



Developing Decentralisation and Reproductive Health Services: Guidelines for Policy-Makers

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¹ Hall, W and Roberts J (2006) Understanding the impact of decentralisation on Reproductive Health and services: South Africa Country Report

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It should, as is normal, be pointed out that the involvement of the above does not imply endorsement of the contents of this document.

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Acronyms

HR	Human Resources
ICPD	International Conference on Population and Development
MoH	Ministry of Health
NGO	Non Governmental Organisation
SRHS	Sexual and Reproductive Health Services

Introduction

Why is this document important?

Both decentralisation and sexual and reproductive health services (SRHS) are priority issues occupying national governments and particularly ministries of health, international, national and local NGOs, multilateral and bilateral international agencies, health user and community groups, and professional and occupational associations.

This booklet looks at these two areas of government policy - decentralisation and SRHS. Health sector decentralisation is a common ingredient of policies on health sector reform. It has many claimed benefits ranging from improved service delivery, better equity and improved community involvement. Yet it has many critics claiming that it can lead to quite the opposite to the above. SRHS are a priority of many governments in the world. This is not surprising given the poor indicators of mother and child health and the HIV/AIDS pandemic. Many governments and both national and international organisations have adopted the rights based agenda, as represented in the ICPD conferences of Cairo and Beijing.

Decentralisation can have a major impact on the planning, financing, management, organisation and delivery of all health services, including SRHS. It is therefore important that policy-makers pay attention to making the introduction of decentralisation as effective as possible for the development of reproductive health services. How then do these two policies relate to each other? Can decentralisation lead to positive results for SRHS? What can be done to make decentralisation work for SRHS?

What does this document contain?

This document provides a number of guidelines for policy-makers intent on introducing both decentralisation and effective SRHS. The guidelines provide a series of factors for policy-makers to consider and be mindful of.

Who is it meant for?

The guidelines should be of relevance to all those groups and institutions who may be considered as stakeholders of both health sector decentralisation and SRHS. It should include national governments and particularly ministries of health, ministries of finance, international, national and local NGOs, multilateral and bilateral international agencies, health user and community groups, professional and occupational associations and academic institutions.

How was it developed?

Between 2003 -2007 a groups of researchers from six countries asked the question: What is the impact of decentralisation on SRHS? Research was conducted in four African countries: Burkina Faso, Mali, South Africa and Uganda. Based on the background of the researchers, discussions within the research group and the results from the research, this booklet sets out guidelines for policy-makers seeking to develop a positive relation between decentralisation and SRHS.

How to use the guidelines

The guidelines should be the object of discussion as to their relevance to specific country situations. They are not a list of universal recipes of how to do things but a set of key considerations to work on during policy-making.

Why we would value your reaction

We are all learning in how to achieve health systems development for better and more equitable health and health care. We would value your reaction to these guidelines by contacting N.Gerein@leeds.ac.uk

How are the guidelines structured?

The first section deals with the policy process and, in particular, relating policies of decentralisation and SRHS. The guidelines then move on to consider the importance of national and local context. There is then a consideration of the key functional areas of service organisation and delivery, financing, human resources, planning / monitoring / evaluation, health governance and logistics.

Developing the Policy Process

The policy process used in the formulation and implementation of policies such as decentralisation and SRHS is important in determining the impact one policy has on the other. Particular attention needs to be paid to:

- The extent to which the rationale for policies and their basic contents are similar and compatible;
- The degree to which policies on decentralisation and SRHS change over time and how this affects the relationship between the two;
- The institutional and individual linking between stakeholders from different policies and the degree to which broader consultation is developed;
- The timing of policies needs to be taken into account and the extent to which they are implemented together or separately;
- The impact of decentralisation on SRHS needs to be monitored using agreed indicators and both qualitative and quantitative data.

