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HEALTH MANAGEMENT CAPACITY ASSESSMENT TOOL FOR POST-CONFLICT STATES

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Decentralized Management in Post-Conflict Transition Framework and Assessment Tool

At the request of USAID's Office for Foreign Disaster Assistance (USAID/OFDA), USAID/BASICS developed a Decentralized Management in Post-conflict Transitions Assessment Tool to assess the capacity of a provincial health system and team and explore the factors that influence their ability to transition from relief to development. The tools will assist provincial health teams to identify their own strengths and weaknesses to support planning decisions at the central and provincial levels and reinforce the transition process in by identifying specific capacity building needs. The framework and tools are based on current concepts in the capacity development field and draw upon the findings from the post-conflict transition assessments in Liberia and Southern Sudan to ensure its practical application.

Three primary approaches frame the Decentralized Management in Post-Conflict Transition Framework and Tool. First of all, the Framework is based on a systems approach. A recent study by ECDPM¹ (European Center for Development Policy Management) describes capacity and capacity development within a complex adaptive systems perspective. This perspective suggests that, "...systems that are made up of a diverse set of actors whose multiple interactions produce behaviors in the whole system not found in any of the actors. They generate adaptation by changing both intentionally and indirectly, in the face of new circumstances in order to sustain themselves."²

Secondly, the methodology relies on an endogenous process. It is considered vital for the different actors to be involved in the assessment to reach consensus on the starting point and existing ability, and to discuss what impedes or may facilitate capacity development. This will enhance the sustainability of subsequent capacity building efforts.

Finally, capacity is understood in the context of enabling or constraining influences. Brinkerhoff defines these influences as a series of interconnected elements which create or challenge capacity improvement. These elements are resources; skills and knowledge; organization; politics and power; and incentives.

a. Objectives of the Decentralized Management in Post-conflict Transitions Assessment Tool

The purpose of this tool is to assist Ministries of Health (MOH) and donors to determine gaps and make recommendations to support the decentralization of health program management to the provincial level. This will be accomplished through the following objectives:

1. Determine stage of transition of the decentralized provincial health system along six health system components.
2. Identify the enabling and constraining factors that influence the provincial health teams ability to manage (plan, implement, and evaluate) a decentralized health system.

¹ ECDPM published the OECD/DAC Study on Capacity, Change and Performance. This was financed by the Australian Government's Overseas Aid Program (AusAID), the Canadian International Development Agency (CIDA), the UK Department for International Development (DfID), the Dutch Ministry of Foreign Affairs (DGIS), the Japanese International Cooperation Agency (JICA) and the Swedish International Development Agency (Sida).
² P.3, Morgan, H. and P., Capacity, *Change and Performance-Study Report. Discussion Paper No 59B*. European Centre for Development Policy Management, Maastricht (April)

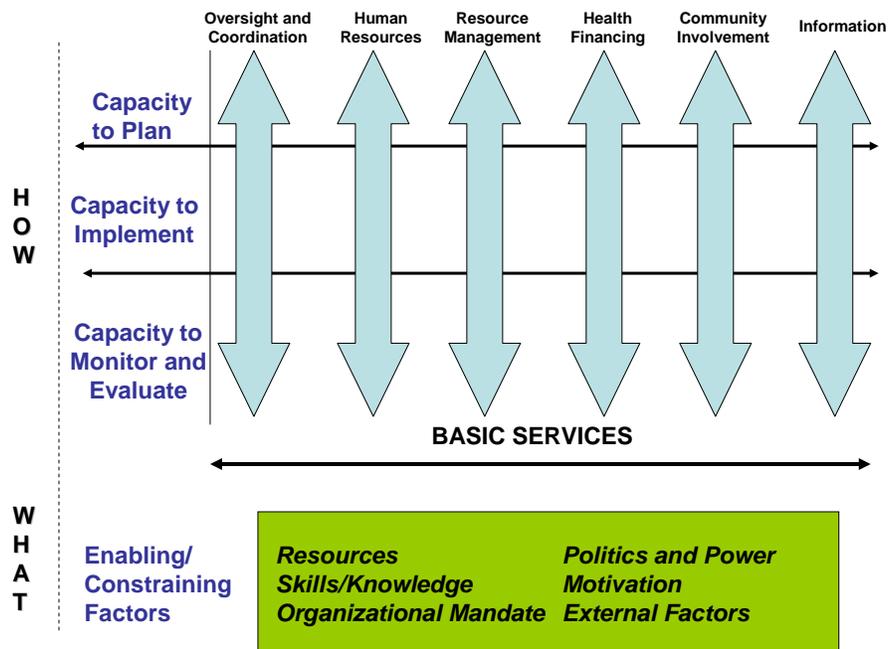
3. Determine the gaps that need to be addressed to increase the ability of the health teams to manage the provincial health system and malaria activities.
4. Propose recommendations to strengthen the ability of the health teams to manage the decentralized provincial health system and malaria activities.

