contains 4 documents:

1) The workshop's program
2) The 'Quality of Partnership' Charter
3) The workshop's evaluation (made by participants)
4) The list of participants

DOCUMENT 1: Workshop's program (October 14,15,16)

Regional Workshop – October 14-16, 2014 - CASABLANCA, MOROCCO

The Partnerships Based Approach for Health in Africa

TUESDAY OCTOBER 14

8.30: Registration and Welcome coffee

9h30 / 10h30 Opening ceremony

M. Abderrahmane Maâroufi, Director of the Epidemiology and Fight against Diseases Directorate, the Ministry of Health, Morocco

M. Yves Souteyrand, WHO Representative in Morocco

Ms Boutaina Selma El Omari, Global Fund Management Unit in Morocco

Farid Lamara, General Secretary of the European ESTHER Alliance

10.30 / 10.40: Warm-up (brief presentation of the participants)

10.40/11.00 coffee break

<u>Session 1: 11.00/12.30 – The European ESTHER Alliance</u>

Chairs : Dominique Israël-Biet and Marianne Monclair

- EEA, overview, Farid Lamara
- EEA Evaluation (2013), Yvonne Schoenemann
- EEA strategic framework 2015/2020, David Weakliam

<u>12.30/13.00 Presentation of the workshop</u>

Concept, objectives, expected results, agenda, organization and logistics, Farid Lamara

<u>13.00/14.00 LUNCH</u>

<u>14.00 – 17.30 - Session 2: The role of the Institutional Health Partnerships (IHPs) for Health System Strengthening (HSS)</u>

Chairs: Joseph Mad-Toïngué and Matina Kouvoussis

Presentation and concept of the WHO Health System Building blocks, Katthyana Apparicio, WHO

<u>1/ Health service delivery (2 presentations) – 45 minutes</u>

The example of Mali, Mariam Sylla

The example of the Cosesca programme, Pankaj Jani

<u>2/ Health workforce (2 presentations) – 45 minutes</u>

Health Human resources. The Role of the IHPs

The example of Ghana, Emmanuel Teye Adjase

Health Human resources and Task Shifting. The role of the IHPs.

The example of Niger, Ide Moussa

Coffee break (15.40 – 16.00)

Chairs: Marcel Mbeko Simaleko and Lyson Tenthani

3/ Health information systems (2 presentations) – 45 minutes

Sefonias Getachew Kalbore, Ethiopia

Eugène Messou, Côte d'Ivoire

4/ Access to essential medicines (2 presentations) – 45 minutes

Supply Chain management in hospital setting, the role of IHPs

An illustration from Malawi, Sam Phiri

An illustration from Côte d'Ivoire, N'guessan Kissiedou

18.00 – WELCOME COCKTAIL

WEDNESDAY OCTOBER 15

9.00 – 13.00 - Session 3: The role of the Institutional Health Partnerships for Health System Strengthening

Chairs: Gilles Raguin and Omeima Salih

5. How IHPs can impact health policies? – 45 minutes

The example of IDUs in Sénégal, Idrissa Ba

The example of HIV/AIDS and infectious diseases in Ethiopia, Marlin Fissha ASFHA

6. IHPs and heath crisis prevention: the example of the EBOLA Virus Disease (EVD)

The Ebola outbreak, Joyce Hightower, WHO

How EVD is managed at hospital level? The examples of:

- Zimbabwe, Cleophas Chimbetete
- Burundi, Jean Bosco Nduwarugira
- Burkina Faso, Paul Ouedraogo

How ESTHER France can provide support to the national Ebola Outbreak response plans? Christophe Michon

The example of ESTHER France in Cameroun, Olivier Terzolo

The example of Ireland, David Weakliam

13.00/14.00 LUNCH

14.00 – 17.30 - Session 4: The quality of partnership and aid effectiveness

Chair: Hervé d'Oriano

- **Objective 1: revisit the EEA Charter for Quality of Partnerships (14.10 / 15.40)**

Working group 1: Chair: Hervé d'Oriano

Working group 2: Chair: Hamidou Ababa Touré

Coffee break (15.40/16.00)

- **Objective 2: how to measure the Partnership quality? (16.00/17.30)**

Working group 1: Chair: Yvonne Schoenemann

Working group 2: Chair: Adrian Sawadogo

THUESDAY OCTOBER 16

9.00 – 10.00 – Quality of Partnership – outcomes of the working groups

10.00 – 13.00 - Session 5 – Specificity, added value and partnerships ‘impact

1/ ROUND TABLE: Mother and Child health

Chairs: Abdessamad Benalla and Tony Ryan

Mariam Sylla (Mali); Haby Sygnate Sy (Sénégal); Samuel Kabota (Malawi); Murwan Omer (Sudan); Koffi Akpadza (Togo)

11.10/11.30 – Coffee Break

2/ ROUND TABLE: Hospital Management

Chairs: Gerd Eppel and Madeleine Mbangue

Salama Khamis (Zanzibar); Thomson Kinge Njie (Cameroun); Berihu Kiros (Ethiopia); Isaac Langat (Kenya); Adam Walter Lyatuu (Tanzania); Jean Bosco Nduwarugira (Burundi); John Rubaihayo (Uganda).

