

LIBERIA

REBUILDING BASIC HEALTH SERVICES

CAPACITY ASSESSMENTS OF CENTRAL MOHSW BONG COUNTY LOFA COUNTY & NIMBA COUNTY

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CONTENTS

ACRONYMS	4
1.0 EXECUTIVE SUMMARY	6
1.1 CONTEXT	6
1.2 SUMMARY SCORE COMPARISON	7
1.3 BUILDING BLOCK 1: DELIVERING ESSENTIAL HEALTH SERVICES	9
1.3.1 CAPACITY TO DELIVER HEALTH SERVICES	9
1.3.2 CAPACITY TO ENSURE APPROPRIATE USE OF POLICIES AND SERVICE DELIVERY STANDARDS	9
1.3.3 CAPACITY OF VERTICAL PROGRAMS	9
1.4 BUILDING BLOCK 2: HEALTH WORKFORCE	9
1.4.1 CAPACITY IN WORKFORCE RECRUITMENT AND DEPLOYMENT	10
1.4.2 CAPACITY TO STRENGTHEN EXISTING WORKFORCE	10
1.5 BUILDING BLOCK 3: HEALTH INFORMATION SYSTEMS	10
1.5.1 CAPACITY TO PLAN FOR AND SYSTEMATICALLY COLLECT HEALTH INFORMATION	11
1.5.2 CAPACITY TO PROMOTE EVIDENCE-BASED DECISIONS AND POLICY MAKING	11
1.6 BUILDING BLOCK 4: ACCESS TO ESSENTIAL MEDICINES	11
1.6.1 CAPACITY TO ENSURE ACCESS TO ESSENTIAL MEDICINES FOR THE POPULATION	11
1.7 BUILDING BLOCK 5: HEALTH SYSTEMS FINANCING	11
1.7.1 CAPACITY TO FORMULATE, DISTRIBUTE AND MONITOR FINANCING FOR THE HEALTH SECTOR	12
1.8 BUILDING BLOCK 6: GOVERNANCE AND LEADERSHIP	12
1.8.1: CAPACITY TO IMPLEMENT ACTIVITIES AIMED AT IMPROVING THE HEALTH OF ALL PEOPLE WITHIN THE COUNTY	12
1.8.2: CAPACITY TOWARDS INTRA AND INTER AGENCY COMMUNICATION	12
2.0 CAPACITY BUILDING ASSESSMENT: PLANNING AND METHODOLOGY	13
2.1 BACKGROUND	13
2.2 FRAMEWORK	14
2.2.1 DEFINING CAPACITY BUILDING	14
2.2.2. CONCEPTUAL FRAMEWORK	14
2.3. CAPACITY BUILDING PROCESS	16
2.3.1 ORGANIZE THE PROCESS	16
2.3.2 IDENTIFY STAKEHOLDERS	16
2.3.3 DEVELOP PARTNERSHIPS	16
2.4 CAPACITY BUILDING ASSESSMENT METHODOLOGY	18
2.5 CONDUCTING THE ASSESSMENTS	19
3.0 CENTRAL AND COUNTY SUMMARIES	20
3.1 CENTRAL MOHSW	20
3.1.1 OVERVIEW OF CENTRAL MOHSW	21
3.1.2 BUILDING BLOCK 1: DELIVERING ESSENTIAL HEALTH SERVICES	22
3.1.3 BUILDING BLOCK 2: HEALTH WORKFORCE	27
3.1.4 BUILDING BLOCK 3: HEALTH INFORMATION SYSTEMS (HIS)	28
3.1.5 BUILDING BLOCK 4: ACCESS TO ESSENTIAL TRAINING MEDICINES	28
3.1.6 BUILDING BLOCK 5: HEALTH SYSTEMS FINANCING	29
3.1.7 BUILDING BLOCK 6: GOVERNANCE AND LEADERSHIP	30

3.1.8 PROVISIONAL RECOMMENDATIONS FOR CENTRAL MOHSW	31
3.2 BONG COUNTY	33
3.2.1 OVERVIEW	34
3.2.2 BUILDING BLOCK 1: DELIVERING ESSENTIAL HEALTH SERVICES	34
3.2.3 BUILDING BLOCK 2: HEALTH WORKFORCE	35
3.2.4 BUILDING BLOCK 3: HEALTH INFORMATION SYSTEMS (HIS)	36
3.2.5 BUILDING BLOCK 4: ACCESS TO ESSENTIAL TRAINING MEDICINES	36
3.2.6 BUILDING BLOCK 5: HEALTH SYSTEMS FINANCING	36
3.2.7 BUILDING BLOCK 6: GOVERNANCE AND LEADERSHIP	37
3.3 LOFA COUNTY	38
3.3.1 OVERVIEW	39
3.3.2 BUILDING BLOCK 1: DELIVERING ESSENTIAL HEALTH SERVICES	39
3.3.3 BUILDING BLOCK 2: HEALTH WORKFORCE	40
3.3.4 BUILDING BLOCK 3: HEALTH INFORMATION SYSTEMS (HIS)	40
3.3.5 BUILDING BLOCK 4: ACCESS TO ESSENTIAL TRAINING MEDICINES	41
3.3.6 BUILDING BLOCK 5: HEALTH SYSTEMS FINANCING	41
3.3.7 BUILDING BLOCK 6: GOVERNANCE AND LEADERSHIP	41
3.4 NIMBA COUNTY	42
3.4.1 OVERVIEW	43
3.4.2 BUILDING BLOCK 1: DELIVERING ESSENTIAL HEALTH SERVICES	43
3.4.3 BUILDING BLOCK 2: HEALTH WORKFORCE	44
3.4.4 BUILDING BLOCK 3: HEALTH INFORMATION SYSTEMS (HIS)	44
3.4.5 BUILDING BLOCK 4: ACCESS TO ESSENTIAL TRAINING MEDICINES	45
3.4.6 BUILDING BLOCK 5: HEALTH SYSTEMS FINANCING	45
3.4.7 BUILDING BLOCK 6: GOVERNANCE AND LEADERSHIP	45
3.5 PROVIDIONAL RECOMMENDATIONS FOR CHSWTs	47
4.0 ANNEXES	50
<hr/>	
4.1 CENTRAL MOHSW DASHBOARD	50
4.2 BONG COUNTY DASHBOARD	51
4.3 LOFA COUNTY DASHBOARD	52
4.4 NIMBA COUNTY DASHBOARD	53
4.5 CENTRAL MOHSW TRAINING NEEDS	54
4.7 LOFA CHSWT TRAINING NEEDS	56
4.8 NIMBA CHSWT TRAINING NEEDS	57
4.9 CAPACITY ASSESSMENT TOOLS: CENTRAL MOHSW QUANTITATIVE	58
4.10 CAPACITY ASSESSMENT TOOLS: CENTRAL MOHSW QUALITATIVE	75
4.11 CAPACITY ASSESSMENT TOOLS: CHSWT QUANTITATIVE	86
4.12 CAPACITY ASSESSMENT TOOLS: CHSWT QUALITATIVE	106

ACRONYMS

ASRH	Adolescent Sexual and Reproductive Health
BLSS	Basic Life Saving Skills
CAT	Capacity Assessment Team
CHAI	Clinton Health Access Initiative
CHO	County Health Officer
CHSWT	County Health and Social Welfare Team
CM	Certified Midwife
CMR	Clinical Management of Rape
DHO	District Health Officer
EPHS	Essential Package of Health Services
EPI	Expanded Program on Immunization
FARA	Fixed Amount Reimbursement Agreement
GOL	Government of Liberia
HIS	Health Information System
HMIS	Health Management Information Systems
HR	Human Resources
HRH	Human Resources for Health
IMNCI	Integrated Management of Neonatal and Childhood Illnesses
LMIS	Logistics Management Information System
LSS	Life Saving Skills
MAPP	Mobilizing for Action through Planning and Partnerships
MOHSW	Ministry of Health and Social Welfare
NACP	National AIDS Control Program
NDP	National Decentralization Policy
NECP	National Eye Care Program
NHA	National Health Account
NHPP	National Health Policy and Plan (2007-2010)
NHSWPP	National Health and Social Welfare Policy & Plan (2011-2021)
NLTCP	National Leprosy and Tuberculosis Control Program
NMCP	National Malaria Control Program
OIC	Officer in Charge
PBC	Performance-Based Contract
PDCA	Plan-Do-Check-Act
PRISM	Performance of Routine Information System Management
RBHS	Rebuilding Basic Health Services
RH	Reproductive Health
SCM	Supply Chain Management
SCMP	Supply Chain Master Plan
SOPs	Standard Operating Procedures
WHO	World Health Organization

1.0 EXECUTIVE SUMMARY

1.1 CONTEXT

Decentralization has been a core component of all MOHSW policy and planning since the finalization of the NHPP. The 2011-2021 National Health and Social Welfare Policy and Plan (NHSWPP) continues to highlight decentralization as an MOHSW policy foundation in which County Health and Social Welfare Teams (CHSWTs) will incrementally increase responsibility for managing all aspects of county health service delivery. Over the past five years, progress has been made in building the capacity of CHSWTs and de-concentrating responsibilities. The CHSWT structure has been expanded to include dedicated positions for Human Resources and Monitoring & Evaluation (M&E). Financial and reporting policies, procedures and tools were developed and disseminated. Despite this progress, many challenges still remain and de-concentration has been slow. In order to successfully implement decentralization and strengthen CHSWT capacity, it is necessary to strengthening capacity of the Central MOHSW. The Central MOHSW, being the guiding force behind decentralization of the health sector, requires capacity building in areas such as regulating health service delivery through Performance-based Contracts (PBCs), and financial management. In addition to the National Decentralization Policy, USAID revised its assistance to a direct Government to Government mechanism. This new system, titled Fixed Amount Reimbursement Agreement (FARA), delivers financial assistance to Central MOHSW to carry out a set of mutually agreed activities that improve the health status of Liberians. FARA ushered in a need for building capacity of Central MOHSW and CHSWTs in order to carry out activities and meet deliverables.

MOHSW has worked with a variety of partners and specialists over the past five years to try and address these challenges. MOHSW coordinated county financial and human resource (HR) management systems through technical assistance from international donors. Cross-cutting service and system delivery partners, such as RBHS, have assisted MOHSW at all levels of health delivery (central, county, district and facility) enabling a comprehensive understanding of decentralization challenges.

Recognizing the complexity of decentralization challenges and the multi-level solutions necessary to address them, MOHSW, donors and partners have recalibrated health sector improvement strategies to focus on quickly strengthening CHSWT capacity. Recently, MOHSW created a Performance-Based Financing (PBF) Unit within the Ministry. Following the two-year Performance-Based Contracting (PBC) “in” pilot between Bomi CHSWT and Central MOHSW, MOHSW is prioritizing Bong and Grand Bassa Counties to be the next PBC “in” counties.

To inform the MOHSW and CHSWT capacity building strategy and operational plans, as well as to support the MOHSW’s PBC “in” priority, RBHS conducted capacity assessments at Central MOHSW and in Bong, Lofa and Nimba Counties. This report presents the assessment findings in six key areas, (1) Delivering essential health services, (2) the health workforce, (3) health information systems, (4) access to essential medicines, (5) health systems financing and (6) governance and leadership. The report presents both the central and county level strengths and weaknesses in order to identify and prioritize capacity gaps necessary for the development of a capacity building strategy and operational plan. Finally, it presents examples of potential interventions for strengthening capacity at Central MOHSW and CHSWT levels in areas of the MOHSW’s immediate priorities and those in Phase One and Phase Two of the Essential Package of Health Services (EPHS). All proposed interventions have been made in collaboration with MOHSW. For more detail on the capacity assessment process, please see Section 2.0.

1.2 SUMMARY SCORE COMPARISON

A summary score comparison across the Building Blocks demonstrates wide variation between Central MOHSW and County level strengths and weaknesses. These variations are narrower but still apparent between the counties. For example, while Building Block 6: Governance and Leadership is a low scoring area across all three counties, it is one of the top performing areas at Central MOHSW. Alternatively Building Block 2: Health Workforce is the lowest scoring area for Central MOHSW but one of the high score areas for the counties, particularly Bong and Lofa. The range of scores across all three counties varies widely with Bong County demonstrating the widest variation (0% to 63%), Lofa the smallest variation but also the lowest top score (24% to 50%) and Nimba the highest score (25% to 69%). Therefore while both Bong and Nimba score a 54% in Building Block 1: Delivering Essential Health Services, the varied range in scores means this is Bong's second highest scoring area while for Nimba it is the second to lowest. These score variations are possibly demonstrative of not only a slow decentralization from Central to the Counties but also inconsistent roll-out in which the one-size fits all de-concentration approach has not been equally effective.

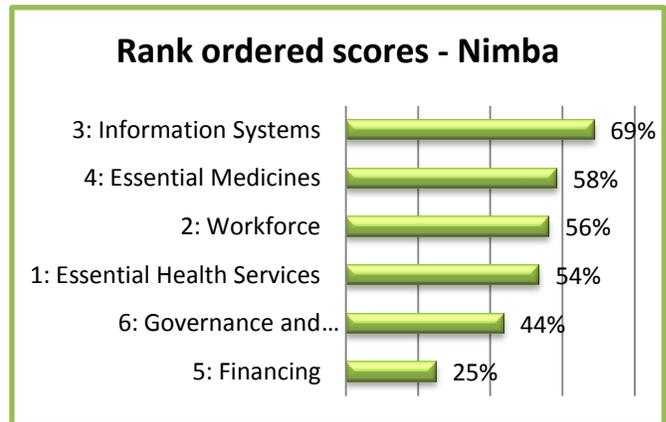
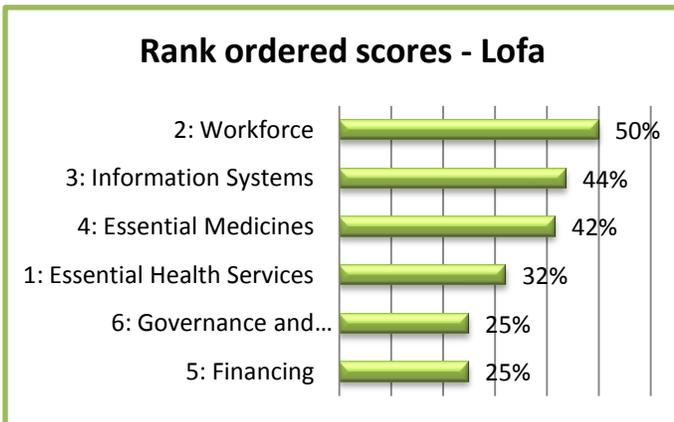
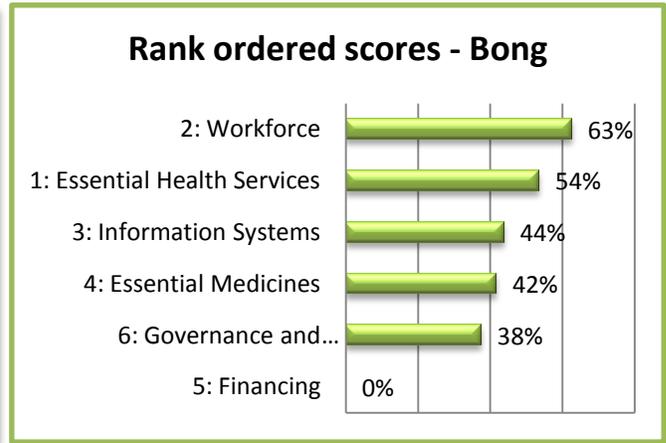
Table 1. Central MOHSW Score Summary

Building Block	Total Points Available	Score	Percentage Score
1: Delivering Essential Health Services	20	10	50%
2: Health Workforce	16	7	44%
3: Health Information Systems	16	13	81%
4: Access to Essential Medicines	16	9	56%
5: Health Systems Financing	16	8	50%
6: Governance and Leadership	16	12	75%
Total Score	100	59	59%

Table 2. CHSWT Score Summary

Building Block	Total Points Available	Bong		Lofa		Nimba	
		Score	% score	Score	% score	Score	% score
1: Delivering Essential Health Services	28	15	54%	9	32%	15	54%
2: Health Workforce	16	10	63%	8	50%	9	56%
3: Health Information Systems	16	7	44%	7	44%	11	69%
4: Access to Essential Medicines	12	5	42%	5	42%	7	58%
5: Health Systems Financing	12	0	0%	3	25%	3	25%
6: Governance and Leadership	16	6	38%	4	25%	7	44%
Total Score	100	43	43%	36	36%	52	52%

Table 3. Rank Ordered Scores by Central and County Levels



1.3 BUILDING BLOCK 1: DELIVERING ESSENTIAL HEALTH SERVICES

1.3.1 Capacity to deliver health services

The capacity to deliver health services is examined by the extent of interaction between Central MOHSW and CHSWTs. Both levels have a limited level of engagement, with Central and all three counties scoring 2 out of 4 possible points. Interaction between central and county levels is limited to budget and health service planning activities. Currently, there is not a significant amount of interaction between the two levels when it comes to maintaining the health facilities and assessing community health needs. CHSWTs are interacting well with health facilities under their jurisdiction, with all three CHSWTs scoring 3 out of 4 possible points.

1.3.2 Capacity to ensure appropriate use of policies and service delivery standards

Supervision at both central and county levels suffers from inconsistency. While Central MOHSW scored 2 out of 4 points on supervising the CHSWTs, the three CHSWTs range from 1-3 out of 4 points. All three CHSWTs conduct supervisory visits and obtain data, but the supervision process is not consistent and key information and policies are not shared. There is no standardized process to provide feedback to health facilities, which results in inconsistent, and/or no feedback. All three CHSWTs report serious challenges with supervision due to inadequate and nonfunctional vehicles. Vehicle management, not captured in these assessments, is an ongoing challenge for all CHSWTs.

1.3.3 Capacity of vertical programs

Central MOHSW scores 2 out of 4 points on average across five vertical programs, while the counties score 1-2 out of 4 points. At the Central MOHSW level, long established programs such as Expanded Program on Immunization (EPI) and National Malaria Control Programs (NMCP) are performing better (3 out of 4 points) than new programs such as National Eye Care Program (NECP), yet they do not reach the intended targets. All three CHSWTs fared poorly with regards to implementing vertical programs, with only one CHSWT scoring 2, while the remaining two scored 1 out of 4 points. Two main challenges were identified as detrimental factors in the success of vertical programs: inadequate/ nonfunctional vehicles and inadequate knowledge of focal personnel. Across all three CHSWTs, many focal personnel were not aware of program targets. In addition, vertical program focal personnel also suffer from poor coordination when it comes to receiving trainings. The ad-hoc training system causes havoc in productivity. Vertical programs need to focus more on policy and state-of-the-art support rather than managing service delivery and in-service training, which need to be the CHSWT responsibilities.