b. Framework Model

The assessment’s methodological framework will help to identify the ability of Provincial Health Teams to manage local health systems and allow Health Teams, Ministries of Health, donors and implementing partners clarify priorities, make planning decisions and target programmatic efforts to reinforce the transition process in a fragile state context. The Decentralized Management Framework is built upon six health system components that have emerged from health systems literature and USAID/BASICS Post-Conflict Transition Assessments in Southern Sudan and Liberia:

1. Oversight and coordination of the health sector
2. Human resource management
3. Resource management (medical and non-medical)
4. Health financing
5. Community involvement
6. Information

Figure 1
Decentralized Management in Post-Conflict Transition
Framework and Assessment Tool



The framework and tool evaluate the ability of the provincial health management teams to carry out the functions of: 1) planning, 2) implementation, and 3) monitoring of the six health system components above. The terminology of two of Brinkerhoff’s elements has been slightly adapted, though the

definitions remain the same. Resources, skills and knowledge, organizational mandate, politics and power, and motivation are the factors that influence the capacity of the Health Teams. These factors are used to understand the Health Teams' success in performing the three functions cited above.

c. Methodology

The assessment methodology is based on an endogenous process that considers internal perspectives (i.e. of the Health Team members) of capacity-related factors. The tool consists of four different instruments designed to enable the gathering and verification of information about the six components. The tools provided represent general guidelines; however ***each instrument must be adapted to the study country context.***

1. **Relief to Development Transition Stage Questionnaire:** Relevant provincial stakeholders (NGOs, Health Teams, and central MOH) describe the current transition stage across the different components.
2. **Semi-Structured Interview:** Health Teams and Central Ministry of Health answer questions about the relationship between various actors in the county, and existing guidelines and information that support coordinated service delivery.
3. **Document Review:** A checklist of important documents, such as policies, guidelines, tools and other information utilized by Health Teams in order to plan, monitor and manage provincial health activities.
4. **Guided Group Discussions:** A guided group discussion with Health Teams, partners and community members to further explore findings from the questionnaire and semi-structured interviews in order to:
 - a. Determine the enabling and constraining factors
 - b. Identify strengths to build on and weaknesses to address.

The methodology is designed to be carried out in the province over several days. The first two instruments should be administered to relevant stakeholders and reviewed by the assessment team. The assessment team will utilize the results to identify specific areas that require further examination and to select relevant discussion questions. The group discussion provides an opportunity to explore these issues and any discrepancy in the perspectives of the Health Teams and partners. Finally, the document review is conducted at the end of the group discussion.

Table 1
Definition of Health System Components

Oversight and coordination of the health sector: the ability to coordinate, manage, monitor, and provide feedback to all levels (health partners, health facilities, districts and communities) to ensure that activities are meeting county health needs and are in line with central level policies and guidelines. Activities include identification of gaps and resources to address gaps, planning, supervision of all health facilities, monitoring health partner activities, conducting coordination meetings, and providing feedback to health partners, health facilities, district health officers and communities.

Human resource management: the ability to identify county level human resource (management and clinical) needs, participate in recruitment and hiring based on national policies, and monitor personnel performance.

Resource management: the ability to manage the provision of drugs and medical supplies and equipment. Activities include tracking stocks, acquiring sufficient quantities of the appropriate drugs and supplies, and distributing drugs and supplies to facilities (and communities, if applicable).

Health financing: the ability to develop a budget based on a work plan, manage funds in accordance with county health priorities, adhere to general accounting principles, and comply with financial reporting requirements.

Community involvement: the ability to involve the community in decisions about health activities through joint planning, implementation and monitoring of health services with community structures.

Information: the ability to gather, interpret, report (to central and back to facilities/communities) and use information from health partners, facilities and communities to improve health services in the county.

County Health Team (CHT) Structured Interview

Name: _____

Job Title: _____

Date: _____

Introduction

The Structured Interview is the first step of the Decentralized Health Service Management Assessment. It is administered to the CHO or most senior CHT manager. The purpose of the Structured Interview is to gather information about the decentralized health system and the role that the CHT plays in managing health services, resources, and partners (including communities).