3/ Operational research: Zara Diallo, Niger

Moderator: Christophe Michon

13.00/14.00 LUNCH

14.00 – 16.00 - Session 6: Networking and perspectives for joint collaboration

- ***Constitution of groups of exchange according to the participant's profiles and interest***
- ***Group meetings from 14.00 to 15.30***
- ***Group restitution from 15.30 to 16.30***

16.00 -17.30 – Workshop closure

- **16.30-17.00: general feedbacks from the participants about the workshop**
- **17.00-17.30: general conclusions**
  - **David Weakliam and Farid Lamara**

18.00: CLOSING COCKTAIL

DOCUMENT 2: Charter on quality of partnership, approved during the meeting by all participants

CHARTER

QUALITY OF PARTNERSHIP

ESTHER is a Development Cooperation Initiative. The European ESTHER Alliance main mode of action is the twinning between hospitals, Universities, Colleges, National laboratories, NGOs, Research Institutions and their counterparts in partner countries. It supports North-South and South-South partnerships to strengthen individual and institutional capacities, reduce north/south inequalities in health and improve quality health care in partners-countries. Quality of partnership is key to reach these goals. The ESTHER Charter for Quality of Partnership is a guiding document for any stakeholders willing to support twinning arrangement and implement quality interventions through ESTHER alliance twinnings.

Successful hospital and Institutional twinnings contribute to health system strengthening and sustainable development of human resources for health. Twinning, as a Development Cooperation instrument, is a mechanism that provides a real added value to accompany a public health policy deployment in low income countries. ESTHER experience indicates that respect of key principles and rules strongly optimize the quality of partnership.

Current and future partners agree to follow these Charter principles to ensure the quality of partnerships and increase impact of interventions in country partners

1. Adherence to national policies and strategies

- Partnership follows a country partners' demand driven process.

- ESTHER strategy in country partners is validated by national health authorities before starting operations

- In general, ESTHER should be included in the bilateral Cooperation arrangements between European country members and country partners.

2. Formal agreements between twinned institutions

- Institutional commitment is key for success.

- General Director of the partner institutions ratifies an agreement to formalize the cooperation between their institutions. This agreement commits the signatory parties to facilitate the realization of the project.

- The partnership is equally rooted among the management and implementation teams in each partner institution and not only based on individuals.

- Partner institutions concretely contribute and support the initiative, notably by providing essential human resources to fulfil the projects.

3. Reciprocity

- Partner institutions must be equally involved in the whole project planning development, implementation and review process.

- Partner institutions equally contribute to the identification, documentation and priority definition of the needs. On these bases, project design and writing is jointly realized.

- North and South partners realize their objectives on the basis of capacity building and expertise exchange.

4. Joint and equal responsibility

- Partner institutions are equally responsible for project follow up and implementation.

- Partner institutions are equally responsible to carry out a joint and objective approach for any project evaluation

- North and South partner institutions, together with other involved stakeholders, are accountable for the partnerships outcomes.

5. Capability

- Partner institutions have capacity to send and receive individuals, either to provide training session or host internships.

- Partner institutions commit for sustainable exchanges and have the capacity to follow a jointly decided program of work.

- Partner institutions commit to sustainable interventions.

- Partner institutions have the capacity to communicate on regular basis and promote communication means, ideally face to face meetings, as an inherent part of the partnership.

6. Equity and respect

- Partnership is built and based on trust and confidence between partners.

- There is no hierarchical relation between North and South institutions.

- North and South Individuals fully respect their counterpart and work with them on an equal basis. Exchanges based on ethical attitude and behaviour are key to the quality and sustainability of the partnership.

7. Transparency

- All partnership related activities and outcomes must be made public and / or accessible to any interested stakeholder or donor.

- Annual narrative and financial reports are produced

- Regular evaluation is carried out to assess the impact of the partnership and monitor the respect of these Charter principles by the involved stakeholders.

8. Ethics

- Ethical principles and rules are scrupulously respected by all stakeholders involved in the partnership
- Partner institutions and individuals commit to declare any conflict of interest

DOCUMENT 3: Workshop's evaluation made by participants

By the end of the last session, participants were asked to give their opinion on the workshop, according to four different categories (each represented by a symbol):

Dustbin

= things to delete

On the workshop structure	time management, too many presentations, round tables
On various aspects	inactive countries, academic ideas, work on already approved charter
On logistics	long journeys, welcoming at the airport

Backpack

= things to keep

On the workshop structure	Good presentations, instant translation, round tables, group dynamic
On partnerships	Experience sharing, ESTHER partnership model, greater understanding
On South-South networking	Common goals, need for an ESTHER African network
Recommandations	More evidence based proof, charter application
On Logistics	Nice venue, workshop organization

Plane

= for future events

On the workshop structure	more group word / discussion, sending out more document beforehand, posters
On partnerships	more event to promote parnerships, operational research partnerships, review of existing partnerships
On south-south networking	keep making contacts
On the Alliance	involve southern partners in the decision making process, common project on Ebola outbreak
On current events (Ebola)	reactivity to current events

Washing machine

= things to change

On the workshop structure	group sessions, need for solid data, time management, more discussions, evaluation process
On translation	different meanings in French and English documents, some supportive documents only in English
On logistics	journeys, allowances, welcoming at the airport

DOCUMENT 4: Liste des participants à l'atelier

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