Assessing the impact of one policy, such as decentralisation, on another, such as SRH policy, is a complex process. Quantitative data may be used which shows that since decentralisation, indicators on SRH and SRHS have changed. Qualitative data showing the perceptions of key stakeholders may also be used. It is important to understand:

- the relationship under analysis takes place in a economic, political and social context and this will have an important bearing on it;
- the policies on decentralisation and SRHS may not be defined in time with a clear starting point;
- there are important issues of attribution to work out and these include (in addition to the broad contextual factors mentioned above) the intertwined operation of the levels of government which makes it difficult to isolate the role of the decentralised level.

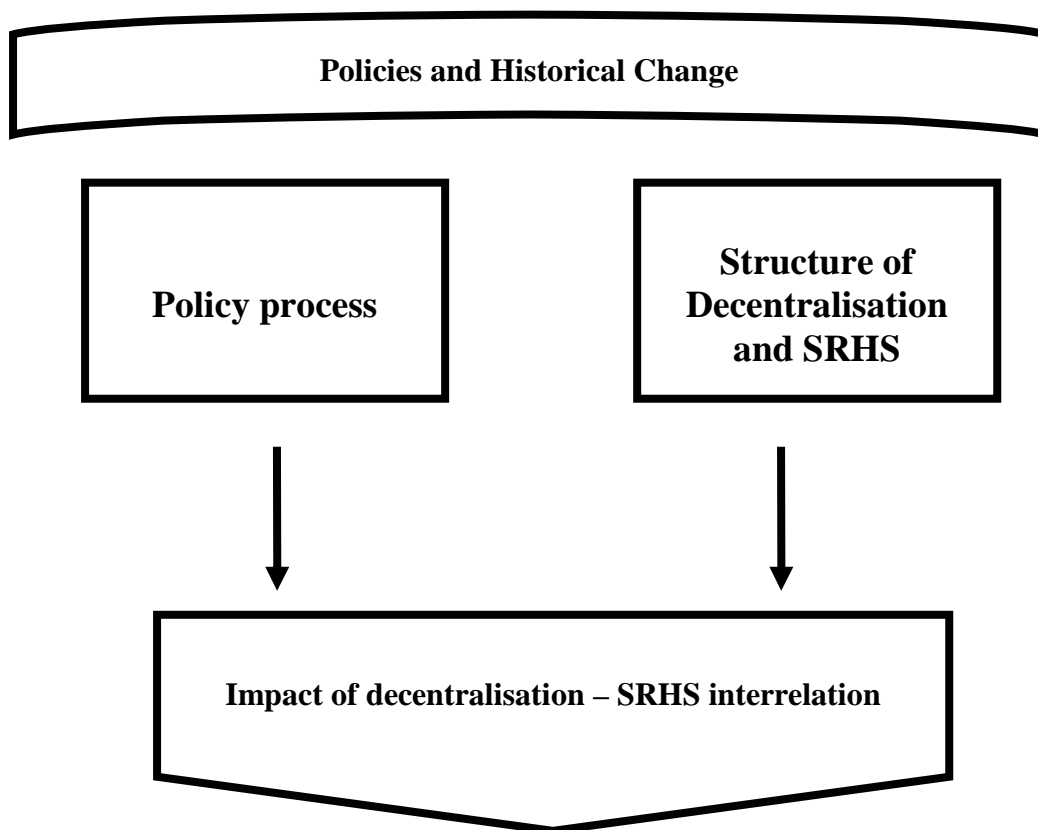
Understanding the National Context

Policy-makers need to understand how policies fit into the bigger picture of social, economic, political and international changes. By doing so, it allows them to understand why policies are on the agenda, why they take such a form, how they can relate to each other and their chances of implementation. All these factors are important in having an impact on the interrelationship between policies such as decentralisation and SRH.

The context refers to all those features in the environment that have a significant impact on what we are trying to understand. In this case, we are interested in the relationship between decentralisation and SRHS. It is important that this contextual understanding be more than an embroidery to the analysis but be used in the explanation of the relationship.

A useful way of understanding the context is shown in figure 1. Firstly, how the policies on decentralisation and SRHS fit into the process of historical change need to be understood. This means the broad economic, political and social factors that affect decentralisation and SRHS. The policy process was referred to above. The structure and organisation of decentralisation and SRHS need to be understood in terms of form, complexity and definition. The form of decentralisation may be characterised according to organisation, resource generation and allocation, planning, resource management and governance. The SRH policy may also be characterised according to international policy trends, such as how it relates to the principles of ICPD.