Guidelines for the Interviewer

1. Find a quiet place to sit with the interviewee.
2. Thank the interviewee in advance for his/her time.
3. Introduce yourself, your organization, explain your relationship with the MOHSW, and the purpose of the Decentralized Health Service Management Assessment.
4. Explain the purpose of the Structured Interview and give the interviewee an estimate of the time the interview will take.
5. Ask the interviewee if he/she has any questions before beginning.

County Context

1. Tell us about the health system in your county:

a. Number and Type of facilities

b. Implementing Partners

c. Activities (primary health care, education, etc)

2. Tell us about the major health problems in your county:

a. How do you come to these conclusions?

3. What is the approximate population of your county (record year of data)?

Oversight and coordination of the health sector

1. What policies and guidelines (i.e. BPHS, Health Policy, supervision guidelines, etc.) are available to help you in your role on the County Health Team?

a. Where do they come from (i.e. MOHSW, NGO, donor, other)?
b. How do you use them?
2. What is the key information that you should have about your county to manage health services?
a. Where would you find that information?
3. What regular information (i.e. HMIS data, reports, etc) do you get regarding the following? Where do you get this information from? How often do you receive the information? (see a-e below)
a. Number of consults per facility per month (i.e. ANC, well baby, family planning, other MHC)
b. Specific diseases
c. Implementing partner activities (NGO)
d. Other

4. How do you use this information?

a. Do you need to send this information to anyone else?

5. Do you have any sentinel surveillance systems in operation?

Yes **No**

a. If yes, for which diseases and when did you last receive this information?

6. Is there information that you don't get that you wish you had regularly?

Yes **No**

a. If yes, what would that be?

7. Is there planning for health services done in your county?

Yes **No**

a. If yes, when and by whom?

b. Is the health facility involved in the planning process?

Yes **No**

8. How often do you need to conduct planning?

a. What information do you use for planning?

9. Do you have to conduct special planning sessions as requested by others (i.e. donors, NGOs, etc.)

Yes No

10. Is there any mechanism for getting input from community leaders or members on the county health plan?

Yes No

11. What are the products that result from the planning process?

12. How do you use those products?

Service Delivery

1. Who manages the health services at the facility level?

2. Who decides which services to provide?

3. Are you able to provide regular supervision of the health facilities?

Yes No

a. If so, how often is each facility supervised?

b. Is supervision done according to a regular schedule or based on special needs and circumstances?

c. Do you have to do a report for each visit (request to see copy of most recent supervision report)?

Yes No

d. Who undertakes the supervisory visit (i.e. NGOs, CHT, others)?

4. Are there any tools or checklists to help with supervision?

Yes No

5. Are you able to supervise the most inaccessible facilities?

Yes No

6. Do you have transportation to conduct supervision visits (i.e. ambulance, bicycle, vehicle, motorcycle, etc.)?

Yes No

a. If yes, what form of transportation?

b. How do you fund the fuel and other operating costs?

Human Resources

1. Do you have input regarding the number and type of health staff assigned to your county?

Yes No

a. If yes, how do you participate?

b. Do you have any flexibility for reassigning staff in your county?

Yes No

2. Do you have a register of all health staff in the county?

Yes No

a. Is it broken down by cadre?

Yes No

3. How many facilities are adequately staffed according to the BPHS guidelines?

4. Over the last 6 months, what type of training has taken place in your county?

a. Who was trained?

b. Who initiated/required the training (MOHSW, NGO/donor/CHT)?

c. Who conducted the training (MOHSW, NGO/donor/CHT)?

d. Who paid for the training (MOHSW, NGO/donor/CHT)?

Resources

1. Where do your supplies and drugs come from?

a. Who decides which supplies and drugs, including quantities, are needed and how?

b. How are the supplies distributed to facilities?

2. Is an inventory maintained for the following:

a. Drugs

Yes No

b. Supplies

Yes No

c. Equipment

Yes No

3. Is there a reporting system for stock balances?

Yes No

a. How often is this reported and to who is it sent?

b. Have you experienced any drug stock outs in the past six months?

Yes No

Financial Resources

1. Where does the funding for health services in your county come from (i.e. donors, NGOs, MOHSW)?

2. Are you allowed to allocate this funding or is it determined for you?

3. How much is needed to run the current health services in your county?

4. Do you have to account for the health sector expenditures?

Yes No

a. To Whom?

Community Involvement

1. How do you receive information about community health needs?

2. Do you have a main contact in the community concerning health issues?

Yes No

a. If yes, who?

b. Are there any community-level structures or groups to help with community involvement?