1.4 BUILDING BLOCK 2: HEALTH WORKFORCE

Since 2006, MOHSW has made great strides to improve Human Resources for Health (HRH); increasing the total number of clinical health workers from 1,396 in 1998 to 4,653 in 2010. From 2006 to 2010, the number of nurses has more than doubled. In 2010, the percentage of the clinical workforce made up by nurses and nurse aides increased to 73%. While the nursing cadre numbers are strong and demonstrate significant improvement since the creation of the Emergency Human Resources Plan in 2007, equitable distribution, retention and performance management continue to be challenges.¹

¹ Varpilah ST, Safer M, Frenkel E, Baba D, Massaquoi M, Barrow G. (2011). Rebuilding Human Resources for Health: A Case Study From Liberia. *Human Resources for Health*. May 9(11).

With the recent release of the EPHS for 2011-2021, MOHSW continues to address these challenges, however has shifted staffing requirements from a “standard” model to a utilization-based model. With this change in shift, the EPHS sets forth the minimum staffing requirements. It is now up to the CHSWTs to determine the right staffing ratios for each facility in their county based on catchment population and facility utilization rates. The capacity assessments demonstrate both sets of challenges and interestingly show a large discrepancy between central and CHSWT health workforce capacity. While the Health Workforce Building Block is one of the highest scoring areas for the three CHSWTs, it is the lowest for Central MOHSW.

1.4.1 Capacity in workforce recruitment and deployment

The capacity assessments found that at both the Central and CHSWT levels, recruitment capacity is high. Lofa County had a perfect score (4 out of 4 points) and Central, Bong and Nimba had very high scores (3 out of 4 points). Alternatively, there is a discrepancy between the two levels for staffing according to the National Staffing Plan. Central MOHSW received only 1 point (out of 4) for this standard while Bong and Lofa received top scores and Nimba fell in the middle with 2 out of 4 points. This indicates either a significant mismatch in Central versus CHSWT communication and/or tracking of staffing or significant discrepancies in CHSWTs abilities to recruit and retain staff.

1.4.2 Capacity to strengthen existing workforce

At both the Central and County levels, the most significant health workforce challenge is the capacity to manage staff performance. Only Nimba County received points for this standard (1 point). Central MOHSW, Bong and Lofa County all received zero points. While absenteeism and poor productivity are addressed in accordance to the Civil Service Code, there is no system for performance management. Finally, the ability to develop the capacity of health staff, as measured by in-service training, varies significantly. Lofa County, in line with its limited capacity to manage staff performance, receives 0 points for this standard while Bong, Nimba and Central MOHSW receive high scores (3 out of 4 points). The zero score of Lofa is reflected in its service delivery, as the inadequate and inconsistent in-service training translates to low performance on vertical programs (1 out of 4).

1.5 BUILDING BLOCK 3: HEALTH INFORMATION SYSTEMS

In 2009, the MOHSW Health Management Information Systems (HMIS) Unit released the Standard Operating Procedures (SOPs) at Central, County and Facility levels including a set of integrated reporting tools. Since then data collection and management has improved with monthly reporting from all facilities aggregated to the County level and finally collected at Central MOHSW. Over the past few years, this data has been used by MOHSW to reevaluate programs, and develop strategies and policy including the 2011-2021 NSWPP. CHSWT involvement in the NSWPP was strong, with CHOs providing critical feedback on county experiences and challenges at stakeholder workshops and further developing County specific operational plans. However, data collection remains difficult with untimely reports from hard to reach facilities. Data collection isn’t consistent and data is not reported out in a format or at a frequency that is useful to CHSWTs and facilities. That HMIS is currently a one-way street (to Central MOHSW) is apparent in the capacity assessments. Building Block 3, Health Information Systems, is Central MOHSW’s highest scoring area however at the CHSWT level, scores are much lower and large gaps remain. The assessments demonstrate that while Central MOHSW routinely uses collected data in decision-making, the same is not true for the CHSWTs.

In addition to the capacity assessment, MOHSW and RBHS jointly conducted a comprehensive assessment of HMIS at the county and health facility levels. The assessment employed the Performance

of Routine Information System Management (PRISM) framework. The Liberia PRISM assessment used a sample of 19 facilities from each county. A total of 57 (out of 147) health facilities from the three counties were randomly selected. The sample size is sufficient enough to provide estimates with precision of 10% plus/minus at the 95% confidence level.

1.5.1 Capacity to plan for and systematically collect health information

Central MOHSW receives high scores (3 out of 4) for rolling out HIS forms and policies, collecting and managing data. At the county levels, these results vary widely by county. Preliminary PRISM assessment findings show that Liberia HMIS has a good data collection and reporting system from health facilities to Central MOHSW HMIS. The completeness of reporting is 90% and timeliness is 65%. PRISM assessment results show that accuracy of data is quite low at both Facility and County levels.

1.5.2 Capacity to promote evidence-based decisions and policy making

Central MOHSW receives a perfect 4 out of 4 points regarding its capacity to use data for planning and policy. However, at the County level, both Bong and Lofa score 0 while Nimba scores 2 out of 4 points. Preliminary PRISM assessment findings showed that while data collection and reporting are doing well, HMIS has challenges in analyzing the collected data and using it in health program decisions. The assessment showed only 14% of facilities assessed demonstrated use of information for their program decision making. Liberia introduced DHIS 2.4 software in October 2011 to facilitate County level use of information for decision-making. Due to inadequate training, the CHSWT data managers and M&E officers are finding it difficult to use the new DHIS 2.4 software.

1.6 BUILDING BLOCK 4: ACCESS TO ESSENTIAL MEDICINES

Following the release of the MOHSW Supply Chain Master Plan (SCMP) in 2010, MOHSW, donors and partners have been working together to reduce facility stock-outs and improve the efficiency of commodity distribution. This system has historically been fraught with complex challenges ranging from requisition forms to the impassable roads that prevent commodities from reaching facilities. Even with improvements in planning, including the roll out of LMIS and the establishment of county storage depots, many facilities continue to experience essential medicine stock-outs. The capacity assessments demonstrate that while Central MOHSW has done the policy and planning groundwork, successfully establishing the Supply Chain Master Plan (SCMP), the SCMP implementation is proceeding slowly.

1.6.1 Capacity to ensure access to essential medicines for the population

At the County level, roll out of LMIS has been inconsistent. Lofa, for example, scores a zero for this standard. Nimba scores the highest with a score of 2 out of 4 points. Commodity storage and distribution also varies greatly depending on the county. Both Bong and Lofa score a 1 out of 4 while Nimba, with its depot at Saclepea Comprehensive Health Center, scores well with a 3. Finally, even though Central MOHSW's capacity to estimate and requisition medicines scores well, this is not true for Nimba CHSWT (score 2 out of 4).

1.7 BUILDING BLOCK 5: HEALTH SYSTEMS FINANCING

The 2009 National Health Accounts (NHA) assessment found a total health and social welfare expenditure of US\$103,496,421 or US\$29.97 per person. Donors and out-of-pocket financing accounted for the majority of this expenditure – 47, and 35 percent respectively. Government spending was 15 percent according to NHA and has remained stable as a percentage of national budget (between 7 and 8 percent over the last 4 years). The majority of donor funds (59%) are spent on contracts with NGOs to support 292 facilities across the country, of which 232 are performance-based. Different departments

and units at the Central MOHSW play different roles in the accounting and financial management of the MOHSW PBF scheme. The Department of Administration assumes tasks pertinent to awarding of contracts to implementers; the External Aid Unit coordinates this process in collaboration with the Procurement Unit. The Pool Fund and the Fixed Amount Reimbursement Agreement (FARA) manage the overall contractual agreements and prepare accounting and budget reports; while the PBF unit, in the department of Health Services, manages the implementation. The contracting units have in place tools for management of funds, including: documented administrative, accounting, and financial procedures; quarterly and annual budget plans; procurement procedures; and defined and documented systems to authorize payments, monitor the disbursement of funds, monitor account balances, and check and control mechanisms. The 2011-2021 NHSWPP explicitly mentions that there is no national formula for determining resource allocation between counties based on population, utilization, and access criteria. This lack of a system for resource allocation is evident in the capacity assessments where CHSWTs consistently have low scores for their ability to create, manage, and monitor a sustainable budget.

1.7.1 Capacity to formulate, distribute and monitor financing for the health sector

Across all three CHSWTs, Health Systems Financing is the lowest scoring capacity area. Bong County scores zero in all three standards, while Lofa does minimally better with a score of one for each category. Nimba's weaknesses vary with the highest score (2 out of 4) in budget planning, creation and allocation and the lowest (0 out of 4) in monitoring finances.

Central MOHSW scores better than CHSWTs in this area, but still low at 50%. While there is average capacity in areas of monitoring and distributing finances, Central MOHSW has inadequate capacity in planning for and allocating a sustainable budget. The problem is compounded by high dependence on international donors and limited capacity of the financial system.

1.8 BUILDING BLOCK 6: GOVERNANCE AND LEADERSHIP

Governance and Leadership is one of Central MOHSW's strongest areas and one of the lowest for the CHSWTs. While Central MOHSW ranks high with a score of 3 out of 4 points, none of the CHSWTs scored above 2 out of 4 points. The strong leadership seen at central level has not transferred to CHSWTs. It is expected that, with the process of decentralization, CHSWTs will be enabled and empowered to take on leadership roles.

1.8.1: Capacity to implement activities aimed at improving the health of all people within the county

Central MOHSW scores high in this area. Strong leadership and visionary efforts of MOHSW are evident in the development and adoption of the NHSWPP and EPHS. However, all three CHSWTs score poorly in their capacity to implement NHSWPP and respective County Operational Plans. Most CHSWT staff are not aware of the NHSWPP and EPHS which reflects in the poor score in this area.

1.8.2: Capacity towards intra and inter agency communication

Similar to indicator 6.1, Central MOHSW scores high in this area, but CHSWTs fared poorly. Central MOHSW exhibits well-defined leadership in taking ownership and responsibility of the health system. While Central MOHSW scores high in its capacity to lead and guide CHSWTs, and CHSWTs, in return, have high capacity to lead and guide the health facilities, there is a disconnect in leadership between CHSWTs and Central MOHSW. All three CHSWTs scored low in their capacity to report, document, and share plans resulting in inconsistent guidance from Central MOHSW. There is no standard communication strategy or plan between Central MOHSW and CHSWTs and amongst either group.

2.0 CAPACITY BUILDING ASSESSMENT: PLANNING AND METHODOLOGY

2.1 BACKGROUND

Liberia's civil war (1989 to 2003) resulted in a severely fragmented and incapacitated health system. By 2003, Liberia had 420 facilities, 45% of which were dependent on NGOs to function. Large numbers of displaced people moved into Monrovia, dissolving community cohesiveness and doubling the population; outgrowing the city's capacity to provide health services with limited health workers and destroyed infrastructure. Health worker training institutions closed during fighting and re-opened during calm periods. In 2006, by the time President Ellen Johnson Sirleaf was inaugurated, the health sector was dependent on more than \$80 million of international humanitarian aid. Without coordination, this aid was distributed according to disparate donor priorities. As a result, the health system was barely functioning with only an estimated 40% of Liberians able to access basic health services.

In 2007, the Ministry of Health and Social Welfare (MOHSW) initiated three reform actions to strengthen healthcare delivery and outcomes: (1) Build an experienced leadership team, divorced from political agendas; (2) Strengthen partnership and coordination to mobilize resources, align programs and harmonize all sector efforts, and; (3) Develop and implement an evidence-based National Health Policy & Plan (NHPP) to unify vision and direction for Liberia's post conflict health sector reform process. Starting in 2008, the Rebuilding Basic Health Services (RBHS) project supported MOHSW on all strategic and planning actions including financial and technical support for the development of both the NHPP, including the Basic Package of Health Services (BPHS) and the 2011-2021 National Health and Social Welfare Policy and Plan (NHSWPP) including the Essential Package of Health Services (EPHS).²

Until the end of year 3 of RBHS, capacity building activities have been focused on providing technical assistance to Central MOHSW in activities such as drafting the National Health and Social Welfare Policy and Plan (NHSWPP), the Country Situational Analysis Report (CSAR), participating in multiple technical groups, drafting policies and plans, and assisting the counties with developing their own County Operational Plans. A comprehensive assessment of MOHSW baseline capacity – at central and county levels – had not been undertaken to date. An internal analysis of the RBHS program, conducted at the end of year 3, called for building capacity of MOHSW at three levels – individual, institutional, and systems – in order to strengthen MOHSW. The internal analysis called for an approach that will build capacity and promote long term sustainability of MOHSW. In addition to calling for building the capacity of MOHSW at central level, the internal analysis report also identified building the capacity of County Health and Social Welfare Teams (CHSWTs) as a priority. In order for decentralization to succeed, it is important that RBHS provide technical support to build capacity of CHSWTs. This recommendation is particularly relevant in the wake of MOHSW rolling out the contracting-in mechanism of performance-based contracting (PBC) in select counties, to be followed in other counties.

During the same time as the internal analysis report, USAID initiated a shift in Implementation and Procurement reform (IPR). The shift in strategy called for direct Government to Government support, leading to a funding mechanism titled Fixed Amount Reimbursement Agreement (FARA). RBHS' role and responsibilities were revised to align with FARA, leading to an enhanced focus on capacity building and

² Varpilah ST, Safer M, Frenkel E, Baba D, Massaquoi M, Barrow G. (2011). Rebuilding Human Resources for Health: A Case Study From Liberia. *Human Resources for Health*. May 9(11).

health systems strengthening. RBHS is now tasked with supporting MOHSW towards carrying out FARA deliverables through a process of participatory and comprehensive capacity building. Following the internal analysis and a change in USAID funding strategy, RBHS shifted gears and redesigned its efforts, under the guidance of MOHSW and USAID, to build capacity of MOHSW. The result of a change in strategy is the first comprehensive capacity building framework developed to strengthen MOHSW.

2.2 FRAMEWORK

2.2.1 Defining Capacity Building

Many donors and partners have identified capacity building for the MOHSW as a proposed activity. However, a standard definition of capacity building has not existed to date. MOHSW and RBHS collaboratively defined capacity building with stakeholder participation. The definition reflects the vision of MOHSW and serves as a guiding principle for all capacity building activities to be undertaken by MOHSW and RBHS. After a review of evidence-based materials, capacity building was defined as follows:

Capacity Building is a process of **workforce development** (capacity of individual health workers to meet objectives), **organizational strengthening** (activities to improve the organizational setup and communications of implementing organizations), and **systems strengthening** (strengthen various elements such as policies, strategies, operational plans of the overall health system and sub-systems) that enables the health sector to meet objectives and perform better resulting in improved health outcomes for Liberia.

2.2.2. Conceptual framework

Depending on the sector, there are various frameworks for capacity building. However, most of them have similar concepts – assess baseline capacity, identify areas to be strengthened, prioritize, and develop interventions to strengthen priority areas. The MOHSW capacity building effort follows the same concepts, using an amalgamation of evidence-based models such as the Health Systems Assessment Approach³, conceptual model developed by LaFond and Brown⁴, Plan-Do-Check-Act (PDCA)⁵, Mobilizing for Action through Planning and Partnerships (MAPP)⁶. This capacity building framework focuses on three levels (individual, institution, and system) using the six building blocks for health systems strengthening developed by WHO⁷. MOHSW capacity building framework focuses on building capacity synchronously at three levels in order to achieve maximum effect – individual, organizational, and health system levels. The significant input for the conceptual framework comes from the six building blocks of a health system: (1) Delivering essential health services; (2) the health workforce; (3) health information systems; (4) access to essential medicines; (5) health systems financing, and; (6) governance and leadership. Diagram 1 below illustrates the conceptual framework for building the MOHSW capacity.

³ Health Systems 20/20. Health System Assessment Approach: A How-To Manual Version 1.75. Available at <http://www.healthsystems2020.org/content/resource/detail/528/>

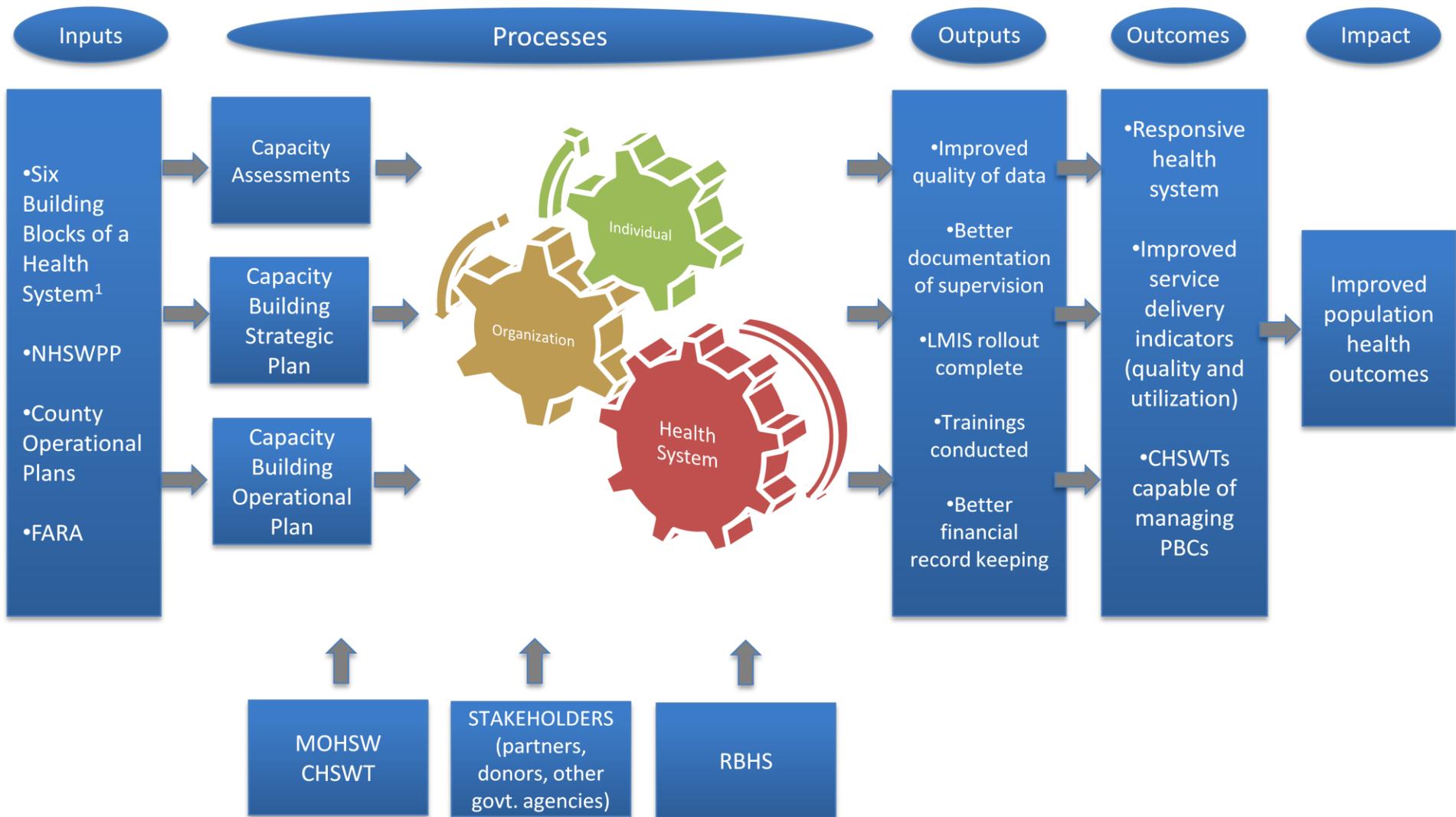
⁴ LaFond AK, Brown L, Macintyre K. Mapping capacity in the health sector: A conceptual framework. *The International Journal of Health Planning and Management*. 2002 Jan-Mar;17(1):3-22.