Figure 1: Understanding the context



Understanding Local Context

The impact of decentralisation on SRHS varies according to local context. Decentralisation might work very well in one district while in another it might not. This clearly affects SRHS.

There are two factors of importance here. Firstly, the reasons why local context affects the impact of decentralisation needs to be understood. These could be local contextual factors, such as social and political historical background, the location of referral and district hospitals, geographical location, local leadership, social and political conflict.

Secondly, it is important to understand how local context has an impact on decentralisation and its effectiveness. This could include the difficulty the district has in generating its own resources due to underdevelopment, which can affect local funding and therefore the quality and quality of services provided. At the same time, we may find that the social relations in the district affect social and political cohesion. The history of social relations may be conflictive or there might be a high degree of social and political cohesion. We need to see how this cohesion / conflict affects governance issues, such as community participation and its impact on developing SRHS in the district.

In interpreting the local context, there are three additional features to be taken into account.

- Local contextual factors do not exist in a separate and isolated manner. Rather, they are highly intertwined. The local contextual factors have an impact on one another and form parts of an interrelated explanation.
- The description of local context needs to use both quantitative and qualitative data. In using this data, an historical approach to interpreting that data needs to be used. The context does not look like a cross sectional collection of quantitative data but appears as a set of historical processes.
- Lastly, the local contextual factors do not present clear negative, benign or positive impacts on the management and planning processes and SRHS. Contextual factors can represent both positive and negative effects on SRHS.

Service Organisation and Delivery

Many countries have adopted centrally determined service packages to be implemented by district health systems. These packages, of which SRHS often form an important part, may be backed up by central funding. This arrangement has the advantage of ensuring service coverage across all the districts in a country. The criteria used in the resource allocation formula may be selected and weighted in such a way as to move towards greater equity between the districts. Service guidelines developed by the centre may also be used to ensure greater social equity within the districts. To achieve this, the supply of resources needs to be sustainable and backed up by the appropriate criteria, good information systems and political support in favour of the redistribution process.

Merely declaring and funding a package of care is no guarantee that it is actually being delivered. Despite central funding, resource scarcity may be a problem. Central resources may be insufficient for most if not all districts. Due to problems such as geographical terrain, the delivery in some districts may be more costly than in others. A lot will depend on the size of the allocations, the criteria used in allocation, and also the capacity of the districts to implement the package. Poor districts may be unable to attract staff to work there. In such circumstances, it is important that the centre has the capacity to monitor service delivery in the districts and a way of feedback such data into the planning system.

How this fits in with decentralisation needs to be discussed. Central packages and funding mean a restriction on the autonomy and space of priority setting by decentralised entities. On the other hand, decentralised districts may be involved in the national decision-making process of the service package and the development of allocation formula. They may also be given the authority to adapt the package to meet local health needs and / or add to the package to meet local needs. This does, however, raise the issue of whether they actually possess the resources to do this.

How decentralisation relates to service integration is another issue. Decentralisation may be seen as overcoming the vertical forms of centrally directed service delivery through vertical programmes and introducing more horizontal forms of service delivery. On this basis, service integration can be developed. National governments may adopt country-wide policies of service integration and require it to be implemented in districts. Ensuring service integration is, however, no easy matter. National programmes may still exist and can exert pressure on decentralised districts to prioritise their own specific disease control measures. Lack of qualified staff to implement service integration is another issue, together with practical difficulties in organising specific clinics and attending patients.

Standards in the provision of health care by the district system can be set by national governments. In countries suffering from resource scarcity, the meeting of these standards by the district health service is a problem. There may be severe shortages in staff, supervision and supplies.

