Evaluation of capacity development at district level of the health sector in Ghana (2006-2009): Evidence-based case study

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Contents

Acronyms and abbreviations

5CC	five core capabilities framework
5YPOW	five-year programme of work
AFAPAC	The African Foundation for AIDS Prevention and Counselling
CHAG	Christian Health Association Ghana
CHeSS	Centre for Health and Social Services
CHO	community health officer
CHPS	Community-based Health Planning and Services
CIDA	Canadian International Development Agency
DA	District Assembly
Danida	Danish International Development Assistance Agency
DDHS	district director of health services
DDP	Dutch development partner
DFID	Department for International Development (UK)
DHS	District Health System
DGIS	Directorate-General for Development Cooperation (the Netherlands)
DHMT	District Health Management Team
DISHOP	District Health Systems Operations
DMHIS	District Mutual Health Insurance Scheme
DP	Development partner
ECDPM	European Centre for Development Policy Management
GHS	Ghana Health Service
GRG	Ghana Reference Group
GTZ	Deutsche Gesellschaft für Technische Zusammenarbeit
ILO	International Labour Organization
IMCI	integrated management of childhood illnesses
IOB	Policy and Operations Evaluation Department, Netherlands Ministry of Foreign Affairs
JICA	Japan International Cooperation Agency
M&E	monitoring and evaluation
MoH	Ministry of Health
NACP	National Aids Control Programme
NGO	non-governmental organization
NHIA	National Health Insurance Authority
OECD	Organisation for Economic Co-operation and Development
RHMT	Regional Health Management Team
SWAp	sector-wide approach
TB	tuberculosis
ToR	terms of reference
UNAIDS	Joint United Nations programme on HIV/Aids
UNDP	United Nations Development Programme
UNFAO	United Nations Food and Agriculture organization
UNFPA	United Nations Population Fund
UNHCR	United Nations Refugee Agency
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development

Executive summary

Background

The Ghanaian Ministry of Health (MoH), concerned about the inconsistency of performance between its districts, approached the Dutch government to assist it in examining the problem – which the MoH assumed may have been caused by capacity issues. The Netherlands Ministry of Foreign Affairs, through its Policy and Operations Evaluation Department (IOB), was at this time in the process of initiating a formative evaluation on capacity, capacity development and capacity development support. For the IOB evaluation, six studies were being carried out in a number of countries, looking at a range of development sectors. A framework of five core capabilities served as the basis for the evaluation. This Ghana MoH study became part of the broader IOB evaluation.

The general objective of the overall evaluation is to provide new insights into how, and under what circumstances, capacities are developed, and how support for capacity development can be provided more effectively.

The general terms of reference (ToR) for the multi-country evaluation focus on the following empirical areas:

1) What changes have taken place in the capacity of Southern organizations?
2) What effects have changes in the capacity of these organizations had on the realization of their development objectives (output and outcome)?
3) How effective have external and internal interventions been in terms of strengthening the capacity of Southern partners?
4) What factors explain the level of effectiveness of these interventions? What lessons can be learned?

External support covers all support provided to a Southern organization that is aimed at developing capacity. This support includes financial and technical assistance, other forms of support and assistance from national sources. When the organization's own resources are allocated to capacity development, this is regarded as *internal support*.

Methodology

This exploratory study was divided into two phases. Phase one was largely qualitative, and phase two had a quantitative component based on the output of phase one. In phase one, in-depth interviews were used to gather data in three districts in Ghana's Eastern Region – two of these districts were among the region's better-performing districts, and the third was an under-performing district. The second phase involved one of the better-performing districts and one under-performing district. The classification of the districts was drawn from a previous self-assessment peer-review project conducted in the Eastern Region in 2008 to examine the performance of its seventeen districts. Based on achievements, each district was give a score out of 100, and then given a grade between A and F, with A being the best grade.

The District Health System (DHS), which has various components, is the focus of this evaluation. Capacity development in the health sector aims to safeguard and improve the health status of the lay community. Therefore, the lay communities (which consist of individuals, families and other natural groups who access healthcare) are the key beneficiaries of the health system.

Developing capacity involves taking a mixed approach including training, developing systems, networking and mentoring, and empowering local communities to address local development challenges**.**

The Ghanaian health system evaluation had as its starting point the output and outcome of the work that took place in the districts. This was assessed using a composite mix of indicators developed by the regional health authorities. The study then used these indicators to assess whether there had been any changes in capacity and whether any enhanced performance could have been attributed to those changes in capacity. The study covered the period from 2006 to 2009.

Several capacity efforts took place in the districts. The four key efforts identified were:

- Training
- The provision of technical assistance
- Infrastructural improvements
- Knowledge management

Funding was not examined because the organizations, being government organizations, had to operate whether or not there was funding. The national insurance scheme did not feature directly in the study, even though it was expected to provide additional funds.

The capabilities were studied in reference to the five core capability (5CC) framework. Because of the difficulties with baseline data, current (2009) capabilities were examined and compared with those of other districts. The indicators for the core capabilities were customized for local circumstances in each case, but returned to their original wording for the analysis.

Key findings

1. **Output and outcome performance**

All three districts improved their performance during the course of the evaluation. But the two better-performing districts (Birim North and Kwahu South) consistently maintained higher scores than Atiwa the under-performing district.

The Kwahu South score went up from about 56% in 2006 to 73% in 2009; Birim North's score went from about 61% to 79%; and Atiwa's score, which was much lower to begin with, rose from 43% to 57%.

2. **Changes in capacity**

Although it was difficult to establish baseline data for the onset of capacity development, we were able to examine how many people benefitted directly from short-term training in the region as a whole, but not in the individual study districts. It appears that training was uniformly assessed and involved more than 55% of the staff in the region.

3. **Summary of the key issues in the application of the five 5CC indicators**

I. Leadership

Respondents discussed leadership in terms of individual characteristics and actions. Some district directors of health services (DDHSs) were described as transformational .They were action-oriented and used a participatory approach that was inspiring and motivational. Their leadership style involved using a consultative and participatory process to achieve results. This motivated staff, reduced staff attrition and generated exogenous support for the district. In contrast, other leaders were considered weak and non-responsive, which adversely affected the performance of their districts. Leadership in the better-performing districts promoted bottom-up communication and used participatory methods to solve problems and ensure work got done. Teamwork emerged as a strong attribute that arose from leadership style. It is clear from the evidence that staff members noticed when leadership was sloppy and inadequate, and could clearly attribute under-performance to the standard of leadership provided.

II. Legitimacy

Conceptual issues emerged in the narratives of respondents from all three districts. There was no ambiguity about who had political legitimacy and who had social legitimacy. Political legitimacy was defined in terms of an organization's relationship with and proximity to government and party political power. The District Health Management Team (DHMT) was perceived as serving a social role and was therefore described as socially legitimate. The differences between the districts lay in how they leveraged social and political legitimacy to support their work. In the under-performing district, the leaders esteemed political legitimacy and remained in awe of it, whereas in the better-performing districts, having such legitimacy was seen as an opportunity to mobilize additional resources.

III. Resource mobilization

The *capability to relate to external* stakeholders also emerged as a critical dimension of capacity. This is particularly so when mobilizing resources and bringing about infrastructural development. There was evidence to suggest that the way in which the DHMTs related to their external stakeholders determined their success and their ability to acquire additional resources. The better-performing districts employed social networking and lobbying, while the under-performing district did not. These were described by respondents as either 'alliances', when they related to public sector institutions, or 'collaborations', when they referred to other partners or communities.

IV. Adapt and self-renew

An analysis of the *capability to adapt and self-renew* highlighted differences between the districts. In the better-performing districts, the expansion of Community-based Health Planning and Services (CHPS) compounds and the use of internal resources to recruit staff suggested a certain level of self-renewal and adaptation. There was evidence of internal reflection, articulation of needs and the implementation of expansion strategies. There was a culture of reflecting on and addressing mistakes that occurred within the district system. There was also evidence of monitoring and evaluation (M&E), but it was unclear whether systematic learning was built into M&E because most DHMT respondents discussed learning in terms of individuals learning on the job. There was no evidence of adaptation and self-renewal in the under-performing district.

V. Community participation

Evidence showed that the better-performing districts involved communities in their health interventions. They saw no barriers in status and position, and were able to map out the comparative benefits offered by different types of stakeholders, and how these could be used to their advantage.

This meant that more communities took part in the health programmes and activities organized by their DHMTs. This active community participation was minimal in the under-performing district.

Conclusions and lessons learned

In general, the 5CC model was applicable when evaluating the DHS in Ghana, despite a few difficulties in applying the indicators to the rather complex health system.

The main lessons learned for policy development were that:

1. It was possible for changes in the capacity of the DHMTs to be realized even when baseline data was difficult to establish and respondents were unable to articulate whether changes that took place were positive, inadequate or problematic.
2. Output and outcome measures can be used when evaluating capacity. Even when attribution was difficult, it was possible to say that positive changes in capacity development did affect outcome.
3. The application of the 5CC framework indicated that endogenous capabilities were the most effective.
4. The key issues that were crucial to policy were:
    a. *Leadership*. Leadership that was transformational, participatory, involved social networking and hard work was crucial to capacity development. Such leadership cannot be acquired easily through training alone, but must be recognized when candidates are being selected for positions in an organization.
    b. *Legitimacy*. Both social and political legitimacy were necessary to achieve developmental objectives. In the best performing districts, this was used to great effect.
    c. *Ability to mobilize resources*. This was particularly relevant to the way in which the DHMTs related to their external stakeholders. As part of the Ghanaian health sector reforms, which were based on a sector-wide approach (SWAp), and in line with Aids effectiveness, external donors were asked to contribute to a 'common basket' of funds. This was then used to fund commonly agreed programmes. Over time, the 'common basket' of funds became smaller as some donors preferred to stay outside the common basket and administer their own funds. This meant that DHMTs that had the capabilities to lobby donors directly for these 'extra' sources of funding performed better.
    d. *Capability to adapt and self-renew*. One of the distinguishing features of the districts that performed well was their ability to use information collected as part of their M&E system to learn lessons about their work and to redirect their efforts. Where leadership, and the team as a whole, were entrepreneurial in their approach to work, they were able to go beyond immediate situations and rise to challenges. In comparison, the under-performing district was defeatist and lackadaisical in its approach.
    e. *Community involvement*. There was extensive community participation in the programmes of the better-performing districts. They received information regularly through community *durbars*[1] and this fostered a sense of ownership of the programme.

[1] Ghanaian traditional rulers sit in state and meet their people at events called *durbars* (a word that comes from an Indo-Persian term for ruler's court).

1. Introduction to the evaluation

1.1 Background of the evaluation

The Netherlands Ministry of Foreign Affairs through its Policy and Operations Evaluation Department (IOB) initiated a formative evaluation on capacity, capacity development and capacity development support. For this evaluation, six studies were carried out in a number of countries across Africa and Asia, and dealing with different development sectors. A framework based on five core capabilities (5CC framework), served as the basis of the evaluation. The Ghana Ministry of Health (MoH) study is part of this broader evaluation. The study was undertaken on behalf of the MoH by The Centre for Health and Social Services (CHeSS), an independent Ghanaian non-governmental organization.

The *general objective* of the evaluation is to provide new insights into how, and under what circumstances capacities are developed and how support for capacity development can be provided more effectively.

The general terms of reference for the multi-country evaluation focus on the following empirical areas:

- What changes have taken place in the capacity of Southern organizations?
- What effects have changes in the capacity of these organizations had on the realization of their development objectives (output and outcome)?
- How effective have *internal* and *external* interventions been in terms of strengthening the capacity of Southern partners?
- What factors explain the level of effectiveness of these interventions? What lessons can be learned?

External support covers all support provided to a Southern organization by third parties that is intended, directly or otherwise, for capacity development. This includes both financial and technical assistance or other forms of support and also covers assistance from national sources. The organization's own resources allocated to capacity development are considered *internal factors*.

1.2 Brief introduction to the development partners

The Government of Ghana and its health sector work with a wide range of development partners (DPs). Partners can be categorized under international organizations, international bilateral partners, UN agencies and other international organizations (see Table 1 below).

One of these health partners is the Christian Health Association of Ghana (CHAG), which represents at least eight mission health institutions[2]. Mission health institutions typically provide health services in remote areas of the country that are not served by government facilities. There is also a growing number of local and international health NGOs that work at national, regional, district and community levels. Ghana's development partners operate a rotating system of leadership where one partner represents the entire group for a period of three years. The Royal Netherlands Embassy took over from the Danish International Development Assistance Agency (Danida) in 2004, the United States Agency for International Development (USAID) became the rotating leader in 2007, and Danida took over the role again in 2009.

Table 1. Ghana's development partners

Category	Institutions
International donor organizations/Development banks	The African Development Bank, the Islamic Development Bank, the World Bank, the European Union, the International Monetary Fund
International bilateral partners	Danish International Development Assistance Agency (Danida), Japan International Cooperation Agency (JICA), Canadian International Development Agency (CIDA), United States Agency for International Development (USAID), Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ), United Kingdom Department for International Development (DFID), Royal Netherlands Embassy
UN agencies	United Nations Development Programme (UNDP), United Nations Population Fund (UNFPA), United Nations Children's Fund (UNICEF), International Labour Organization (ILO), United Nations Food and Agriculture organization (UNFAO), Joint United Nations programme on HIV/Aids (UNAIDS), United Nations Refugee Agency (UNHCR)
Other international organizations	Red Cross, Rotary Club, World Vision International

1.3 Reason for and purpose of the evaluation

In 2008, Ghana's MoH requested Dutch government support in studying what determines capacity and capacity development in the Ghanaian health sector. This study was to be part of the implementation of the sector's third, five-year programme of work (5YPOW III). The MoH was concerned about the poor performance of some district health services, despite financial and other investments. They assumed that the variations in performance were due to differences in capacity between districts. The Netherlands Ministry of Foreign Affairs responded to Ghana's request by holding an introductory workshop on evaluating capacity development in Accra in October 2008. The current evaluation study is an empirical follow-up to the workshop. As discussed in Section

[2] These include The Catholic Health Service, The Presbyterian Health Service, the Methodist Church, the Baptist Church, the Seventh Day Adventist Relief Agency (ADRA), The Assemblies of God Relief and Development Services, The Church of Pentecost, and the Lutheran Health Network.

1.1, this evaluation forms part of a multi-country evaluation study on capacity development in various developmental sectors.

The purpose of the overall evaluation of support for capacity development is to respond to the need, of the Ministry, the Dutch NGOs and their partners in developing countries, for knowledge and insights that would contribute to further policy development. The Ministry and the Dutch NGOs and their partners wanted to gain a better understanding of how, and under what circumstances, capacity development support can be effective, and how they can help to improve the performance of the sector. For that reason, this evaluation focused on understanding and identifying the factors and processes underpinning capacity development.

1.4 Objectives, key issues and evaluation questions

The conceptual framework for the study is presented in Figure 1.

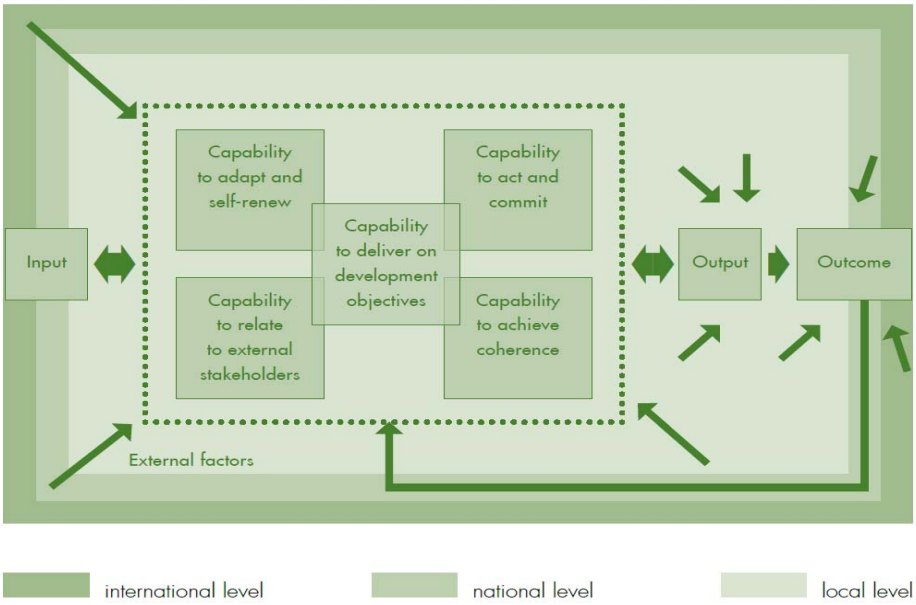


Figure 1. The 5 CC framework – a balanced approach to monitoring and evaluating capacity (source: de Lange and Feddes)

Changes in capacity are a central focus of this evaluation. The conceptual framework is informed by five core capabilities: (a) the capability to act and commit; (b) The capability to deliver on development objectives; (c) The capability to relate to external stakeholders; (d) The capability to adapt and self-renew; (e) The capability to achieve coherence. The indicators developed for these five core capabilities were customized to suit the specific context of the Ghana health sector.

Other issues that emerged from our interviews and the review of local and international literature on capacity development provided six thematic areas for investigation:

- The concepts of capacity
- Change agents

- Leadership
- Partnerships
- Health planning
- The socio-psychological dimension of human resources

Initial insights into these key issues were discussed comprehensively in the inception report and are presented in Annex 1.

The general objective of the overall evaluation is to provide new insights into how and under what circumstances capacity is developed. It also looks at how support for capacity development can be provided more effectively in order to make the sector to perform better. The evaluation focuses on identifying the factors that explain the results of support for capacity development. The main questions to be answered were drawn out as follows:

- What changes have taken place in the capacity of the health sector?
- Why do some districts perform better than others, and to what extent could this be explained by capacity?
- How do different approaches and interventions affect change and contribute to the success of the District Health System (DHS) and the realization of its objectives and those of the District Health Management Team (DHMT)?
- What are the internal and external factors that influence the development of capacity in the DHS?
- What are the main policy and implementation recommendations needed to develop DHS capacity?

1.5 Data collection

This is an exploratory, case-comparative study divided into two phases: a qualitative open-ended interview phase, and a structured quantitative data phase. The DHS is the unit of study in this evaluation, with special focus on the DHMTs. In the first phase, in-depth interviews were held to gather data in three districts in the Eastern Region – two fell into the category of 'better-performing district' and one was categorized as an 'under-performing district'.

1.5.1 Links to impact, outcome and output of the districts.

The starting point of the evaluation was the assessment of outcome, as shown in Figure 1 above. The indicators assessed in the Ghana evaluation were programme implementation issues such as services and management indicators (See Table 2 below). These indicators were derived from the MoH sector-wide indicators for measuring the performance of the health sector. They are in the form of a checklist, which was used to assess a district's performance. Targets were set by the Eastern Region, and each district's performance was measured according to the extent to which each of these targets was met. Numerical scores were given for each indicator. The scores were aggregated over all the indicators, and depending on the total scored, a grade from A to D was awarded. (See Report on Performance 2008 evaluation attached as Annex 3). The indicators are translated into impact, outcome and output indicators presented in Table 3 below. When reviewing the indicators it was clear that process indicators were equally important and these were then included. At the end of each year, districts were classified according to performance in a league table.

Table 2. Table of indicators used to assess the performance of districts in the Eastern Region.

Key Areas	Indicators
Maternal health	Maternal deaths Stillbirths Antenatal care Supervised deliveries Family planning
Child health	Under-five deaths Under-one deaths Malaria under-five death rate (CFR) Penta 3[3] immunization Measles immunization coverage
Disease control	Cholera cases Guinea worm cases detected Tuberculosis defaulter rate Tuberculosis cure rate HIV prevalence rate
Management	Doctor -to-population ratio Nurse-to-population ratio Emergency preparedness Financial management system development Carrying out of training

Table 3. Indicators for assessing districts' performance[4]

Criteria	Indicators
Impact	• Case fatality for malaria, diarrhoea in children • Institutional maternal death ratio
Service delivery outcome	• Coverage for antenatal care • Coverage for immunization • Coverage for family planning • Coverage of skilled attendants at delivery
Service delivery output	• Outpatient attendance per capita • In-patient attendance per capita • Disease control statistics
Service delivery processes	• Quality assurance system present • Emergency preparedness. • Finance and administration. • Training conducted

[3] Penta refers to pentavalent vaccines that combine five vaccines into one, and which is administered three times to children at monthly intervals starting at the age of ten weeks.