Yes No

c. If yes, which ones?

3. Does the community provide you with any feedback on the services provided?

Yes No

a. If yes, how?

County-Level Relief to Development Questionnaire

Name: _____

Job Title: _____

Organization: _____

County: _____

Introduction

Thank you for your time and assistance in completing this questionnaire. This is one part of the Decentralized Management in Post Conflict Transitions Assessment. Through this assessment, the CHT and health partners will come together to review the capacity of the county health system and explore the factors that influence the ability of the CHT to transition from relief to development. It is important to first identify the current stage of transition from relief to development in the county. As you are very familiar with the county health system, we are asking you to share your perspective on the stage of transition.

Instructions

The numbers 1-4 correspond to a relief to development continuum with 1 representing a relief setting (e.g. CHTs provide no input) and 4 representing a development setting (e.g. CHTs are fully involved). Please circle the number (1-4) representing the stage of transition which you feel most reflects the current situation. **Please circle only one.** If you feel none of the described stages provides an adequate description, briefly describe what you feel the current stage entails in the space identified as “other.”

Key

MOHSW = central level MOHSW

CHT = county level MOHSW

Health partners = NGOs, donor bilaterals, private organizations, etc.

Component 1: Capacity to provide oversight and coordinate the health sector

1.1 Ability to adequately engage health facilities

<i>Stages of transition from relief to development:</i>	
1.	CHT has minimal interaction with health facilities because all coordination and oversight is carried out by health partners.
2.	CHT, as representative of MOHSW, disseminates information (i.e. national policies and guidelines) to health facilities and oversight and coordination is carried out by health partners (i.e. supervision, routine health information data collection, feedback).
3.	CHT provides some oversight and coordination of the facilities through supervision and the collection of routine health information from facilities. However, facilities do not receive feedback from CHT to improve services based on supervision visits or routine health information.
4.	CHT and health facilities jointly determine county health service needs based on two-way information exchange and feedback.
	Other:

1.2 Ability to lead and engage with state and central MOHSW level

<i>Stages of transition from relief to development:</i>	
1.	Limited information provided to CHT on MOHSW policies and guidelines. CHT has no or limited engagement with MOHSW to be an advocate for county health service needs.
2.	Information on MOHSW policies and guidelines provided to CHT. CHT provides limited input (including reporting) to MOHSW level in regards to decisions affecting the county health services.
3.	Information on MOHSW policies and guidelines provided to CHT. CHT informs MOHSW through regular reporting. CHT provides input to MOHSW level in regards to decisions and policies affecting the county health services.
4.	Information on MOHSW policies and guideline provided to CHT. CHT fully involved in decision making and policy development affecting the county health services.
	Other:

1.3 Ability to coordinate and monitor actors involved in the health sector

<i>Stages of transition from relief to development:</i>	
1.	Health partner led coordination processes are functioning with no CHT involvement. Donors monitor (quality and quantity of activities in county health sector.
2.	Health partner led coordination processes functioning with CHT presence. MOHSW/CHT receive regular monitoring information (e.g. reports) from health partners (incl. CBO's and FBO's) in the county health sector
3.	Close collaboration between health partner and CHT through regular coordination meetings to jointly plan, manage and monitor health services (incl. community health activities).
4.	CHT led coordination to harmonise inputs of health partners and other stakeholders through regular coordination mechanisms. CHT collects monitoring information on (e.g. quantity, quality, appropriateness, etc.) of services provided by external actors in the health sectors, including community activities, to ensure they are in-line with national policies and guidelines and county health plan.
	Other:

Component 2: Capacity to manage human resources for health

2.1 Ability to plan and decide on human resources for health

<i>Stages of transition from relief to development:</i>	
1.	Health partners plan and decide on numbers, qualifications, and distribution of all levels of staff in the county based on health partner identified needs, no coordination with MOHSW.
2.	Health partners plan and decide on staff levels and distribution but provide information to MOHSW and CHT.
3.	Health partners and CHT jointly plan on staff levels and distribution in the county based on workforce assessment in the county and MOHSW policies (e.g. BPHS).
4.	CHT plan and allocate human resources, together with MOHSW, based on evidence of county workforce priorities (e.g. distribution, morbidity) and national plans for human resources (e.g. BPHS). Health partners support its implementation.
	Other:

2.2 Ability to mobilise human resources for health

<i>Stages of transition from relief to development:</i>	
1.	Health partners recruit and develop job descriptions for staff. Health partners pay (using NGO pay scale) the staff in the health facilities.
2.	Health partners recruit and develop job descriptions for staff with input from CHT. Health partners pay (using MOHSW pay scale) the staff in health facilities.
3.	Health partners recruit staff based on jointly identified needs with CHT, providing MOHSW job descriptions to staff. Health partners pay staff (using MOHSW pay scale).
4.	CHT/MOHSW coordinates the recruitment and payment of staff. Staff are provided MOHSW job descriptions. Health partners support its implementation.
	Other:

2.3 Ability to monitor staff performance and coordinate required human resource capacity development

<i>Stages of transition from relief to development:</i>	
1.	Health partners monitor staff performance (e.g. staff meetings, performance assessment) and provide necessary training based on health partner curricula and processes.
2.	Health partners monitor staff performance and provide necessary training based on health partners guidelines and processes and provide information to MOHSW and CHT.
3.	Health partners support staff performance process utilising MOHSW guidelines. Health partners support training utilising curricula developed by MOHSW with CHT input.
4.	CHT coordinates and supports staff performance process utilising MOHSW developed guidelines. CHT coordinates training, together with MOHSW, utilising MOHSW developed curricula. Health partners support its implementation.
	Other:

Component 3: Capacity to manage resources (including drugs, non medical supplies, equipment, and infrastructure) for health services

3.1 Ability to plan and decide on resources for health

<i>Stages of transition from relief to development:</i>	
1.	Health partners determine resource needs and utilize own systems to order and procure drugs, supplies and equipment based on their identified needs in the specific partner facility catchment areas and protocols and guidelines.
2.	Health partners identify resources needs (i.e. construction, equipment) for county but receive MOHSW and CHT input (e.g. MOHSW protocols and guidelines).
3.	Health partners, MOHSW and CHT jointly determine (i.e. county health facility mapping) resource needs (i.e. construction, equipment) for county and coordinate ordering of supplies.
4.	CHT, together with MOHSW, determine resource needs (i.e. construction, equipment) for county- and order all drugs and supplies from central stock based on national policies and treatment guidelines. Health partners support implementation.
	Other:

3.2 Ability to mobilise and distribute resources for health

<i>Stages of transition from relief to development:</i>	
1.	Health partners purchase and distribute supplies, drugs and equipment to the health facilities. Health partners renovate/construct health facilities if needed.
2.	Health partners purchase and distribute supplies, drugs and equipment based on MOHSW policies and carry out renovations with MOHSW input.
3.	MOHSW/CHT and health partners jointly identify needs, place orders, and distribute drugs, supplies and equipment to health facilities and determine facility renovation needs.
4.	CHT orders and distributes drugs, supplies, and equipment utilising MOHSW logistics systems and county-level storage facilities. CHT coordinates health facility infrastructure renovation and equipment provision. Health partners support its implementation.
	Other:

3.3 Ability to manage and monitor resources for health and adapt accordingly

<i>Stages of transition from relief to development:</i>	
1.	Health partners monitor use of supplies, drugs and equipment utilising NGO processes (e.g. protocol development, training on rational use, quantity provided) and use information to identify resource needs (e.g. drug stocks, vehicles, etc.).
2.	Health partners monitor use of supplies, drugs and equipment utilising NGO processes with CHT input. Information is used to identify resource needs.
3.	Health partners and CHTs jointly monitor use of supplies, drugs and equipment utilising MOHSW supply management and monitoring processes. Information is used to identify resource needs.
4.	CHT monitors use of supplies, drugs and equipment (quality and quantity) utilising MOHSW supply management and monitoring processes and identify resource needs based on evidence (e.g. rational drug use, morbidity data). Health partners support monitoring and implement changes.
	Other:

Component 4: Capacity to finance health services

4.1 Ability to budget for sustainable financial resources

<i>Stages of transition from relief to development:</i>	
1.	Health partners/donors budget for the health services in the county based on their own processes and identified needs.
2.	Health partners/donors budget for the health services in the county based on own processes (i.e. NGO budget template and pay scale), but with MOHSW and CHT input regarding county needs.
3.	Health partners/donors budget for the health services with MOHSW and CHT input and consideration for financial sustainability (i.e. MOHSW pay scale). Health partners provide financial information to the MOHSW and CHT.
4.	CHT, together with MOHSW and health partners, plan and budget for county level activities and health services, based on national policies and county priorities. County budgets include co-financing from health partners to achieve activities in county plan.
	Other:

4.2 Ability to disburse health financing for the county health sector

<i>Stages of transition from relief to development:</i>	
1.	Health partners disburse funds and carry out procurement based on the partner identified priorities and processes.
2.	Health partners disburse funds and carry out procurement based on NGO, MOHSW and CHT jointly identified priorities.
3.	CHT provides input to MOHSW to disburse funds and carry out procurement for the county health sector.
4.	MOHSW disburses funds to CHT to carry out procurement for county health sector.
	Other:

4.3 Ability to monitor health financing for the health sector and redirect funding flow, if necessary

<i>Stages of transition from relief to development:</i>	
1.	Health partners monitor and adjust finances utilising NGO/donor reporting processes with accountability to donors.
2.	Health partners monitor and adjust finances utilising NGO/donor reporting processes on but provides expenditure information to MOHSW and CHT. Partners are accountable to donors.
3.	Health partners and MOHSW monitor and adjust finances utilising separate reporting processes (i.e. NGO/donor and MOHSW). MOHSW provides input regarding how partner funding is used to support national priorities and partners are accountable to donors and MOHSW for achievement of activities.
4.	Health partners and CHT monitor and adjust finances utilising separate reporting processes (i.e. NGO/donor and MOHSW). CHT and MOHSW provide input regarding how partner funding is used to support county health plan and partners are accountable to donors, MOHSW, and CHTs for achievement of activities.
	Other:

Component 5: Capacity to involve the community in county health services

5.1 Ability to plan and decide on community health services and facility health services with community involvement

<i>Stages of transition from relief to development:</i>	
1.	Limited or no community participation in planning and deciding on services delivered. Community is not informed and community demand/need (e.g. CHV's, TTM, outreach or BCC activities) is not considered.
2.	Limited or no community participation in planning and deciding on services delivered. CHT provides information to community on services planned and provided.
3.	Community representatives (through Health Committees) provide input to the CHT for planning and decision making on county health services (curative, preventative) with consideration of community needs.
4.	Active participation of community in CHT planning and decision making on county health services in order to meet health needs (e.g. prevention, health promotion).
5.	Other:

5.2 Ability to mobilise communities and manage implementation of service delivery at community level

<i>Stages of transition from relief to development:</i>	
1.	No community contribution to health activities (i.e. community leaders do not mobilize community members to participate).
2.	Community leaders and other specific individuals participate in one-time activities, such as campaigns
3.	CHT promotes community awareness about health activities and healthy behaviours through community mobilization (i.e. mother groups).
4.	Community members contribute to the implementation of health activities jointly with CHT; active social mobilization (i.e. establish emergency committees, selection of CHVs) and community contributions (i.e. community insurance, revolving drug funds) are fairly common.
	Other:

5.3 Ability to monitor service delivery (incl. its resources) with community involvement and adapt accordingly

<i>Stages of transition from relief to development:</i>	
1.	Limited or no community participation in the monitoring of the health services, including the resources (e.g. drugs) provided.
2.	CHT shares information about community health activities and health services delivered by NGO and CHT with community.
3.	CHT shares information with and collects feedback/health data from the community (i.e. from CHVs and community leaders) about health needs and community satisfaction with the services provided.
4.	Community works jointly with CHT to monitor health services (needs, quality) and supervise activities of community based health workers (CHV's). Community is actively involved in identifying and implementing corresponding changes (i.e. replacement of CHV).
5.	Other:

Component 6: Capacity to manage health information

6.1 Ability to plan and decide on health information to collect

<i>Stages of transition from relief to development:</i>	
1.	Health partners determine health indicators and which health information is collected based on donor/NGO requirements. There is no consultation with local government.
2.	Health partners determine health indicators and which health information is collected, but consult with MOHSW or CHT to ensure their priorities are reflected.
3.	Health partners and CHT jointly determine which health information is to be collected based on national policies and indicators and donor/NGO requirements.
4.	CHTs coordinate with health partners to ensure that they are aware of which health indicators are to be collected. All health information is based on with national policies.
	Other:

6.2 Ability to manage the collection, analysis and transmission of quality health data

<i>Stages of transition from relief to development:</i>	
1.	Health partners collect, analyze and transmit health data to donors. Information is not shared with local government.
2.	Health partners collect, analyze and transmit health data to donors and local government.
3.	Health partners and CHT jointly collect, analyze and transmit health information to donors and national MOHSW.
4.	CHTs collect and compile all health information for county. Information is transmitted to the MOHSW and results are shared with district, facility and community levels.
5.	Other:

6.3 Ability to utilize health information to improve services

<i>Stages of transition from relief to development:</i>	
1.	Health partners review information collected at facility to decide on and make changes to service delivery based on facility-level catchment area health needs. Local government is not notified to changes to health services.
2.	Health partners review health information collected at facility to decide on and make change to service delivery based on facility-level catchment area health needs. Local government is notified of changes.
3.	Health partners and CHT jointly review health information that has been compiled from all facilities in county to decide on and implement changes to service delivery based on county health needs.
4.	CHTs coordinate partners, districts and facilities to review health information that has been compiled from all facilities to decide on and implement changes to service delivery. District officers and facilities also review facility level data and make changes to service delivery based on county-level priorities and catchment area health needs.
5.	Other:

Group Discussion with Relevant Representatives of CHT, Partners, and Community

Introduction

The purpose of this group discussion is to:

- o Review the outcomes of the self assessment.
- o Examine the challenges faced in the management of the decentralized county health system.
- o Discuss the contextual factors that contribute to the CHTs ability to manage the decentralized county health system.
- o Discuss specific factors related to the implementation of malaria programs.

The group discussion questions will be tailored for each session depending in the outcomes of the self assessment and structured interview. The guidance below is a list of *possible* questions, but should be reviewed and considered for inclusion for each separate session. The discussion is designed for a 2 to 2 ½ hour session. In order to accommodate this time chose questions from 5 to 6 sections listed below. It is important to prioritize these due to fact that some question discussions may require more time than others.

The proposed agenda for the guided discussion is as follows:

Group Discussion Guidelines

- 1) Present purpose of discussion (5-10 minutes)
- 2) Establish together the rules for an open, honest, respectful exchange of ideas (5 minutes)
- 3) Discuss the six enabling and constraining factors and how these can be used as a framework with which to consider each of the questions. Present examples each factor explaining how they may contribute to the CHTs ability to manage (*see power point*) (5-10 minutes)
- 4) Introduce the first discussion topic "Vision: Setting the Context." (10 – 15 minutes)
- 5) Lead the Group discussion working through each of the six components to assess CHT capacity using the 5 to 6 selected questions (1 - 1 ½ hours):
 - a. Determine enabling and constraining factors that influence the CHTs ability to manage the 6 components.
 - b. Identify strengths to build on and weaknesses to address.
- 6) Conclude the discussion by having the group create a list of priorities for completing the decentralization process. From these, have the group create their 3 top recommendations for the Decentralization Process. (20 minutes)

Group Discussion Questions

Instructions:

- a. Questions to elaborate on enabling and constraining factors that influence CHT capacity to manage a decentralized health system.
- b. Questions to identify weaknesses and strengths to build the ability to manage a decentralized system.

1. Vision: Setting the Context

These questions are designed to set the context for the discussion by allowing the participants to visualize how the decentralized health system would operate. This will frame the discussion so that participants will be better able to identify gaps and determine needs and next steps for decentralization. It is recommended that this section be included in each group discussion.

- a. If you were operating in a truly decentralized system, what would the CHT's role be?
- b. What is the Central's MOHSW role in a decentralized system?
- c. What is your role in relation to your health partners?

Questions in sections 2-14 are based directly on the components of the Decentralized Management Capacity Framework.

2. Ability to plan and decide:

The following questions are to be asked specifically in relation to planning and deciding on:

- ***Human resources for health***
- ***Non-human resources (supplies, drugs, equipment as well as infrastructure)***
- ***Budgeting for services***
- ***Malaria Activities***

- a. What affects (positive and negatively) the CHT's role and responsibility for decision making in planning for the county? Why?

What would be benefits if the CHT was leading or involved in the planning and decision making for the county? What would be disadvantages? Why?

- b. What are weaknesses to address as soon as possible?
What are strengths that can be built on?

3. Ability to lead and engage health facilities

- a. How could the facilities be better engaged with the CHT? Who needs to take action for this to happen?

Why would it be good for CHT to lead and engage health facilities, or at least be involved in the process? Why not?

- b. What are weaknesses to address as soon as possible?
What are strengths that can be built on?

4. Ability to adequately engage with state and central MOH level

- a. How is the relation between CHT and MOH organised? How could this relationship be improved?
- b. What are weaknesses to address as soon as possible?
What are strengths that can be built on?

5. Ability to coordinate and monitor external actors involved in the health sector

- a. What could be done to improve the CHT's ability to coordinate and monitor external actors involved in the health sector?

What would be the advantage if the CHT would be more involved or responsible for coordination and monitoring of external actors? What would be the drawback? For who?

- b. What are weaknesses to address as soon as possible?
What are strengths that can be built on?