A key issue on service delivery and organisation is that of the referral system. Typical issues to be faced here are patients by-passing health centres and clinics and going directly to hospitals, lack of transport, lack of coordination between the levels of care and the long distances patients are required to travel. The development of decentralised health systems will clearly be important in meeting these challenges. For example, the decentralised system will need to strengthen primary care to reduce unnecessary patient contact with higher level hospitals, develop innovative ways in improving patient mobility and ensure coordination with higher levels of government responsible for secondary and tertiary hospitals. These are important challenges for a decentralised health system.

Finances

Financing concerns the generation, allocation and use of adequate financial resources for the decentralised district to be effective in the provision of SRHS. In this respect, there are a number of important issues to deal with.

The overall funding for the district needs to be mapped out. The principal forms of funding are usually central government allocations through both conditional and unconditional grants, local government allocations to the health sector, user fees and contributions from donors and NGOs. There may also be payments made by social health insurance agencies for services provided by government health facilities. These sources need to be reviewed in terms of:

- The extent to which SRHS funding is part of the general district financing, or is separated as specific to SRHS through funding channels such as Family Planning and HIV/AIDS disease control;
- The adequacy of decentralised funding in general and more specifically the extent to which the sums allocated to SRHS are adequate to meet SRHS needs;
- The extent to which the different sources of funding are predictable (not too volatile as may be the case, for example, with donor funding), thus facilitating planning and programming of sustainable services;
- The capacity of the district to coordinate the various forms of funding.

Given the use of consolidated budgets and the process of service integration, it is often not possible to identify how much is being spent on SRHS. Yet this is important for monitoring and evaluating district health plans and priority spending.

An important issue in decentralised financing is that of equity. This needs to be reviewed in terms of the impact of district funding and expenditure decisions on:

- Equity between districts with different economic development, e.g. the extent to which districts with the greatest need get additional funding;
- Social equity between different groups within the same district, e.g. the extent to which district expenditure on SRHS expresses the needs of the poor;
- The equity implications of the funding, e.g. reliance on user fees can lead to the poor being excluded from care.

How financing fits in with decentralisation also has to be reviewed. As suggested above, too much district generation of funding (through user fees and local taxes) can lead to inequity, just as poorly devised systems of central allocation. Central government allocations based on centrally determined service packages may well be designed to ensure coverage, equity and quality of care, but also have to be set against the limitations these represent on decentralised and local decision-making. This area of financing needs to be carefully reviewed to achieve a balance between central planning, resource allocation and expenditure controls, and the need for a degree of decentralised and local decision-making

Experience suggests that districts and health facilities need to be strengthened in the systems and staff skills of financial management.

Budget formulation and implementation offers a number of opportunities for community involvement. For example, the community may have representatives on the institution responsible for approving the local and district budget.

Human Resources

Decentralisation can have important implications for health human resources (HR) which, in turn, can have an impact on SRHS. Particular attention therefore needs to be paid to how human resources are managed and planned at both the national and district levels.

Countries operate different institutional structures for determining how the HR function is managed. At the national level there may be HR Commissions and Departments of Public Service, while the form of decentralisation adopted sets out a range of functions to be maintained at the centre and others to be decentralised. Central functions often include setting and monitoring staffing norms, conditions of service, and national guidelines, standards and salaries, while the district may have functions in hiring and firing of staff, supervising, training, performance management, and assigning staff to specific responsibilities and locations. This mix of institutional responsibilities can lead to tension over issues such as the distribution of staff between districts. There is a need to invest time and resources in the collaboration of the range of institutions involved in HR management and planning.

Many countries face major problems of HR scarcity and staff retention, particularly in the poorer districts. This can have an important impact on the capacity of the district in providing SRHS.

Developing supervision is an important challenge. A balance may be required between general supervision from the district and more specialised supervision through national health programmes. Resources, particularly time and transport, are needed to facilitate supervision. Two words of caution: the effectiveness of supervision can vary greatly between districts and, when questioned, supervisors may reflect a more positive image of supervision than the supervisees.

Training is an important area with potential gains but some pitfalls if poorly managed. In addition to improving staff knowledge and skills, it can also be important in contributing significantly to staff motivation. However, favouritism and discriminatory practices in staff selection for training and donor-led priorities for training can lead to distorted priorities.