[4] These indicators were reconstructed from those used in Table 3 to reflect the system used by the MoH as sector-wide indicators.

The classification of the districts was drawn from a previous self-assessment peer review project carried out in 2008 in the Eastern Region to examine performance in its seventeen districts.[5]

- Five districts received high marks: Birim North (which has no hospital), West Akim, Kwahu South, Kwahu West and Kwaebibirem. They scored an aggregate of B+, which was a measurement of the best team work among the district institutions.
- Three districts were placed in the bottom category: Atiwa, Yilo Krobo and Birim South. They scored either a C or a D. Atiwa and Yilo Krobo were described as deprived and under-resourced.

Based on the score card and discussions with the regional health authority, three districts were selected for the study: Kwahu South and Birim North, from the better-performing group; and Atiwa from the under-performers.

Working backwards (see the framework in Figure 1 above), we can examine the part played by capacity changes in the observed performance of the selected districts. According to the methodology represented in the framework, the districts that performed best should have had more of the positive attributes of the capacity criteria than those that did not do well. The five core capabilities of the three health districts were assessed during the case studies and examined to determine the extent to which changes in outcome could be related to changes in their capabilities. The capabilities indicators were first customized to suit the local situation during the inception phase.

1.5.2 Capacity changes

The principal limitation of this study is that baseline capabilities were difficult to establish. Even though capacity, or the lack of it, was seen as critical to the performance of the health sector, there was no systematic programme or strategy for developing capacity in the MoH or its agencies. It was however acknowledged that capacity development took place in a uniform manner and was an integral part of the health sector reforms. This was consistent with the way the health sector reforms were rolled out uniformly and simultaneously across the country, as opposed to in a phased approach. To make up for this lack of baseline data, the capability levels of the better-performing and the under-performing districts were compared. And it was assumed that any changes in the capacity development would be uniformly applicable in the districts. Both positive and negative changes in capacity were reviewed. Four main typologies or 'products' were examined: training, technical assistance, infrastructural development and knowledge management. Though financing was considered, it was not explored because generally, government institutions still have to operate with or without the requisite funding – unlike NGOs, whose operations cease once funding dries up.

1.6 Focus and limitations

The focus of the evaluation is the DHS. The Ghanaian DHS is a complex system comprising the Ghana Health Service (GHS), DHMTs, hospitals and health centres, and Community-based Health Planning and Services (CHPS) zones. It is answerable to the District Assembly (DA), and works in partnership with community health systems, private health systems (hospitals, health centres,

[5] Appiah-Denkyira E., Djan K., Commey K., Sarkordie B., Fianko A (2008). 'Performance League Table For Districts - An Initiative In The Eastern Region Of Ghana, with focus on the Health-related Millennium Development Goals.

pharmacies), and development partners. Partnerships with agencies responsible for public health determinants that lie outside the GHS-MoH remit, such as water and sanitation, have also been identified as important. This partnership of service-oriented institutions provides health services to lay communities, who are described as integral to the DHS as both drivers and benefactors. The key institutions, groups and communities that have been collectively identified in existing literature as the DHS are presented in Table 4.

It is important to note, that following the terms of reference, the evaluation employed a bottom-up approach to understanding capacity development. We aimed to focus on the structures and processes of capacity development as conceptualized and experienced within the DHS. We aimed to work our way from *within* the DHS (what happens at district level in terms of management of service provision) to the outside (the governance role and power of the Ministry of Health, the GHS, the District Assembly and development partners to structure and support capacity development at district level). This necessitated identifying and following up the broad range of partners of the DHS, both within and outside the system, as articulated by the DHS community. This approach had two implications. First, we had to record discrepancies between prevailing concepts and what was experienced on the ground. Second, we had to be open to new forms of partnerships that had not been identified and discussed in the local literature.

We aimed to study both the structure and the process of capacity development within the DHS. We worked on the premise that a bottom-up approach did not exclude top-down processes. On the contrary, bottom-up processes deepened understanding of how top-down process were perceived, experienced, and negotiated by recipients. Our conceptual framework included the concepts of endogenous and exogenous accountability (see Annexe 1), in order to understand external, internal, and insider-outsider dynamics of capacity development.

Table 4. The DHS and its partners[6]

DHS: Categories of partners	**List of Partners**
1. Service delivery	Ghana Health Service (GHS) • Hospitals • Health centres; CHPS zones • Community healthcare workers, traditional birth attendants, etc. Health partners • Formal: private hospitals, clinics, maternity homes • Chemists and pharmacies • Health NGOs (especially Christian Health Association Ghana (CHAG)) • Informal: traditional healers, faith/spiritual healers; alternative health providers

[6] In the inception report we used 'stakeholders' and 'partners' interchangeably. This reflected the way the terms were used within the local context. We anticipated that a systematic examination of the nature (structure, relations, goals) of 'collaborations', 'networks' or 'associations' characterizing the DHS would reveal the most appropriate (endogenous) label for groups working together within the DHS.

2.Coordination, management and planning	GHS services: The District Health Management Team (DHMT)
3. District partners: Governance structure	District Assembly (DA) structures • Administrative • Political • Environmental health
4. Community partners – the ultimate beneficiaries of services and capacity development	Lay community • Individuals and families, • Civil, religious and political groups
5. Sector departments at district level	• Education • Local government • Department for Water and Sanitation
6. Regional and national partners: Governance structure	Regional health management teams Ministry of Health, including priority programmes Universities and research centres The National Health Insurance Authority (NHIA) regional office and the District Mutual Health Insurance Scheme (DMHIS)
7. Development partners	Development partners (working directly with districts)
The shaded sections of the table refer to categories of partnership that are not formally acknowledged in the local literature but appear regularly in the accounts of the DHS community.	

1.7 Organization

The study was conducted in two phases:

1. Phase one was a *preparatory phase* in which the following activities took place:

    - Stakeholder meetings. Several such meetings were held with IOB staff. Among those who attended were Paul Engel of the European Centre for Development Policy Management (ECDPM), a representative from the MoH, a group of partners involved in capacity development and known as the 'Reference Group', and GHS staff from regional and district levels. The meetings were to (i) inform all actors involved about the study and how it was to be managed; (ii) to discuss scope, objectives, specific study questions and expected results and to outline how the determinants of capacity development would be determined, and (iii) to agree on the inception report.
    - The establishment of the Ghana Reference Group (GRG), or steering committee.
    - A desk study on capacity development policies in the country's health sector – what policies and strategies already existed in the MoH, GHS, and the various priority

programmes in the country. At central level, representatives of the development partners and all the members of the GRG were contacted and their documents collected and studied in terms of the specific characteristics of different health partner's support for capacity development.
- Interviews were conducted with all members of the GRG, which included MoH staff.
- Translation of the 5CC framework into Ghana-specific indicators (see Annex 5 for this translation as well as the data collection tools used for the qualitative and quantitative phases).
- In the Dangbe West district, whose district director is on the GRG, pre-testing of data collection tools was carried out.

The output of this phase was written up as an *inception report*, which was reviewed by the external reference group, and the feedback that was received was used to amend the tools.

A reference group was established by the MoH to direct the evaluation. The role of the reference groups, as conceptualized by IOB, was to ensure that there was consistency with the other external country evaluations, and with the information needs of the Ghana health sector. The main tasks of the reference group were to:
- provide advice
- ensure the link between this study and the overall review process
- review the application of the evaluation methodology
- monitor progress
- advise on the quality and relevance of the reports

The reference group consisted of representatives of different agencies who had a stake in health sector capacity and capacity development. The representatives were drawn from the MoH, GHS, the development partners, DHMTs, patient groups and independent health policy experts.

1.8 Conducting the evaluation

A. Phase one: qualitative data collection

An open-ended questionnaire was developed based on the 5CC framework presented in Figure 1. These were complemented with other issues that emerged from our interviews, along with a review of local and international literature on capacity development, and provided six thematic areas for investigation:
- The concepts of capacity
- Change agents
- Leadership
- Partnerships
- Health planning
- The social and psychological quality of human resources

By choosing systems issues that lay at either end of the performance spectrum, and by analyzing the internal dynamics within that system and between it and its stakeholders, we envisaged that we could evaluate the 'connections between the capacity development of a DHS and its effects on the health-related dimensions of Ghanaians' as outcome or impact.[7]

[7] Review comments on the inception report by Alan Fowler.

For each district, we actively recruited respondents from the partners listed in categories 1 to 3 in Table 4 above. Depending on access, we also recruited respondents from at least two of the categories 4 to 7. We aimed for the minimal set of four respondent groups that are presented in Box 1.

Box 1. Segmentation of the capacity development evaluation respondents
Group 1: The Ghana Health Service
1a. The DHMT (management)
1b Hospitals, health centres, CHPS zones, community healthcare workers (service delivery)
1c. Chemists, pharmacies, NGOs in the health sector (health partners)
Group 2: The District Assembly
Group 3: Regional and national partners
3a. NHIA/DMHIS
3b. Other NGOs and private sector institutions;
Group 4: The community (civic, religious and political groups)

The fieldwork was carried out in February 2010. Data was gathered using mainly one-to-one interviews. In the initial methodology presented in the inception report, we aimed to conduct individual discussions and focus group discussions in each district. Because of the small number of respondents available, only individual interviews were conducted, with the exception of Birim North, where one focus group discussion was conducted with three community health volunteers. This allowed for more in-depth understanding of personal and professional histories and viewpoints.

Seven key areas and 23 sub-themes were explored in the interviews. All the interviews were transcribed verbatim and analyzed using a thematic framework. Attention was paid to consensus, conflict and absence within each transcript, across transcripts belonging to strong groups (for example, the DHMT and hospital management) and across all the data that was collected. A manual was produced to guide the analysis process. Each district's data set was analyzed by one member of the research team.

B. Phase two: Quantitative data collection

This second phase grew out of the observation of change that took place in the field of study. After conducting the first phase, the research team had wanted to validate which of the five concept areas stood out as the most significant in influencing performance. Unfortunately, this couldn't happen because the district director of health services (DDHS) in Birim North (a better-performing district) was transferred to Atiwa (an under-performing district) in the middle of the process in January 2010. This unexpected change in the research field was a setback for the researchers, who then decided that it might be useful to repeat the study in a quantitative form eight months after the district director's move to assess changes in responses. The object of this was to validate the phase one findings, which indicated that the quality and style of leadership was crucial and had an effect on perception and action in the five element areas. The questionnaires were therefore administered in only Birim North and Atiwa. The findings of this phase are published separately as an addendum to this report.

1.9 Report outline

The report is presented in five chapters. Chapter 1 presents the background to the evaluation. Chapter 2 focuses on the case studies and the results of the evaluation – the results of each district case study are described and a synthesis of key findings is presented and discussed. Chapter 3 focuses on the implications of the evaluation findings on policy reconstruction. Chapter 4 focuses on lessons learned from the evaluation study. Chapter 5 contains the Annexes.

2. The case studies

2.1 Changes in the outcome of district performance and links to capacity changes

Table 5 shows the grades of the three districts analyzed for monitoring and continuity scores for 2009. Table 6 shows changes in output and outcome from 2006 to 2009, the period of the study. The health profile of each of the districts is provided in Annex 3.

Table 5. Output of the three selected districts, Birim North, Kwahu South and Atiwa

District	Disease surveillance and control	Prevention of under-5 mortality	Prevention of maternal mortality	Management	Monitoring scores 2009 (40%)	Continuous assessment 2009 (60%)	Final grade (2009)
Birim North	A	A	A	A	B	C+	B+
Kwahu South	B+	C+	B	A	B+	B+	B+
Atiwa	B+	C	B	B	B	D	C
Source: Performance league table for districts: An initiative in the Eastern Region of Ghana, 2009.							

Table 6. Output/outcome performance of the three districts studied in the Eastern Region, using numeric scores

District	Overall score			
	2006	2007	2008	2009
Kwahu South	56.5	76.2	73	72.7
Atiwa	43.3	57.1	54	57.4
Birim North	61.2	81.4	80	79

Generally, the two better-performing districts, Kwahu South and Birim North, achieved higher scores over time than the under-performing district, Atiwa. This is despite the fact that all three districts showed upward trends. We can infer from this that the capacity development processes that took place had more effect in the better-performing districts than in the under-performing district.

2.1.1. Types of capacity development provided

In the case studies, four types of capacity development were examined. But a good deal of emphasis was placed on the effectiveness of training and human resources. These are indicated for each case study. In general, the capacity development processes were deemed to be positive. Where they were mentioned as negative, it was more in relation to the fact that what was provided was inadequate.

Table 7 gives an overview of the training that took place in the Eastern Region as a whole. This level of detailed information was not available for the individual districts being studied, but it was understood that the benefits were the same for all the districts.

Table 7. Training carried out in the Eastern Region as a whole

Year	Numbers trained	% of staff receiving training	Content of training
2006	2550	58	Family planning, HIV/Aids, safe motherhood and trauma management, financial management, leadership, etc.
2007	2480	54	Capital investment, nutrition, surveillance
2008	2885	64	Sexually transmitted infection, expanded immunization programme, outpatient department management, etc.

Funding was not extensively analyzed because, being a government institution, whether they have funding or not, the District Health Management Team (DHMT) has to operate. However, funding *was* examined in the case of the District Mutual Health Insurance Scheme (DMHIS). In all the districts, the scheme's effect was described as 'problematic'. One of the scheme's objectives was to raise more funds for the sector, but since its inception no specific allocations were made for the districts. The intention was to reimburse service providers for their clinical care. However, there were reports of indebtedness that have affected the operation of hospitals and clinics. The National Health Insurance Authority (NHIA) responsible for providing subsidies to DMHIS to pay for claims submitted to them has reported marked improvements in reimbursements to the providers. The insurance scheme in itself does not have the objective of providing capacity development support for the districts.

In the health sector, it is always difficult to attribute outcomes to any specific initiative. This is because capacity development indicators are always the result of a complex combination of factors, some of which are not directly related to any action undertaken by the health service organization. As noted earlier, the Eastern Regional Health Administration uses a peer-review mechanism to evaluate the performance of its districts. The results are translated into annual performance league tables. The results in Table 8 show that the level of capacity development activities in the Birim North District put it above its peers in terms of achieving its objectives. In the three-year period 2007–2009, Birim North had consistently been ranked as one of the Eastern Region's better-performing districts.[8] Three of the region's 17 districts, including Birim North, tied for first place in 2009. Because of the training and the high level of long- and short-term technical assistance received, this district had a near perfect score for a number of selected indicators.

[8] This is based on the annual peer review reports produced under the 'Performance League Table for Districts; An initiative in the Eastern Region; Ghana Health Service; 2007, 2008 and 2009'.

The local community contributed to this by providing technical support – but this contribution has not yet been adequately explored. However, in the course of the interviews, it became clear that the part played by district-level stakeholders in facilitating access to resources contributed significantly to the results achieved.

2.2 Presentation of the case studies

Each case study in this evaluation will be presented in two parts. The first part will focus on a summary of what was discussed in the interviews, under three headings: (1) The definition of capacity development; (2) A brief history of capacity development in the DHMT; and (3) The five core capabilities that constitute capacity development. Note that the five core capabilities had a further 23 sub-themes that were explored in all the interviews.

For each case study, a general rule was applied. Consensual themes were discussed first, followed by conflicting and absent themes. The district reports presented a broad range of quotes from across the three main areas and 23 sub-themes. However, to achieve the brevity and clarity demanded in this synthesis report, the quotes are presented as follows. For consensual themes, one quote that captures shared meaning is given as an example; for conflicting themes, quotes that reflect the nature of the conflict are given; and for absent themes, underlying factors are discussed.

The second part of each case study will discuss the results by focusing on the following key questions outlined in the terms of reference:

- What positive and negative changes have taken place in the capacity of the organization with reference to the five core capabilities?
- What effects have changes in the capacity of the organization had on the outputs of the organization and the realization of its development objectives (outcomes)?
- How effective have development partner (DP) and other external interventions been in terms of strengthening the capacity of the organization?
- What explains the level of effectiveness of DP and other external interventions? What lessons can be learned from the case study?

2.3 Case study 1: Birim North

A total of 13 respondents participated in the Birim North evaluation. These were spread across the four segmented groups, as shown in Box 2.

Box 2. Birim North respondents across categories	
Group 1: The GHS	
1a. The DHMT	5
1b. Hospitals, health centres, CHPS zones, community healthcare workers	1
1c. Chemists, pharmacies, NGOs in the health sector	2
Group 2: The DA	1
Group 3: Regional and national partners	
3a. The NHIA and the DHMIS	1
3b. Other NGOs and private sector institutions	0
Group 4: The community (civil, religious and political groups)	3

2.3.1 Definition of capacity development

Training emerged as a consensual definition of capacity development – mentioned by 11 of the 13 respondents. This broad theme included definitions such as human resources development and knowledge to improve work. In all the narratives, healthcare workers were the target of training. This was understood as basic skills acquisition and on-the-job training.

> *Training is building upon what you already know in terms of skills. For example, I was trained as a community health nurse and when I came into this district, I had to understudy a community health officer (CHO). That was on-the-job training. My capacity was developed when I was taken to Nkwanta to be trained as a CHO ... and we are also called at the district level to be trained on the job.* – Quote from a community health officer

Three respondents provided definitions that captured human resources, institutional and infrastructural development. These respondents were mainly Ghana Health Service (GHS) partners. One respondent articulated as follows:

> *Capacity development to me is about strengthening the institutional capabilities to be able to deliver. I think this deals with human resource development, building the institution itself, providing logistics and all that the institution will need in order to be able to function or provide the services for which it has been instituted.* – Quote from a Dutch development partner

Capacity development was also defined in terms of leadership; leadership style, the background of a leader and that leader's capacity development. A respondent said that in his opinion, leadership is a particular trait of an individual.

> *Capacity development may also be dependent on the type of leadership* [an individual embraces]. *Not all leaders see capacity development as important … I believe it all depends on who is at the helm of affairs at a particular time.* – Quote from a district coordinating director of the District Assembly

This view was not a minority view. One respondent, asking to be excused for having no academic or English-language words for the concept, expressed an understanding in a local language (Twi), loosely translates as follows:

> *We have heard of the word 'capacity' but as to the real meaning, I cannot tell. Madam* [meaning District Director of Health Services] *and the authorities at Abirim* [meaning Birim North District] *have not explained its meaning to us. I see a lack of capacity to be a lack of strength. A lack of capacity is the inability to do work. I see the lack of capacity as something not being up to a required standard.* – Quote from a community-based health volunteer

There were no conflicting definitions of the concept of capacity development. However, there was a clear case of absence. Three respondents did not answer the question and all three stated that they did not know the answer and had not been educated about the term 'capacity development'. Absence in this case could be interpreted in two ways. All three belonged to Group 4 (the community) and did not have a way of expressing the concept of capacity development. This may also suggest that the term was a technical term known to health experts and their partners for the purposes of doing their work at institutional level and within the community. However, it is important to note that the definitions presented by the community health volunteer and the chemist in the district suggested that a lack of knowledge of the technical English definition of capacity development did not mean inability to understand the meaning of capacity or capacity development.

2.3.2 Types of capacity development and impact on output in Birim North

Types of capacity development activities: Respondents from the DHMT and District Health System (DHS) partner groups were asked to provide a brief history of any capacity development activities in the DHS.

The majority of DHMT respondents observed that *we came to meet it* [capacity development]. No timeline was ascribed to the introduction of capacity development in organizational practice. The respondent with the longest history of service was the district coordination officer, who had worked in the district since 1980. His response mirrored the general view: *I came to meet it so I don't know where it came* [from].