6. Ability to Implement

The following questions are to be asked specifically in relation to planning and deciding on:

- ***Human resources for health***
- ***Non-human resources (supplies, drugs, equipment as well as infrastructure)***
- ***Disburse funds***
- ***Information***
- ***Malaria Activities***

7. Ability to mobilise human resources for health

- a. What would be the benefits if the CHT was mobilising staff (paying, job descriptions)? What are disadvantages? For who?
- b. What are weaknesses to address as soon as possible?
What are strengths that can be built on?

8. Ability to mobilise and distribute non-human resources for health

- a. What are constraining factors for the CHT to mobilise and distribute non-human resources for health in the county? What are enabling factors?

What tools/info and resources are available for CHT to mobilise and distribute non-human resources? What is lacking? Why?

If the CHT would be responsible for the mobilisation and distribution of non-human resources- what would be the advantages? What disadvantages?

- b. What are weaknesses to address as soon as possible?
What are strengths that can be built on?

9. Ability to disburse financing for the county health services

- a. Why is CHT not responsible for disbursement of finances and carry out procurement?

How would different actors (e.g. MOH, community, CHT, NGO, donors) react if the CHT was responsible for finances and procurement?

- b. Give an example of when you team faced a real problem, but was able to come up with a solution so that services were still delivered.

10. Ability to manage the collection, analysis and transmission of information

- a. How could the exchange of information between the CHT and MOHSW be improved?

What kind of feedback does the CHT require from the MOHSW?

- b. Give an example of when this process worked well and give an example of when it didn't work well.

11. Ability to monitor:

The following questions are to be asked specifically in relation to monitoring:

- **Human resources for health**
- **Non-human resources (supplies, drugs, equipment as well as infrastructure)**
- **Finances**
- **Information**
- **Malaria Activities**

- a. What affects (positive and negatively) the CHT's ability to carry out monitoring? Why?

What could be done to improve the CHT's ability to monitor health partners and strengthen their (partner) accountability to CHT plans and decisions? What would be the benefits if this was the case? What disadvantages? Why?

- b. What are weaknesses to address as soon as possible?
What are strengths that can be built on?

12. Ability to plan and decide on community health services and facility health services with community involvement

- a. Why is the community involvement in planning and decision-making for (community) health services not more extensive?

What would be the benefits if the community was more involved? What would be disadvantages? For who?

- b. What are weaknesses to address as soon as possible?
What are strengths that can be built on?

13. Ability to mobilise communities and manage implementation of service delivery at community level

- a. What are constraining factors in the relation between the health facility and the community? What are enabling factors?

What needs to change in order to ensure the community is more involved in the functioning of the health facility? What needs to change to ensure increased involvement of the community in health activities? Why?

- b. What are weaknesses to address as soon as possible?
What are strengths that can be built on?

14. Ability to monitor service delivery (incl. resources) with community involvement and adapt accordingly

- a. What facilitates the community to play a more active role in monitoring service delivery? What impedes their involvement? Why?

What are the advantages of strengthened community involvement in monitoring? What are the inconveniences? For who?

- b. What are weaknesses to address as soon as possible?
What are strengths that can be built on?

15. Creative Leadership: This question is an opportunity for the participants to reflect on the discussion and propose creative solutions to ensure the delivery of basic services despite obvious challenges.

- a. Given all that we have discussed today, please give your insight on the following question: While waiting for the process of decentralization to be completed, what does the CHT do to meet the health needs of the people in the county?

Date: _____

County: _____

Observer: _____

Checklist for Record Review

Check box if document exists and is available at the county level:

Document	Exists	Available	Comments
HMIS data collated/analysed for county level			
County health plan for current year			
A copy of the National Health Plan			
A copy of the BPHS			
County health service mapping			
Job descriptions			
County training plan			
Training Records			
Facility Supervision Reports from last six months			
Drug inventory			
Supply/Equipment Inventory			
MOHSW malaria treatment protocols			
Budget for County Health Plan			
Financial management manual			
Supply management manual			
Storage for drugs and supplies at county level			
Community health services policy			

Date: _____

County: _____

Observer: _____

Check records for:

Item	Number/ Percentage	Source
% of facilities delivering BPHS in county		
% of facilities staffed according to BPHS standards		
% of staff who meet MOHSW qualification standards		
Number of meetings held with community/representatives in past 6 months		
Number of coordination meetings held with relevant actors in health in past 6 months		
% of facilities maintaining complete data systems per MOH standard		
% of facilities that sent their completed health information data to the CHT last month		
Number of CHVs trained		
Number of partners who have a current agreement (i.e Memorandum of Understanding) directly with CHT		