HR management can be an area in which significant differences can be found between districts. These differences need to be monitored and extra support and strengthening needs to be given to the weaker districts. Capacity development is clearly required in the area of HR. Staff skills and systems are required in key areas such as recruitment and selection, supervision, training, and performance management.

Planning, Monitoring and Evaluation

Many countries operate health strategic planning by the centre and operational planning by lower levels. It is important to develop means by which the district can play a significant role in setting priorities within the context of both national planning / resource allocation and the existence of minimum care packages for implementation by all districts.

Effective district health requires constructive centre – periphery planning relations, including relations with the national health programmes and more comprehensive district planning done by the local government. This also opens up the possibility of intersectoral collaboration. Attention also needs to be paid to relations with the community and their participation in health planning, the development of a district planning cycle, and linking between the district plan and the district budget.

The development of district health planning also requires attention to be paid to the development of an effective information system that provides an input into planning. This will require central initiative in the incorporation of the district information system into the national health information systems.

Different forms of monitoring and evaluation of district effectiveness are possible – periodic management meetings in the hierarchy of government, involvement of the information system, and participation of the district governance structures, including local councillors.

Health Governance

Governance plays a vital role in the development of decentralisation and SRHS and these guidelines refer to four of the key issues: institutional decision-making, community participation, public-private relations and intersectoral collaboration.

Decentralised management can involve a complex network of interrelations between, on the one hand, the centre and the periphery and, on the other hand, among institutions at the decentralised level. A network of district public sector institutions can include general administrative representatives of the state (e.g. district commissioners, prefects), district based MoH managers, health facilities with varying degrees of semi-autonomy, community representatives and political municipalities. In some countries this has led to confusion among stakeholders as to how decisions are made. There can also be tension between them as different interests within the health system can disagree. There is also a trend in many countries for political municipalities (local government) to take on a more prominent role in service provision. All this really puts the onus on managers to clarify how the decentralised system is organisationally structured. It also means that managers have to work at collaboration and finding innovative and constructive means for health systems development. There will be variations between districts in the managerial capacity to work together and the context in which they are working. Once again, particular support will be required in those districts experiencing difficulties in institutional collaboration.

Attention has to be paid to the impact of community participation on SRHS and health services in general. In addition to playing a role in decision-making on planning and budgeting, it can help in resolving problems such as shortage of drugs, health centre repair, staff shortages and health centre/clinic opening hours. The complexity of different forms and mixtures of decentralisation is reflected in the different forms of community participation. This may be organised through, for example, local political councils, health unit management committees, and community representatives on local governance bodies. Care needs to be taken in evaluating participation as different actors will have different approaches and views on its effectiveness. It will also vary a great deal depending on the social, economic and political context of the district.

Districts can play an important role in initiating contacts with NGOs and developing, for example, joint planning, sharing resources and increasing coverage. In order to do this, the districts need to work within a national policy and regulatory framework. The districts also need the authority and capacity to move ahead with effective and innovative public – private relations. This is of clear importance to SRHS and is one of the reasons for decentralising authority to the districts. A potentially important area to consider developing is that of an increased role of the district in relation to regulating the private sector.

Intersectoral collaboration is of great relevance to the development of SRH. This is particularly clear in areas such as HIV/AIDS. Local governance bodies concerned with decision-making and community participation can take lead roles in this area. Planning processes can also have an intersectoral component. However, there is a real challenge in making intersectoral work a priority and ensuring district and health facility workers are allowed the space to be creative in an intersectoral fashion.

Logistics

Drug supply, transport, laboratory services and infrastructure are important but potentially problematic and controversial areas. There can be little doubt that in key areas such as drug supply and regulation together with transport and infrastructure development, the centre has an important role to play. However, it is important not to ignore the special role decentralised management can play.

In drug and other supplies, the introduction of a ‘pull’ system may be an effective way of improving access and availability. Decentralised and participative management can also be useful in fixing some drug prices and developing innovative systems of district and community based distribution.