⁵ Nancy R. Tague. *The Quality Toolbox*, Second Edition, ASQ Quality Press, 2004, pages 390-392.

⁶ National Association of County and City Health Officials. *Mobilizing for Action through Planning and Partnerships: Web-based Tool*. Washington, DC: National Association of County and City Health Officials; 2001

⁷ World Health Organization. *Monitoring the building blocks of health systems: a handbook of indicators and their measurement strategies*. Available at: <http://www.who.int/healthinfo/systems/monitoring/en/index.html>

Diagram 1: MOHSW Capacity Building Framework



¹ 1) Health Service Delivery; 2) Health Workforce; 3) Health Information Systems; 4) Access to Essential Medicines; 5) Health Systems Financing; 6) Leadership and Governance. World Health Organization. Monitoring the building blocks of health systems: a handbook of indicators and their measurement strategies. Available at: <http://www.who.int/healthinfo/systems/monitoring/en/index.html>

In addition to the six building blocks of a health system, the capacity building framework is driven by inputs such as the NSWPP, the County Operational Plans, and FARA. These inputs create impetus for the capacity building process (further described in section 2.3), which involves assessing baseline capacity and creating capacity building strategic and operational plans. The capacity assessments provide data for identifying a baseline and specific areas to build capacity of MOHSW. Areas to build capacity will be prioritized by MOHSW with technical assistance from RBHS. Following prioritization, a strategic plan will be developed to address capacity building in the priority areas. The strategic plan will be implemented with the help of an operational plan, where MOHSW and RBHS will jointly identify interventions to build capacity in the priority areas. A work plan with activities and an M&E Plan with indicators will be developed to track progress of capacity building activities.

The goal of the capacity building process is to build capacity at a comprehensive level – individual, organizational, and health system. Each level is closely related to each other; building capacity at individual level goes simultaneously with building capacity at organizational and health system levels. This comprehensive approach allows us to build effective, efficient, and sustainable capacity in our priority areas. For example: training of workforce (individual level) in using the LMIS system will be followed by a roll out of LMIS at CHSWTs (organizational level) and linking LMIS data with HMIS and financial databases (health system level). This results in a stronger Supply Chain Management System where quality data is collected in a timely and accurate manner, enabling MOHSW to use the data to make evidence-based decisions for ensuring access to essential medicines (Building Block 4 of the six building blocks).

The capacity building process results in outputs such as improved quality of data, complete roll out of LMIS, and better documentation of supervision. Additional outputs will be developed based on interventions identified by MOHSW in the capacity building operational plan. The outputs result in outcomes such as improved service delivery indicators and improved financial capacity of CHSWTs to manage PBCs. The impact, which occurs over the long-term, is improved population health outcomes such as a reduction in the Maternal Mortality Rate (MMR).

2.3. CAPACITY BUILDING PROCESS

2.3.1 Organize the process

RBHS provided technical assistance to the MOHSW in developing a process to organize the capacity building interventions. The final process is depicted in diagram 2 below.

2.3.2 Identify stakeholders

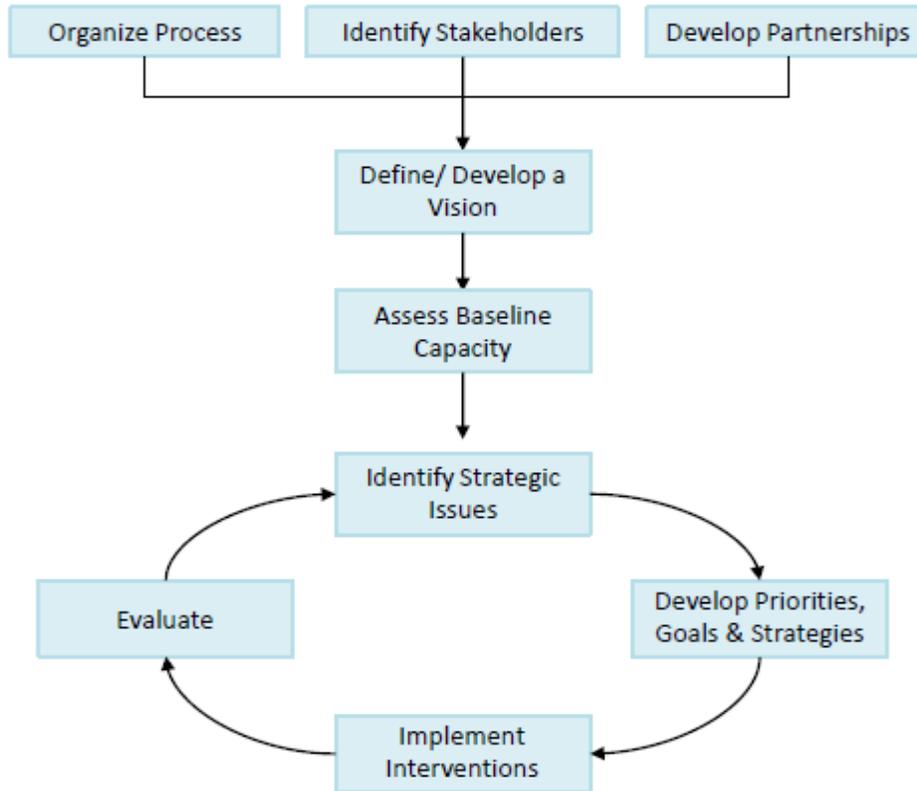
A successful capacity building initiative involves all key stakeholders. The Department of Planning, Research, and Development at the MOHSW took the lead and assigned two senior staff to work with the RBHS Capacity Building and Health Systems Strengthening Director towards the capacity building process. In collaboration with MOHSW, RBHS facilitated stakeholder buy-in and participation from USAID, implementing partners, external donors, and other Government of Liberia officials.

2.3.3 Develop partnerships

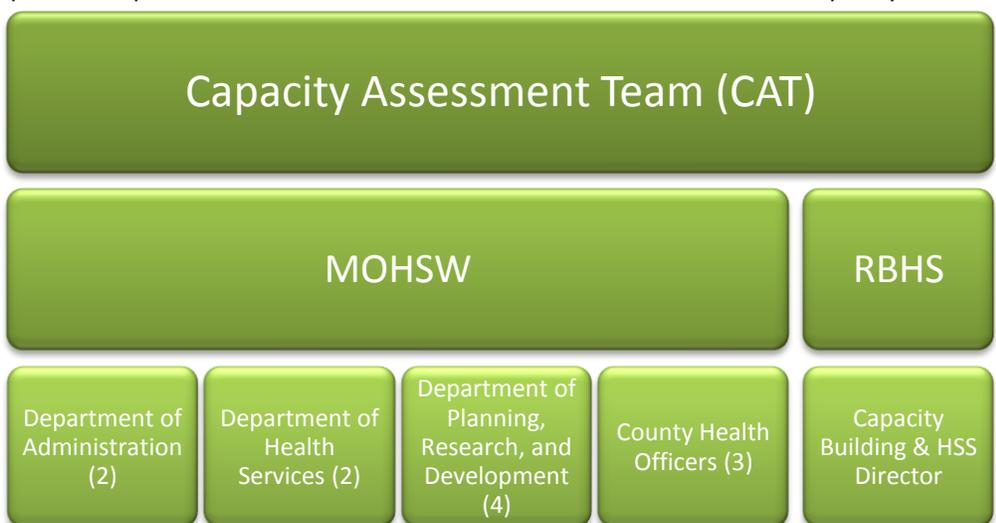
Following stakeholder buy-in, partnerships were formed between MOHSW, RBHS, and stakeholders. RBHS facilitated the creation of a Capacity Assessment Team (CAT). The initial CAT had two senior staff from MOHSW and the one from RBHS. The CAT later grew to a 12 person team – eight senior level staff

from Central MOHSW, three CHOs representing three CHSWTs, and the Capacity Building and Health Systems Strengthening (HSS) Director from RBHS.

Diagram 2: MOHSW Adopted Capacity Building Process



With technical assistance from RBHS, the CAT took the lead in defining capacity building and forging partnerships with CHSWTs and stakeholders to initiate the capacity building framework. RBHS



implementing partners provided feedback on the framework and partnered with the CAT in developing assessment tools, while USAID provided support through overall guidance. Partnerships were also formed with other external donors of the

MOHSW – such as other USAID-funded projects, and the European Commission – to synchronize capacity building efforts and avoid duplication of activities.

2.4 CAPACITY BUILDING ASSESSMENT METHODOLOGY

In line with the NSWPP, the MOHSW capacity assessments are structured according to the six building blocks of a health system framework as defined by the World Health Organization⁸. The six building blocks are: (1) delivering essential health services; (2) health care workforce; (3) health information systems; (4) access to essential medicines; (5) health financing systems; and (6) leadership and governance. By using the WHO six building blocks framework as used in the NSWPP, it enables MOHSW and RBHS to align capacity building with NSWPP and ensures that capacity building efforts reflect MOHSW's vision and objectives.

The capacity assessment tools were developed by MOHSW, with technical assistance from RBHS. Evidence was gathered from peer-reviewed journals, and tools originally designed for implementation in other countries were adopted to suit the Liberian context. After an extensive process of development and validation, MOHSW finalized four assessment tools in total – two for Central MOHSW and two for CHSWTs. The assessment tools follow a mixed methodology utilizing qualitative and quantitative methods. The quantitative tools capture baseline capacity across specific areas in each of the six building blocks. The qualitative tools capture detailed information regarding current capacity of the health system and areas that need to be strengthened at Central and county levels. Following extensive discussions between the MOHSW and RBHS, it was decided to keep the assessment tools to a manageable level, resulting in an overall score of 100 for each tool. Although additional indicators and standards could have been included in the assessment tools, the CAT decided to explore selective areas in order to facilitate better implementation of the tools. A full set of the tools can be found in Annexes 4.9 - 4.12.

Quantitative assessment tools

The quantitative assessment tools are designed to assign a score for select indicators in each of the six building blocks, thereby giving an overall score to the health system. As other country experiences have shown, the assessment tools can be extensive. However, the CAT in consultation with the MOHSW decided to streamline the tool to ensure manageability; limiting the score to 100. Separate quantitative tools for Central MOHSW and CHSWTs were developed to reflect differences in form and function.

Qualitative assessment tools

The qualitative assessment tools are designed to capture in-depth information regarding the current capacity of MOHSW – at Central and county levels – and identify specific areas for strengthening. The qualitative tools are semi-structured interviews that are organized according to each of the six building blocks. In addition to providing in-depth information and identifying specific areas for building capacity, the qualitative tools capture data that could not be scored in the quantitative indicators.

The Capacity Assessment Team validated all assessment tools within three counties – Lofa, Nimba, and Grand Cape Mount – along with Central MOHSW. Further revisions were made based on validation feedback and a final draft was developed. A full set of tools can be found in Annexes 4.9 – 4.12.

⁸ World Health Organization. Monitoring the building blocks of health systems: a handbook of indicators and their measurement strategies. Available at: <http://www.who.int/healthinfo/systems/monitoring/en/index.html>

2.5 CONDUCTING THE ASSESSMENTS

Following validation, an operational plan was developed to conduct the assessments. RBHS conducted two orientation workshops for CAT and RBHS staff. The workshops provided details regarding final versions of the assessment tools, logistics for conducting the assessments, guidelines for being an effective interviewer, and tips for note taking. A Terms of Reference (TOR) document was developed by RBHS for CAT members to clearly define roles and responsibilities.

Following orientation, assessment exercises were scheduled in three counties from April 5-12, 2012. The CAT traveled to three county capitals to conduct the assessments. Each county assessment took place over a period of 2 days, with maximum participation from all CHSWT staff. A list of key participants was circulated in advance to the CHSWTs in order to facilitate maximum participation. All assessments were successfully conducted and gathered extensive data.

CHSWT assessments were conducted from April 5-12, 2012. Central MOHSW assessments were conducted from April 23 to May 15, 2012. Each assessment was split into building blocks for efficiency. CAT and RBHS technical staff actively participated in conducting the assessments. Data collected from central and county assessments has been compiled to create this report.

3.0 CENTRAL AND COUNTY SUMMARIES

3.1 CENTRAL MOHSW

CENTRAL MOHSW SCORE CHART			
	Total Points Available	Points Received	Percentage Score
BUILDING BLOCK 1: DELIVERING ESSENTIAL HEALTH SERVICES			
TOTAL SCORE	20	10	50%
Extent of interaction between the Central MOHSW and CHSWTs	4	2	50%
Capacity of the Central MOHSW to develop and distribute (to the CHSWTs) policies, plans, and standards for key health areas	4	2	50%
Capacity of Central MOHSW to supervise CHSWTs in the use of health service delivery standards	4	2	50%
Number of operational public health facilities as compared to those projected in the National Health and Social Welfare Plan	4	2	50%
Capacity of Central MOHSW to develop and implement priority health programs	4	2	50%
BUILDING BLOCK 2: HEALTH WORKFORCE			
TOTAL SCORE	16	7	44%
Ability to recruit human resources for health worker positions	4	3	75%
Capacity of Central MOHSW to staff health facilities as per national staffing guidelines	4	1	25%
Capacity of Central MOHSW to review health worker staff performance	4	0	0
Capacity of Central MOHSW to coordinate capacity development of health staff	4	3	75%
BUILDING BLOCK 3: HEALTH INFORMATION SYSTEMS (HIS)			
TOTAL SCORE	16	13	81%
Capacity of Central MOHSW to develop and roll out HMIS policies and forms	4	3	75%
Capacity of Central MOHSW to collect quality data	4	3	75%
Capacity of Central MOHSW to manage data	4	3	75%
Capacity of Central MOHSW to use collected data for planning and policy making	4	4	100%
BUILDING BLOCK 4: ACCESS TO ESSENTIAL MEDICINES			
TOTAL SCORE	16	9	56%
Capacity of the Central MOHSW to develop a Logistics Supply Chain Master Plan	4	3	75%
Central MOHSW's capacity to estimate commodity needs, develop a supply plan and procure/source these commodities	4	3	75%
Central MOHSW's capacity to develop and use a Logistics Management Information System (LMIS)	4	2	50%
Central MOHSW and CHSWT's capacity to effectively store and distribute commodities	4	1	25%
BUILDING BLOCK 5: HEALTH SYSTEMS FINANCING			
TOTAL SCORE	16	8	50%
Capacity of the Central MOHSW to ensure that adequate funds from the total government budget are allocated to health and social welfare	4	2	50%
Capacity of Central MOHSW to plan for, create and allocate a sustainable budget	4	1	25%
Capacity of Central MOHSW to effectively distribute finances	4	3	75%
Capacity of Central MOHSW to monitor finances at the National and County levels	4	2	50%
BUILDING BLOCK 6: LEADERSHIP AND GOVERNANCE			
TOTAL SCORE	16	12	75%
Capacity of Central MOHSW to develop and implement a National Health Policy and Plan	4	4	100%
Capacity of Central MOHSW to communicate within the Central MOHSW and other Ministries within the Government of Liberia	4	1	25%
Capacity of the Central MOHSW to lead and engage with CHSWTs	4	3	75%
Capacity of Central MOHSW to hold responsibility and ownership for the health system	4	4	100%

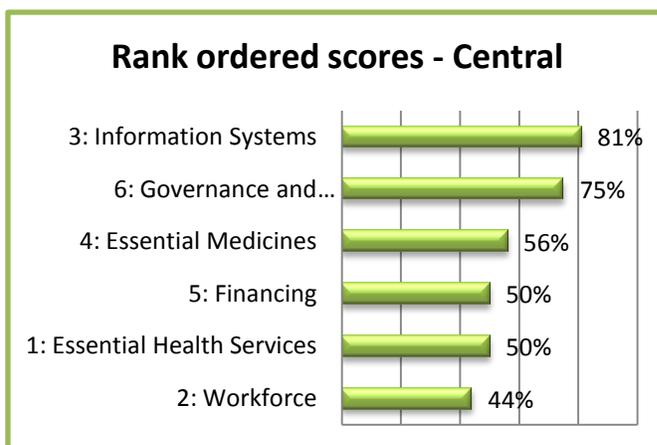
3.1.1 Overview of Central MOHSW

Score: 59 out of 100

Assessment Dates: April 23 to May 15, 2012

Assessment Team Members: C. Sanford Wesseh (MOHSW Planning), Margaret Korkpor (MOHSW Health Services), Luke Bawo (MOHSW Planning), Oliver Pratt (MOHSW Health Services), Justin Korvayan (MOHSW Planning), Shelford Somwarbi (MOHSW Administration), Rose Macauley (RBHS), Theo Lippeveld (RBHS), Vamsi Vasireddy (RBHS), Marion Subah (RBHS), Floride Niyuhire (RBHS), Bal Ram Bhui (RBHS), Zaira Alonso (RBHS), Joe Moyer (RBHS), J. Mehnmon Tokpa (RBHS), Lauretta Nagbe (RBHS), Sarah Hodge (RBHS), Maima Zazay (RBHS), Marietta Yekee (RBHS), Shef Kpanjai (RBHS), Jacob Nueville (RBHS), Nowai Johnson (RBHS), Teah Doegmah (RBHS), David Franklin (RBHS)

Building blocks	Max	Score	%
1. Essential Health Services	20	10	50%
2. Workforce	16	7	44%
3. Information Systems	16	13	81%
4. Essential Medicines	16	9	56%
5. Finance Systems	16	8	50%
6. Governance & Leadership	16	12	75%
Overall score	100	59	59%



Central MOHSW performed the best in areas of Health Information Systems (HIS) and Governance and Leadership. The newly implemented DHIS 2.4, collection of routine health information on a periodic basis, and usage of collected data at Central level to inform decision making are testaments to the performance of Building Block 3 – Health Information Systems, which ranked highest with a percentage score of 81%. Closely following Building Block 3 is Block 6 – Governance and Leadership with a score of 75%. The MOHSW has strong leadership at the Central level as evident by the adoption of NHSWPP, mobilizing the CHSWTs to create County Operational Plans, and rolling out decentralization well ahead of other ministries in GOL. Despite the achievements in HIS and strong leadership, MOHSW fares poorly in Building Block 2 – Health Workforce, with a score of 44%. The poor performance in strengthening MOHSW workforce is due to lack of a performance management system, inconsistency in tracking staff at health facilities, and uncoordinated training schedules, especially from the vertical programs.