These views suggested that capacity development was part of institutional ethos and practices and not a systematically planned intervention. But in keeping with the limited definitions of capacity development, there did not appear to be much discussion and of the concept, or questioning of it, within the DHMT. The interviews suggested that capacity development was one of a range of institutional rules and practices an employee encountered and engaged in, with minimal reflection or critique.

There was consensus that different aspects of capacity development support had been provided by 'local and foreign partners'. Some respondents mentioned a range of capacity development

supporting institutions and organizations, either in response to this segment of the interview or during other sections, such as when discussing the availability of resources. The types of capacity development activities mentioned are mainly across four areas: training, technical assistance, infrastructure and knowledge management. But the focus has been on training and technical assistance. The list in Table 8 is generated from respondent accounts and official documents. It is important to note that a significant proportion of MoH, GHS, National Aids Control Programme (NACP) and other government agency support is based on development partner funding. The way in which training and technical assistance is provided to the district by these institutions can result in these services not being made available to district-level workers.

Table 8. Birim North health partners and types of capacity development support provided

	Training	**Technical assistance***	**Infrastructural development****	**Research and information systems**
GHS				
Health NGOs Ntiamoah Foundation Peace and Love Foundation Quality Health Partners Ghana Sustainable Change Foundation	(+)	(+) (+) (+) (+)		
Community health volunteers***		(+)		
Licensed chemists		(+)		
District Assembly		(+)	(+)	
Sector departments				
Ghana Education Services		(+)		
Ministry of Food and Agriculture		(+)		
Regional and national partners				
Regional Health Management Team (RHMT)		(+)		
MoH	(+)	(+)		
National AIDS Control Programme (NACP)		(+)		
Pharmacy council	(+)			
Development partners & other int. partners				
Japanese International Cooperation Agency (JICA)	(+)	(+)		
Newmont Mining Company		(+)		
Population Council		(+)		(+)
USAID		(+)		(+)
Community				
Chiefs/assemblymen/unit committees		(+)	(+)	
Teachers		(+)		
General community		(+)		

*Technical assistance includes the provision of services and the donation of funds, minor equipment and perishable goods.

**Infrastructural development includes the provision of land, buildings and labour to build infrastructure.
***Community health volunteers are usually placed in the 'community' category. It is important to place them explicitly within the GHS service category as they invest significant time in providing valuable services at community level (see case studies).

Long-term training opportunities had transformed the skills base of the core management staff. Within the period studied, the district director and the hospital superintendent had both received Master of Public Health degrees. As we can see from the national-level analysis presented in Chapter 3 of this report, the funding for this further education came from the Aide Pool Account. All senior staff had also gone through the District Health Systems Operations (DISHOP) courses provided by the MoH/GHS. The National AIDS Control Programme (NACP) and USAID had also delivered refresher courses in relation to surveillance and monitoring activities around the three Millennium Development Goal areas (MDGs 4, 5 and 6). Every staff member interviewed acknowledged that they had received some form of training that directly related to their work.

There had been no long-term technical assistance provided to the district. However, short-term technical assistance at both senior and junior levels was provided by the agencies and community members referred to in Table 4. The technical assistance provided by the Ghana Health Service (GHS), USAID and NGOs in the health sector had mainly focused on providing technical experts for planning and management systems development, surveillance design and implementation, monitoring and evaluation of programmes. The training and technical assistance received has improved the report and proposal-writing skills of the district managers and has given them the confidence to approach external partners to mobilize additional human and financial resources for the district. Support from community members has focused on service delivery, particularly in relation to immunization services, health education and creating awareness, specifically in terms of introducing new policies and changing agendas. The individual and total costs of training and technical support provided for the district is not known.

2.3.3 The five core capabilities

A. *The capability to act and commit*

As a result of enhanced capacity, the Birim North district healthcare workers were able to better manage resources and coordinate their activities to improve their capability to act and commit. On the question of planning, all respondents observed that the DHMT had a plan, took decisions and acted on them, and monitored their plans collectively. This collective approach was employed at DHMT level, at the health centre level and the Community-based Health Planning and Services (CHPS) compound level.

> *Yes, we have a composite action plan where all the units bring their action plans together. Because of inadequate funds we don't run vertical programmes. If it is time to go for monitoring, we all go together and when we have a training programme, we add other things to the agenda. Our composite action plan is annual. We have meetings every week and we also have weekly and monthly action plans.* – Quote from the Birim North district director of health services

Yes, we have drawn a format so every month you analyze your report to see if you are on track. We try to fill the gaps if there are some. With other services, I sit with the community health nurses and then we pick up from where we are not performing compared to the target we have been given from the district. We also do performance appraisals and then quarterly we do job evaluation. – Quote from a community health officer

These actions were possible because of the post-graduate and DISHOP training received and the technical assistance provided by external partners to strengthening the district's capacity in terms of planning. Indeed, respondents acknowledged that because they now have better developed plans, they were able to engage in adequate human, institutional and financial resources mobilization. In terms of human resources mobilization, they now have the capability to develop active plans to recruit the categories of staff required. In terms of institutional and financial mobilization, the DHMT continued to work with the DA and other stakeholders to address limitations. Money for the DHMT came largely from the GHS/MoH. But there was also cash and in-kind contributions from the DA and NGOs. The mobilization activities of the DHMT were corroborated by key stakeholders from the DA and from the NGO community.

Recently, during our annual review we talked about adequate and skilled midwives in the system so our human resources manager has written to the region. ... with financial mobilization, we lobby for it by writing proposals. Quote from a deputy director of nursing services

We provide support in the form of vehicles for national immunization days, infrastructure and logistics … Based on the requests of the DHMT over the years, we know their requirements and we always set resources aside to meet that aside that for the physical constructions of health infrastructure that we budget for. We also help in the construction of CHPS compounds and provide accommodation for their staff. However, I cannot readily give the percentage of our budget that goes into health. – Quote from a district coordinatng director

B *The capability to deliver on development objectives*

The impact information in Table 5 demonstrates clearly that the Birim North District was able to deliver on its development objectives. However, there was a combination of constraining as well as positive factors at work in the district.

On the positive side, respondents noted that leadership played a significant role in attaining the institutional objectives. Leadership was discussed in terms of individual characteristics and actions. There was a strong consensus that the previous DDHS was a transformational leader.[9] He employed an action-oriented participatory approach that was inspiring and motivational. This view was expressed by respondents from all groups – representatives from the Department of Community Development, NGOs, district health insurance schemes and members of the community – when the question about the *capability to relate to external stakeholders* was asked. While 'integrity' was not explicitly discussed, the views expressed on the participatory and transformational leadership style of the previous DDHS, and his ability to inspire and motivate staff, suggested that he was perceived to have integrity.

[9] Birim North's immediate past DDHS is now the DDHS for Atiwa.

Yes! Mr. X encourages us when we are doing well, and when we are falling short, he tries to help us out. With him, I did not mind staying late at work because of his leadership style and his relationship with us. – Quote from the disease control officer

Mr. X had an extraordinary sense of commitment … I saw him to be a practical man and somebody who was prepared to serve. He led by example and could be seen in the office even at night. He went the extra mile to ensure that things were done properly. I have had interactions with the DHMT staff and I realized that they were all prepared to help him achieve his vision. In fact I will say he was a driving force. – Quote from district coordinating director of the District Assembly

One other leader was identified at the community level: the CHPS coordinator.

My CHPS coordinator is very inspiring. CHPS is in Birim North because of him and most of us are in CHPS because of him. – Quote from a community health officer

The second positive factor in the Birim North district was the ability of the leadership to mobilize logistics. Respondents noted that they were able to deliver on development objectives because they were able to mobilize adequate drugs and vaccines. At community level, infrastructure was considered to be adequate because the communities had contributed to the building of CHPS compounds – and according to the community health officer and the district director of health services, some rooms were even under-used. Below are some sample responses:

With logistics, we are doing well because most of the time we go to Koforidua stores for our vaccines, drugs, etc. – Quote from the district nursing officer

Birim North is well endowed in CHPS, there are plans in place and some communities have even put up CHPS compounds, which are running, and others are yet to be commissioned because the CHOs are yet to be posted. – Quote from the district director of health services

But however positive certain factors were, Birim North still lacked adequate resources. There was a consensus that the district lacked the ideal combination of personnel and infrastructural and knowledge resources that would enable healthcare workers to carry out their work effectively. Collectively, the DHMT respondents generated a list of the resources they lacked. This list included transport, technology, human resources and access to information and information technology.

Table 9. A list of resources and personnel required by Birim North DHS

Resource category	**List of resources required**	**Selected quotes**
Infrastructure	Premises for the DHMT Vehicles (motorbikes and cars) Lab equipment (e.g. oxygen cylinders) Computers *Financial resources	*…with computers we need more. The resources are not enough but we are able to manage. When it comes to transport, we have only one car which restrains our movements. We are really lacking when it comes to transport*. – Quote from the district nutrition officer
Human resources	Midwives Doctors Field technicians.	*Human resources are not adequate. One person can handle about three programmes at a time. We also have only four midwives in*

	Health extension workers. A health information officer	*the district. We have CHPS zones where many people go for antenatal care, but when it comes to delivery, staffing is still low.* – Quote from the district nutrition officer
Knowledge resources	Library of health literature Internet	*No! We only get some publications from the district to read. We don't have a library neither do we have internet service.* – Quote from the district coordinating officer

In terms of human resources in the district, two DHMT respondents felt that the human resources situation was not stable. A dearth of career progression opportunities for young healthcare workers and a lack of motivation were cited as key factors causing the instability of the district's workforce. There was also the threat of a steady loss of community volunteers because they were not appropriately supported.

Challenges notwithstanding, respondents, including DHS partners, stated explicitly that the DHMT worked hard to deliver on its objectives, despite lacking adequate resources.

> *Though they don't have adequate resources, they are still able to manage most of the cases that are brought to the clinic.* – Quote from the chemist

C. *The capability to relate to external stakeholders*

This theme was explored by all respondents. The ability of the DHMT to relate to its external stakeholders was said to be the principal factor that helped the DHMT deliver on its objectives. There was also evidence to show that the DHMT was able to deliver on its objectives through the alliances it had built and maintained with the DA, the NGO community and the lay community (with specific reference to community health volunteers, chiefs and teachers).

Two conceptual issues emerged that are worth further discussion because they were also referred to by respondents in Kwahu South and Atiwa. First, most DHMT respondents made a distinction between political legitimacy and social legitimacy. Political legitimacy was defined in terms of an organization's relationship and proximity to power (government and party-political power). For many respondents, the DA had political legitimacy. In contrast, the DHMT was perceived as serving a social role and was therefore described as not having social legitimacy rather than political legitimacy. There was consensus on the social legitimacy of the DHMT.

> *They see us as a social entity not a political one.* – Quote from the district nursing officer

Second, respondents appeared to prefer the terms 'collaboration' or 'alliance' to 'coalition'. Generally DHMT respondents discussed 'alliances' in terms of working with DHMTs in other districts.

D. *The capability to adapt and self-renew*

First, there was a consensus within the DHMT that management had an understanding of shifting contexts and relevant trends (external factors).There was also a consensus that management had the

confidence to change. Under the previous DDHS, the DHMT had always 'left room for diversity, flexibility and creativity'. A number of change issues were recounted. These included

- the introduction of the exemption scheme
- the abolition of user fees
- the introduction of health insurance as a prepayment mechanism
- the move from chloroquine to artemisnin-based combination therapy for the treatment of malaria
- the adjustment in policy on the recommended level of CD4 count that was needed before putting patients on HIV treatment

All of these were put down to the fact that the district received appropriate technical support and training to effect these changes.

Respondents also observed that trying to adapt to a fast-changing environment can be difficult in an under-resourced environment. The challenge of changing community health practices was a central theme. One community health officer put it succinctly: *It is not easy to change*.

There was evidence of monitoring and evaluation, but it was unclear whether systematic learning was built into this. Most DHMT respondents discussed learning in terms of individual, on-the-job learning. This bias was perhaps a product of individual definitions of capacity development.

Concerning renewing knowledge, the DHMT leadership expressed interest in training and developing the potential of healthcare workers. They were, however, concerned that healthcare workers working in districts, remote areas and at community level were least likely to have ongoing education opportunities. They believed that this was likely to affect motivation and be a disincentive for retention of staff. The following statements reflect these sentiments.

> ***...****We do not have the means to continue our education. Those in the towns are really benefitting more than us.* – Quote from the disease control officer
>
> *We depend heavily on our volunteers but from what I have seen in the records, their numbers are reducing. The reason for this is that they are not motivated.* – Quote from the district director of health services

E. *The capability to achieve coherence*

Birim North draws its mandate from being a government agency. It subscribes to the general health sector vision and aspirations of the Medium Term Health Strategy. However, the district has as one of its goals the promotion of universal coverage of a level of service of intervention, based on the CHPS concept. Responses from respondents suggest that individuals were able to translate this vision and reflect it in their work ethic.

> *Yes, with nutrition, I know that I am supposed to improve the nutritional status of the community. With children, our mission is to improve malnutrition so we make sure mothers feed their children for six months. We draw our plans alongside the vision. They are known by all staff.* – Quote from the district nursing officer

2.3.4 Interpretation of Birim North's results

Most GHS respondents could not provide a historical account of capacity development in their district. This made it difficult to track positive and negative changes over time. However, two dominant developments in capacity at Birim North were support for health worker training and technical assistance to deliver services (see Table 5).

In terms of positive changes in capacity development, two partners had supported infrastructural development. The DA provided support for the construction of CHPS compounds and chiefs and the traditional leader provided land for the construction of the DHMT building (Table 5). The development of the CHPS system had strengthened healthcare services at the community level.

Two forms of capacity emerged. First was the role of good leadership. The previous district director of health services was described by the DHMT and its stakeholders as 'transformational'. He had inculcated a strong goal-oriented work ethic at the DHMT and at the community level. This ethos was visible to stakeholders. The second form of capacity was community engagement in health sector activities. Birim North communities were both the agents and the beneficiaries of health service delivery, particularly through the work of volunteers and the largesse of traditional leaders. Both forms of capacity can be categorized as 'endogenous capacity'.

Negative changes that occurred included the following:

- A continuing lack of resources – human resources, infrastructural resources, and knowledge resources
- Weak support for community-level workers, which threatened to undermine the benefits of endogenous capacity

Birim North has a new district director of health services. This director may or may not have similar attributes to the previous director and might have a different approach to leadership. This presents a unique opportunity to examine the nature of a good leader (whether dispositional, situational or both), and the relationship between quality leadership and capacity development input–output–outcome. It will be useful to track the progress of the district with the new district director of health services in charge to examine the role of top-down and bottom-up processes in successful healthcare delivery. This will be a key focus of the quantitative strand of this evaluation.

Training has led to better-skilled workers particularly at community level. The development of CHPS compounds has strengthened the quality of healthcare, also at community level. More generally, there is a collective sense that the DHMT has delivered on its health delivery goals. As one community member observed, the DHMT has managed to contain disease outbreaks and to manage prevalent conditions effectively (see also Figure 1 and Figure 2). DHMT failures are predominantly attributed, by the DHMT as well as external stakeholders, to a lack of resources.

Vertical programmes from the MoH assisted the DHMT to deliver disease-specific healthcare. Annual DHMT reports showed that emphasis had been systematically placed on controlling HIV/Aids, malaria and tuberculosis (TB), especially in terms of service delivery and the monitoring and evaluation of this service delivery. The dominant areas of capacity development support, from the majority of stakeholders, had been on training and technical assistance. There was strong evidence that health-worker training had taken place (this is backed up by the numbers of respondents who stated they had received training). Training was also carried out at community level to improve the detection rate and management of priority diseases such as TB.

Direct engagement took place between the DHMT and partners such as JICA, Population Council and USAID. This benefited specific programmes such as the HIV/Aids programme. This

engagement included the development and implementation of research projects such as the CHPS impact assessment. Indirect support came through DPP support of local NGOs. For example, the Ntiamoah Foundation's work benefits children's health in the community.

There was a relationship between training, service delivery, the monitoring and evaluation (M&E) of this service delivery in the priority disease areas and outputs such as a reduction in new cases of malaria.

The level of effectiveness of DDP interventions can be explained through:

- The presence of committed stakeholders that support DHMT activities
- Strong leadership that has a clear vision of who should carry out and monitor plans
- A culture of maximizing minimal resources
- Community engagement through volunteering and the legitimization of the DHMT by local leaders

2.3.5 Lessons learned

The health sector needs both endogenous and exogenous capacities. Exogenous capacities are needed because, fundamentally, healthcare workers need financial, infrastructural and knowledge resources in order to carry out their work. Funding from regional and national levels is inadequate and is often disbursed late. New sources of income from insurance schemes are also problematic. Financial support from the DA is minimal, and technical support is not always guaranteed. For practicality, resources need to be sourced from outside these systems. But endogenous capacities are also needed because the available resources must be used efficiently in order for organizational goals to be attained.

For these processes to work, the socio-psychological qualities of the health workforce and the communities they serve become important. This was defined in the inception report, which recommended focusing on 'psychological variables such as trust and motivation that point to inter-individual and group-level processes, as well as to the interactions between individuals (the healthcare workers), their institutions (history, memory, resources, leadership), their community/society (health needs, demands, power) and broader Ghanaian society (attitudes to work, accountability, work ethic)'.

2.4 Case Study 2: Kwahu South

A total of 15 respondents participated in the Kwahu South evaluation. These were spread across the four segmented groups, as shown in Box 3.

Box 3. Distribution of Kwahu South respondents across categories	
Group 1: The GHS	
1a. The DHMT	4
1b. Hospitals, health centres, CHPS zones, community healthcare workers	5
1c. Chemists, pharmacies, NGOs in the health sector	2
Group 2: The DA	1
Group 3: Regional and national partners	
3a. The NHIA and the DHMIS	1
3b. Other NGOs and private sector institutions	0
Group 4: The community (civil, religious and political groups)	2

2.4.1 Definition of capacity development

Capacity development was defined by one civil society volunteer as *Things that will make the work improve.*

As with Birim North, training again emerged as a consensual definition of capacity development – mentioned by 14 of the 15 respondents. Sub-themes included training to improve the knowledge and skills of healthcare workers. Career development was implied or explicitly stated.

> *I view capacity development to be career development based on training. A working person will have to improve in order to be able to improve upon his or her service. The approach to rendering these services must be improved.* – Quote from the district nursing officer

Another dimension that received the consensus of respondents was logistics, which seen as integral to capacity development. One community-based surveillance volunteer's statement sums up the responses.

> *Capacity development may not be different from building the capacities of individuals to be able to deliver within their settings … capacity development also involves the provision of logistics to enable the staff carry out the work that has been assigned to them. Without the necessary logistics, the goals of the organization cannot be achieved. You can train your staff, but if there are no resources for them to work with, you will still not be able to achieve anything.* – Quote from the district coordinating director of the DA

One respondent emphasized monitoring and evaluation as a key component of capacity development. He observed the important role of financial and other resources in conducting effective monitoring evaluation.

2.4.2 Brief history of capacity development in the district

Kwahu South respondents had limited ideas about when capacity development activities started in their district.

> *I have been in this district for five years but I learned capacity development was ongoing before I came to the district.* – Quote from the disease control officer

There was general acknowledgement that different aspects of capacity development had support from local and foreign partners. Some respondents mentioned a range of capacity development supporting institutions and organizations. Table 10 is list of organizations who support capacity development in Kwahu South, the institutions supported by them, and the kinds of capacity development activity that have taken place across four areas: training, technical assistance, infrastructural development, and research and information systems. This list is generated from respondent accounts.