Decentralised management can also play a role in developing innovative schemes of health worker and patient mobility together with taking a role in infrastructure and vehicle maintenance.

Roles of the Centre and the District

Decentralisation sees the district, or its equivalent, take on important roles in the planning, management and delivery of SRHS.

- Formulating and implementing a district health plan (including SRHS, health information system and priority setting);
- Service delivery of SRHS through community health programmes and government health units such as the district hospital, health centres and health posts;
- Managing and developing health human resources through, for example, supervision, and in-service training;
- Managing financial resources through central allocations, local resource generation and budget management;
- Managing logistics for the government health system;
- Developing working links with the private sector (non and for profit organisations) through support, supervision, regulation and collaboration;
- Promoting intersectoral collaboration;
- Working with the community.

At the same time, the centre has a vital role to play in:

- Taking the lead in policy-development by emphasising policy values, such as equity and reproductive health as a right, in addition to promoting key policy areas of SRHS;
- Undertaking national strategic health planning and linking this to the budget and resource allocation;
- Establishing the overall framework of the health system;
- Providing policy, managerial, technical and political support to the district level;
- Regulating the decentralised system to ensure it keeps within national norms and standards and quality is maintained.

Capacity Development

Whether the centre and the district are able to carry out these roles in an effective manner will, to a large extent, depend on its capacity. We refer here to the availability of resources, the aptitude and skills of the staff, the structure and relations of authority, and the systems for management, planning and policy-making.

This requires major adaptations and capacity strengthening for the centre. For example:

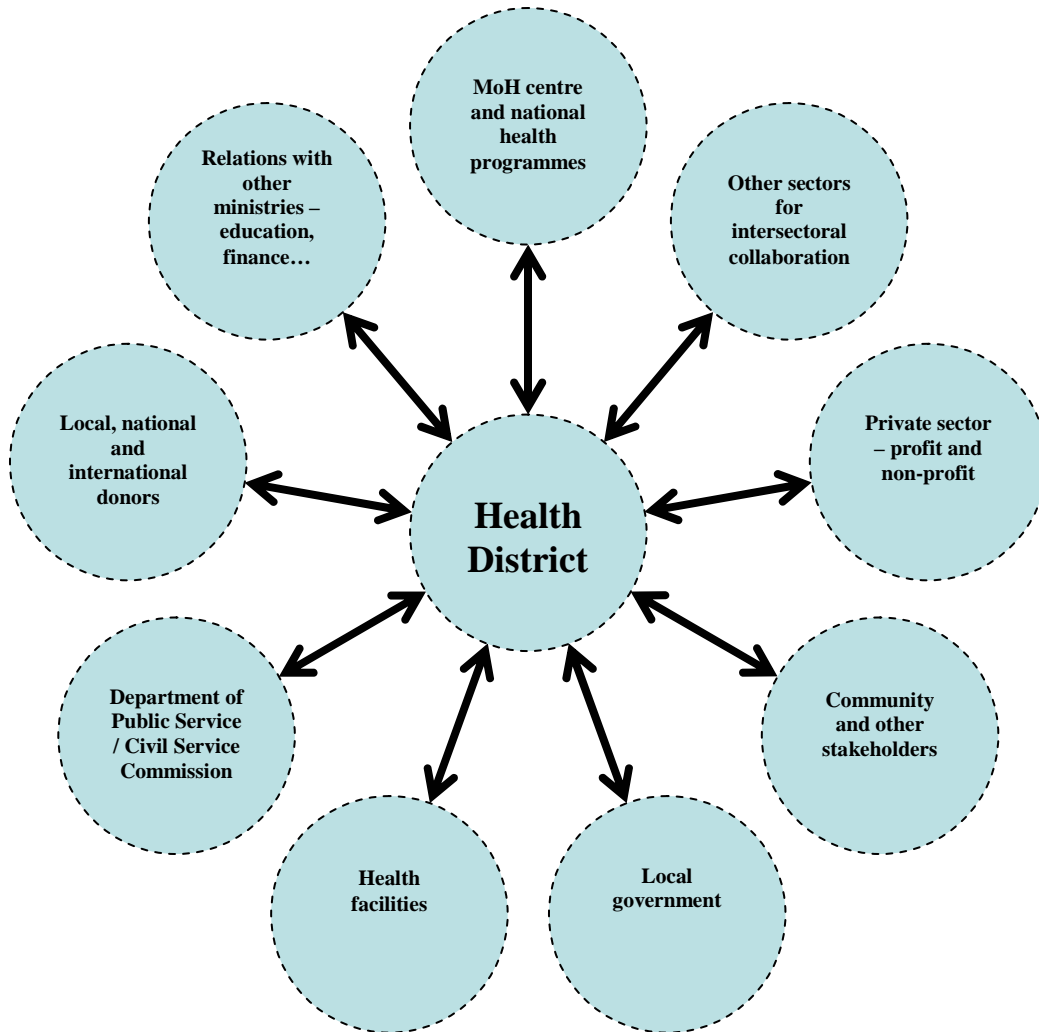
- Management, planning and policy-making structures, skills and systems need to be developed;
- Organisational links relating decisions in the MoH on health systems and SRHS need to be developed;
- Systems for stakeholder consultation should be implemented;
- There needs to be collaborative work between the MoH and other governmental bodies, such as the Ministry of Finance, the Ministry of Planning and the Civil Service Commission or Department.