The second lowest performing areas are Delivering Essential Health Services (Block 1) and Health Systems Financing (Block 5), with scores of 50%. The low performance in the area of Delivering Essential Health Services is due to inconsistent and inadequate supervision, minimal guidance to the CHSWTs towards service delivery, and inconsistent performance of various vertical programs. Inadequate capacity of Central MOHSW to monitor finances at the CHSWT level, lack of a system to allocate a sustainable budget for CHSWTs, and dependence on international donors led to poor performance in the area of Health Systems Financing.

3.1.2 Building Block 1: Delivering Essential Health Services

Score: 10 out of 20 points (50%)

Indicator 1.1: Capacity of Central MOHSW to engage CHSWTs in delivering health and social welfare services

Indicator 1.1 is measured by two standards: extent of interaction between Central and counties, and capacity to develop and distribute policies and service delivery standards. Central MOHSW scores a 2 out of 4 possible points for both standards, resulting in a score of 4 out of 8 points for indicator 1.1. The level of interaction between Central MOHSW and CHSWTs mirrors what we found at the CHSWT level – interaction happens almost exclusively on budget and health services planning activities. Central MOHSW provides little to no guidance to the CHSWTs in physical maintenance and coordination of health facilities or assessing community health needs. While Central MOHSW ensures that clinical standards for EPHS are developed and distributed to all CHSWTs, there is no consistent and coordinated training of staff at county and facility levels. The inadequate and inconsistent training of staff on using clinical standards reflects in poor performance of focal persons at the county level. More often than not, the CAT encountered CHSWT focal persons who are not aware of program targets or guidelines.

Indicator 1.2: Capacity of Central MOHSW to ensure appropriate use of policies and standards related to health service delivery for the Essential Package of Health Services (EPHS) areas and subareas

Indicator 1.2 is measured by two standards: capacity of Central MOHSW to supervise CHSWTs, and the number of operational public health facilities across Liberia. Once again, Central MOHSW scored in the middle, with 2 out of 4 points for each standard, resulting in 4 out of 8 possible points for indicator 1.2. While Central MOHSW has made strides in creating a system of supervision with the newly rolled out integrated supervision guidelines, the use of these guidelines is not consistent at both Central and county levels. Central MOHSW has limited capacity to monitor the adherence of service delivery standards at CHSWT level. The limited capacity is due to an uncoordinated supervision schedule resulting from fragmented vertical programs, inadequate capacity of workforce in supervisory areas (especially vertical programs), and no system to track supervision at county level. Central MOHSW maintains an updated list of operational health facilities across the country, but the number has remained unchanged (within 5%) from the last reported levels in NHSWPP.

Indicator 1.3: Capacity of Central MOHSW to deliver health care in priority areas

Indicator 1.3 measures the capacity of various vertical programs under the Department of Health Services. While some programs seem to be performing better than others, there seems to be a general lack of coordination across the vertical programs. Understandably, established programs such as National Leprosy and Tuberculosis Control Program (NLTCP), National Malaria Control Program (NMCP), and Expanded Program on Immunization (EPI) are performing at a higher level (3 out of 4 possible points) than newly established programs such as National Eye Care Program (NECP) and Neglected Tropical Diseases (NTD) (scores of 1 and 2, respectively). The National HIV/AIDS Control Program (NACP) scores in the middle with 2 out of 4 possible points. Besides the aforementioned disease-specific vertical programs, CAT also looked at the different divisions/ units under the Department of Health Services.

National HIV/AIDS Control Program (NACP)

While the scale-up of HIV Counseling and Testing (HCT) services from 11 to 235 sites from 2008 to 2011, and Preventing Mother to Child Transmission (PMTCT) services from 12 to 230 sites from 2008 to 2012 in all counties has been significant during BPHS implementation, NACP continues to face challenges due to an uncoordinated national and multi-sector response. To improve upon this, NACP engaged multiple stakeholders in the development of a strategic plan and activities. Input from facility-based staff,

CHSWTs, international and national partners and civil society organizations was used to establish a collaborative process for all stakeholders working within the sector. Examples of collaborative planning include the 2010-2015 Integrated PMTCT/ART Scale-up Plan, Standard M&E Data Collection and Reporting tool and Treatment Guidelines.

Going forward, NACP is specifically addressing shortcomings in adherence to counseling and testing protocols, integration of services, retention, ensuring HIV test confidentiality, decreasing stigma, improving referrals, inconsistent supervision, and strengthening the quality of care. While many of these challenges are being addressed in the integrated scale up plan, others are addressed through broader MOHSW programs. For example, the MOHSW Master Supply Chain Management Plan focuses on improving the supply chain system to more reliably provide all health commodities, not only those used for HIV. To improve its capacity to deliver quality services, NACP stressed the need for additional and better-trained staff. The top identified health workforce challenge was high staff turnover following advanced training due to low salaries. NACP currently does not have a plan for in-service staff training and development; however, it has identified priority areas for training including skills in adherence counseling, testing, psychosocial trauma and pediatrics care.

National Leprosy and Tuberculosis Control Program (NLTCP)

Over the last year, NLTCP placed 6000 patients on treatment. Currently, there are 153 diagnostic sites and 681 treatment sites with 98 of 136 health districts performing microscopic diagnostics. Eighty-two percent of laboratories are performing TB diagnostic services. Despite these successes and a strong operational plan with set targets, NLTCP continues to face significant challenges in program implementation due to stigma and a lack of technical as well as financial support. Unlike the other vertical programs, there is very little partner and donor support for Leprosy and Tuberculosis activities. Long treatment courses plus stigmatization result in a high default rate and difficulties monitoring and evaluating. Limited donor funding has resulted in limited and concentrated community-based activities. Challenges in the supply chain and referral systems create significant challenges in ensuring specialized care and limited human resources (e.g., only one focal person for large counties such as Nimba and Lofa) make oversight difficult. Finally, NLTCP identified a major challenge as the lack of resources (both diagnostic and treatment facilities) to address Multidrug Resistance (MDR) TB. To improve capacity, NLTCP is focusing on finding technical support to manage MDR TB, advocating with Central MOHSW to improve community work and resources and empowering CHSWTs to take ownership of TB activities. Unlike many other areas, NLTCP identifies training needs and has a training plan focusing on monitoring & evaluation skills, MDR TB services and laboratory strengthening. The program has identified a need for greater support and collaboration from Central MOHSW.

National Malaria Control Program (NMCP)

During the BPHS implementation, NMCP significantly increased community understanding of malaria causes and prevention and put malaria on the agenda of high-level decision makers. Like NACP, NMCP faces primary challenges in trying to coordinate prevention and treatment services in an area of high resource, national and multi-sector response. The program identified many partners working on malaria, many of whom are not providing reports to the program, making it difficult for NMCP to coordinate, monitor and evaluate one MOHSW approved approach. Timely reporting generally is a problem for NMCP, as is the low utilization of services due to a lack of Rapid Diagnostic Tests (RDTs).

With the new protocol that all fever cases must be tested before treatment, NMCP will get a better understanding of the malaria prevalence in Liberia. NMCP relies heavily on staff to get answers for why people aren't using ITNs and pregnant women are not taking IPT. In addition to operational research

and data management, NMCP is prioritizing staff capacity, stating that the entire workforce needs to be trained as malaria diagnosis and treatment is complex and integrated. More specifically, NMCP wants more staff to be trained in microscopic diagnostics (rather than relying on RDT), drug management and case management. A specific concern regarding skilled staff turnover included loss of skilled personnel to other offices in Central MOHSW.

National Health Promotion Unit

During BPHS implementation, the National Health Promotion Unit developed a national health promotion policy and strategy, rolled-out national tobacco regulation as well as a national health fair and collaborated on many behavior-change and training initiatives at the county, facility and community levels. Contributing to the low capacity of the National Health Promotion Unit is the lack of an operational plan and targets. The plan is still pending as part of the Unit's 150-day deliverables. The Unit identified specific challenges such as low levels of support from some programs, partners and senior MOHSW management, inadequate budget support, multiple functions of unit staff and no vehicle support at both Central and County levels. To strengthen its capacity, the Unit has been working on strengthening and incentivizing its staff through trainings, Terms of References (TORs), and in some cases promotions. Going forward, they would like to receive support to train District focal persons, all staff in M&E and Community Planning. Further, they would like to be able to motivate staff through adjusted incentives and scholarship/advancement opportunities.

Mental Health Unit

Following the development of the National Mental Health Policy and Plan in 2011 and a set of required facility and community level services in the EPHS, the Mental Health Unit has begun to expand the availability and access of mental health services to all health facilities and catchment communities. However, the complexity of building these services from scratch and the lack of resources has to date meant that mental health services are strengthened primarily through partners such as RBHS, the Carter Center, Medicines Du Monde (MDM) and WHO. The Unit works collaboratively with these partners to plan, coordinate, monitor and evaluate mental health activities. The Unit has an established five-year operational plan and targets, prioritizing improving capacity through mental health legislation, the development of treatment guidelines, more trained mental health professionals, support to the CHSWTs to establish one 'Wellness Unit' per county and to ensure access and availability of essential psychotropic drugs. Like all programs, the Mental Health Unit identified vehicle and budget support as their two biggest needs. Unlike other programs, the Unit's in-service training is well organized, strategic and regular.

Neglected Tropical Diseases (NTD) Unit

Newly established as part of the 2011-2021 EPHS, the Neglected Tropical Disease Unit works with multiple sectors and partners to prevent, raise awareness, control and eliminate NTDs. The Unit has an operational plan developed in collaboration with partners using the WHO standardized framework. The Unit identified its major capacity challenges as inadequate support from Central MOHSW because NTDs are not considered a priority, the lack of trained staff, small office space and a weak M&E as well as financial system. To address these capacity constraints, the NTD Unit needs advocacy with Central MOHSW for all staff to be placed on payroll, and technical and financial assistance to improve administration. While there is a training plan, trainings are rarely and irregularly held.

Family Health Division (FHD)

Despite successes in developing policy, protocols and strategies over the last five years, the Family Health Division faces challenges of inadequate workforce and commodities. While FHD has an

operational plan with targets, the Division identified program management training, and financial and technical assistance as needs to successfully meet these targets. Specifically, FHD noted the need for a dedicated Reproductive Health budget, vehicle and logistic support, a focus on increased community participation, promotion, support for program management skills, systematic training for all staff, and improved supervision and monitoring.

Nutrition Unit

The Nutrition Unit is an example of how planning and effective leadership, coupled with technical assistance from partners such as RBHS, can improve capacity. Despite not having a trained nutritionist, the Unit is making use of the expertise available and planning activities. With an operational plan at both Central and County levels, the Unit has specific targets to decrease under-five stunting and increase exclusive breast-feeding. The unit identifies its primary challenge as funding, stating that because GOL does not include nutrition in the national budget, funding from other sources is needed. After funding, the Unit identifies training needs to strengthen capacity. While there is an in-service training operational plan, trainings are done during supervision and monitoring. As a result, high-level training needs such as Central directors and coordinators as well as County supervisors are not being met. The biggest need for the Nutrition Unit is for a trained nutritionist.

Training Unit

The Training Unit, historically, has been slow to build capacity and has faced significant management as well as administrative challenges. It is lost between, and lacks support from, the Departments of Health Services and Planning and for over two years has not had an appointed Director. Moreover, it has only one staff member; the second is a volunteer. It is not surprising then that all three CHSWTS and most vertical programs as well as other divisions have identified unsystematic and unresponsive training as one of their primary challenges in building capacity. These challenges, according to the Training Unit, are a result of inadequate funding and support from the MOHSW, as well as inadequately defined role and functions of the Unit. Among the Unit's successes are a two-year operational plan, training of Master Trainers, training of County level trainers, and roll out of step down in-service training in 7 of the 15 counties (including Bong and Nimba). Setting targets, however, seems to be a problem with identifying the number of health workers. According to the Training Unit, high turnover in human resources has resulted in no accurate records of the number of health workers in Liberia. A large part of BPHS and now EPHS implementation is the integrated training curriculum. This curriculum needs significant review as well as development of modules for the areas introduced in the EPHS (e.g., NCDs, NTDs, Prison Health Services, School Health Services, and Eye Health Services). Additional specific challenges include a lack of materials and supplies and no assigned vehicle or fuel allotments. To improve its capacity, the Training Unit needs assistance to determine where in Central MOHSW it fits, including its specific roles and responsibilities. It also requests additional staff and management training, supplies, increased budget and vehicle support.

Non-Communicable Diseases (NCD) Unit

The NCD unit is in its initial stages. A risk factors survey was recently completed, which will enable the unit to develop targeted messages to raise awareness in the areas of NCDs. The unit is currently planning to estimate the prevalence rate for NCDs through a hospital-based survey. An operational plan and targets will be established for the unit after determining the prevalence rates and risk factors. As such, the unit has limited capacity, awaiting results from the surveys. While the NCD unit made progress by completing the risk factors survey and gathering attention from Central MOHSW, challenges remain in the form of inadequate workforce, finances, and logistics. The NCD unit was not able to specify training needs due to lack of adequate data. The one priority area where the unit currently needs help is

conducting research to determine the burden of NCDs in Liberia. The NCD unit continues to make progress with its newly appointed Director.

Community Health Services (CHS) Division

During BPHS implementation, the Community Health Services Division revised its policy and strategy and began orientation in the three counties assessed during capacity assessments: Bong, Lofa and Nimba. All three of these counties now have a CHS focal person. All staff in CHS are Master Trainers and the Division has a two-year operational plan. However, no formal targets have been set for the division. The roll-out of Community Health modules has been slow and heavily dependent on partner support. The Division identified the following challenges: limited resources, limited experience of staff, no job security as all staff are receiving incentives from partners, no opportunities for advancement or higher education, small office space, conflicting priorities at Central MOHSW, slow integration from vertical programs, inadequate budget and poor computer skills. While the Division has made improvements building current staff capacity by delegating responsibilities and including them in planning, the Director noted that the Division has no input in hiring and all staff selection is done by upper management at Central MOHSW.

National Eye Care Program (NECP)

Newly established as part of the 2011-2021 EPHS, the National Eye Care Program was created to establish an eye health delivery system in which eye health services are accessible to all. NECP has an operational plan with early targets focused on establishing the prevalence of blindness in Liberia and establishing appropriate programming and infrastructure to address eye health needs. The program has already established an eye health unit at Redemption Hospital but identified a number of challenges to its current capacity including an unclear organogram, inadequate staffing and a lack of logistical support as well as funding. Currently, training presents a significant challenge for NECP as there is not an in-country training program available. Identified training priorities such as community and facility ophthalmic nurses, ophthalmologists and cataract surgeons require travel to Ghana, Gambia and Nigeria. Going forward, NECP is prioritizing developing international partnerships in order to quickly increase and improve eye health human resources.

Infrastructure Unit

The Infrastructure Unit works with MOHSW implementing partners to build health care in infrastructure across Liberia. In addition to building health care facilities, the Infrastructure Unit monitors and evaluates the activities in implementing partners in maintenance of facilities. The Unit also assesses, plans, and develops specifications for new and old buildings. As a part of decentralization, the Infrastructure Unit focuses on building capacity of the CHSWTs to maintain health facilities in respective counties. The Unit has set targets to construct 300 new buildings and renovate 150 old buildings in the NHSWPP 10 year period. The Infrastructure Unit has coordinated the building and renovation of 78 health centers since 2008. Prototypes have been developed for hospitals and clinics and a draft policy has been developed with international technical assistance. Despite the aforementioned accomplishments, the Infrastructure Unit suffers from inadequate skilled workforce. Training of workforce continues to be a major need. The Unit identified training of workforce in construction standards as one of the major training needs.

Environmental Health Division

The Environmental Health Division (EHD) has multiple roles: water quality, food safety, health waste management, and chemical safety. The EHD has developed a five year strategic plan and two year operational plan, which outline focus areas and activities. At the CHSWT level, the EHD is represented by

Environmental Health Coordinators who carry out the functions identified in the five year strategic plan. The operational plan sets targets in select areas, such as providing sanitation services in 5000 communities in five years. The EHD identified health waste management, water quality, chemical waste management, food safety, and air pollution as major environmental health challenges facing Liberia. The Division touts the development of National Environmental Health Policy and Health Care Waste Management Policy, and the overall reduction in Cholera cases as its achievements. Major challenges facing the EHD are inadequate skilled staff in the areas of water quality testing, health waste management, and food safety; heavy reliance on international donors, and inadequate vehicles. The EHD requires logistic support in the form of functioning vehicles, building technical capacity of its workforce, and increases support from Central MOHSW in the form of resources. While NGO partners have trained CHSWT staff on environmental health policies and procedures, there is still inadequate knowledge and skills when it comes to enforcing the policies.

3.1.3 Building Block 2: Health Workforce

Score: 7 out of 16 points (44%)

Indicator 2.1: Central MOHSW capacity in workforce recruitment and deployment

Indicator 2.1 is measured by two standards: ability to recruit and retain health workers; and the capacity of Central MOHSW to staff health facilities according to the national guidelines. Central MOHSW performed well in its ability to recruit and retain the workforce with 3 out of 4 points. Currently CHSWTs and implementing partners recruit staff based on jointly identified needs. Central MOHSW job descriptions and pay scale are used for the staff recruited by CHSWTs and partners. However, the common theme across staff recruitment and retention is inadequate pay. Health workers pay is low and not enough to retain staff. Incentives are not distributed in a consistent manner leading to discontent among health facility staff. While national staffing guidelines have been developed and are readily available, Central MOHSW does not have a system to track staffing levels at facilities, resulting in 1 out of 4 points. There is no health worker profile that explains the number and quality of workforce at facilities across Liberia. Currently another USAID-funded project is undertaking a health worker profile survey that intends to address this challenge.

Indicator 2.2: Capacity of Central MOHSW to strengthen the existing health workforce

Indicator 2.2 is measured by two standards: capacity to monitor staff performance; and in-service training. Central MOHSW scored 0 out of 4 points on the capacity to monitor staff performance. There are no guidelines or policies in place at Central MOHSW to review CHSWT staff performance. While the National Policy on Human Resources serves as a guideline for addressing the issues of absenteeism and poor productivity, there is no active performance appraisal/ management system at MOHSW.

Central MOHSW scored well on the ability to build training capacity of its workforce with a score of 3 out of 4 points. Implementing partners and MOHSW conduct trainings for CHSWT staff using curricula approved by Central MOHSW. However, the training schedules are not fully coordinated and communicated to relevant stakeholders. Fragmentation of trainings from various vertical programs results in loss of clinical service delivery time at county and facility level. In addition, productivity at Central MOHSW is affected by an inadequate number of master trainers. Senior management of some divisions has to travel to counties to conduct trainings because that person is the only master trainer in a certain category. This results in a loss of productivity at the Central level. Training needs of Central MOHSW are listed in Annex 4.5.