Table 10. Kwahu South health partners and types of capacity development support provided

	Training	**Technical assistance***	**Infrastructural development****	**Research and information systems**
GHS				
Health NGOs Consolidated Child Care Foundation Planned Parenthood Association of Ghana (PPAG)		(+) (+)		
Community health volunteers***		(+)		
Private midwife		(+)		
Chemists		(+)		
District Assembly		(+)	(+)	
Sector departments				
Ghana Education Services		(+)		
Ministry of Food and Agriculture		(+)		
Forestry Department				
Regional and national partners				
Ghana Aids Commission		(+)[i]		
MoH	(+)	(+)		
Member of Parliament (local)		(+)		
Pharmacy council	(+)			
RHMT		(+)		
Development partners and other international partners				
Danida				
JICA		(+)		
The Hunger Project		(+)	(+)	
Kwahu Citizens Association		(+)		

Migration for Development in Africa		(+)[i]		
Organization of Rural Associations for Progress			(+)	
Regional Coordinating Council (RCC)				
Community				
Chiefs, assemblymen, unit committees		(+)		
The general community			(+)	

*Technical assistance includes the provision of services and the donation of funds, minor equipment and perishable goods.
**Infrastructural development includes the provision of land, buildings and labour to build infrastructure.
***Community health volunteers are usually placed in the 'community' category. It is important to place them explicitly within the GHS service category as they invest significant time in providing valuable services at community level (see case studies).
(+)[i] - indirect support (e.g. to the DA or local NGOs)

2.4.3 The five core capabilities

A. *The capability to act and commit*

Only the GHS/DHMT and hospitals were probed on this issue. All respondents observed that the DHMT and hospitals had plans, took decisions and acted on these decisions, and monitored their plans collectively at all levels. They acknowledged the existence of a composite action plan. Each of the units within the DHMT further elaborated on how they intended to address the indicators related to their work. Two respondents replied as follows:

> *At these meetings, we discuss the action plan of each unit after which they are integrated to give us the overall action plan of the DHMT. These unit action plans are given to the health service administrator who compiles them to get our composite action plan. At the meetings, the district director acts as a moderator and a guide and allows us to do the discussions. –* Quote from the disease control officer

> *Yes, we have an action plan, an itinerary and a duty roster, which we follow in our day-to-day activities. We have regular meetings to discuss our plans. This clinic has several CHPS compounds under, us so when we are having meetings; they all come for the meetings. We all come together to discuss issues and take decisions. –* Quote from the midwifery superintendant

B. *The capability to deliver on development objectives*

As was the case with Birim North, Kwahu South also lacked the ideal set of resources. As a result, mobilizing resources was prioritized. Human and financial resources were seen as urgent priorities. The issues raised in addition to shortages of human resources included the lack of infrastructural

resources, logistics resources and knowledge resources – all of which are needed in order for healthcare workers to carry out their work effectively. The list and selected quotes are shown in Table 11.

Table 11. List of resources required by Kwahu South DHS

Resource category	**List of resources required**	**Selected quotes**
Infrastructure	premises for the DHMT; Hospital space (e.g. outpatients department) CHPS compounds; Vehicles Financial resources	*…the DHMT does not even have one vehicle. Previously, the district had five medical assistants but with the re-demarcation of the district, we lost four of them to the new district. We are seriously in need of more doctors because OPD attendance has increased tremendously with the inception of the NHIS. Even the funds the region gives for the running of the DHMT is inadequate, not regular and does not come on time. We are always indebted to other people because our stationery and logistics are always purchased on credit. The DHMT is not (sufficiently) resourced to be able to meet the targets we have set for ourselves.* – Quote from the district director of health services
Human resources	Medical specialists (e.g. obstetrics and gynaecology, physiotherapy) Dentists Midwives Community health nurses Diploma nurses	
Knowledge resources	Library of health literature Internet	*We don't have internet and library facilities in this community. Nobody in this facility buys a newspaper.* – Quote from the medical superintendent

Respondents stated that staff on the current government payroll could not cope with the current workload. They use internally generated funds to pay for the additional capacity required.

> *...What we do is that when we see a need, we recruit the person and pay the person locally. We have about 40 casual workers and even though the person is a casual worker we pay just like a staff on government payroll. With financial mobilization, we have the fee-for-service and through the national health insurance.* – Quote from health service administrator

Limited resources notwithstanding, leadership attributes were considered essential for being able to get work done and for motivating others to deliver on agreed objectives. The district director of health services, who left just before this study was conducted, was described by the DHMT and respondents from the hospital as 'an efficient, supportive and action-oriented leader'. This was seen as setting him apart from his peers and thereby reducing staff attrition.

> *When Dr X was around, the leadership was action-oriented because he took his work very seriously. Whenever I had the opportunity of meeting colleagues from other districts and they complained about their directors not taking the work seriously, it was always like a new story to me. Dr X was very efficient. Since he left, the place has become a little bit dull.* – Quote from the district nursing officer

Staff attrition is not high in this district. What I have observed is that attrition is usually very high when the leadership is not favourable. – Quote from the disease control officer

There is however some level of staff attrition in the Kwahu South district. This is largely as a result of requests for transfers from female healthcare workers, who, after marrying, need to move to other areas. There was also the difficulty of finding suitably qualified nurses for some posts, and this had an adverse effect on service delivery. The medical superintendent observed that enrolled nurses outnumbered diploma nurses; the shortage of diploma nurses undermined the quality of nursing. Community health volunteers were also not well supported.

At the hospital, respondents observed that information that flows freely from the bottom to the top is a capacity enhancing attribute. They commented that senior management disseminated information and plans democratically and ensured that plans were adhered to. One management respondent observed that decision making was a consultative process and was generally carried out with staff participation. The tone however included some coercive measures which may be representative of an authoritarian leadership style, in contrast to the charismatic style observed earlier.

We always try our best to make staff feel part of the change process. At such staff durbars, we state in clear terms the sanctions that will be applied or the punishment which will be applied if any staff [member] *refuses to cooperate. Even yesterday, management had to sack somebody for continuous non-performance. Changes from outside are dealt with through the same procedures*. – Quote from the medical superintendent

Despite a lack of resources that severely interfered with the ability of the DHMT and the hospital to meet the targets, some respondents held a positive outlook on their work and emphasized the importance of maximizing their minimal resources. As one respondent stated:

I don't think resources will ever be adequate. What I believe in is efficiency; the scarce resources must be used judiciously. With the scarce resources, you should still be able to perform efficiently. I know for a fact that there will never be a situation whereby we will have adequate resources for our work. – Quote from the district nursing officer

C. *The capability to relate to external stakeholders*

There was evidence to suggest that the DHMT and hospital management used their links with external stakeholders to maximize the resources that would be available to them. At times, this drew on social networks and dexterity with collegial acquaintances. It also depended on in-depth knowledge of the partner terrain in terms of who could best support what types of activity. There is also a sense that external relations were courted constantly and may have been selected based on interests.

When we need equipment and logistics, we again write to the region. This however involves a lot of lobbying. I have always had my way out when it comes to lobbying because I knew most of the people in authority back at the medical school. For our supplies and other smaller equipment like scissors, blades, among others, we buy them from the internally generated fund IGF. Our funds mainly come from the IGF and 98% of this IGF comes from reimbursements from the insurance schemes. Whenever the insurance schemes delay in reimbursing us our claims, we are always in serious financial crisis. Of late, subventions

from the government have not been forthcoming. Sometimes, we also write to the Kwahu Citizens Association both at home and abroad, and they mostly come to our aid by donating equipment and logistics. We also always solicit support from the DA which sometimes comes to our aid. The Kwahu Citizens Association abroad donated an ambulance and some theatre equipment to the hospital. – Quote from the medical superintendant

No, but the people in this district have a positive attitude. Wherever we go in this district, the communities are always willing to put up structures for health service delivery. We also have a number of health facilities so they don't find it difficult accessing health. – Quote from the district nursing officer

The district coordinating director of the DA said he believed that the DHMT performed well, although their lines of communication could be improved. The NGO representative was invited to participate in health planning meetings. However there did not appear to be an established relationship between the GHS and the licensed chemists, unlike in Birim North. The chemist received periodic training from the Pharmacy Council, but had had no interactions with the disease control officer or other members of the DHMT. Respondents said they were also conscious that support is time bound.

D. *The capability to adapt and self-renew*

There was consensus that the DHMT and the hospital management were capable of adaptation and self-renewal. Specific examples of where and when they adapted to new national initiatives were provided – such as their engagement with the CHPS concept, the NHIS and changes in malaria treatment.

Management is aware of new trends and we always try as much as possible to adapt very quickly. For example, the nation has decided to place emphasis on the CHPS concept and we, as a service delivery institution, are working very hard to implement the concept effectively. – Quote from the district director of health services

What we know is that health is dynamic, so you must be prepared for change at any time. – Quote from the disease control officer

Respondents also stated that there was a culture of reflecting on and addressing mistakes that occurred within the district system. One respondent suggested that the internal dynamics of DHMT management were limited, and led to recurring mistakes in the area of training.

When new community health nurses come into the system, it is supposed to be an opportunity for the unit heads to give them orientation. However, in this DHMT, it is only the public health nurse and the HR management who do the orientation. For example if the disease control officer wants to introduce his reporting format to these people, he doesn't get the opportunity. This contributes to the repetition of the same mistakes over and over again. – Quote from the district nursing officer

There was also evidence that the DHMT initiated change in the way healthcare was delivered. One form of change was engaging with communities in churches. Another was the creative use of funding for vertical programmes for integrated health training.

E. *The capability to achieve coherence*

Positive responses were given to the following sub-themes:

- The organization has a clear mandate, vision and strategy – all of which are known by staff and used by management to guide the decision-making process.
- The organization has a well-defined set of operating principles.
- Leadership is committed to achieving coherence and balancing stability and change.

Fundamentally, the mandate, vision, strategy and operating principles were handed down from the MoH and the GHS, and the districts followed them. However, while the leadership was committed to achieving the goals outlined by the MoH and GHS, the majority of respondents did not believe there was 'consistency between ambition, vision, strategy and operations'. The inconsistency they perceived was attributed to a lack of resources.

> *We are severely handicapped. For any work to be effective, you have to ensure strict monitoring and supervision but here it is the case the DHMT does not even have one vehicle. ... The DHMT is not well enough resourced to be able to meet the targets we have set for ourselves.* – Quote from the district director of health services

> *We have not been able to achieve all the goals of the facility due to a number of factors notably inadequate funds and logistics. In spite of the numerous challenges, we are working very hard towards achieving this vision.* – Quote from the medical superintendent

2.4.4 Interpretation of Kwahu South's results

Positive changes: the district received technical support from almost all its stakeholders (see Table 6). The areas of capacity development that were supported included training and infrastructural development, although Kwahu South has yet to attain its ideal number of CHPS compounds.

Like Birim North, leadership and community emerged as forms of endogenous capacity. However, unlike Birim North, leadership in Kwahu South appeared to be experienced as a group phenomenon rather than as a quality that resided in one charismatic individual. This may be because Kwahu South has a hospital and therefore another GHS institution that guides the affairs of health service delivery and influences the perception of health service users. A second distinction between the districts was that, whereas the community was viewed as a major health partner in respondent accounts and official reports from Birim North, the community as a source of endogenous capacity appeared only in respondent accounts in Kwahu South. This may have been an inadvertent omission (which reflects a lack of thoroughness in reporting procedures), but it suggests, a potential disjointedness between informal discourse and formal practice in the area of monitoring and evaluation.

Negative changes in Kwahu South were similar to those in Birim North: the district lacked infrastructural resources, human resources and knowledge resources. Previously the Kwahu district was a single district. The re-demarcation of geographical boundaries into north and south had led to the loss of trained medical assistants to the north. The hospital, more appropriately referred to as a health centre, had not been adapted to an increasing population and a wider diversity of medical needs.

The effects were similar to those described for Birim North. Training led to better-skilled workers. Technical support in priority disease areas yielded positive returns. For example, the number of

malaria cases declined between 2007 and 2009. In Kwahu South, these vertical programmes provided extra funding for integrated training. Although the district still lacked enough of them, the development of CHPS compounds had strengthened quality of healthcare at community level.

Direct engagement between development partners and the DHMT had benefited the HIV/Aids programmes. Indirect support had come through DPP support for the DA and local NGOs. For example CCCF's funding from the Ghana Aids Commission supported HIV/Aids activities in the district.

There was a relationship between training, service delivery, the monitoring and evaluation of that service delivery in the priority disease areas, and output such as the reduction of malaria cases, for example.

There are four principle explanations for the effectiveness of capacity development interventions:

- The sustained technical support in priority areas
- Good leadership
- The creative use of human resources and funding
- The engagement of the community in health service delivery

2.4.5 Lessons learned

- A combination of endogenous and exogenous capacity is important for health-sector success.
- There needs to be a recognition of the structural limitations of resource allocation and a judicious use of resources

2.5 Case Study 3: Atiwa

A total of 13 respondents participated in the Atiwa evaluation. These were spread across the four segmented groups, as shown in Box 4).

Box 4. Distribution of Atiwa respondents across the segmented categories	
Group 1: The GHS	
1a. The District Health Management Team (DHMT)	
1b. Hospitals, health centres, CHPS zones, community healthcare workers	
1c. Chemists, pharmacies, NGOs in the health sector	
Group 2: The DA	
Group 3: Regional and national partners	
3a. The NHIA and the DHMIS	
3b. Other NGOs and private sector institutions	
Group 4: The community (civil, religious and political groups)	

2.5.1 Definition of capacity development

Eight respondents regarded training as synonymous with capacity development. They divided training into two sub-themes: training to enhance knowledge and training to enhance skills. Three respondents emphasized the importance of enhanced skills in improving an organization's standards and in providing specific services. One remarked that:

> *This could be having training at the district level. We have been trained on HIV/Aids and malaria management and infection prevention*. – Quote from the community health nurse

Other dimensions such as infrastructure and logistics were mentioned by a respondent but not elaborated upon. These were seen as significant ... *because if you don't have the necessary logistics and infrastructure, you will not be able to achieve the organizational goals*. – Quote from district coordinating director of district assembly

2.5.2 Brief history of capacity development in the district

Four respondents provided a response to this theme indicating that capacity development initiatives had long existed in the region. One offered a history of capacity development dating back to 1984.

> *The GHS started this from a process called Strengthening of District Health Systems championed by one Dr. X around 1984. After that, they came up with another word called DISHOP (District Health System Operation), where periodically they sent a whole team of leaders to Kintampo or Navorongo to have about one or two weeks' intensive training to build their capacity and then after that the leaders are strengthened to go back to the*

districts to work. They go back to their districts to organize the same training programme for the sub-district and at other levels. – Quote from the district director of health services

The four respondents viewed capacity development as being both internally and externally driven. Internally driven capacity development related to work carried out at district level, within the DHMT and the hospital. Externally driven capacity development related to assistance provided by the region. The majority of stakeholders that were mentioned by respondents were government ministries, national professional groups and local communities.

While one respondent from the pharmaceuticals sector had the impression that Atiwa did not receive any NGO support, the disease control officer referred to one NGO, World Joy. In fact, official records show that three organizations – World Joy, The African Foundation for AIDS Prevention and Counselling (AFAPAC) and The Hunger Project – had provided support. And the laboratory technician pointed out that the hospital's laboratory had been 'well equipped by the National Aids Control Programme'.

Table 12. Atiwa DHS health partners and types of capacity development support provided

	Training	**Technical assistance***	**Infrastructure development****	**Research and information systems**
GHS				
Health NGOs World Joy The African Foundation for AIDS Prevention and Counselling (AFAPAC)		(+)	(+) (+)	
Community health volunteers***		(+)		
Private midwife		(+)		
Licensed chemists		(+)		
District Assembly		(+)	(+)	
Sector departments				
Ghana Education Services		(+)		
Ministry of Food and Agriculture		(+)		
Water and sanitation sector		(+)		
Regional and national partners				
Ghana Registered Nurses Association				
MoH	(+)	(+)		
National Aids Control Programme		(+)		
The Pharmacy Council	(+)[i]			
RHMT		(+)		
Development partners and other international partners				
Hunger Project			(+)	
National Aids Control Programme		(+)		
Community				
Chiefs, assemblymen, unit committees			(+)	

The general community			(+)	

*Technical assistance includes the provision of services and the donation of funds, minor equipment and perishable goods.
**Infrastructural development includes the provision of land, buildings and labour to build infrastructure.
***Community health volunteers are usually placed in the 'community' category. It is important to place them explicitly within the GHS service category as they invest significant time in providing valuable services at community level (see case studies).
(+)[i] – indirect support (e.g. to the DA, local NGOs or GHS service partners such as midwives and chemists)

2.5.3 The five core capabilities

A. *The capability to act and commit*

The DHMT and the health partners were asked about the capability to act and commit. All respondents believed that the DHMT had a plan, which was developed and acted upon through collective decision making. The district director of health services was able to articulate the various processes and the nature of the plans that were used to guide work implementation and reporting.

> *Yes! We will have our annual review meeting; we will stock and draw new plans for 2010. Ghana Education Services, the DA, the water and sanitation sector, and other bodies have been invited to the meeting. All these people are part of the health sector, which makes it a complete one. In these plans we have roles spelt out at the district level and the community level, they render services to the CHPS system. Within this CHPS compound, the community people are assisting the community health officer, but at the end of the month we send reports only to the district level and then those in the community are not given a copy of the report.* – Quote from the district director of health services.

All accounts of the Atiwa district indicate that it is a severely deprived area. Collectively, DHMT respondents generated a list of resources they lacked. Table 13 lists these resources and includes some comments on the situation.

Table 13. List of resources required by Atiwa DHS

Resource category	**List of resources required**	**Selected quotes**
Infrastructure	Buildings: staff accommodation, office space, hospital buildings Transport: cars Equipment: computers *Financial resources	*We don't even have the requisite infrastructure. Three other officers alongside me occupy this space we are sitting in now. We don't have space to do our work independently. We easily lay hands on confidential documents or materials about others or our work. For example TB and HIV/Aids are supposed to be confidential but they are scattered all over the office because of no space. Even these offices that we are using as DHMT offices belong to the Kwabeng clinic. –*

		Quote from the disease control officer
Human resources	Nurses and Midwives Doctors and specialists Medical assistants. Technical staff for the hospital	*We have six health centres in the district but with only one medical assistant. We have only one Ghanaian doctor and a recently posted medical assistant at the district hospital. The midwives are not many to manage the Reproductive and Child Health centres and the CHPS zones. Most of our facilities do not have midwives, especially the CHPS compounds*. – Quote from the disease control officer
Knowledge resources	Library of health literature Internet	*We do not have access to information from outside. We have no internet and even we don't get the newspapers here. The only source of information is the DHMT or when we go for trainings or workshops*. – Quote from the community health officer

Possibly, even more important than a dearth of resources, is the work culture and attitude in the district. Everything is conveniently blamed on a lack of funds, and laxity permeates the language.

> *I should be the one to monitor but sometimes I do not bother myself to monitor the activities. This is because most of the things need financial commitment so we concentrate on the activities that do not involve so many funds. There are so many things that we want to do but there are no funds*. – Quote from the health services administrator

B. *The capability to deliver on development objectives*

Respondents stated that the human resources situation in the district was not stable. Insufficient career progression opportunities for young healthcare workers, coupled with a lack of adequate accommodation, were given as the main causes of personnel instability in the district. One exceptional view of human resources emerged from the midwife-in-charge. With a team of community health nurses and a disease control officer, she felt that she had adequate human resources to deal with the health needs of the community. However, the statement has some contradictions, which gives the impression that she does not understand how work could be better organized.

> *We have the kind of people we want to work with. We have the community health nurses and that is okay because when one is on home visit, one will be here. We have the disease control officer and the others. I am the only one who goes for meetings because I am the leader. When I go for meetings the midwifery side is left vacant because antenatal is on a daily basis. Sometimes a delivery happens while I am away then the person has to go to the nearest town to deliver*. – Quote from the midwife-in-charge

Some respondents were unhappy with poor information flow and the lack of consultation when receiving direction from the regional and national levels.

> *My problem is that decisions are taken at the higher level without consultations with the implementing level and we always get such information very late. Certain things go on without even we, the head of the facilities, knowing anything about them. The information flow in the GHS must be improved.* – Quote from the medical superintendent

The respondents were of the opinion that leadership was non-consultative and generally weak in the past. As a result, they were neither motivated nor interested in delivering anything beyond the minimum. In the absence of focused leadership, social networks evolved to promote organizational cohesion and sense of belongingness.