For the district, there needs to be a similar emphasis on capacity development. For example, districts can lack capacity in key areas such as financial and HR management. They may also be poorly informed about recent technical and policy developments in SRHS. Technical and policy support from the centre may well be required.

Linking

An important feature in the effectiveness of a health district in developing SRHS is that of its capacity to link up with other organisations and stakeholders. This has been a theme throughout this text and needs to be emphasised. The capacity of the district to link up with a wide range of organisations and stakeholders is vital to the development of its effectiveness. Figure 2 provides an idea of the extent to which a health district has to operate a network of interrelations with a wide variety of organisations. Centre – periphery relations are fundamental to effective management, planning and policy-making. These may be even more complex with the roles of intermediate levels such as states, provinces and regions. More horizontal relations need to be developed for the private sector, other functional sectors (such as education), the community and other stakeholders. An important feature of the district capacity is that of the skills, values, structures and systems that allow for the development of collaborative relations within this network.

Figure 2: The health district and interrelations



A checklist for developing effective decentralisation for SRHS

Is there an agreed national policy-making process for developing the relation between decentralisation and SRHS?

- Are the rationale and contents of the two policies similar and compatible?
- Are the policies changing over time and how does this affect the relationship?
- Are there good institutional and individual links between the stakeholders associated with the two policies?
- What is the timing of the two policies and how does this affect the relationship?
- Is the impact of decentralisation on SRHS being monitored? If so, what methods are being used and how is the issue of attribution being dealt with?

Is there an understanding of the national context?

- How do the policies on decentralisation and SRHS fit into the broad process of historical change?
- Is there an agreed national policy making process, as noted above?
- What is the structure and organisation of decentralisation and SRHS in the country?

Is there an understanding of the local context?

- Why do local contexts differ?
- How does this impact on decentralisation and SRHS?

What is the impact of decentralisation on the service organisation and delivery of SRHS?

- What is the impact on priority setting?
- What is the impact on service integration?
- What is the impact on regulating norms and standards?
- What is the impact on the referral process?

What is the impact of decentralisation on SRHS financing?

- What are the sources of district financing and are they coordinated?
- Are funds predictable and adequate to meet SRH needs?
- What is the impact of district financing on equity?
- What is the financial management capacity of the district?

What is the impact of decentralisation on SRHS human resources?

- How do district responsibilities fit into the national HR framework?
- What is the impact on key areas such as staffing, supervision and training?

What is the impact of decentralisation on planning, monitoring and evaluation?

- How does district planning fit into the overall structure of health and developmental planning?
- Is there an effective decentralised planning and information system?

What is the impact of decentralisation on health governance for SRHS?

- district decision-making
- community participation
- public-private relations
- intersectoral collaboration