3.1.4 Building Block 3: Health Information Systems (HIS)

Score: 13 out of 16 points (81%)

Building Block 3: Health Information Systems is the highest scoring block for Central MOHSW with a score of 81%. A detailed assessment of HIS at the county and facility levels was conducted under a separate process called Performance of Routine Information Systems Management (PRISM). PRISM focuses on the performance of the District Health Information System (DHIS) including data collection, quality, storage, and use. A detailed report of the PRISM assessment findings will be issued in a separate report. Besides the PRISM assessment, the CAT assessed the overall capacity of Central MOHSW towards HIS.

Indicator 3.1: Capacity of Central MOHSW to plan for and systematically collect health information

Indicator 3.1 is measured by two standards: capacity of Central MOHSW to develop and roll out policies and forms; and the capacity to collect data. Central MOHSW scored well on both standards with 3 out of 4 possible points. Central MOHSW has an elaborate policy outlining key components of HIS, and has developed and distributed data collection tools for most of these key components to all counties. However, training of staff on using these forms is not complete as less than 75% of key staff in 75% of counties has been trained. MOHSW is making progress on training CHSWT staff in using the new DHIS 2 system. Central MOHSW has a national data collection system, as evident by the DHIS 1 and 2. However, timely reporting from counties continues to be a challenge, with less than 75% of counties reporting timely and complete health data.

Indicator 3.2: Capacity of Central MOHSW to promote evidence-based decisions and policy making

Indicator 3.2 is measured by two standards: capacity to manage data; and the capacity to use the collected data for making evidence-based decisions. Central MOHSW scored well on managing data with 3 out of 4 points. Electronic storage systems exist for various components of HIS and data is routinely extracted for use. However, other health management systems such as financial, logistics, and physical assets data systems are not linked together. Central MOHSW scored exceptionally well on using data to make evidence-based decisions, with a score of 4 out of 4 points. Data collected from counties is analyzed and analysis reports are distributed to key members of Central MOHSW and CHSWTs on a quarterly basis. Central MOHSW is able to identify multiple examples of how data has been used to inform decision-making in the past year.

3.1.5 Building Block 4: Access to Essential Training Medicines

Score: 9 out of 16 points (56%)

Indicator 4.1: Capacity of Central MOHSW to ensure access to essential medicines for the population

Indicator 4.1 is measured by four standards. Central MOHSW scored well on its capacity to develop a Supply Chain Master Plan (SCMP) with 3 out of 4 points. However, implementation of the SCMP has reached only up to 50% of the counties. Central MOHSW also scored well in its capacity towards quantification and procurement with 3 out of 4 points. With minimal technical assistance from partners, Central MOHSW is able to estimate commodity needs and develop a supply plan, and is partially able to procure essential commodities. It is important to note that while CHSWTs forecast their commodity needs regularly, they do not always receive what they projected for. This results in inflated forecasting at times to compensate for lacking commodities. Currently the CHSWTs are not aware of how quantification and distribution works at the Central level, adding further confusion and mistrust in the process.

The capacity to develop and use a Logistics Management Information System (LMIS) is well developed, resulting in a score of 3 out of 4 points. However, reporting of LMIS data is below 70% for all facilities, with the capacity of counties to use an LMIS system being very low. This results in inadequate and untimely data reporting from CHSWTs. There is a major discrepancy between capacity of counties and Central MOHSW in understanding and usage of LMIS. This discrepancy results in improper forecasting and untimely requests for commodities. Montserrado is the only county that reports facility level commodity data. Only Lofa CHSWT forecasts consistently according to guidelines as evidenced by Lofa CHSWT's score of 4 out of 4 points on forecasting.

The weakest area in Block 4 is the capacity of Central MOHSW to effectively distribute commodities with a score of 1 out of 4 points. More often than not, distribution of commodities does not reflect CHSWT usage. A major challenge is inadequate supply of commodities followed by inadequate and nonfunctional vehicles.

3.1.6 Building Block 5: Health Systems Financing

Score: 8 out of 16 points (50%)

Indicator 5.1: Capacity of the Central MOHSW to ensure that adequate funds are allocated to health expenditures within the overall Government of Liberia budget

Central MOHSW scores 2 out of 4 points on indicator 5.1. While MOHSW has input in to the GOL's overall budget, health expenditures are not systematically calculated on an annual basis and do not total at least 10% of the overall government budget.

Indicator 5.2 Capacity of Central MOHSW to formulate, distribute, and monitor financing for the health sector

Indicator 5.2 is measured with three standards: plan for, create, and allocate a sustainable budget; effectively distribute finances; and effective monitoring of finances. For purposes of the capacity assessment, a sustainable budget is defined as a budget that meets four criteria: planning, input, allocation, and initiative. The four key criteria are defined in the assessment tools listed in Annexes 4.9 and 4.11. Central MOHSW scores low on the capacity to plan for, create, and allocate a sustainable budget with a 1 out of 4 points. While some elements of the aforementioned four criteria exist, the system is not comprehensive. Central MOHSW has better capacity in taking the initiative, but there is inadequate capacity in areas of planning, input, and allocation.

There are four factors necessary in order to effectively distribute finances: a viable distribution system, tracking, policies, and responsibility. Central MOHSW scores well on this standard with 3 out of 4 points. The distribution system is strong, tracking happens although it is not consistent, and policies are in place to guide distribution. However, responsibility, defined by monthly review of expenses versus revenue, happens monthly within Central MOHSW, but not between Central MOHSW and counties.

Similar to above standards, there are four factors necessary to monitor finances: documentation, review, reporting, and audit. Central MOHSW scores 2 out of 4 points in this standard. While all four factors exist at Central level, documentation and reporting are lacking between Central and county levels. The documentation policies adopted by Central MOHSW are not consistently transmitted to CHSWTs and adherence to these policies is not consistently monitored. Similarly, a reporting system exists for Central MOHSW to report to GOL and for CHSWTs to report to Central MOHSW. However, the CHSWT reports are untimely and inconsistent.

It is important to note that Block 5: Health Systems Financing ranks consistently the lowest among all three CHSWTs. The inadequate capacity of Central MOHSW to create and allocate a sustainable budget, coupled with minimal capacity in monitoring finances, leads to a severe lack of CHSWT capacity to plan, create, manage, and monitor finances.

3.1.7 Building Block 6: Governance and Leadership

Score: 12 out of 16 (75%)

Indicator 6.1: Capacity of Central MOHSW to lead efforts aimed at improving the health of all Liberians

Central MOHSW scores exceptionally well in indicator 6.1 with 4 out of 4 points. The current NSWPP has been adopted in its entirety by the MOHSW and operational plans have been developed for at least 80% of the NSWPP policy orientations.

Indicator 6.2: Capacity of Central MOHSW towards intra and inter agency communication

Indicator 6.2 is measured by 3 standards: capacity of Central MOHSW to communicate within the Ministry; capacity to lead and guide CHSWTs; and clearly defined leadership roles. Central MOHSW scored well in 2 of the 3 standards: leading CHSWTs, and leadership roles. The capacity of Central MOHSW to communicate within the Ministry and other GOL Ministries is limited, as evident by the lack of a communication strategy and plan. Central MOHSW scores well in the area of leading and guiding CHSWTs with a score of 3 out of 4. Key information is shared between Central and counties during regularly scheduled meetings, and Central MOHSW receives regular input from CHSWTs. However, the reporting system is inconsistent, resulting in less than 50% of CHSWTs reporting to Central MOHSW on a timely basis. Central MOHSW emerges as a leader in its capacity to hold responsibility and ownership for the Liberian health system, scoring 4 out of 4 points. Clear leadership over the Six Building Blocks is evident by the NSWPP, EPHS, and agreements with donors and partners.

3.1.8 PROVISIONAL RECOMMENDATIONS FOR CENTRAL MOHSW

Building Block 1: Delivering Essential Health Services

Individual:

- Address training needs identified in annex 4.5.
- Train key program/ division staff on program management techniques.
- Orient the CHSWT staff on EPHS.
- Train the CHSWT staff on conducting and documenting supportive supervision.

Organizational:

- Revisit the organizational structure of multiple vertical programs and divisions to address the issues with fragmented service delivery.
- Reorganize the Training Unit by locating it under the Department of Health Services and clearly define its role with a leadership structure.
- Hire additional staff for high-activity divisions such as Family Health and Community Health Services.
- Revisit the CHSWT structure of multiple focal persons.

Health System:

- Install a user-friendly method of documenting supervisory visits.
- Meet quarterly with CHSWTs to discuss PBC indicator data and other key information. Give written feedback during these quarterly meetings and follow-up on actions.

Building Block 2: Health Workforce

Individual:

- Conduct training in areas identified for staff in specific Central MOHSW departments/ divisions/ units. Additional training needs may be identified after the capacity building process is initiated.

Organizational:

- Prioritize development of training modules and curricula rather than delivering in-service trainings.
- Decentralize the process of in-service trainings to CHSWT level. Central MOHSW should build capacity of CHSWTs to conduct a training needs assessment, identify staff to be trained, and the schedule of training.

Health System:

- Develop a performance management system in order to retain and strengthen existing workforce.
- Develop and implement a user-friendly Human Resources Information System (HRIS) to keep track of staffing data at CHSWT and health facility level.
- Link in-service training with pre-service training institutions. Deliver trainings through per-service training institutions rather than Central MOHSW itself.

Building Block 3: Health Information Systems

Individual:

- Roll out training for DHIS 2.4.

Organizational:

- Build the CHSWT capacity to collect, manage, and use the collected data.

Health System:

- Build system – at Central and CHSWT level – capacity to conduct population and facility-based surveys.
- Recruit additional skilled staff to manage and analyze the collected data.
- Link HMIS with other data sources such as LMIS, HRIS, and financial databases.

Building Block 4: Access to Essential Medicines

Individual:

- Train CHSWT staff on using the LMIS system.

Organizational:

- Fully implement the Supply Chain Master Plan with technical assistance from USAID-DELIVER.

Health System:

- Roll out LMIS fully at the CHSWT level.

Building Block 5: Health Systems Financing

Individual:

- Train Central MOHSW staff on linking financial data to the PBF data.

Organizational:

- Integrate funding from vertical programs into the CHSWT budget, rather than fragment the budget to focal persons.

Health System:

- Redesign the financial management system to support implementation and tracking of PBF indicators, with close collaboration with the PBF Unit of Central MOHSW.

Building Block 6: Governance and Leadership

Individual:

- Train CHSWTs on vehicle management.

Organizational:

- Develop and implement a communication strategy and plan for Central MOHSW to communicate within the Ministry and with other GOL Ministries to streamline communications, promote partnerships, and raise the profile of MOHSW.

Health System:

- Develop a partnership manual that clearly defines the roles and responsibilities of Central MOHSW, implementing partners, CHSWTs, and donors. This manual should serve as a guide for CHSWTs to work with partners in the field.

3.2 BONG COUNTY

BONG			
	Total Points Available	Points Received	Percentage Score
BUILDING BLOCK 1			
TOTAL SCORE	28	15	54%
Extent of interaction between CHSWTs and Central MOHSW	4	2	50%
Extent of Interaction between CHSWTs and Health Facilities	4	3	75%
Capacity of CHSWTs to Supervise Health Facilities in the Use of Health Service Delivery Standards	4	2	50%
Number of operational public health facilities as compared to those projected in the National Health and Social Welfare Plan	4	4	100%
Capacity of CHSWT to safely handle and dispose of medical products and bi-products	4	0	0%
Capacity of CHSWT to implement programs developed by the Division of Health Services at the Central MOHSW level	4	1	25%
Capacity of CHSWT to address community health needs	4	3	75%
BUILDING BLOCK 2			
TOTAL SCORE	16	10	63%
Ability to recruit human resources for health worker positions	4	3	75%
Capacity of the CHSWT to staff health facilities as per National Staffing Guidelines	4	4	100%
Capacity to review staff performance	4	0	0%
Capacity of CHSWTs to coordinate capacity development of health staff	4	3	75%
BUILDING BLOCK 3			
TOTAL SCORE	16	7	44%
Capacity of the CHSWT to roll out HIS policies and forms	4	0	0%
Capacity of CHSWT to collect health data	4	4	100%
Capacity of CHSWT to report health data to the MOHSW and back to health facilities	4	3	75%
Capacity of CHSWT to use collected data for planning and policy making	4	0	0%
BUILDING BLOCK 4			
TOTAL SCORE	12	5	42%
Capacity of the CHSWT to estimate commodity needs and request these commodities from the Central MOHSW	4	3	75%
The CHSWT's capacity to use a Logistics Management Information System (LMIS)	4	1	25%
CHSWT's capacity to effectively store and distribute commodities	4	1	25%
BUILDING BLOCK 5			
TOTAL SCORE	12	0	0%
CHSWT capacity to plan for, create and allocate a sustainable budget	4	0	0%
Capacity of CHSWT to effectively distribute finances	4	0	0%
Capacity of CHSWT to monitor finances at the County and facility levels	4	0	0%
BUILDING BLOCK 6			
TOTAL SCORE	16	6	38%
Capacity of CHSWT to implement the National Health and Social Welfare Policy and Plan	4	1	25%
Capacity to communicate and share reports, documents and plans with the Central MOHSW and other CHSWTs	4	0	0%
Capacity of the CHSWT to lead and engage with DHSWT and health facilities	4	3	75%
Capacity of CHSWT to hold responsibility and ownership for the health system within their county	4	2	50%

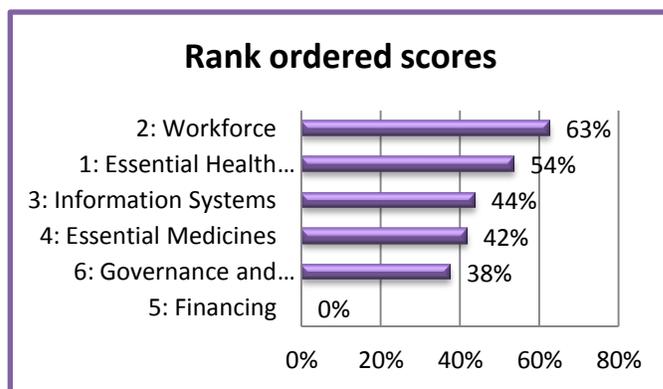
3.2.1 Overview

Score: 43 out of 100

Assessment Dates: April 11 and 12, 2012

Assessment Team Members: Sophie Parwon (USAID), Margaret Korkpor (MOHSW Health Services), Marcus Gonny (MOHSW Planning), Garyezohn Clark (MOHSW Administration/ FARA Accountant), Rose Macauley (RBHS), Vamsi Vasireddy (RBHS), J. Mehnmon Tokpa (RBHS), Catherine Gbozee (RBHS), Marietta Yekee (RBHS), Rufus Domah (RBHS).

Building blocks	Max	Score	%
1. Essential Health Services	28	15	54%
2. Workforce	16	10	63%
3. Information Systems	16	7	44%
4. Essential Medicines	12	5	42%
5. Finance Systems	12	0	0
6. Governance & Leadership	16	6	38%
Overall score	100	43	43%



Bong County’s score falls in the middle of the three counties assessed. While the strong and weak building blocks are essentially the same across all three counties, Bong CHSWT has staffed all health facilities, meeting EPHS requirements. Further, they have institutionalized a system of supervision that is regular, detailed, and thoroughly implemented. A significant challenge that impacts the capacity of the CHSWT in all areas is that leadership and governance seem to be concentrated within two people, the CHO and CHDD. As a result, the assessments found that most CHSWT members don’t understand decentralization, Performance-Based Contracting, and policies and procedures including EPHS. This has resulted in poor coordination within the CHSWT, with partners and across the vertical programs. Bong CHSWT, like all of the counties, has significant challenges managing its supply chain and the county finances. The CHSWT is constrained by a lack of commodities, particularly for Family Planning, HIV/AIDS and Malaria as well as the untimely distribution of medicines from NDS. The assessments found no systems in place for creating, maintaining, monitoring, and distributing a sustainable budget. Detail on each Building Block follows. For more information on Bong County’s scoring please see Annex 4.2: the Bong County Dashboard.

3.2.2 Building Block 1: Delivering Essential Health Services

Score: 15 out of 28 (54%)

Indicator 1.1: Capacity of CHSWTs to engage with Central MOHSW and Health Facilities in delivering the health and social welfare services

Bong CHSWT performs well on this indicator, with room for improvement. THE CHSWT meets at least monthly with health facilities to share key information and policies, conducts supervisory visits, and obtain health and logistics data. While interaction with health facilities is regular and timely, they did not receive the top score on the standard because supervisory responsibilities are not clear and feedback is not given to facilities on data submitted. During this past year, as part of the 2011-2021 NHSWPP planning, Central MOHSW and the CHSWT worked together to develop an operational plan for

budget, finance, health service planning activities, and maintenance and coordination of facilities. The amount of Central and CHSWT interaction, outside of these activities, remains to be seen.

Indicator 1.2: Capacity of CHSWTs to ensure appropriate use of policies and standards related to health service delivery for the EPHS areas and subareas

Bong CHSWT scores in this area vary significantly. A perfect score was received for the number of operational facilities as compared to those projected in the NHSWPP. The three additional facilities projected in the NHSWPP were all completed. While supervision is strong and Central MOHSW has lent support, the capacity of the CHSWT to conduct standardized and quality supervision is limited. Most vertical program focal personnel were assessed to have never seen program policies, procedures, or targets. EPI was the only exception. The lowest score for this indicator was a zero for CHSWT capacity to safely handle and dispose of medical products and bi-products, describing no policies and procedures to do so.

Indicator 1.3: Capacity of CHSWTs to deliver health care in priority areas

Contrary to the other counties, the CHSWT capacity to address community health needs was assessed much higher than their ability to implement programs developed by Central MOHSW Health Services. The CHSWT has conducted a community health needs assessment with the help of health partners to identify and prioritize community health problems. However, high staff turnover and delayed/inadequate medicines have made implementing priority MOHSW programming difficult. The Bong CHSWT scored only 1 out of 4 on this standard.

3.2.3 Building Block 2: Health Workforce

Score: 10 out of 16 (63%)

Indicator 2.1: Capacity of CHSWT in workforce recruitment and deployment

Bong CHSWT's capacity to recruit health workers and staff facilities is high. The CHSWT and health partners recruit staff based on jointly identified needs, routinely using Central MOHSW job descriptions. However, it should be noted that the Bong CHSWT does not have the authority to review and change job descriptions. This is done at Central MOHSW. Adequate staffing data exists and at least 75% of the reported health facilities have both key clinic staff (OIC and CM).

Indicator 2.2: Capacity of the CHSWT to strengthen existing health workforce

The CHSWT capacity to strengthen the existing workforce through performance review and development is far more limited. While the CHSWT has a manual to monitor staff performance, it has not been implemented. As a result the CHSWT scored a zero in this standard. Without performance reviews and with low remuneration, the CHSWT has challenges developing and incentivizing health workers. There currently is not a system to assess workforce needs and the CHSWT does not maintain a database of the trainings/workshops attended by staff. While the CHSWT and health partners provide training on EPHS using MOHSW-approved curricula and processes, training schedules are not fully coordinated/ communicated to all relevant stakeholders.