> *... About 90% of the workforce is between the ages of 25 and 35 and only three or four people are over the age of 40. Whenever there is a problem with a particular person, we sit down and talk it over.* – Quote from the health services administrator

> *Most of the DHMT staff and those of the NHIS are my church members so I have very good relations with them.* – Quote from the presiding member of the district assembly

Leadership had changed in recent times, bringing with it a new sense of direction. One respondent made explicit reference to a more inspiring and action-oriented leadership approach by the new district director of health services.[10]

> *Yes! Now I feel that I have a good leader who always wants results. Formerly, it wasn't like that.…..With the new leader, I am happy and this has given me the zeal to work. One of the staff noticed it and even made mention of it.* – Quote from the district accounts officer

The new leader appears to be able to foster motivation and encourage a go-getter attitude that the staff is warming to:

> *Yes, the new director has done something. If you are able to meet the deadline for the submission of the reports, he asks the accountant to reward you.* – Quote from the disease control officer

> *... if we are given a target to cover 90% of our district population, we will be entitled to 50% or 70% annual bonus. Then we all work toward achieving that goal.* – Quote from the administrator of the District Mutual Health Insurance Scheme

C. *The capability to relate to external stakeholders*

Resource mobilization was seen as problematic by the majority of respondents. Two specific areas of mobilization were discussed: human resources and financial resources, with the greater emphasis on the latter. Reasons for limited DDP presence could be because the district has been abandoned by its donors or that the leadership does not have an active network or the capacity mobilize resources.

Unlike the other two districts in this evaluation report, Atiwa relies mainly on nationally appointed and regionally posted healthcare workers. Through internally generated funds (IGF) and the national health insurance scheme, resources *are* available. There was no account of these funds being used to recruit much needed staff or to motivate personnel in the run up to the arrival of the new district director and district chief executive. Instead, there were accounts of poor funding flow, late disbursement of funds from regional level and of insurance claims remaining unreimbursed (see Box 5). One also gets the sense that this district does not have many individuals with strong social networks, the capacity for lobbying and the persistence needed to achieve results.

[10] The new district director of health services referred to here was the previous Birim North district director of health services.

Box 5. Poor mobilization of financial resources as a product of passive leadership?

For finance, we don't really mobilize funds; rather we get the resources from the regions. For programmes like the National Immunization Day, we contact the District Assembly. From the time I came here, they gave us nothing – until the new district chief executive came and supported us. – Quote from the public health nurse

There is no other source of income for the hospital excerpt the insurance. The mobilization of funds is not that good. The regional health directorate once in a while sends money for earmarked specific purposes. Last year, we took our action plan to the DHMT. It took us over two months to access that plan, but I learned the money was there but I do not know why it was delayed. – Quote from the health services administrator

We get our funds through the IGF and other service fees. Reimbursements from the NHIS contribute over 90% of our IGF. There are no NGOs in this area. Help from the government has not been forthcoming, government only pays our salaries. – Quote from the district pharmacist

Our funds mostly come from the region. We submit our action plans to them for which the funds are released. The DA sometimes comes in with support. World Joy has also shown the willingness to support. – Quote from the disease control officer

Management waited on the external Regional Health Management Team (RHMT) to provide all resources needed in the district. However, volunteers and some staff working at levels below the management level had some idea of how to network for support on a needs basis.

> *The volunteers have always been so helpful to us. I always go to the assembly woman for anything. When the volunteers go round and detect anything, they quickly rush to report to us*. – Quote from the community health officer

DHMT respondents made a distinction between the political legitimacy of the DA and the social legitimacy of the DHMT. They viewed the DHMT's services as socially legitimate to their stakeholders.

> *The DHMT has no political colours so they do not see us to be a political institution. We are not here to serve any government but the people.* – Quote from the disease control officer

While no responses were given to the question of leadership integrity, the majority of respondents (the DHMT and the health partners) stated that the DHMT had operational credibility.

> *They have always shown considerable trust in us and they know that we are on top of our job. We are incorruptible. We use the recommended standard guidelines and operating procedures in the course of our duties. We have all undergone one form of training or another. Our services operate 24 hours a week.* – Quote from the disease control officer

Four respondents observed that the DHMT maintained adequate alliances with relevant stakeholders and that these stakeholders, such as the Ghana Registered Nurses Association, provided regular supervisory support and to respond to personal problems.

D. *The capability to adapt and self-renew*

There was consensus that the DHMT had an understanding of shifting contexts and relevant trends and that it had the confidence to change.

> *Yes, for instance I have worked with the DHMT on child welfare for eight years now. When the NHIS was introduced, I had to expand their facilities to meet their standards*. – Quote from the presiding member of the DA

One DHS partner expressed the view that his department (the DA) did not exhibit the confidence to change. There were also apprehensions of victimization which cowed people into keeping to old routines:

> *We don't adapt to changes in a quick fashion because most of the staff lack the capacities and also because they learn very slowly. The system here is not the best. Do you know that the coordinating director can be transferred if the DCE doesn't like you?* – Quote from the district coordinating director

In terms of encouraging and rewarding learning and exchange, references were made to using opportunities and financial incentives to motivate and to reward hard work. Some references were made to sponsoring health worker training. However, no views were presented on the DHMT's ability to acknowledge mistakes and to stimulate the discipline to learn. There were no responses on the theme 'the organization plans and evaluates its learning systematically'.

E. *The capability to achieve coherence*

According to the health services administrator, district coordinating director and administrator of the DMHIS, the DHMT, the DA and the DMHIS had a well-defined set of operating principles directed by the GHS. Four respondents suggested that the leadership is committed to achieving coherence, and balancing stability and change – but no respondent elaborated on how or why they felt this was the case. There was one view that suggested that procedural consistency was maintained at the expense of innovation. The health services administrator noted that the ... *system does not accept innovation* and that a rigid adherence to rules produces consistency.

2.5.4 Interpretation of Atiwa's results

The positive changes in the Atiwa district related to investment in training, technical support and infrastructural development, and community engagement in the form of technical support and infrastructural support.

The negative changes related to poor leadership and a culture of inaction and dependence – despite investment in training and motivation.

Here, the 'socio-psychological quality' argument is quite compelling. Even though they were given the same resources as the other districts, a lack of group-level action and the pervasiveness of negative attitudes to structural failures (which two other districts acknowledge), have undermined any potential benefits.

But something new is happening here: the new district director of health services comes from Birim North, a better-performing district. It will be useful to track developments and see if this district director will be able to transform Atiwa in the way he transformed Birim North. This will be the focus of the quantitative strand of this capacity development evaluation study.

In Atiwa, the hospital has changed from being NGO-run to being government-run
Promises made to build capacity have not materialized (according to the hospital pharmacist), although some building maintenance and other infrastructural work has been carried out by the government.

Three forms of capacity development emerged from the interviews with the respondents:

- Training (mainly in HIV/Aids and malaria management) and funding for training/study leave
- The provision of lab equipment and the provision of infrastructure by communities
- Indirect capacity development through resources provided to midwives by stakeholders

These initiatives have been inadequate. The strong assertions that, *resources are weak, but we are managing*, that we heard from respondents in the Birim North and Kwahu South districts, are completely missing from the narratives of respondents from Atiwa.

Mobilization of resources has been poor, particularly on the financial side.

Leadership has been a big challenge – the poor leadership style of the previous district director, senior management that is isolated from the GHS powerbases at national and regional levels, and a general feeling of disempowerment have all contributed to Atiwa's poor performance.

The DA has its own internal problems: a lack of lobbying power (coupled with a defeatist attitude that discourages partnerships with donors and development partners); a lack of transformational leadership; and gaps in knowledge regarding mandate, vision, etc. The DA should be a strong DHS ally and funder. So a weak DA is likely to have an adverse impact on the capacity development needs of the DHS. In Atiwa, there does not seem to be a strong relationship between members of the DHS and the DA, compared with the strong informal relationships described in Birim North.

In Atiwa, it appears that the most consistent application and monitoring of skills has occurred at the community level:

- There are CHPS compounds, though not enough midwives
- The community health officer is happy with team she has, and works towards achieving her mandate

Atiwa has the fewest development partners of all the districts evaluated. They have had to rely predominantly on national-level resources. The district's lack of lobbying power means they have not been able to generate as much support as either Birim North or Kwahu South. This means that training is the most visible outcome of capacity development; but the culture of pessimism has meant that the impact of training on outcomes and outputs has not been high.

If we are to use the lessons from Birim North and Kwahu South, then it can be argued that a lack of exogenous capacity can 'cripple' a health system, even within the context of endogenous capacity development. We see this in the sense that while community engagement at Atiwa appears to be as strong as in the other districts, the quality and output of health services are poor. A key factor here is the collective attitude of healthcare workers and their pessimism.

2.5.5 Lessons learned

- It is important to recognize and draw on endogenous capacity – for example, from within the community.
- Developing partnerships with external stakeholders strengthens endogenous capacity.
- The socio-psychological dimension of leadership and motivation should not be underestimated.

2.6 Analysis and conclusions

2.6.1 Analysis

All districts were able to give some form of a definition of capacity development, but in only one district, Atiwa, was a respondent able to provide a historical perspective. There is a general lack of resources in all three districts. The evidence shows marked contrasts in performance between Atiwa and the other two districts, Birim North and Kwahu South. This disparity in performance runs along all five core capabilities used to define capacity.

In terms of the district having the *capability to act and commit*, even the better-performing district demonstrated that it was not enough to have strategies and plans in place. These strategies and plans needed to be consolidated into action, and this required resources. In their limited and resource-constrained environments, Birim North and Kwahu South had to innovate and make bold decisions about using internally generated funds to augment their allocated budgets. However, the funds needed to be directed at clearly articulated needs.

All three districts defined several areas of need, but only Birim North and Kwahu South prioritized human resources. They did this because they recognized that service delivery was labour intensive. Organizing services was emphasized, particularly in Birim North and Kwahu South. The expansion of CHPS compounds in these two districts showed a clear commitment to act in response to needs. Larger CHPS compounds made it all the more urgent to recruit highly qualified staff. It also reduced the need for regular commuting and took some of the pressure off the districts' limited supply of vehicles. Ultimately, this made it easier to bring the services they needed to the clients in both communities.

Financing care delivery and the logistics needed to carry it out were considered inadequate in all three districts. Most respondents, including DHS partners, stated explicitly that the better-performing DHMT worked harder to deliver on its objectives, despite lacking adequate resources. Because of their commitment and their determination to act, the Birim North district had out-performed its own expectations, and in some cases had oversupplied facilities.

Atiwa on the other hand lacked the ability to be proactive. It relied excessively on regional and national health authorities for direction before doing anything. The approach was one of conservative adherence to rules and guidelines for planning and execution.

Attaining development objectives is connected to the *capability to act and commit*. An outstanding attribute found in both Birim North and Kwahu South was the way in which the leadership was able to motivate staff to appreciate results. The heads of these districts were described as being 'efficient', 'supportive' and 'action-oriented'. This set them apart from their peers. The leadership style of these leaders was based on a consultative and participatory process that achieved results. This motivated staff, reduced staff attrition and brought outside support into the district. In contrast, the leadership in Atiwa was considered weak and non-responsive. This left staff members to develop their own coping strategies and to generate cohesion by relying on internal social networking.

The evaluation study found a clear relationship between leadership, staff attrition and commitment. As a respondent in South Kwahu noted, *attrition is usually very high when the leadership is not favourable*. The Birim North and Kwahu South DHMT leaders expressed an interest in training healthcare workers and developing their potential. There were, however, concerns that healthcare workers located in the more remote areas and at community level were missing out on continuing education opportunities.

Another attribute that was found to be necessary for attaining development objectives was information flow. In Birim North and Kwahu South, information was seen as flowing freely from the bottom to the top. Senior management disseminated information democratically and ensured plans were adhered to. Decision making was consultative and generally done with staff participation. Charismatic engagement was observed more in Birim North than in Kwahu South, where tones of coercion were observed. The information and leadership attributes in the two districts however were in sharp contrast to what was observed at Atiwa. In Atiwa, information flow was seen as flowing only from the top down. Those at 'the bottom' had no means of contributing to decision making. Leadership was described as inadequate and weak, and a clear appreciation of the change of leadership in January 2010 was openly expressed, as were hopes of a new commitment to attaining results.

The *capability to relate to external stakeholders* also emerged as an essential contributor to capacity, particularly in terms of mobilizing resources and leveraging infrastructural development. There was evidence to suggest that the ways in which the DHMTs and hospital management related to their external stakeholders, determined their success and their ability to leverage additional resources.

Two words stand out in the two better-performing districts – social networking and lobbying. These were described by respondents as either 'alliances' when it related to the public sector institutions or 'collaborations when it related to other partners and the local communities. In Kwahu South, retaining past acquaintances them played a significant part in mobilizing resources from regional and national levels. In Birim North, the evidence showed that having knowledge and mapping partner terrain to understand who can best support what type of activity can help the district to attain set objectives.

The scope of stakeholders need not be limited to just foreign donors. We saw in the course of the evaluations that community partnerships yielded significant results. Successful districts courted external relations constantly, based on the stakeholder interests. These attributes were significantly missing in the Atiwa district. Here, management waited on regional health management teams to provide all their resources. In one instance where an ordinary staff member engaged a community leader, results were achieved.

Two conceptual issues emerged that are worth discussing, as they also appeared in the narratives of the Kwahu South and Atiwa respondents. The issues of institutional legitimacy showed that in none of the three districts was there any ambiguity about who had 'political legitimacy' and who had 'social legitimacy'. Political legitimacy was defined in terms of relationships with and proximity to political power (government and party political power). All the respondents considered that the District Assembly had 'political legitimacy'. In contrast, the DHMT was seen as serving a social role, and was therefore described as having 'social legitimacy'. The difference between these two lay in how the districts used their 'legitimacy' to support their work. In Atiwa, the leaders esteemed and were cowed by political legitimacy, whereas in Birim North and Kwahu South, it was seen as an opportunity to engage with the politically legitimate DA in order to mobilize additional resources.

Probing into the question of whether they demonstrated the *capability to adapt and self-renew*, really highlighted differences between the districts. The expansion in CHPS compounds and the use of internal resources to recruit staff suggested a certain level of internal process reflection, an ability to articulate needs, and an ability to implement expansion strategies. This was particularly so in Birim North and Kwahu South. In these two districts, there was a culture of reflecting on mistakes and addressing them. There was evidence of monitoring and evaluation systems, but it was unclear whether systematic learning was built into these systems.

Most DHMT respondents discussed learning in terms of individual learning on the job. This bias was perhaps a product of individualistic definitions of capacity development. In Atiwa, there is no evidence of a capability to adapt and self-renew. What was described was a willingness to adopt service delivery protocols or the introduction of new interventions such as the national health insurance schemes. These were mandatory requirements directed from the centre. The evidence suggests that the internal dynamics of DHMT were limited and led to recurring mistakes in the area of training.

Affirmative responses were given to the following themes in Birim North and Kwahu South when assessing the *capability to achieve coherence*.

- The district health service has a clear mandate, vision and strategy, which is known by staff and used by management to guide decision-making process.
- The district health service has a well-defined set of operating principles.
- Leadership is committed to achieving coherence and balancing stability with change.

Fundamentally, all three districts agreed that the mandate, vision, strategy and operating principles were handed down from the MoH and the GHS, and that the districts followed them. Kwahu South respondents observed some inconsistency between ambition, vision, strategy and operations, mainly in relation to having limited resources. An interesting observation made in Atiwa was that consistency was achieved mainly because of the need for pattern maintenance. Indeed, the fear of sanctions if a staff member did not adhere to set rules and administrative procedures for carrying out a task, was seen as the reason for maintaining 'consistency'. This view was not observed in either Birim North or Kwahu South.

Table 14 ranks the performance of the three districts.

Table 14. Synthesis of results based on the 5CC framework in the three districts, Birim North, Kwahu South and Atiwa[11]

	Birim North	Kwahu South	Atiwa
The capability to act and commit	Yes	Yes	No
The DHMT has a plan, takes decisions and acts on these decisions collectively.	+++	+++	+++
The DHMT maintains effective human, institutional and financial resource mobilization.	+/-	+/-	-
The DHMT carries out effective monitoring of the plan.	+	+	-
Leadership is inspiring and action-oriented.	+++	+++	-
The integrity of the leadership is accepted by the staff	+++	+++	-
The capability to deliver on development objectives	No	No	No
The DHMT has adequate resources.	-	-	-
The DHMT's infrastructure is considered sufficient for and relevant to its core tasks.	-	-	-
The DHMT has adequate and sufficiently stable human resources at its disposal.	-	-	-
The DHMT has access to knowledge resources.	-	-	+/-
The capability to relate to external stakeholders	Yes	Yes	Underutilized
The DHMT is seen as politically and socially legitimate by relevant stakeholders.	+++	+++	+++
The leadership and staff have integrity (are upright and incorruptible), according to its stakeholders.	+++	+++	No response
The DHMT has operational credibility /reliability in the eyes of relevant stakeholders.	+++	+++	+
The DHMT is aware of the importance of entering into coalitions, and it puts this conviction into practice.	+++	+++	+
The DHMT maintains adequate alliances with relevant external stakeholders.	+++	+++	+

[11] In preparing this table, the customized indicators were brought back to the original indicators we were provided with for comparison with other studies.

The capability to adapt and self-renew	Yes	Yes	No
The DHMT has an understanding of shifting contexts and relevant trends (external factors).	+++	+++	+++
The DHMT has the confidence to change: it leaves room for diversity, flexibility and creativity.	+++	+++	-
The leadership provides encouragement and rewards learning and information exchange, including in its own processes.	+/-	+/-	+++
The DHMT uses opportunities and incentives, acknowledges mistakes that have been made and stimulates the discipline to learn.	+	+	No evidence
The DHMT plans and evaluates its learning systematically.	+/-	+/-	No evidence
The capability to achieve coherence	Yes	Yes	No
The DHMT has a clear mandate, vision and strategy, which is known by staff and used by management to guide its decision-making processes.	+++	+++	+++
The DHMT has a well-defined set of operating principles.	+++	+++	+++
Leadership is committed to achieving coherence and balancing stability with the implementation of change.	+++	+++	-
There is consistency between ambition, vision, strategy and operations	+/-	+/-	-

Key:

+++ Strong positive response (majority view)

+ Weak positive response (minority view)

+/- A mixture of positive and negative responses – or 'yes, but' answers (across the majority of respondents)

- Negative responses (across all, or the majority, of respondents)

2.6.2 Conclusions

Most GHS respondents could not provide a historical account of capacity development in their districts, so it was difficult to track positive and negative changes over time. Negative accounts included the following: (1) lack of human resources, infrastructural resources and knowledge resources; (2) weak support for community-level workers, which threatened to undermine the benefits of endogenous capacity.

The three case studies demonstrate that understanding and deploying the five core capabilities was essential to the performance of the various DHMSs. From these capabilities, three forms of capacity emerged which have had significant impact on service delivery.

The first was the role of good and transformational leadership. We saw that high performance was linked to having a leader who was able to inculcate a strong goal-oriented work ethic in the DHMT and in the community. We saw that it was important for the leader to inspire trust, generate confidence among the staff, motivate innovation and reward positive results – all of these helped to reduce staff attrition. Staff were at their most motivated and most effective when the leader promoted bottom-up communication and used participatory methods to solve problems and implement work routines and guidelines. The issue of teamwork emerged as a strong attribute that arose out of the leadership style. It is clear from the evidence in the case studies that staff members notice when leadership is sloppy and inadequate and can clearly attribute under-performance to the type of leadership they receive. They are able to deduce that efficiency suffers when leadership is weak.

The second form of capacity that emerged was the ability to network with stakeholders and use this as a mechanism to lobby for resources. The better-performing health districts knew how to maintain social networks to use them to facilitate resource mobilization. These districts saw no barriers in status and position and were able to map out the comparative advantages and the opportunities offered by different types of stakeholders to their advantage. This meant that while the resources from mainstream health sector providers were limited, some districts, such as Birim North, had an oversupply in areas such as CHPS facilities. However, it may be important to examine more carefully the network of colleagues in terms of the academic backgrounds of the various district leaders. In a health sector setting, where medical doctors are more likely to be the decision makers at regional and central levels, leveraging collegial networks can have its own constraints. That said, it cannot be denied that those who understand how to networks, forge alliances and develop collaborations are more likely to succeed than those who don’t.

The third form of capacity that emerged was the ability to articulate priorities and ensure that whatever resources are available are directed to addressing them. In resources scarce districts, those that were able to leverage internally generated funds to support their most pressing needs, such as recruiting new staff, were able to attain higher levels of performance. This is not just limited to mainstream staff, but also to engaging the community in health sector activities. These districts transformed communities into being both the agents and the beneficiaries of health service delivery. This was particularly so through encouraging the work of volunteers, which gained the largesse of traditional leaders.

The study also showed that DDP interventions were significant in strengthening the capacity of the DHMTs. The dominant areas of capacity development support, from the majority of stakeholders, had been on training and technical assistance. There was strong evidence that healthcare worker

training had taken place, particularly community-level training in the detection and management of priority diseases. The DDP interventions also consolidated the relationship between output and training, service delivery and the monitoring and evaluation of service delivery in the priority disease areas. The disease-specific interventions in facilities were also mentioned as having had a transformational effect on equipping laboratories and improving infrastructure. Given the central part played by the ability of leaders to leverage stakeholder response, the presence of DDP interventions has significantly contributed to the results attained in the better-performing districts.

3. Policy reconstruction

3.1 Present policy in perspective

The Ghanaian Ministry of Health (MoH) instituted a range of health sector reforms in the 1990s. These included:

- The creation in 1996 of the Ghana Health Service (GHS) as a para-statal institution that would be autonomous of the Ministry and responsible for service delivery
- Health sector reforms in 1997, based on the concept of a sector-wide approach (SWAp)
- The development in 2001 of a community-based primary healthcare approach through the Community-based Health Planning and Services (CHPS) system
- The development in 2003 of a National Health Insurance Authority (NHIA), and the implementation of an insurance scheme in 2006
- A paradigm shift from curative to preventative services based on lifestyle and risk factors for diseases. A key strategy in this area was the Regenerative Health and Nutrition Programme introduced in 2007

The reforms of the late 1990s were necessary for four key reasons. First, Ghana had a high burden of largely preventable diseases. Second, health service access and uptake were very low. Third, there were rising social and developmental challenges that impinged on health. These included a deficit of clean water and sanitation, low education uptake, particularly among women, and high levels of poverty. Finally, the country's economic decline in the 1970s and 1980s had a significant impact on the organization and financing of the health sector.

After a comprehensive consultation process, the guiding principles and programme design for Ghana's health sector were developed, and the five-year Programme of Work (5YPOW) was established to outline strategy and policy in relation to service delivery. There have been three separate 5YPOWs since 1997: we refer to these as 5YPOW I, 5YPOW II and 5YPOW III. The 5YPOW I, developed in 1996, outlined five objectives, and seven targeted strategies to achieve the objectives. Two of these strategies (strategy one and strategy four) were linked to capacity development. Strategy one placed emphasis on strengthening 'primary health services with a focus on district health services, that is, services provided by sub-districts, district hospitals and district health management teams' (MoH, 1996, p.13). Strategy four focused on 'improving capacity for monitoring and evaluating policy, performance and regulation of service delivery'. The overarching policy document from which the 5YPOW I was derived was the medium-term health strategy: Towards Vision 2020.

The concept of capacity development entered MoH discourse more explicitly in the 5YPOW II, which was developed in 2002. By this time, the impact of the brain drain within the health sector had become evident (Nyonator and Dovlo, 2005). This POW led to the first of Ghana's Human Resources Policies and Strategies (HRPS) for the Health Sector. The HRPS identified the human resources situation as one of the main impediments to solving many of the sector's problems. It also underscored human resources as the starting point for solving these problems. Three approaches were recommended:

- Educating healthcare workers
- Providing incentives to stem the loss of staff from the brain drain and various other forms of staff attrition

- Recruiting additional healthcare workers from overseas, with the necessary skills and sending them to areas experiencing significant shortages

By the time the 5YPOW III was in the pipeline, MoH policy priorities were being shaped by the Millennium Development Goals (MDGs) and the government's Poverty Reduction Strategy (GPRS), itself a response to evidence of growing poverty in the country. Titled, Creating Wealth Through Health, the 5YPOW III sought to 'scale up health delivery and human capital development and contribute to poverty reduction and wealth creation'. (MoH 2008, p.1)

The 5YPOW III defined capacity development broadly as:

> *Strengthening health system capacity to expand, manage and sustain high coverage of high quality health interventions and services for promoting health, preventing diseases, treating the sick and rehabilitating the disabled* (MoH 2008, p.16).

This strategy focuses on developing and maximizing technical, managerial and logistical capacities for healthcare delivery at both clinical and organizational levels. Emphasis is placed on technical and managerial capacity within district healthcare systems. Capacity development is to be approached on four main fronts (MoH 2008, p.9): human resources, infrastructural development, equipment renewal and developing a local health industry with the private sector as key partners.

3.2 Development partners' intervention theory regarding capacity development

As part of this evaluation study, interviews were conducted between development partners in Ghana and the MoH and GHS officials before fieldwork began. In the three districts, interviews were also conducted with GHS stakeholders including key officials of the District Assembly (DA), the District Mutual health Insurance Scheme (DMHIS) and health NGOs. This section presents the views of these respondents.

3.3 Development partners' perspectives on capacity development and related themes

The development partners defined capacity in comprehensive terms. The health desk officer of the Royal Netherlands Embassy, for example, stressed that capacity development went beyond training. he stated that capacity development involved contextualized health professional learning ('learning by doing') and the provision of the enabling environment for building capacity, specifically well-equipped health organizations and non-hierarchical organizational structures that valued and nurtured creativity and innovation. Other respondents emphasized the importance of monitoring and evaluating capacity development and of using the resources that were available to them efficiently and creatively. Fundamentally, the comments from the respondents suggested that capacity development could be defined in two ways: as a means to an end (process) and as an end in itself (outcome).

> *Capacity is not only technical – it is about planning and implementing what was planned, and then monitoring and evaluating performance of the implementation. Capacity is being able to implement* [change] *with your existing resources (human, financial and material), not much*

resources are needed – it is about how efficient and effective you are with existing resources. – Quote from a USAID health desk officer

There was general consensus in the responses that capacity development needed to focus on technical mid-level staff and in the areas of changing work ethics and budgetary improvement.

MoH and GHS officials offered similarly broad views of capacity development. These encompassed the availability and efficient use of human, financial and infrastructural resources to meet health-service delivery targets. They considered that, ... *the definitions in the literature* [on capacity development] *are too wide (OECD/DAC) or too narrow (EU). Relating to other stakeholders (other sectors, education, water and sanitation and district assemblies) is crucial to capacity development*. – Quote from the GHS human resource director

Key informants underscored the importance of leadership and good governance in the development and sustainability of capacity development.

Leadership affects a lot of parameters. It may affect performance, and this differs from district to district – some districts perform less well than others with the same resources. The mere presence of a leader with certain leadership traits can lead to the improvement and accurate keeping of information (you change a medical officer in the district and performance may change considerably) – it is about making the right choices. – Quote from the MoH budget officer

Capacity is more about leadership and using management skills to achieve results than about technical capabilities. It is about the skills to use technical skills in an effective way. – Quote from the GHS human resources director

The importance of transformational, creative and innovative leadership in bringing about capacity development was also a dominant theme in the responses of other key interviewees from the development partner community, from the College of Physicians and Surgeons and from the district director of health services (DDHS) of Dangme West District. These persons were interviewed to provide a broad understanding of how health workers perceive leadership qualities. Their views mirrored other reviews of capacity development in the Ghanaian health sector (Appiah Denkyira et al., 2008; MoH, 2009)[12] as well as discussions on the role of leadership in health capacity development at the regional level (Watson, 2006).[13]

One point emerged clearly in one of the interviews and was discussed generally in other interviews. This was the fact that the health policy reform process itself, and the new funding and (exogenous) accountability structures it produced, were partly to blame for the demise of district health leadership, and by extension responsible for the poor progress on capacity development. This statement affirms an earlier reaction by an Atiwa district respondent mentioned in Chapter 2.

[12] Appiah Denkyira et al. (2008) 'Leadership training and re-orientation for all managers has been adopted, since lack of leadership was identified as a major set back to good performance.'

[13] 'The recent report of the Commission for Africa (2005) ... acknowledges that past efforts on capacity building have been disappointing, despite an estimated 25% of donor support having been devoted to it. Key reasons include the piecemeal nature of reforms; poor political commitment and leadership; reforms that were ill-focused on behavioural issues; 'short-termism'; destructive donor practices (especially with regard to aid management structures) and inadequate monitoring of the impacts of reforms.' (Watson, 2006, p. 2)

Box 6 The health reform process and the demise of district health leadership

When the country embarked on the MTEF [Medium Term Expenditure Framework] *process, the Ministry Of Finance thought it was too heavy a burden to have a different plan for each of the sub-districts (and other districts) and decided to standardize plans. A standardized form with 'generic activities' for each level of the MoH arrived, which resulted in people simply having to put figures to standard activities – filling in a demand of a number of material costs (air conditioners, etc.) – which was not very inspiring and not beneficial for creativity. This resulted in the loss of a sense of ownership and commitment and the loss of any opportunity for self-analysis and self-renewal. Also, attributing performance became based on sector-wide indicators that measured the performance of the facility and its clients as a whole, of all health staff together – and only on medical-technical issues, and in terms of effects/outcome, only, not on outputs the facility should be responsible for. This meant discouraging leadership (bringing change and fostering creativity and innovations) even more.* – Quote from the GHS human resources director

3.3.1 District-level perspectives on capacity development

All three DA respondents defined capacity development in terms of strengthening human resources, financial recourses and institutional resources. For them, capacity development included the concept of monitoring and evaluating capacity development. The health NGO representatives offered similar comprehensive definitions of capacity development. All of them emphasized the importance of bottom-up approaches to capacity development, and in particular, empowering communities to own their healthcare systems. The role of DPs in capacity development at district level was evident in the responses of these stakeholders. To some extent, the strength of health delivery at community level was partly due to the support that health NGOs received from DPs and other national and international donors. In all three districts, the health NGOs operated with medium-term funds, and so faced periodic funding challenges that affected the quality of their services.

3.4 Strategy for and approach to capacity development

The human resources division of MoH has developed many tools and guidelines that will be extremely useful in developing capacity in Ghana's health sector. As part of the sector-wide approach, all the development partners adhere to these policies and strategies. The following list shows some of the documents, procedures and initiatives that will lead to enhanced capacity development:

- *Policies and Principles for Development of Human Resources for Health.* This report describes the human resources principles and policies needed to guide the organization and the delivery of health services.

- Chapter IV, *Human Resources for Health,* in the 5YPOW II. This chapter describes priority interventions and activities that are needed to:

    - re-structure the distribution and skills mix of the health staff

- develop and implement continuous professional development programmes
- decentralize health staff management
- develop performance management systems and promote collaboration between public sector health providers and private practitioners

- *In-service Training Policy.* This is a document that provides clear guidelines for all aspects of the training process and outlines how they should be carried out at each level.
- In-service training centres have been established in three regions
- The *Health In-service Training (HIST) Project.* This captures data on what training is being provided and for whom.
- *Re-designed Performance Appraisal Form.* This is being pilot-tested in three regions: Volta, Ashanti, and Central. The expectation is to implement this in all the districts.
- An employee manual is currently being written. This will help with the interpretation of policies and strategies.
- A process for selecting participants for external courses is being formulated. This will enhance capacity development.

3.4.1 The provision of capacities

A. Fellowship programmes

Fellowship programmes were available in the form of internal and external, long or short courses. The long courses were mainly masters degree programmes. These were in the areas of health economics, education management, health promotion and information sciences, hospital management, tropical medicine, medical electronics, occupational therapy and radiology. The commonly offered short courses were in nutrition project management, health services management, reproductive health, gender and healthcare financing.

Table 15. Distribution of training fellowships by region and facilities in 2006

Headquarters	8
Greater Accra	8
Eastern	8
Volta	4
Central	5
Western	5
Brong Ahafo	6
Northern	6
Upper West	4
Upper East	6
Ashanti	8

Komfo Anokye Hospital	8
Korle-bu Teaching Hospital	14

The distribution of training fellowships in 2006 was similar to the distribution in earlier years (Table 15). Nominations and awards for these programmes are largely decentralized, and co-ordinated by the Human Resources Development Division. There were also several in-service training courses in place to make up for weak internal capacity

B. In-service training

The GHS designed a training programme called District Health Systems Operations (DISHOP), specifically to train DHMT members in improved policy analysis, performance monitoring, and the evaluation and regulation of health service delivery. This was to enable them to cope with the increasing demands brought about by the health sector reforms.

The first round of DISHOP training organized for DHMTs was held in Ghana between 1999 and 2003. All 110 DHMTs and selected Regional Health Management Teams (RHMTs) were covered.

The engagement and appointment of new middle-level health managers, as well as the positive impact of the training programme on the beneficiaries, resulted in the continuation of the DISHOP training programme that ended in 2005. Some of the funds from the African Development Bank's Health Sector Support Project III were used to re-launch the DISHOP training programme in 2006. Alongside that, integrated management of childhood illnesses (IMCI) training was also launched to build capacity in the area of the effective integrated management of childhood illnesses.

Table 16 below gives data on the status of these in-service training initiatives as of 2008:

Table 16. Coverage of in-service training under Health Sector Support Programme III

Districts (from across the country)	**Numbers trained**				
	DISHOP			IMCI	Grand total
	Short course	Long course	Total		
Adaklu-Anyigbe	3	0	3	0	3
Amansie Central	5	0	0	3	8
Amansie East	6	4	10	13	23
Amansie West	4	0	4	0	4
Assin South	2	2	4	4	8
Asunafo South	3	0	0	4	7
Atiwa	4	0	4	4	8
Atwima- Mponua	7	10	17	5	22
Atwima Nwabiagya	4	0	0	0	4
Bia	4	0	4	0	4
Central Gonja	5	2	7	4	11
Ejisu Juaben	4	0	4	4	8
Ga West	4	0	4	0	4
Garu-Tempane	4	0	4	0	4

Kintampo North/ Rural Health Training School/Hospital	4	4	8	2	10
Kintampo South	6	0	0	0	6
Krachi East	4	0	4	0	4
Krachi West	4	0	4	0	4
Pru	4	0		0	4
Sawla-Tuna-Kalba	5	0	0	0	5
Sene	0	0	0	2	2
Sissala East	5	0	5	3	8
Tain	6	0	0	4	10
Talensi-Nabdam	4	0	4	0	4
Wa	0	0	0	4	4
Wassa Amenfi East	4	0	0	7	11
Wassa Amenfi West	4	0	0	0	4
Wassa West	7	9	16	8	24
Total	**116**	**31**	**147**	**71**	**218**

In all, 147 district health managers and 71 maternal, newborn, and child health (MNCH) staff have been trained in IMCI. The rest of the districts were to be covered by the end of 2009. Information about this was not available at the time of preparing this report.

C. Technical assistance

When technical assistance became an important policy issue in Ghana at the end of the 1990s, the strategy of the DPs was to provide long-term support by placing representatives in the MoH and in other relevant departments to oversee and evaluate technical assistance initiatives that were often funded by the DPs themselves. Now the strategy is short-term assistance. There is consensus within the DP community that the districts and the sub-districts are the focus of capacity development. Funding and assistance usually comes from DP representatives. But there is a growing move towards the active recruitment of local consultancies – such as Shawbell Consulting, which focuses on general issues, and the Centre for Health and Social Services (CHeSS), which focuses on health systems and policies – to carry out technical assistance work. The new culture of hiring of local consultants was initiated by Marius de Jong during the 2004–2006 tenure of the Netherlands as DP sector leaders.

Within the current context of short-term assistance, different DPs adopt different approaches. Some DPs provide capacity development support for organizations, in the way that as Danida supports Christian Health Association Ghana (CHAG), the Ghana AIDS Commission (GAC), and even the MoH directly. Some DPs (such as USAID), provide technical assistance directly to the districts. Other DPs provide sector budget support, with the assumption that this will support technical assistance through the national system. Thus the DPs target for technical assistance is broad. It includes individuals (through one-off training programmes), organizations (such as GAC), networks of organizations (such as CHAG), and a combination of these, especially when the focus is on the complex DHS.

3.5 Donor funding and programme support

This section attempts to map out donor interest areas in terms of health services and funds allocated to it. In 2008, a donor mapping activity was undertaken to examine donor policy and priority areas of funding since the introduction of the health reforms. Most of the information available then was based on 2006 figures.[14] However, this report does not represent a thorough review of the programmes in Ghana – where the health sector in general is a myriad of complex entities, programmes and budgets. Twelve bilateral and multilateral foundations participated in this study: USAID, the EU, DFID, Danida, UNFPA, JICA, UNICEF, the World Bank, the Royal Netherlands Embassy, the African Development Bank, GTZ and the WHO.

A. Donor coordination and funding channels

The Government of Ghana takes a sector-wide approach (SWAp) to donor fund coordination and the implementation of its health programmes. Donor resources are channelled into the health sector through three different mechanisms:

- The pooling of donor aid: This is a pooled account for programmes that are preferred by donors that have funds earmarked only for these projects or programmes. All donors who have an interest in such a programme, pool their funds into a common account that is managed by the MoH. Currently, this fund has migrated to the Ministry of Finance (MoF) under the Multi-Donor Support Budget system, and has been re-branded under Sector Budget Support funds. These funds are earmarked within the MoF and released to the MoH on request. The funds are accounted for under the general accounting framework of the Ministry of Health.

- Direct earmarked funding: These are funds held by donors and earmarked for specific programmes and preferred projects. The funds are spent on these programmes directly by the donors. Recipients of these funds are required to account for what they do with the funding, using donor-preferred accounting systems.

- The Health Fund: This funding mechanism has depleted significantly since its inception. It is a programme of support funding based on sector plans and budgets agreed to by all partners and government. It is not earmarked but aims to support government-led priorities that have been determined through wide-ranging consultations. The account is usually referred to as the common basket and reporting is based on the government's main accounting systems. Currently, this source represents less than 5% of health sector funding.

Donor funding through the Health Fund allowed the government to identify key health priorities for Ghana and to focus its health sector spending. The Health Fund allowed the MoH to develop and finance the first and second five-year Programmes of Work (5YPOW I and 5YPOW II) in 1997–2001 and 2002–2006 respectively. It aimed to increase access to, and the efficiency and quality of a decentralized health service. As a result of the POWs, the total budget allocated at district level and below increased from 23% in 1996 to 41% in 2008.[15]

Because of the nature of common basket funding, it is difficult to know how the un-earmarked donor funds are spent, and it is difficult to identify gaps in government spending and the programmes that result from it. Though the Health Account, donors are pleased with how the

[14] Seddoh, A. (2008) Donor Mapping of the Health Sector in Ghana. Harare, WHO.
[15] Ministry of Health budget statement to Parliament (2009) Accra, MoH.

overall SWAp was implemented. There remains substantial donor involvement in Ghana's health sector through earmarked assistance and managed assistance. The following is a representative sample with data based on 2006 figures.

Table 17 shows figures before the study period.