A detailed list of trainings requested by Bong CHSWT to strengthen their workforce is listed in Annex 4.6. Priority training areas have been identified and action will be taken based upon agreed-upon priorities.

3.2.4 Building Block 3: Health Information Systems (HIS)

Score: 7 out of 16 (44%)

Indicator 3.1: Capacity of the CHSWT to plan for and systematically collect health information

While the Bong CHSWT received timely and complete health data from at least 75% of the health facilities during the last reporting period, there are significant gaps in how the data is used. The assessments found that the CHSWT is not aware of the HIS policy and has not integrated LMIS into current data management systems. Moreover, data is not used for facility decision-making and no written feedback, only verbal, is provided back to facilities.

Indicator 3.2: Capacity of CHSWT to promote evidence-based decisions and policy making

The capacity assessments found that data is not being used for high-level decision making and planning. The Bong CHSWT M&E Officer resigned and currently the position remains empty. This is creating significant process and planning setbacks.

A detailed assessment of HIS in Bong County and at the facility level will be issued under the PRISM assessment report.

3.2.5 Building Block 4: Access to Essential Training Medicines

Score: 5 out of 12 (42%)

Indicator 4.1: Capacity of CHSWT to ensure access to essential medicines for the county

While the Bong CHSWT scores well in estimating and requisitioning essential medicines (3 out of 4 points), their capacity to use LMIS, and store and distribute commodities is very low (1 out of 4 points). The Bong CHSWT is able to estimate commodity needs, however the timing of these estimates is haphazard which prevented a top score for this standard. THE CHSWT noted that a major challenge continues to be the untimely delivery of supplies from NDS. More than 60% of staff involved in the LMIS have been trained on the system however the CHSWT and facilities do not have all of the LMIS forms, and use of these forms is inconsistent. County warehouses for commodity storage exist, with some accommodation for items requiring special storage. Cleanliness is adequate, but maintenance and size of the county warehouse are inadequate.

3.2.6 Building Block 5: Health Systems Financing

Score: 0 out of 12 (0%)

Indicator 5.1 Capacity of CHSWT to formulate, distribute and monitor financing for the health sector

While this is a very low scoring area for all three counties, Bong CHSWT's capacity is the lowest with a score of zero. The CHSWT does not have the capacity to manage county financing at any level and they are unclear on PBC. They are unable to plan for, create and allocate a sustainable budget; effectively distribute finances and monitor finances at the county and facility levels. There is, therefore, no transparency in budget spending and allocation. Most Bong CHSWT staff, including the accountant, do not know where funding comes from and where it goes. The only two people who are aware are the CHO and CHDD. Funding for vertical programs bypasses the county system and goes directly to the focal person. This poses challenges because the focal personnel do not have the capacity to manage budget (and most of them do not have an understanding of program policies, procedures, and targets). When asked what they need in order to implement PBC, the following were mentioned: vehicles, a

procurement system, a database to track drug management and a system to track vehicles. This demonstrates a lack of understanding of PBC.

3.2.7 Building Block 6: Governance and Leadership

Score: 6 out of 16 (38%)

Indicator 6.1: Capacity of CHSWT to implement activities aimed at improving the health of all people within the county

The Bong CHSWT is aware of both National and County health plans; however no systems of communication exist between CHSWT and the Central MOHSW to implement the plans. Only 3 members of the CHSWT have read the County Health plan.

Indicator 6.2: Capacity of CHSWT to communicate and share best practices with the Central MOHSW and with other CHSWTs

The CHSWT was assessed to have zero planned communication with Central MOHSW and other CHSWTs. However, they were successful communicating within the county, to the DHSWTs and facilities. Meetings are regularly held between the CHSWT and all health facilities. The CHSWT receives regular reports from at least 50% of health facilities. The District Health Officer (DHO) meets with health facilities monthly and there is a quarterly OIC meeting that rotates between facilities so they can share hosting responsibilities. Leadership and a sense of ownership of the county health system is generally held by the CHSWT, with significant input from donors and health partners. The CHSWT scores poorly on their capacity to hold responsibility and ownership for the county health system. This is primarily because of the lack of established policies and/or procedures for guiding interactions within the CHSWT, between the CHSWT and Central MOHSW, and between the CHSWT and partners. The CHSWT identified the following as their primary challenges in the area of leadership and governance: health workers taking training materials with them when they leave for another facility; little involvement of county government and county health and social welfare board; no terms of reference for staff from vertical programs; lack of clarity in the area of lines of responsibility; inadequate support from districts (turf wars); and political interference from some Chiefs.

3.3 LOFA COUNTY

LOFA			
	Total Points Available	Points Received	Percentage Score
BUILDING BLOCK 1			
TOTAL SCORE	28	9	32%
Extent of interaction between CHSWTs and Central MOHSW	4	2	50%
Extent of Interaction between CHSWTs and Health Facilities	4	3	75%
Capacity of CHSWTs to Supervise Health Facilities in the Use of Health Service Delivery Standards	4	1	25%
Number of operational public health facilities as compared to those projected in the National Health and Social Welfare Plan	4	2	50%
Capacity of CHSWT to safely handle and dispose of medical products and bi-products	4	0	0%
Capacity of CHSWT to implement programs developed by the Division of Health Services at the Central MOHSW level	4	1	25%
Capacity of CHSWT to address community health needs	4	0	0%
BUILDING BLOCK 2			
TOTAL SCORE	16	8	50%
Ability to recruit human resources for health worker positions	4	4	100%
Capacity of the CHSWT to staff health facilities as per National Staffing Guidelines	4	4	100%
Capacity to review staff performance	4	0	0%
Capacity of CHSWTs to coordinate capacity development of health staff	4	0	0%
BUILDING BLOCK 3			
TOTAL SCORE	16	7	44%
Capacity of the CHSWT to roll out HIS policies and forms	4	2	50%
Capacity of CHSWT to collect health data	4	3	75%
Capacity of CHSWT to report health data to the MOHSW and back to health facilities	4	2	50%
Capacity of CHSWT to use collected data for planning and policy making	4	0	0%
BUILDING BLOCK 4			
TOTAL SCORE	12	5	42%
Capacity of the CHSWT to estimate commodity needs and request these commodities from the Central MOHSW	4	4	100%
The CHSWT's capacity to use a Logistics Management Information System (LMIS)	4	0	0%
CHSWT's capacity to effectively store and distribute commodities	4	1	25%
BUILDING BLOCK 5			
TOTAL SCORE	12	3	25%
CHSWT capacity to plan for, create and allocate a sustainable budget	4	1	25%
Capacity of CHSWT to effectively distribute finances	4	1	25%
Capacity of CHSWT to monitor finances at the County and facility levels	4	1	25%
BUILDING BLOCK 6			
TOTAL SCORE	16	4	25%
Capacity of CHSWT to implement the National Health and Social Welfare Policy and Plan	4	0	0%
Capacity to communicate and share reports, documents and plans with the Central MOHSW and other CHSWTs	4	1	25%
Capacity of the CHSWT to lead and engage with DHSWT and health facilities	4	1	25%
Capacity of CHSWT to hold responsibility and ownership for the health system within their county	4	2	50%

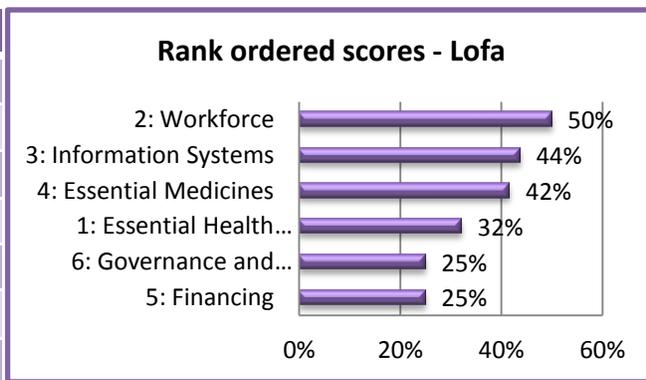
3.3.1 Overview

Score: 36 out of 100

Assessment Dates: April 9 and 10, 2012

Assessment Team Members: Margaret Korkpor (MOHSW Health Services), Marcus Gonny (MOHSW Planning), Garyezohn Clark (MOHSW Administration/ FARA Accountant), Rose Macauley (RBHS), Vamsi Vasireddy (RBHS), J. Mehnmon Tokpa (RBHS), Catherine Gbozee (RBHS), Marietta Yekee (RBHS), William Zazay (RBHS)

Building blocks	Max	Score	%
1. Essential Health Services	28	9	32%
2. Workforce	16	8	50%
3. Information Systems	16	7	44%
4. Essential Medicines	12	5	42%
5. Finance Systems	12	3	25%
6. Governance & Leadership	16	4	25%
Overall score	100	36	36%



Lofa County's score is the lowest of the three counties assessed and doesn't score above 50% in any of the areas assessed. While the strong and weak building blocks are essentially the same across all three counties, Lofa CHSWT was assessed to have the lowest capacity in Building Block 6: Governance and Leadership. Conflicts within the CHSWT and a lack of clear HR procedures are likely impacting the CHSWT's capacity in all five other areas. Detail on each building area follows. For more information on Lofa County's scoring please see Annex 4.3: the Lofa County Dashboard.

3.3.2 Building Block 1: Delivering Essential Health Services

Score: 9 out of 28 (32%)

Indicator 1.1: Capacity of CHSWTs to engage with Central MOHSW and Health Facilities in delivering the health and social welfare services

The assessment demonstrates that the interaction between the CHSWTs and Central MOHSW needs to be improved. Lofa CHSWT scored 2 out of 4 possible points on this standard. Interaction between the CHSWT and health facilities is better (3 out of 4 points). The Lofa CHSWT convenes regular stakeholder meetings including with CHDCs. From these meetings, community projects have been developed to expand some existing health facilities to include staff accommodations. Health facility supervision is conducted regularly using the national tools. However, the Lofa CHSWT noted challenges with conducting supervision that included only one clinical supervisor for 57 facilities, and interruptions from Central level activities.

Indicator 1.2: Capacity of CHSWTs to ensure appropriate use of policies and standards related to health service delivery for the EPHS areas and subareas

Lofa CHSWT scores poorly across all three standards for this indicator with zero capacity for safely disposing medical products; stating no policy exists. The CHSWT has made the new EPHS available through email, however only a few people have email access. As a result, most county staff know of the

EPHS but have not read it. The CHSWT has no plan to address the facility infrastructure problems in their County Plan, including facility size and/or missing pumps and incinerators. They noted that they need an infrastructure focal person who can work with Central MOHSW to coordinate construction and ensure completion and quality work by contractors.

Indicator 1.3: Capacity of CHSWTs to deliver health care in priority areas

Lofa scores poorly on this standard mainly due to stock-outs of necessary medicines namely, malaria drugs and ITNs, vaccines and FP commodities as well as inadequate training for facility staff. Currently, the CHSWT does not have focal persons for NMCP and NECP. At the community level, the CHSWT noted accomplishments in increasing facility-based deliveries through TTM referrals, establishing CHDC formation for most health facilities and ensuring an adequate number of gCHVs based on catchment population size.

3.3.3 Building Block 2: Health Workforce

Score: 8 out of 16 (50%)

Indicator 2.1: Capacity of CHSWT in workforce recruitment and deployment

Lofa CHSWT received top scores for its capacity to recruit health workers and staff facilities. Eighty to eighty-five percent of facilities are fully staffed per EPHS requirements.

Indicator 2.2: Capacity of the CHSWT to strengthen existing health workforce

Alternatively, Lofa CHSWT received zero scores on its capacity to review staff performance and coordinate existing staff development through in-service training. While each position has a job description, there are currently no mechanisms in place to review guidelines and staff performance. When a problem arises, the CHSWT uses the Civil Service Agency (CSA) guidelines to warn, transfer or dismiss staff. The CHSWT noted that in-service trainings are based on what Central MOHSW, the vertical programs and implementing partners decide to provide. The CHSWT does not maintain a database for trainings. The CHSWT conducts supervision visits to develop staff performance; however, supervisors were noted to need training and only verbal feedback is given post supervision visits.

A detailed list of trainings requested by Lofa CHSWT to strengthen their workforce is listed in Annex 4.7. Priority training areas have been identified and action will be taken based upon agreed-upon priorities.

3.3.4 Building Block 3: Health Information Systems (HIS)

Score: 7 out of 16 (44%)

Indicator 3.1: Capacity of the CHSWT to plan for and systematically collect health information

The Lofa CHSWT needs improvement managing HMIS data. While the CHSWT scores well (3 out of 4 points) in collecting the data, the roll out of HMIS forms and policies as well as reporting the collected data scores lower (2 out of 4 points).

Indicator 3.2: Capacity of CHSWT to promote evidence-based decisions and policy making

Lofa scores a zero on its capacity to use collected data for evidence-based planning. Currently no data is used for making decisions at the CHSWT level.

A detailed assessment of HIS in Lofa County and at the facility level will be issued under the PRISM assessment report.

3.3.5 Building Block 4: Access to Essential Training Medicines

Score: 5 out of 12 (42%)

Indicator 4.1: Capacity of CHSWT to ensure access to essential medicines for the county

Lofa CHSWT received the top score for estimating and requisitioning essential medicines (4 out of 4 points), however their capacity to use LMIS, and store and distribute commodities is very low (0 and 1 out of 4 points). The CHSWT counts amongst its accomplishments strict enforcement of the Supply Chain Master Plan SOPs, yet describes challenges distributing drugs due to Central MOHSW distribution schedules and transportation constraints.

3.3.6 Building Block 5: Health Systems Financing

Score: 3 out of 12 (25%)

Indicator 5.1 Capacity of CHSWT to formulate, distribute and monitor financing for the health sector

Lofa CHSWT scores one point for each of the standards in Health Systems Financing demonstrating significant capacity constraints in budgeting and effectively distributing and monitoring finances. The CHO, CHSA and Accountant manage the budget, reviewing it every 3 months. Budget information is not shared with other members of the CHSWT and there is no system in place to track spending. Lofa CHSWT had a good understanding of PBC but suggested they needed technical help and training in order to effectively implement it. The CHSWT identified Central MOHSW allotted funding as one of its major financing challenges. They stated that the allocated funding was generally not based on the CHSWT needs, was often not paid on time and sometimes was not paid at all.

3.3.7 Building Block 6: Governance and Leadership

Score: 4 out of 16 (25%)

Indicator 6.1: Capacity of CHSWT to implement activities aimed at improving the health of all people within the county

Lofa CHSWT scores the lowest out of the three counties in Governance and Leadership. Only 4 members of the CHSWT are familiar with the NHSWPP.

Indicator 6.2: Capacity of CHSWT to communicate and share best practices with the Central MOHSW and with other CHSWTs

While the Lofa CHSWT scores a zero in implementing the NHSWPP, they do slightly better in their capacity to communicate with Central MOHSW and DHSWTs. The CHSWT conducts regular integrated supervision at 15 health facilities each month. Verbal feedback is given to facilities along with irregular written reports. However, there are no regularly scheduled meetings with the DHSWTs and/or the facilities. There are regular coordination meetings with the county-implementing partners. THE CHSWT has made great strides in managing facility-based staff, the number of whom has increased to 191 from a baseline of 45. They state that all staff are now paid on time despite difficulties accessing the bank and that PBC bonuses have been used to renovate facilities. The CHSWTs low score in this area, including taking responsibility and ownership for their county health system, can be explained by ongoing challenges including a lack of respect for OIC authority, a lack of management training for OICs, no HR policy, no clear channels of communication within the CHSWT and externally, and inadequate CHSWT collaboration with partners.

3.4 NIMBA COUNTY

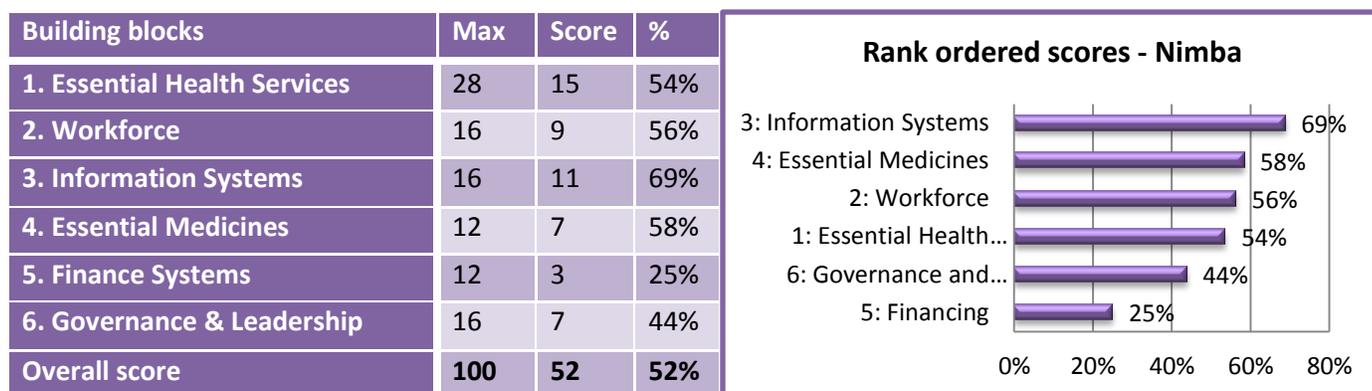
NIMBA			
	Total Points Available	Points Received	Percentage Score
BUILDING BLOCK 1			
TOTAL SCORE	28	15	54%
Extent of interaction between CHSWTs and Central MOHSW	4	2	50%
Extent of Interaction between CHSWTs and Health Facilities	4	3	75%
Capacity of CHSWTs to Supervise Health Facilities in the Use of Health Service Delivery Standards	4	3	75%
Number of operational public health facilities as compared to those projected in the National Health and Social Welfare Plan	4	2	50%
Capacity of CHSWT to safely handle and dispose of medical products and bi-products	4	2	50%
Capacity of CHSWT to implement programs developed by the Division of Health Services at the Central MOHSW level	4	2	50%
Capacity of CHSWT to address community health needs	4	1	25%
BUILDING BLOCK 2			
TOTAL SCORE	16	9	56%
Ability to recruit human resources for health worker positions	4	3	75%
Capacity of the CHSWT to staff health facilities as per National Staffing Guidelines	4	2	50%
Capacity to review staff performance	4	1	25%
Capacity of CHSWTs to coordinate capacity development of health staff	4	3	75%
BUILDING BLOCK 3			
TOTAL SCORE	16	11	69%
Capacity of the CHSWT to roll out HIS policies and forms	4	3	75%
Capacity of CHSWT to collect health data	4	3	75%
Capacity of CHSWT to report health data to the MOHSW and back to health facilities	4	3	75%
Capacity of CHSWT to use collected data for planning and policy making	4	2	50%
BUILDING BLOCK 4			
TOTAL SCORE	12	7	58%
Capacity of the CHSWT to estimate commodity needs and request these commodities from the Central MOHSW	4	2	50%
The CHSWT's capacity to use a Logistics Management Information System (LMIS)	4	2	50%
CHSWT's capacity to effectively store and distribute commodities	4	3	75%
BUILDING BLOCK 5			
TOTAL SCORE	12	3	25%
CHSWT capacity to plan for, create and allocate a sustainable budget	4	2	50%
Capacity of CHSWT to effectively distribute finances	4	1	25%
Capacity of CHSWT to monitor finances at the County and facility levels	4	0	0%
BUILDING BLOCK 6			
TOTAL SCORE	16	7	44%
Capacity of CHSWT to implement the National Health and Social Welfare Policy and Plan	4	2	50%
Capacity to communicate and share reports, documents and plans with the Central MOHSW and other CHSWTs	4	2	50%
Capacity of the CHSWT to lead and engage with DHSWT and health facilities	4	1	25%
Capacity of CHSWT to hold responsibility and ownership for the health system within their county	4	2	50%

3.4.1 Overview

Score: 52 out of 100

Assessment Dates: April 5 and 6, 2012

Assessment Team Members: Oliver Pratt (MOHSW Health Services), Justin Korvayan (MOHSW Planning), Shelford Somwarbi (MOHSW Administration), Theo Lippeveld (RBHS), Vamsi Vasireddy (RBHS), J. Mehnmon Tokpa (RBHS), Teah Doegmah (RBHS), Luogon Willie-Paye (RBHS).



Nimba CHSWT was assessed as having the highest scoring capacity of the three counties. They scored significantly higher than the other counties in Building Block 3: Health Information Systems (69% as compared to 44%), making it their top scoring area. Similar to the other CHSWTs, Building Block 5: Health System Financing presented their biggest challenge with a score of 25%.

3.4.2 Building Block 1: Delivering Essential Health Services

Score: 15 out of 28 (54%)

Indicator 1.1: Capacity of CHSWTs to engage with Central MOHSW and Health Facilities in delivering the health and social welfare services

The assessment demonstrates that the interaction between the CHSWTs and Central MOHSW needs to be improved. Nimba CHSWT scored 2 out of 4 possible points on this standard noting that while interaction occurs several times each year, it is not coordinated. Interaction between the CHSWT and health facilities is better (3 out of 4 points). The CHSWT noted that while the county planning process was highly participatory on both sides, the CHSWT continues to rely heavily on Central MOHSW for procurement, logistics and human resource management. Specific examples included low procurement threshold amounts, the inability to service vehicles in county and the inability to terminate staff at the county level. The county scores are higher for interactions at the health facility and community levels. The County Health Board is dormant, described as a result of politics.

Indicator 1.2: Capacity of CHSWTs to ensure appropriate use of policies and standards related to health service delivery for the EPHS areas and subareas

While facility supervision is regular and comprehensive, the CHSWT stated that supervisors could use additional training. Like all of the counties, feedback is verbal and not written and the number of facilities plus long distances means one clinical supervisor cannot supervise all facilities monthly. Approximately 75% of the 63 facilities are reached each month. The CHSWT noted that the feedback mechanism to Central MOHSW needs to be strengthened and implementing partners should help to

distribute tools and guidelines to health facilities. While new Service Delivery Points have been built in Nimba, all are private. Those projected in the County Plan have not yet been developed. Finally, while the Nimba CHSWT recognizes there is a policy for safe disposal of medical waste, they have not implemented it yet.

Indicator 1.3: Capacity of CHSWTs to deliver health care in priority areas

While the Nimba CHSWT is aware of the targets for each EPHS program, they identified a number of challenges at the facility level, reflective of their score (2 out of 4 points). Primarily these challenges include high staff turnover and resulting high in-service training needs, frequent stock-outs especially of malaria commodities, no focal person for the NLTCP and limited TB diagnostic centers. At the community level, implementing partners have done health assessments but the CHSWT was not part of the process.

3.4.3 Building Block 2: Health Workforce

Score: 9 out of 16 (56%)

Indicator 2.1: Capacity of CHSWT in workforce recruitment and deployment

As compared to the other counties, Nimba CHSWT's scores for its capacity to recruit health workers and staff facilities are low. The CHSWT is currently recruiting additional staff for facilities with high utilization.

Indicator 2.2: Capacity of the CHSWT to strengthen existing health workforce

Like the other counties, Nimba CHSWT received a low score (1 out of 4 points) on its capacity to review staff performance. However, unlike the other counties, Nimba performed well (3 out of 4 points) on coordinating existing staff development through in-service training. Performance appraisal forms are available but are currently not being used by the CHSWT or partners. The CHSWT noted that, in addition to not being able to review staff performance, they are also unable to take action for poor performance as dismissal is done by Central MOHSW. Usually warnings are issued by the CHSWT where necessary. There is no formal system to identify staff training needs and gaps. Most needs are identified through supervision visits. Most in-service training is implemented by partners.

Although Nimba CHSWT did not respond to multiple requests for training needs, the CAT was able to put together a list of trainings to strengthen their workforce based on our findings. The training needs, as identified by CAT, are listed in Annex 4.8.

3.4.4 Building Block 3: Health Information Systems (HIS)

Score: 11 out of 16 (69%)

Indicator 3.1: Capacity of the CHSWT to plan for and systematically collect health information

The Nimba CHSWT scores well, especially as compared to Bong and Lofa, for managing HMIS data. In all three areas (rolling out of policies and forms, collecting data and reporting) Nimba CHSWT scores 3 out of 4 points. Timely data collection from facilities is at approximately 90% with one exception; the hard to reach MOHSW-run facility is generally late.

Indicator 3.2: Capacity of CHSWT to promote evidence-based decisions and policy making

Nimba CHSWT uses monthly reports in which data is aggregated from the health facilities to determine the county priority health needs and activities. However, this does not seem to be translating into

planning, as there is no county workplan in use, other than the county operational plan. The CHSWT noted that collected data is not fully integrated and analysis of the data is minimal. The CHSWT recognizes the need to build capacity for data utilization in order to improve county performance.

A detailed assessment of HIS in Nimba County and at the facility level will be issued under the PRISM assessment report.

3.4.5 Building Block 4: Access to Essential Training Medicines

Score: 7 out of 12 (58%)

Indicator 4.1: Capacity of CHSWT to ensure access to essential medicines for the county

Nimba CHSWT receives consistent but low scores for estimating and requisitioning essential medicines and their capacity to use LMIS (2 out of 4 points). The CHSWT seems to depend heavily on implementing partners and does not have a formal plan for assessing commodity needs. Nimba is the only county with a depot pharmacist and this strength shows in their capacity to store and distribute commodities (3 out of 4 points), particularly when compared to Bong and Lofa. Like all of the CHSWTs, Nimba reports challenges distributing drugs due to inadequate and untimely supply from NDS as well as transportation constraints.

3.4.6 Building Block 5: Health Systems Financing

Score: 7 out of 12 (44%)

Indicator 5.1 Capacity of CHSWT to formulate, distribute and monitor financing for the health sector

Nimba CHSWT, like all three counties, has significant challenges in its capacity to budget as well as distribute and monitor finances. The CHSWT has low scores in all three areas with zero capacity to monitor finances at the County and health facility levels. The CHO, CHSA and Accountant manage the county budgeting, however no formal mechanism is in place and budget reviews are never conducted. Therefore, except for the three persons listed, no one in the CHSWT is aware of the budget or spending. While the CHSWT described improved transparency and accountability following Central MOHSW SOP distribution, they stated that budget allocation from Central MOHSW does not reflect county level needs and is often delayed. Further, they identified a main challenge as the Logistician who is unable to do their job effectively because they are not involved in some procurement processes, the Logistician serving a dual role at the CHSWT and hospital, and a need for improved skills in SCM and a formal tracking system. The Nimba CHSWT understands PBC but requested technical support in proposal writing, calculating and analyzing bed occupancy rates, and monitoring PBC indicators.

3.4.7 Building Block 6: Governance and Leadership

Score: 4 out of 16 (25%)

Indicator 6.1: Capacity of CHSWT to implement activities aimed at improving the health of all people within the county

Like all three counties, Nimba CHSWT has a two- and ten-year operational plan, developed with Central MOHSW. Nimba CHSWT was actively involved in creating the two-year county operational plan, but the plan is more of a position statement rather than an operational plan. While Nimba CHSWT has strong leadership in the form of a well-trained CHO, it still requires guidance from Central MOHSW in the area of operationalizing the two-year county plan.

Indicator 6.2: Capacity of CHSWT to communicate and share best practices with the Central MOHSW and with other CHSWTs

Nimba CHSWT again scores consistently low across all Governance and Leadership standards with their lowest performance area being their capacity to lead and engage with DHSWTs and health facilities. Much of the CHSWT interaction with health facilities is heavily dependent on their implementing partners whose collaboration they foster through monthly meetings. There is a significant problem between the CHSWT and Tappita Hospital in which the Hospital is reportedly not collaborating with the CHSWT and acting independently. Amongst many concerns, Tappita Hospital is not submitting their data to the CHSWT for monthly reporting. The CHSWT noted that its capacity to communicate with the health facilities through supervision is limited by inadequate funding (Nimba budget arguably should be greater than smaller counties), many outstanding facility rehabilitation projects, and a very large geographic area.

3.5 PROVISIONAL RECOMMENDATIONS FOR CHSWTs

Building Block 1: Delivering Essential Health Services

Individual:

- Orient staff on EPHS.
- Train supervisory staff to provide written feedback to the people they are supervising.

Organizational:

- Orient the supervisors towards EPHS policies, plans, and targets.
- Organize quarterly meetings with Central MOHSW to share key information on PBC indicator data, exchange feedback, and discuss action items.
- Organize monthly meetings between CHSWTs and Health Facilities where key information on PBC indicators is shared, feedback is exchanged, and action items are discussed.
- Lofa CHSWT: Recruit additional supervisors.

Health system:

- Implement a system of written feedback for supervision conducted at health facilities.
- Seek adequate technical expertise in supervisory areas from Central MOHSW.
- Enforce a comprehensive medical waste disposal policy at CHSWT level.

Building Block 2: Health Workforce

Individual:

- Address training needs identified for respective counties (see Annexes 4.6, 4.7 and 4.8 for training needs).

Organizational:

- Review job descriptions at facility level, and discipline and dismiss incompetent staff as needed.
- Bong CHSWT: Reorganize the organogram to delegate responsibilities to supervisors.

Health System:

- Develop a CHSWT-specific performance management system to provide consistent supportive feedback to CHSWT and Health Facility staff.
- Create a reserve pool of qualified staff who can serve in health facilities during times of need.
- Lead the entire system of in-service training, including identifying appropriate staff for training, identifying training needs, and determining the training schedule.

Building Block 3: Health Information Systems

Individual:

- Train all relevant staff on using DHIS 2.4.
- Train M&E staff, senior CHSWT management, OICs, and DHOs on using data for decision-making.

Organizational:

- Improve accuracy of data collection and provide written feedback on data collection at facility level.
- Bong CHSWT: Hire a competent M&E officer and train the existing data manager (the hiring mechanism seems to be in process).

Health System:

- Strengthen CHSWT capacity to conduct population- and facility-based surveys.
- Link HMIS with LMIS, HRIS, and financial databases.

Building Block 4: Access to Essential Medicines

Individual:

- Train CHSWT and Health Facility staff on using LMIS.

Organizational:

- Address issues in each CHSWT with warehouse storage.

Health System:

- Roll out LMIS completely at CHSWT level.
- Clarify the Central MOHSW process of commodity distribution to CHSWTs in order to avoid mistrust and confusion.

Building Block 5: Health Systems Financing

Individual:

- Orient all CHSWT staff to the PBC mechanism.
- Train the CHSWT staff on tracking financial and expenditure data, and managing budgets.
- Address CHSWT-specific financial training needs (see training needs for each CHSWT in Annexes 4.6, 4.7, and 4.8).

Organizational:

- Integrate funding for vertical programs into CHSWT budget in order to avoid confusion and fragmentation.

Health System:

- Redesign the CHSWT financial management system to manage budgets, expenditures, and projections, and link the financial data to HMIS data.

Building Block 6: Governance and Leadership

Individual:

- Train staff on vehicle management.
- Train health facility workers to work with implementing partners.

Organizational:

- Establish clear lines of responsibility for supervision.
- Develop CHSWT-specific communication strategies and plans to guide and promote communication and collaboration between CHSWTs, Central MOHSW, and implementing partners.

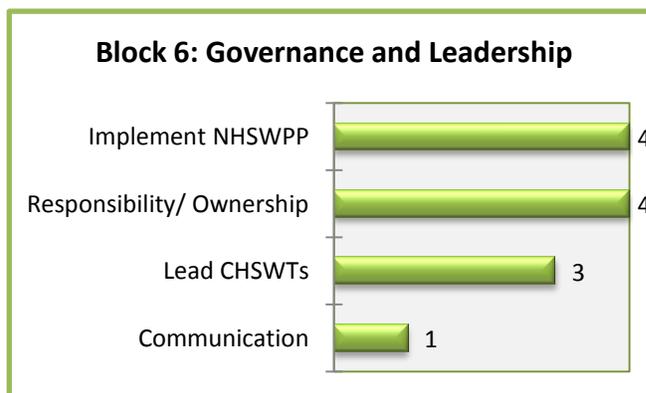
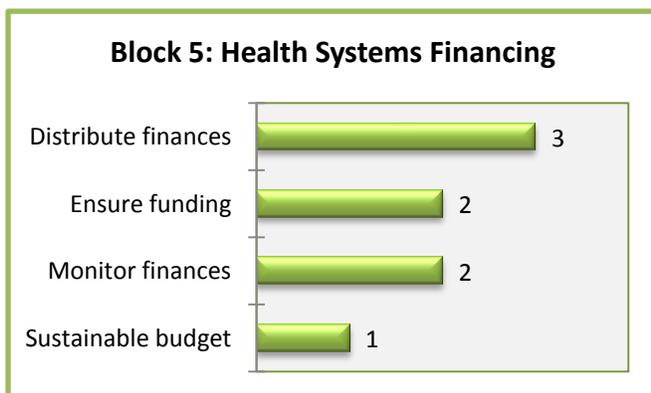
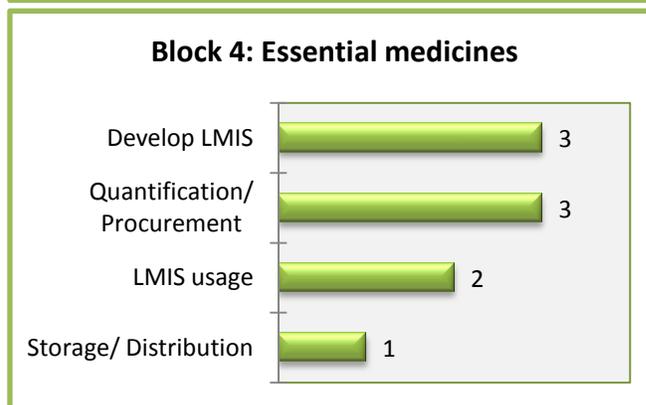
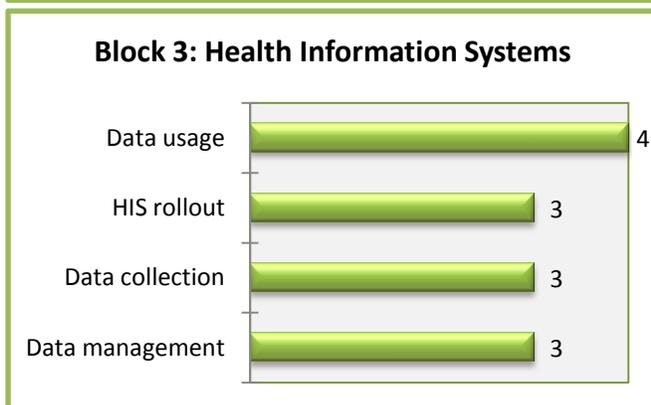
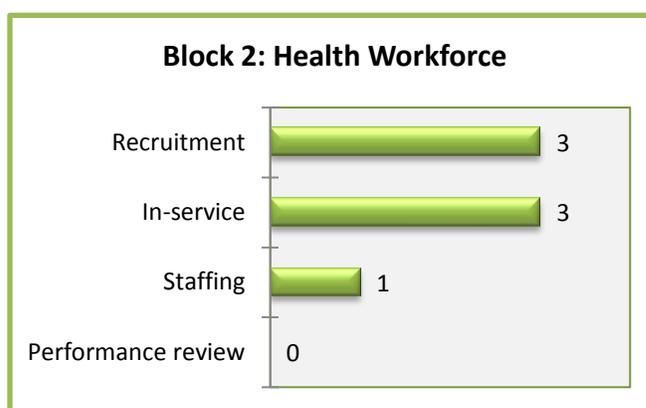
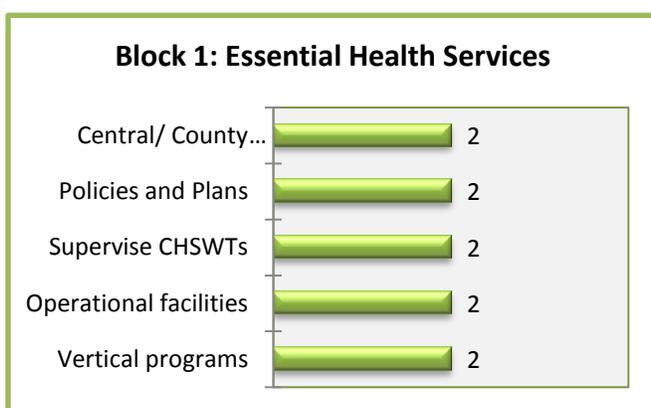
Health System:

- Engage the County governments and County Health and Social Welfare Boards in areas of oversight and overall guidance.
- Bong CHSWT: Delegate responsibility instead of concentrating.