- The EU contributes 68% of its SWAp funds for Ghana through earmarked funding. It also has national education programmes and activities for sexually transmitted disease (STD) and HIV/Aids that focus specifically on school children, commercial sex workers, and military and civil service personnel.
- Denmark's Danida contributes 77% of its total funding for Ghana to the common basket and 23% to specific projects such as national health reform and supporting HIV/Aids NGOs.
- The World Bank supports the implementation of the Government of Ghana's National Strategic Framework on HIV/Aids (GARFUND), and a water and sanitation project in three of Ghana's ten regions. It also contributes to the common basket funding.
- The UK's DFID contributes 52% of its SWAp funding for Ghana through earmarked funds for the procurement of supplies, vehicles, drugs, vaccines and other, non-drug, consumables. Additionally, it supports the Ghana Aids Partnership Programme and a family planning and reproductive health (dissemination of best practices) programme in five districts. DFID also supported the training of five capacity development NGOs to disseminate reproductive health best practices.
- The Netherlands contributes the majority of its portofolio to the health sector throughthe health basket and a minor part trough earmarked funds for the Ghna National Drugs Programme. It also gives financial support to bilateral health research projects, integrated community-based distribution programmes, family reproductive health programmes, care and support of people living with Aids, and a small support project for the victims of female genital mutilation. Various Dutch agencies work in the area of reproductive health rights and assist community-based organizations to improve service delivery, increase men's role in reproductive health and address the needs of young people. The Netherlands also provided support for the National Drug Programme, increased the capacity for operations research and the in-country training of medical specialists
- USAID works in the areas of reproductive health service delivery and advocacy, including the social marketing of contraceptives. It also supports information, education, and communication (IEC) resources and CHPS compounds. USAID also works in the area of corporate social responsibility and sustainability of the Ghana Social Marketing Foundation.
- Eight agencies have also assisted the implementation of Ghana's health strategy with direct earmarked project assistance and technical support. The agencies are UNAIDS, JICA, UNFPA, UNICEF, WHO, the African Development Bank and GTZ. The Gates Foundation also funds a number of research studies and programmes in Ghana. Donors contributing through earmarked funding and through specific project assistance worked in the following health sectors:

Table 17. Summary of selected donor funding 2002–2006

Donor	**Health sector funding**	**Program areas**
USAID	$16.8m/year	Reproductive health/family planning, HIV/Aids,
The European Union	$2.9m/year	SWAp, medical supply procurement, technical assistance for the Centre for Health Information Management, HIV/Aids/sexually transmitted disease

DFID	$15.2m/year	SWAp, HIV/Aids, reproductive health and family planning
DANIDA	$8.1m/year	SWAp, health reform, HIV/Aids
UNFPA	$2.56m/year	Integrated reproductive health/family planning services
JICA*	$1.1m/year	Training, technical assistance, community empowerment, grassroots grant aid
UNICEF**	$5.64m/year	Child health, maternal and neonatal health environmental health, nutrition, school health
World Bank	$12m/year	SWAp, HIV/Aids
The Royal Netherlands Embassy	$17 m/year	SWAp, national drugs programme, research, reproductive health, family planning, female genital mutilation, people living with Aids
The African Development Bank	$3.1m/year	Rehabilitation of three district hospitals and three regional hospitals
GTZ	$700,000/year	Health sector reform
WHO	$2m/year	Health reform, child and adolescent health, maternal health, TB, HIV/Aids, Malaria
Total	$74.9m/year	

* Figure is based on information provided on completed projects alone.
** UNICEF provides other support services whose information was not readily available to the team

3.6 Analysis and conclusions

3.6.1 Analysis

Capacity development needs to be approached on four main fronts (MoH, 2008, p. 9): human resources; infrastructural development; equipment renewal; and the development of a local health industry with the private sector as key partners. The interviews for this evaluation resulted in a broader understanding than could have been captured in written documents alone. From these interviews, it became clear that respondents believed that capacity development involved contextualized health professional learning (or 'learning by doing') and the provision of an enabling environment that allows capacity to be developed. Such an enabling environment was envisaged to consist of well-equipped organizations with non-hierarchical organizational structures that value and nurture creativity and innovation.

Health sector policy on capacity development focuses mainly on human resources development. Three approaches were recommended:

- educating healthcare workers
- providing incentives to stem the loss of staff through the brain drain and other forms of staff attrition
- recruiting additional skilled healthcare workers from overseas and deploying them in areas with significant shortages

This was further expanded under the 5YPOW III to 'scale up health delivery and human capital development and contribute to poverty reduction and wealth creation' (M0H, 2008, p.1). However,

the strategy also intended to develop and maximize technical, managerial and logistical capacities for healthcare delivery at both clinical and organizational levels. Emphasis is placed on technical and managerial capacity within district healthcare systems.

There are concerns that government funding to the sector will remain squeezed, with 90% of its contribution going to pay salaries. This will continue to affect the level of funding available for services and infrastructural development. At the current level of expenditure, the health sector will require the equivalent of about $60 per capita expenditure on maternal health services if it is to achieve the 75% reduction in maternal mortality targeted in Millennium Development Goal 5.

These challenges would be better addressed if there were a clear policy on capacity development to support resource mobilization. Unfortunately, cogent policies remain a scarce commodity, leaving ordinary healthcare workers racking their brains to find solutions to problems. Current fellowship programmes and in-service training opportunities are a positive development, but they need to be extended to more people in the districts to enable them to develop their capacities. Though not thoroughly investigated as part of this study, the views from interviews in the district suggest that the opportunities are skewed in favour of health professionals living in urban areas.

Despite these challenges, development partners have proved to be indispensable partners for health development. The core areas that were tackled to date appear to have been approached in a strategic way, based on real health needs. DP investments have brought about significant transformation in the area of training and institutional development. Given the desire of many district-level staff to pursue professional development, this is a critical investment area, especially the in-service training, which appears to be a priority for partner projects that do not come under common basket funding.

The technical assistance that was targeted at strengthening the capacity of the MoH and CHAG institutions has been particularly beneficial. Though the impact has not been measured, these interventions can be seen to be supporting the expansion of general health system and disease-specific interventions. The use of local expertise and institutions to carry out capacity development efforts has also been widely appreciated.

There is consensus within the DP community that the focus of capacity development in Ghana's health system should remain on the districts and sub-districts. National-level perspectives on capacity development indicated that it was broadly in line with the range of health needs being experienced in the districts. The unanimous acknowledgement of the need to empower communities to assume ownership of their own healthcare is an endorsement of the initiatives currently going on in the better-performing districts.

To some extent, the strength of health delivery at community level was partly due to the support that health NGOs received from DPs and other national and international donors. The importance of 'transformational', creative and innovative leadership was also a dominant theme in the responses of many interviewees from the DP community. One point emerged clearly: The health policy reform process at national level and the new funding and (exogenous) accountability structures it produced were seen as partly to blame for the demise of district health leadership, and by extension, led to poor progress on capacity development. This implies that no matter how welcome DP support is, its alignment can often be a problem outside the reform process and the pooling of resources towards a common goal.

3.6.2 Conclusions

The concept of capacity development at the national level is widely appreciated. Both the MoH and development partners are generally aware that the MOH is severely resource constrained. Development partners' core products have been designed with this in mind. However, the absence of a clear policy is likely to affect the impact of capacity development efforts. This needs to be addressed quickly in order to consolidate the emerging capacity development that respondents observed resulting from the DHMTs' adherence to the five core capabilities defined in the 5CC framework. To do this, all stakeholders will need to engage in a consultative manner to define key priorities. It is essential that a formula is found to disburse funds equitably and even out the imbalance between personnel emoluments and resources for other capacity development initiatives. The districts remain an important focus for all stakeholders, and this must be encouraged.

4. Analysis and lessons learned

4.1 Analysis

In recent years, districts and sub-districts have been at the heart of Ghana's health planning system. At the core of the District Health System (DHS) is the District Health Management Team (DHMT) – a structure that is operated more directly by the Ghana Health Service (GHS). The DHMTs have regularly been the focus of capacity development in the health sector. However, partnerships with other agencies responsible for healthcare, but which lie outside the direct management of the GHS were described by interviewees who took part in this evaluation report as integral to the DHS as both drivers of the system as well as its beneficiaries.

Capacity development in the health sector has not been implemented systematically. Indeed, until the MoH's third Programme of Work (5YPOW III) in 2007, there was no explicit mention of capacity development – although it was acknowledged that it took place. Not surprisingly, a key finding of this study was that few healthcare workers knew the history of capacity development evolution in their districts. Without this knowledge, it was difficult to track the processes and outcomes of capacity development interventions over time at the district level.

There are many elements that influence capacity, and these generate variables that are interdependent. This interdependence exists at all levels, between all levels and in the interaction between all stakeholders. The study brought to the fore the significance of capacity development in improving the performance of the health sector. It showed the ways in which the DHMTs adhered to, or failed to adhere to, the five core capabilities outlined in the 5CC framework, and how success or failure in this affected outcomes in the three districts. The study demonstrated that these capabilities were essential to the health system at organizational, health professional and DP levels. The study illustrated the interactions between stakeholders and showed that if deployed consistently and over time, health system performance would be sustained, as would improvements in the health of the population.

Confounding factors related to culture, society, the economy, political systems, laws and regulations, and the environment were shown to influence capacity in the health sector. There was no ambiguity between the way interviewees in the study perceived the 'political legitimacy' of the District Assembly (DA) and the 'social legitimacy' of the DHMTs. The impact of national level actors and their policies and actions were seen to directly affect the core capacity issues identified in the study. The individual case studies and the national-level interviews also suggested crucial elements of capacity that should be present in order to ensure adequate health system performance.

In order to be efficient and to perform at its best, the evidence showed that leadership needs to have the *capability to act and commit*. To act requires clear national policies and guidance, alongside adequate resources. Respondents participating in the evaluation interviews indicated that weaknesses in policy and the in effectiveness in implementing policies were widespread. Financial resources, infrastructural resources, logistical resources and human resources were all mentioned as being inadequate or weak. Funding from regional and national level was found to be inadequate and often disbursed late. New sources of income, from insurance schemes were also problematic. Financial support from the DA was declared to be minimal, and technical support was not always guaranteed. Available resources have never been enough to meet the health needs of the communities. The reasons for this are beyond the scope of this study. However, the gaps in capacity

pointed to limited resources and inequitable resource targeting. In order to be practical, resources need to be sourced from outside. In response to this, DPs at the national level have developed core 'products' that tackle these practical areas of development need and have provided technical assistance at all levels to support action. This needs to be further strengthened to improve equity and needs to be targeted at areas of maximum impact.

Birim North and Kwahu South, the better-performing districts, demonstrated that in a limited and resource constrained environment, it is possible to innovate and make bold decisions about using internally generated funds to augment allocated budgets. However, the study showed that these funds need to be directed at clearly articulated needs. All three districts defined a number of needs, but Birim North and Kwahu South prioritized human resources. They did this because they recognized that healthcare delivery was labour intensive. They developed their own performance-based incentive packages to motivate and reward staff. The ways in which services were organized was also emphasized in the study. The expansion of CHPS compounds showed a clear commitment to act in response to community needs. This view was reinforced by MoH national staff and development partners at all levels, who stated explicitly that the better-performing DHMT worked harder to deliver on its objectives, despite lacking adequate resources. The capabilities that contributed to Birim North's success were clearly absent in Atiwa. Strengthening the adaptive capacity, as exhibited by Birim North, for all service providers should inject dynamism into the health system. Development partners can help to make this happens by ensuring that a system of performance-based financing is introduced to reward districts and individuals that perform well.

Recruitment and training have emerged as mechanisms for developing the *capability to deliver on developmental objectives.* All three districts complained about the shortage of adequate staff and the weakness of their capacities. Staff in all three districts expressed a desire to develop and grow and to be efficient in delivering services. The emphasis on human resources development at the national level, points to consistency in interest and the willingness of decision makers and development partners to support this aspiration. As observed by staff in Atiwa, training opportunities (and probably staff recruitment and allocation) favoured regional and national-level staff. The two better-performing districts, Birim North and Kwahu South, found innovative ways of addressing this through the use of internally generated funds. There was a conscious effort here to encourage training, and innovative ways were found to recruit and motivate staff using internally generated funds. By contrast, Atiwa, an under-performing district, waited for national intervention. Because of the perceived inequities in the provision of training opportunities and staff allocation, a good deal of discontent was observed in this district and there was a feeling of apathy about achieving development objectives. If true, this needs to be corrected with a clear formula for how opportunities should be allocated – a formula that is developed to favour districts in deprived areas.

Evidence for the *capability to adapt and self-renew* came principally from respondents in the districts. The study provided confirmation that staff was ready to adopt guidelines, to embrace the introduction of new health systems and to give their backing to efforts to strengthen service delivery. There were, however, concerns that rigidity in organizational rules could stifle innovation.

And innovation was where the leadership in the better-performing districts excelled. Guidelines did not prevent them from using their creativity and adaptability to break new ground. First, they identified the priority areas. Then they engaged stakeholders to assist in institutional transformation. There was evidence of supervision as well as monitoring and evaluation, but it was unclear whether systematic learning was built into the activity. Most DHMT respondents discussed learning in terms of individuals learning on the job. This bias was perhaps a product of narrow definitions of capacity

development. A better appreciation of this capability needs to be developed among professionals so that it becomes part of organizational culture.

The *capability to relate to external stakeholders* and the ability to network through what the respondents called forming 'alliances' and 'collaborations' proved an important asset in acquiring resources in a resource constrained environment. Birim North and Kwahu South used their capabilities in this area to significant advantage, and it yielded more than a proportional results. A frequent weakness, however, was resorting to unidirectional communication when two-way interaction was needed. This seems to hinder staff performance in Atiwa. It was observed to have happened when national and regional-level organizations issued instruction to staff in the district, without allowing them to have any input into programme design or implementation. Appropriate guidelines are required to ensure that all staff members have input into policies and directives.

Consultative and participatory leadership lay at the heart of the positive accounts from respondents talking about the better-performing districts. This leadership style was found to be motivational, reduced staff attrition and generated exogenous support for the district. A clear relationship was also established between leadership, staff attrition and commitment. As a respondent in South Kwahu put it, *attrition is usually very high when the leadership is not favourable*. Managing top-down and bottom-up approaches includes lobbying regional and community groups, sharing information at both levels and encouraging community ownership. This is a core competency that needs to be strengthened in order to develop capacity at all levels

Birim North has a structured system of communication and engagement between the hospitals, clinics and the DHMT and between the DHMT and communities. Kwahu South has the full range of GHS services and may therefore require leadership based on teamwork between the DHMT and the hospital. These differences need to be probed further. It will be interesting to follow what happens in the under-performing Atiwa district now that the action-oriented, former DDHS of Birim North has been transferred there to lead health services in the district.

4.2 Lessons learned

The 5CC framework for capacity evaluation was applied successfully in evaluating capacity development at the district level of the Ghanaian health system – a particularly complex field of study. In the course of the evaluation, it was possible to establish outcome based on the indicators that were developed to measure performance in the districts being studied. A complex composite set of indicators that measures output/outcome was available to be used, and trends were examined over time; albeit limited to the period during which the assessment methodology was developed.

Much more difficult to establish were changes in capacity over time. The link to performance can only be inferred, but in this evaluation where comparisons were made between better-performing performing districts and an under-performing district, it was possible to deduce certain facts about adherence to the five core capabilities outlined in the 5CC framework.

The health sector needs both endogenous and exogenous capacities. Exogenous capacities are important because healthcare workers fundamentally need financial resources, infrastructural resources and knowledge resources in order to carry out their work. But endogenous capacities are also important because available resources must be used efficiently in order to attain organizational goals. For these processes to work the socio-psychological acumen of the healthcare workforce and the communities they serve become important. This was defined in the inception report as focusing

on ‘psychological variables such as trust and motivation that point to inter-individual and group-level processes’, as well as ‘the interaction between the individuals (the healthcare workers), their institutions (history, memory, resources and leadership), their community/society (health needs, demands and power), and broader Ghanaian society (attitudes to work, accountability and ethics)’. Leadership stands as an embodiment of all these attributes. To be able to attain high performance at the institutional level, there should be:

1. Committed stakeholders that support DHMT activities
2. Strong leadership with clear vision about who takes action and how this is monitored
3. A culture of maximizing minimal resources
4. An ability to network with stakeholders and engage community members through volunteer structures and a legitimization of the DHMT by local leaders

The lessons learned from Atiwa show that the absence of these socio-psychological attributes is quite stark. Although they had the same resources as the other districts, a lack of group-level action and the prevalence of negative attitudes to structural failures undermined the district’s ability to reap benefits. But the issue of transformational, creative and innovative leadership needs to be explored beyond merely recognizing that it is desirable. A clearly articulated training module needs to be developed so that these attributes, where they do not arise naturally, may be taught.

The greatest challenge that the MoH and GHS face, is how to appoint such transformational leaders into responsible positions, not only at the district level but at all levels of the health system. Leadership training has been put in place but it is not clear whether this will produce type of leadership outlined above. The starting point for ensuring that the system employs such leaders needs to be at recruitment. The appointment process should go beyond inspecting qualifications and target leadership qualities as the crucial factor in selecting leaders to fill key positions.

In conclusion, the main lessons learned for policy development are that:

1. It was possible for changes in the capacity of the DHMTs to be realized even when baseline data was difficult to establish and respondents were unable to articulate whether changes that took place were positive, inadequate or problematic.
2. Output and outcome measures can be used when evaluating capacity. Even when attribution was difficult, it was possible to say that positive changes in capacity development did affect outcome.
3. The application of the 5CC framework indicated that endogenous capabilities were the most effective.
4. The key issues that were crucial to policy were:
    a. *Leadership*. Direction that was transformational, participatory, involved social networking and hard work was crucial to capacity development. Such leadership cannot be acquired easily through training alone, but must be recognized when candidates are being selected for positions in an organization.
    b. *Legitimacy*. Both social and political legitimacy were necessary to achieve developmental objectives. In the best performing districts, this was used to great effect.
    c. *Ability to mobilize resources*. This was particularly relevant to the way in which the DHMTs related to their external stakeholders. As part of the Ghanaian health sector reforms, which were based on a sector-wide approach (SWAp), and in line with aids effectiveness, external donors were asked to contribute to a ‘common basket’ of funds. This was then used to fund commonly agreed programmes. This became the

downfall of many districts because some donors preferred to stay outside the common basket and administer their own funds. This meant that DHMTs that had the capabilities to lobby donors directly for these 'extra' sources of funding performed better.

d. *Capability to adapt and self-renew*. One of the distinguishing features of the districts that performed well was their ability to use information collected as part of their monitoring and evaluation system to learn lessons about their work and to redirect their efforts. Where leadership, and the team as a whole, were entrepreneurial in their approach to work, they were able to go beyond immediate situations and rise to challenges. In comparison, the under-performing district was defeatist and lackadaisical in its approach.
e. *Community involvement*. There was extensive community participation in the programmes of the better-performing districts. They received information regularly through community *durbars* and this fostered a sense of ownership of the programme.

5. Annexes

Annex 1. Feedback on the methodology

Consultations and preparatory activities

A meeting on capacity development was organized by the Ghanaian Ministry of Health (MoH) in October 2008. At this meeting, the Netherlands Ministry of Foreign Affairs, Policy and Operations Evaluation Department (IOB), working, with a local consultant, made presentations on capacity development and the value of capacity development evaluation. The MoH asked for IOB support to carry out a study on the determinants of capacity and capacity development in the Ghanaian health sector. This was to be part of the implementation of the sector's third five-year Programme of Work (5YPOW III).

After this meeting, the Centre for Health and Social Services (CHeSS) was contacted by the MoH and formally mandated to undertake this study on its behalf. This was followed by a series of meetings and consultation between the chief executive officer (CEO) of CHeSS, Dr Sam Adjei, and IOB staff. The evaluation was to be overseen by IOB's Piet de Lange. In late 2008 and 2009, a series of meetings took place in Amsterdam and Accra between, Dr Sam Adjei, Piet de Lange, Paul Engel, director of the European Centre for Development Policy Management (ECDPM), and the MoH. These culminated in a presentation to the MoH staff early in 2009.

A work programme was developed, an initial research team was assembled by CHeSS, and a contract was then formally signed in 2009. These consultations were extremely useful in finding a common understanding on roles and responsibilities, as well as defining what the different players expected the evaluation to achieve. One key agreement was that the Ghana evaluation should not be limited to capacity development provided by Dutch development partners (DDPs) but should include government and wide range of development partners (DPs) involved in Ghana's health sector during the period of the study (1997–2007). During this time, Ghana initiated a programme of health sector reforms based on a sector-wide approach (SWAp). Under this, development partners worked together with government to support a series of five-year programmes of work (5YPOWs).

The Ghana Reference Group (GRG) is also referred to as the steering committee. This committee agreed to the basic design of a comparative case study, which compared better-performing and under-performing health districts. This was important for Ghana, where capacity development was not seen as discrete intervention, and where previously it had not been possible to carry out a before-and-after type study to examine the impact of capacity development interventions. It was also suggested that more effort should go into the qualitative aspects of the study rather than the quantitative aspects. It was decided that the quantitative aspects should be limited to pre-testing the indicators and confined to the study districts. It was also suggested that interviews with key individuals in the sector should be used extensively in the formal sector of the evaluation, and that informal focus-group discussions should be used at the community level and with ordinary healthcare workers, where greater divergence and variability were felt to be likely to exist.

Selection of study sites

Ghana's Eastern Region was purposely selected for the study. This was because the Eastern Region carries out annual performance analyses of all the districts, which meant that data existed to serve as a guide for the evaluation.

The indicators of the five core capabilities were customized to suit the specific context of the health sector in Ghana. When these were pre-tested in one district, certain key indicators such as leadership and work culture became very prominent and had to be included in the customization. In presenting the reports however, the original indicators were retrospectively applied in order to maintain consistency.

Compliance with the work plan
The work plan was followed and the field work was completed on time in February 2010. However, the analysis took much longer than expected, mostly as a result of two factors

- The development of code books for the analysis took much longer than expected
- A good deal more effort than was anticipated was put into writing and producing the individual case studies

Conclusions
Overall, the evaluation was informative and constructive. The conceptual framework was useful and the application of the five core capabilities helped those involved in the study to focus on the work in hand. Ghana's assessment was different from other evaluations in this series in that it did not evaluate capacity development as a specific intervention by any DDP. Rather, it looked at capacity development initiatives from all DPs and included local efforts as well. This proved to be a challenge, and something of an eye opener as well in terms of how capacity development is perceived in the Ghana's health sector.

Specific comments
The comments will be dealt with under two headings: technical and managerial.

Technical

1. While the framework was helpful, there were a number of themes that spread across more than one of the five capabilities. How leadership is assessed, for example, needed to be discussed in terms of several of the capabilities. This made the discussion repetitive at times.
2. The language used in the 5CC framework did not always adapt itself very well to the situations on the ground in the Ghanaian health sector. For example, discussions about political legitimacy were interpreted by respondents in terms of political party membership.
3. In the community, it was discovered that it was better not to ask technical questions, but rather to concentrate on relationship-type questions and to ask whether specific encounters with the health system had improved in comparison with previously. In this way, the study tried to establish a timescale during which capacity development took place in the districts. This made the information-gathering process difficult and complex.
4. Capacity development appears to be a foreign concept; something brought as from outside rather than what the people themselves felt they had. A few of those interviewed, however, described it as *something you have which must be built on*. There is often a narrow perception of capacity development, limited to individual training in most cases.

Managerial
This section relates to the way in which the evaluation was organized and managed.

1. CHeSS was mandated by the MoH in Ghana but contracted by IOB. The Netherlands embassy also initially wanted to have some input, as did the steering committee set up by

the MoH. At times it was felt as though it was necessary to report to four masters. To further confound the bureaucracy of the situation, it was necessary to deal with the regional health authority, which looked for clearance from the GHS at national level, before even starting to get to the districts. While this may have had the advantage of fostering the participation of all, it made progress considerably slower than anticipated.

2. The region and districts in which the evaluation took place did not want to be merely the passive objects of a study. They wanted the evaluation to be used to build their own capacity using the 5CC framework as a tool. The monitoring and evaluation (M&E) division of the Ministry of Health similarly wanted to learn in a participatory way. Staff at the division were therefore included on the research team to accommodate this request.
3. It would have been useful to have had the opportunity to interact with other teams and to share experiences along the line.

Annex 2. References

Campbell, C. and Jovchelovitch, S. (2000) Health, community and development: Towards a social psychology of participation. *Journal of Community & Applied Social Psychology*, 10: pages 255–270.

De Lange, P. and Feddes, R. (2008) General Terms of Reference, Evaluation of Dutch support to capacity development: Evidence-based case studies on how to support organisational development effectively. The Hague, IOB.

Doise, W. (1986) *Levels of explanation in Social Psychology*. Cambridge, UK, Cambridge University Press.

Fraser, H. (2005) Four different approaches to community participation. *Community Development Journal*, 40(3): pages 286–300.

Gervais, M., Morant, N. and Penn, G. (1999) Making sense of "absence": Towards a Typology of Absence in Social Representations Theory and Research. *Journal for the Theory of Social Behaviour*, 29 (4): pages 419–444.

Ghana Health Service (2008) Five Year Strategic Framework for Service Delivery: 2007 – 2011. Accra: Ghana Health Service.

Ghana Health Service (2004) Collaboration with District Assemblies for a Healthy Population: A Manual for District Workers. Accra: Ghana Health Service.

Ministry of Health (MoH) Ghana (1996) Health Sector 5 Year Program of Work I: 1997-2001. Accra Ministry of Health.

MoH Ghana (2009) Pulling together, achieving more. Independent Review, Health Sector Programme of Work 2008. Accra, Ministry of Health.

MoH Ghana (2008) The Ghana Health Sector 5 Year Programme of Work, 2007 – 2011. Accra, Ministry of Health.

MoH Ghana (2008b) Implementation of 5YPOW III: 2007–2011. 2007 Annual Progress Report. Accra, Ministry of Health.

MoH Ghana (2007) *The Ghana Health Sector 2007 Programme of Work*. Accra, Ministry of Health.

MoH Ghana (2005) Creating Wealth Through Health. Minister's Press Briefing. Accra, Ministry of Health.

MoH Ghana (1996) Health Sector 5 Year Programme of Work. Accra, Ministry of Health.

Watson, D. (2006) Monitoring and evaluation of capacity and capacity development. Discussion paper No 58B, European Centre for Development Policy Management.

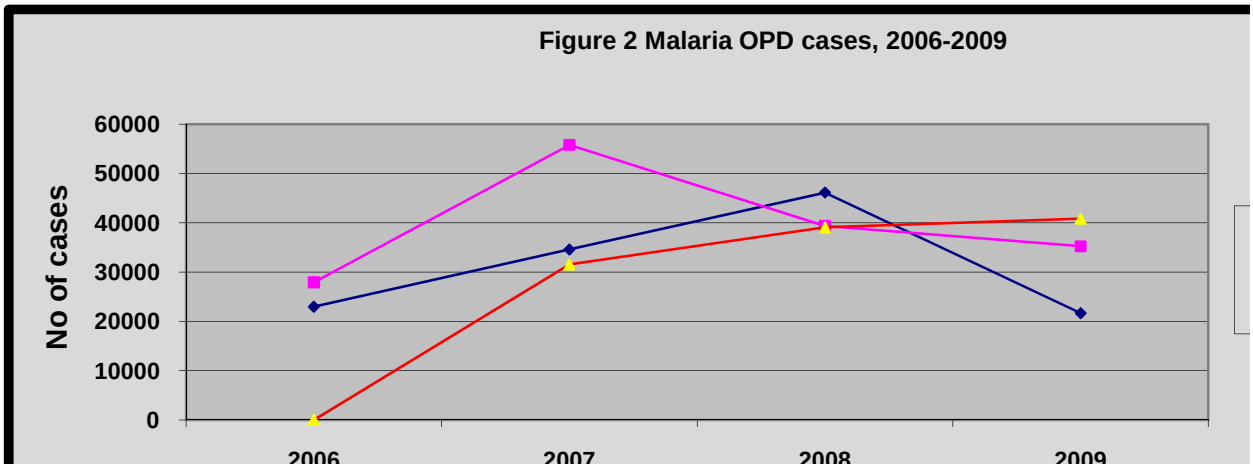
Annex 3. Health profile of the three study districts

Table 18. Health systems profiles of Birim North, Kwahu South and Atiwa districts

	Birim North	**Kwahu South**	**Atiwa**
Population	82,809	87,350	102,467
Health facilities	Christian health Association Ghana (CHAG) – 1 RCH Centre – 2 CHPS – 9	Hospital – 1 Training institution – 1 Health centre – 2 Clinics – 4 CHPS – 4 Private maternity home –1	Hospital –1 Health centres – 6 CHPS – 17 Private maternity home – 1
Health workers	Doctor – 1 Pharmacist – 0 Medical assistant – 1 Midwives – 5 Public health nurse – 1 State registered nurses – 6 Community health nurse – 33 Enrolled nurses – 3	Doctor – 1 Pharmacist – 1 Medical assistant – 1 Midwives – 4 Public health nurses – 3 State registered nurses – 7 Community health nurses – 25 Enrolled Nurses – 0	Doctor 1 Pharmacist 0 Medical assistant 1 Midwives – 4 Public health nurses – 4 State registered nurses – 5 Community health nurses – 36 Enrolled Nurses – 0

Table 19. Health profiles of Birim North, Kwahu South and Atiwa districts

	Birim North	**Kwahu South**	**Atiwa**
Population	82,809	87,350	102,467
Top ten outpatients department cases (2009)	1. Malaria 2. Acute respiratory infection (ARI) 3. Rheumatism 4. Skin diseases and ulcers 5. Hypertension 6. Diarrhoea 7. Vaginal discharge 8. Home accidents 9. Onchocerciasis 10. Schistosomiasis	1. Malaria 2. Other ARI 3. Hypertension 4. Diabetes mellitus 5. Skin diseases and ulcers 6. Diarrhoea diseases 7. Home accidents 8. Anaemia 9. Intestinal worms 10. Rheumatism and joint pain	1. Malaria 2. Other ARI 3. Rheumatism and joint pain 4 Skin diseases and ulcers 5. Diarrhoea diseases 6. Hypertension 7. Home accidents 8. Anaemia 9. Malaria in pregnancy 10. Pyrexia of unknown origin (not malaria)



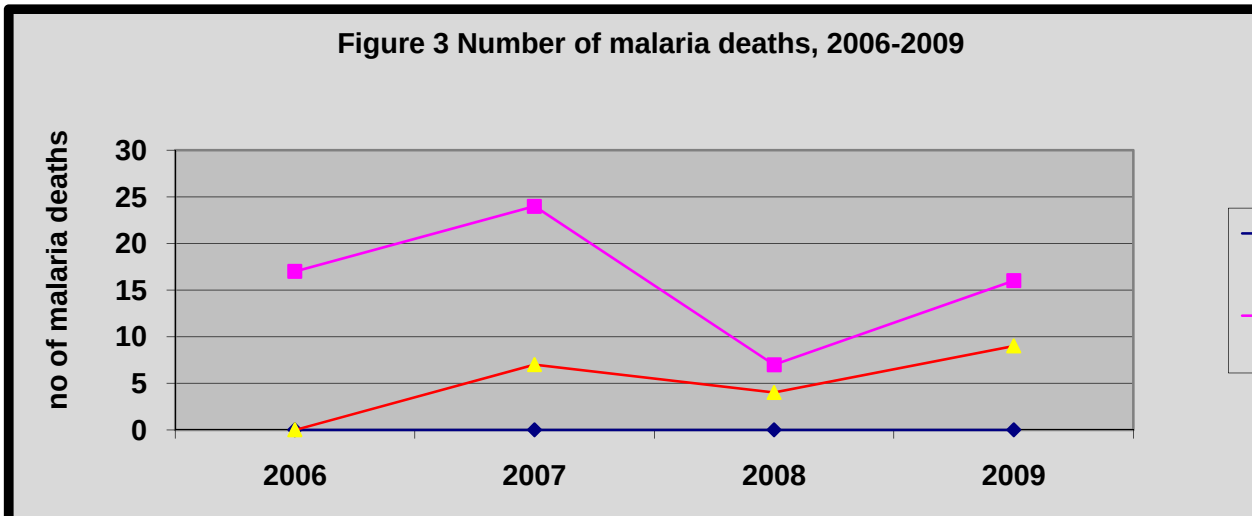
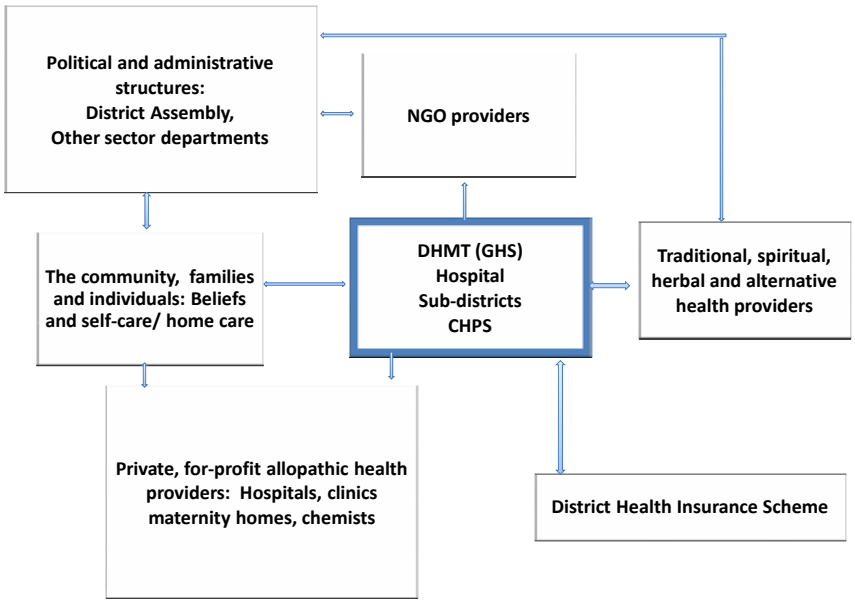


Table 20. Trend and percentages of supervised delivery, 2004 2009

	Numbers of supervised delivery and percentage of total delivery in a year for the period 2004 to 2009					
District	2004	2005	2006	2007	2008	2009
Birim North	1219 (23%)	1612 (31%)	2019 (38%)	1633 (30%)	979 (36%)	697 (21 %)
Atiwa	Not create d	1258 (32%)	1144 (30%)	1301 (33%)	1420 (35%)	1659 (41 %)
Kwahu South	5760 (65%)	1254 (53%)	3262 (55%)	3159 (46%)	2933 (85%)	2532 (71 %)

Annex 4. The District Health System (DHS)

Figure 4 The District Health System



Annex 5. Customization of capabilities into the Ghana context

Core capability	Indicators	Source of information	Data collection methods
General • Definitions of capacity and capacity development • Examples of capacity development	• How do different stakeholders understand capacity and capacity development • Documenting 'stories of capacity development'	Development partners (DPs) Key informants Reports (including review of capacity development in the DP community)	Key informant interviews (KIIs) Desk review (of reports and other grey literature)
1. The organization is capable of acting and committing. ◆ The organization has a plan, takes decisions and acts on these decisions collectively. ◆ The organization maintains effective human, institutional and financial resource mobilization. ◆ The organization conducts effective monitoring of the plan. ◆ Leadership is inspiring /action oriented. ◆ Leadership's integrity is accepted by the staff.	*The District Health Management Team (DHMT) is capable of acting and committing.* ▪ The relevance and appropriateness of the District Health Plan (DHP) ▪ The process of DHP development, support provided to the DHMT, decision-making power, stakeholder involvement ▪ *Realization:* health activities planned, of agreed actions with stakeholders, of tracers: plans (priority programmes) and problem solving for realization • *Resource mobilization:* needs analysis made, entrepreneurship, reducing waste in the system, efficient use resources between partners • *Effective monitoring of the plan:* type of monitoring and indicators,	DHMT GHS (hospitals, health centres, CHPS zones) The DA (especially district coordinating directors) Health service workers	KIIs Desk reviews (existing reports; supervisory reports; relevant grey literature) Focus group discussions (FGDs) Narrative methods: 'Work Stories' approach (see Watson, 2006, p. 23) and 'Most Significant Change' (MSC) technique (see Watson, 2006, p. 25) Note on leadership data: we will develop a typology of leadership (see page 26; footnote 15) and then

	by level and type of care, scope of monitoring and use of monitoring results • *Leadership:* organization, teamwork, organizational leadership, situational leadership, receptiveness, coaching, change agent		quantitative indicators for measuring leadership within the broader context of the DHS.
2. The organization is capable of delivering on development objectives. ◆ The organization has adequate resources. ◆ The organization's infrastructure is considered sufficient and relevant for its core tasks. ◆ The organization has adequate and sufficiently stable human resources at its disposal. ◆ The organization has access to knowledge resources	*The DHMT is capable of delivering on sector objectives.* • *Adequate resources:* budget for running costs and predictability, autonomy, infrastructure DHMT and facilities, appropriate and equitable distribution facilities, (contra-) referral, availability drugs and equipment, planning and management instruments, access to knowledge resources • *Human resources:* right skills-mix and right size DHMT and facilities, retention, motivation, appropriate working and living conditions	DHMT GHS (hospitals, health centres, CHPS zones) The DA (especially district coordinating directors) Health service workers The Regional Health Management Team (RHMT)	KIIs Desk reviews (existing reports; supervisory reports; relevant grey literature) Focus group discussions (FGDs) Narrative methods: 'Work Stories' approach (see Watson, 2006, p. 23) and 'Most Significant Change' (MSC) technique (see Watson, 2006, p. 25)
3. The organization is capable of relating to external stakeholders. ◆ The organization is seen as politically and socially legitimate by relevant stakeholders.	*The DHMT is capable of relating to internal and external stakeholders.* • Document the range of internal and external stakeholders • *Legitimacy:* by type of provider, as perceived by stakeholders and health staff	DHMT and all DHS partners (see Table 4): GHS Health partners The DA The lay community The RHMT	KIIs Interviews FGDs Narrative methods (as appropriate)

◆ The organization's leadership and staff have integrity (upright, incorruptible) according to its stakeholders. ◆ The organization has operational credibility /reliability in the eyes of relevant stakeholders. ◆ The organization is aware of the importance of entering into coalitions and puts this conviction into practice. ◆ The organization maintains adequate alliances with relevant external stakeholders.	• *Leadership:* by type of provider, as perceived by stakeholders and health staff • *Operational credibility /reliability:* patient's perception of quality of care by type of provider and by type of services • *Entering into coalitions:* involved in management and planning, effective meetings, added value partners, trust, unity and direction • *Adequate alliances:* communication, network attributes distribution roles and responsibilities, management of the relationship (contractual?), sharing resources and procurement, harmonized procedures, mutual accountability, achievement of expected benefits	Sector departments DPs	
4. The organization is capable of adapting and self-renewing. ◆ The management has an understanding of shifting contexts and relevant trends. (external factors). ◆ The management has the confidence to change: it leaves room for diversity, flexibility and	*The DHMT is capable of adapting and self-renewing.* • The DHMT understands shifting contexts (e.g. new health threats, sudden changes in financial arrangements) • *Confidence to change:* Receptiveness to new ideas, change agents, vision, changing national policies (decentralization, NHIS) • *Rewarding learning*: training plan, capacity development based on	DHMT GHS DA Insurance schemes such as NHIA and DMHIS	KIIs FGDs Narrative approach (MSC) Desk review

creativity. ◆ Management is encouraging and rewards learning and knowledge exchange, including in its own management. ◆ The organization uses opportunities and incentives, acknowledges mistakes that have been made and stimulates the discipline to learn. ◆ The organization plans and evaluates its learning systematically.	needs assessment, transparency, on-the-job training • *Opportunities and incentives to learn*: sanctions and bonus system, performance monitoring, accountability criteria, availability of resources • *Systematic learning:* M&E of performance, use M&E for planning, platform for analysis results		
5. The organization is capable of achieving coherence. ◆ The organization has a clear mandate, vision and strategy, which are known by staff and used by its management to guide its decision-making process. ◆ The organization has a well-defined set of operating principles. ◆ Leadership is committed to	*The DHMT is capable of achieving coherence.* • *DHMT's mandate, vision and strategy:* based on local context, known by staff and stakeholders, guidance decision-making • *Operating principles:* standard operational procedures, business plan, continuity of care, norms and standards • *Leadership of the DMO is committed to achieving coherence and balancing stability with change.* • *Consistency of ambition, vision,*	DHMT GHS The DA NHIA/DMHIS	KIIs FGDs Narrative approach (MSC) Desk review

achieving coherence, and balancing stability with change. ◆ There is consistency between ambition, vision, strategy and operations	*strategy and operations:* logical results chain which prioritizes balancing national strategies with local conditions		