4.0 ANNEXES

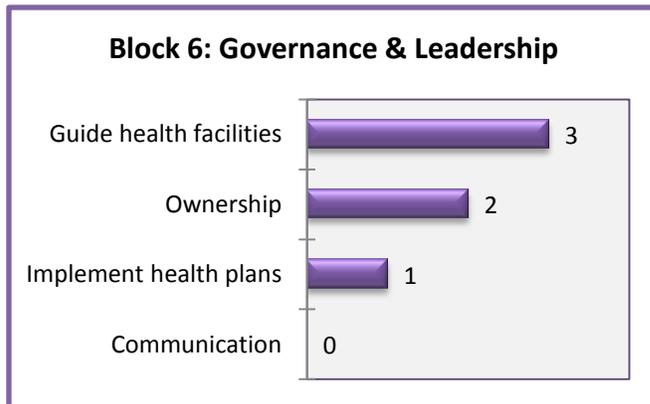
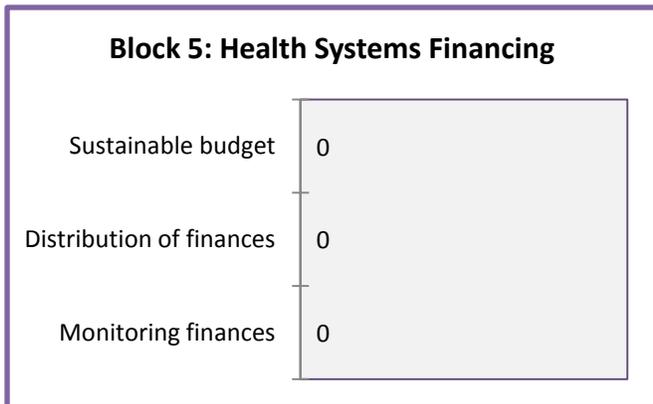
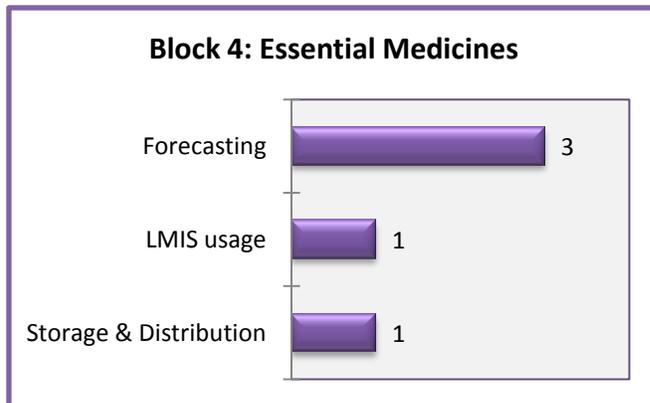
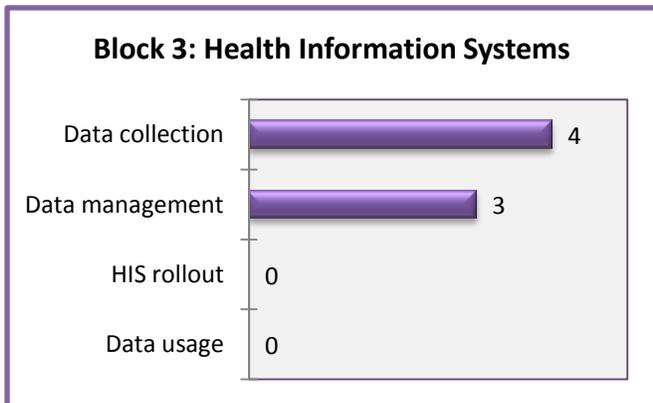
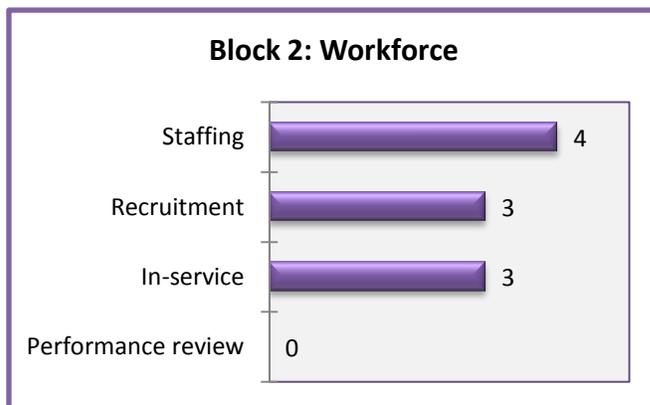
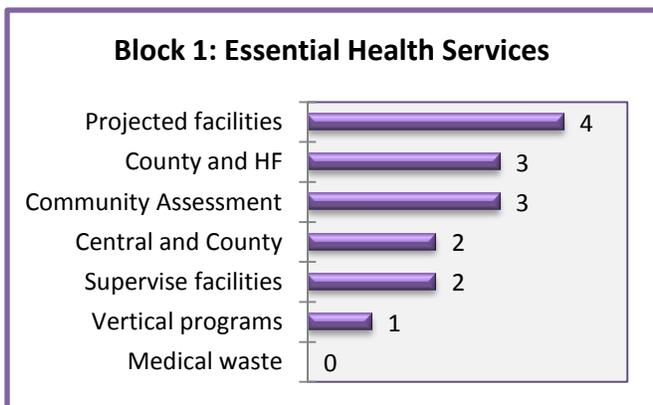
4.1 CENTRAL MOHSW DASHBOARD

	Total Points Available	Points Received	Percentage Score
TOTAL SCORE	100	59	59%
1: Delivering Essential Health Services	20	10	50%
2: Health Workforce	16	17	44%
3: Health Information Systems	16	13	81%
4: Access to Essential Medicines	16	9	56%
5: Health Systems Financing	16	8	50%
6: Governance and Leadership	16	12	75%



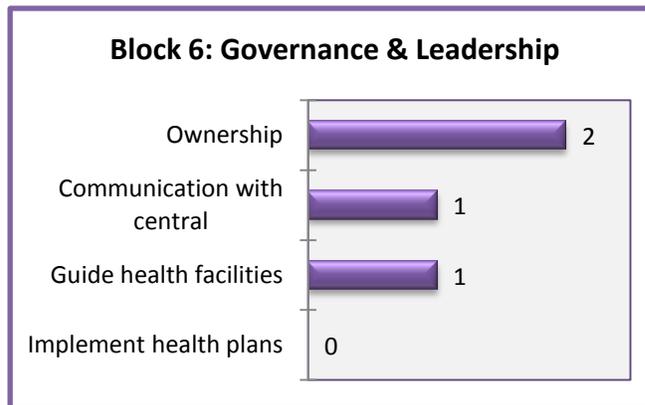
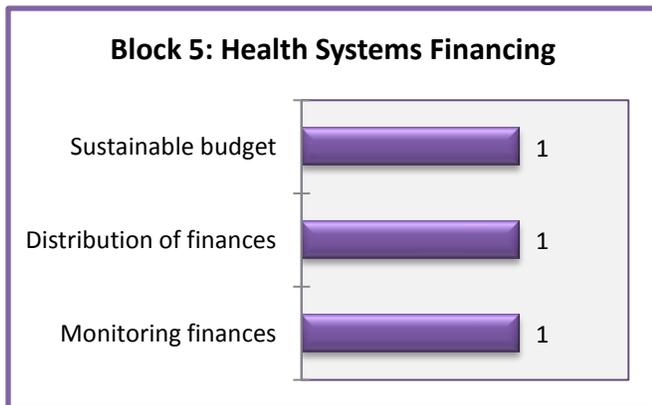
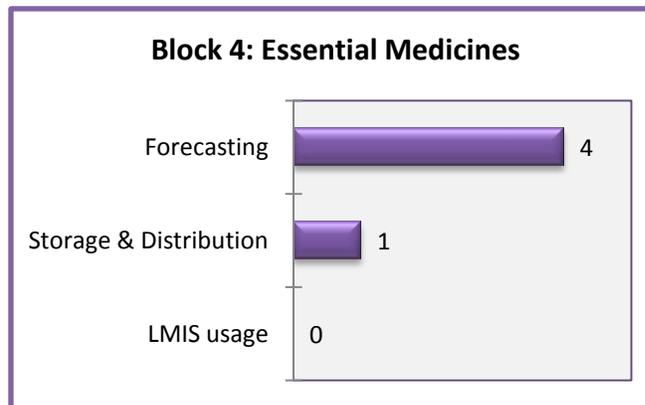
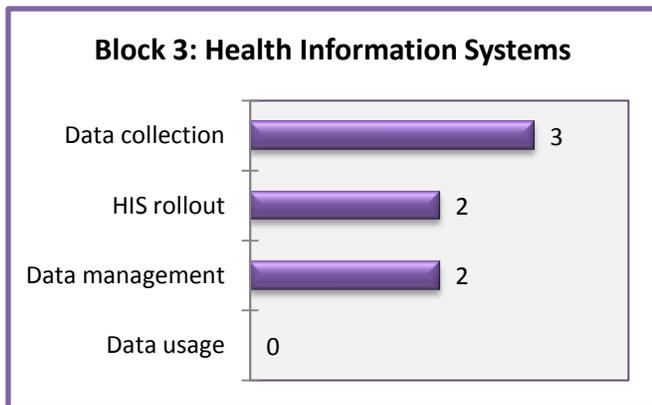
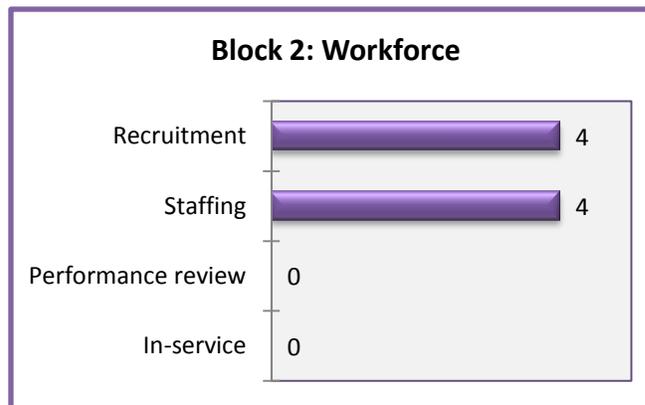
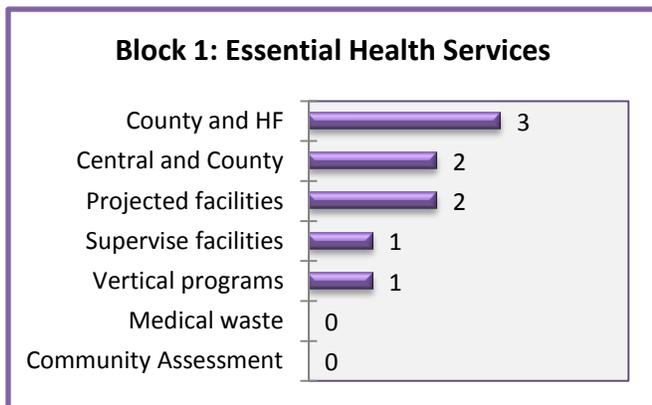
4.2 BONG COUNTY DASHBOARD

	Total Points Available	Points Received	Percentage Score
TOTAL SCORE	100	43	43%
1: Delivering Essential Health Services	28	15	54%
2: Health Workforce	16	10	63%
3: Health Information Systems	16	7	44%
4: Access to Essential Medicines	12	5	42%
5: Health Systems Financing	12	0	0%
6: Governance and Leadership	16	6	38%



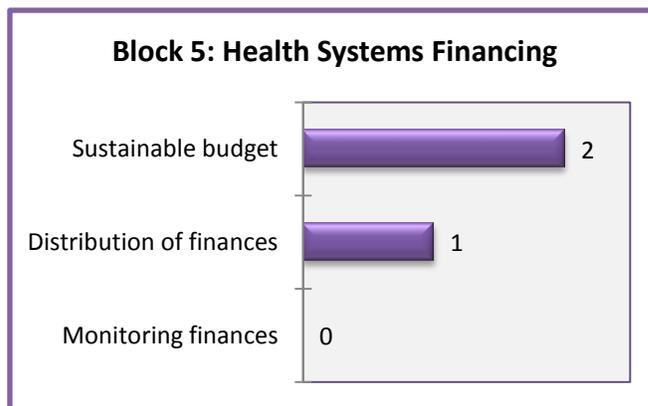
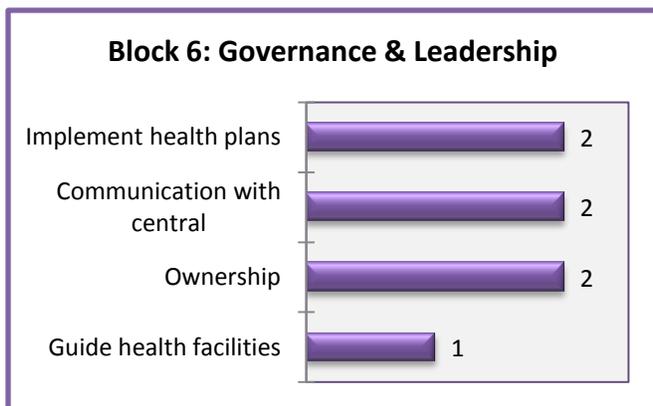
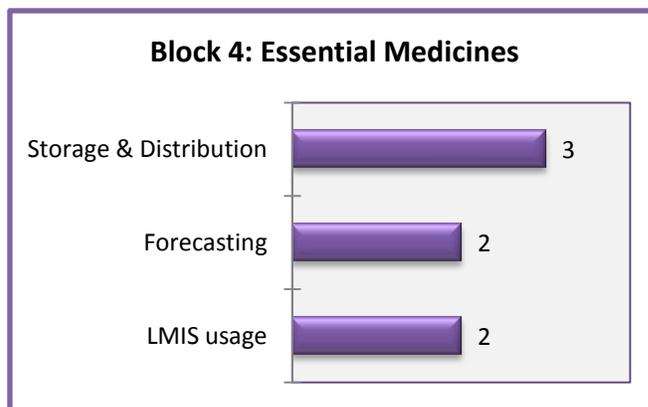
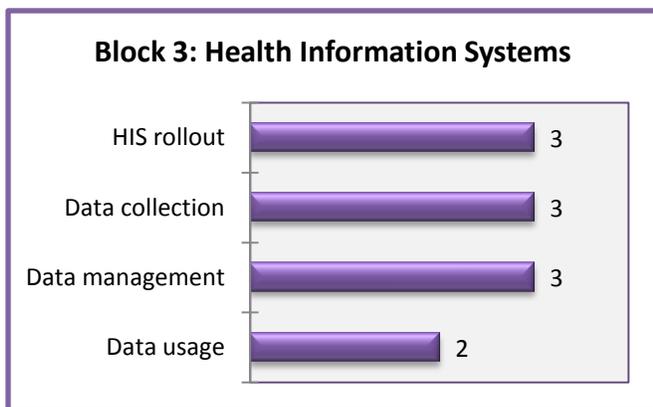
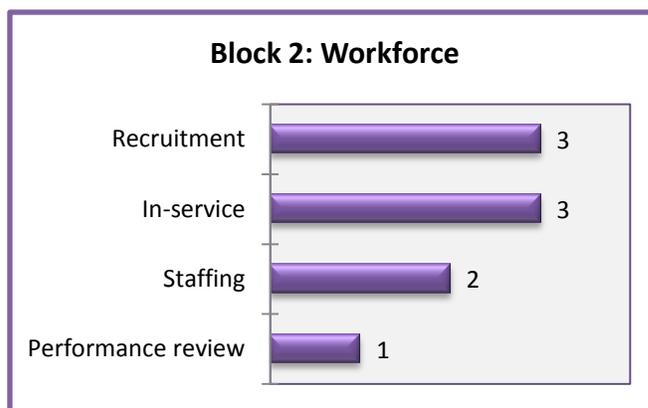
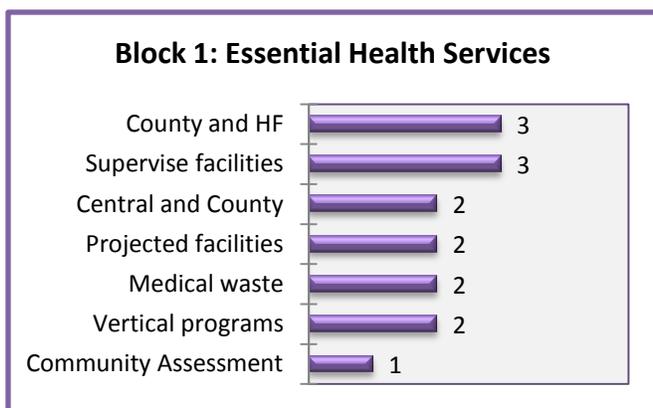
4.3 LOFA COUNTY DASHBOARD

	Total Points Available	Points Received	Percentage Score
TOTAL SCORE	100	43	43%
1: Delivering Essential Health Services	28	9	32%
2: Health Workforce	16	8	50%
3: Health Information Systems	16	7	44%
4: Access to Essential Medicines	12	5	42%
5: Health Systems Financing	12	3	25%
6: Governance and Leadership	16	4	25%



4.4 NIMBA COUNTY DASHBOARD

	Total Points Available	Points Received	Percentage Score
TOTAL SCORE	100	43	43%
1: Delivering Essential Health Services	28	15	54%
2: Health Workforce	16	9	56%
3: Health Information Systems	16	11	69%
4: Access to Essential Medicines	12	7	58%
5: Health Systems Financing	12	3	25%
6: Governance and Leadership	16	7	44%



4.5 CENTRAL MOHSW TRAINING NEEDS

Training area	Target staff	Priority
Financial management	Department of Administration	
LMIS roll out	SCM	
TTM training manuals	Family Health Division	
Adolescent Sexual and Reproductive Health	Family Health Division	
Clinical Management of Rape (CMR)	Family Health Division	
IMNCI	Family Health Division	
Life Saving Skills (LSS)	Family Health Division	
Leprosy training for health workers	NLTCP	
MDR TB Case management	NLTCP	
Lab tech training in AFB staining	NLTCP	
Community based TB/ Leprosy management	NLTCP	
M&E training for TB/ Leprosy focal persons	NLTCP	
Financial management training	NLTCP	
Data management	NMCP	
Operational research skills	NMCP	
Micronutrient training	Nutrition Division	
Nutrition specialist (nutrition degree)	Nutrition Division	
Management of training programs	Training Unit	
Developing EPHS training modules	Training Unit	
Training of HP focal persons in Counties	Health Promotion Unit	
M&E training	Health Promotion Unit	
Community planning and mobilization	Health Promotion Unit	
Master ToT	Community Health Services	
Working with Communities (WWC)	Community Health Services	
Project management, development and report writing	Community Health Services	
Case management	Neglected Tropical Diseases	
Preventive chemotherapy	Neglected Tropical Diseases	
M&E training	Neglected Tropical Diseases	
Alcohol, substance abuse, rehabilitation	Mental Health	
Management of psychotropic drugs	Mental Health	
Case management of mentally ill	Mental Health	
HIV Care in Pediatrics	NACP	
Quality chronic care services	NACP	
Adherence counseling	NACP	
In-service for ophthalmic nurses	NECP	
Community ophthalmology	NECP	
Cataract training for ophthalmic nurses	NECP	
Water quality testing	Environmental Health Division	
Food safety	Environmental Health Division	
Health waste management	Environmental Health Division	
Construction standards	Infrastructure Unit	

4.6 BONG CHSWT TRAINING NEEDS

Training area	Target staff	Priority
Procurement/ Logistics	Logistician, Accountant, CHSA	1
Leadership training skills	Clinicians and supervisors	2
Data management	Data manager, M&E officer, Clinicians, DHOs, and Supervisors	1
Supervision skills	All Supervisors	1
Financial management	Accountant, CHSA, CHO	1
Results-based management	All senior management	1
IMNCI/ Community IMNCI	Supervisors and Clinicians	1
TB/ Leprosy Case management	Supervisors and Clinicians	2
Malaria Case Management	Supervisors and Clinicians	2
HIV/ AIDS (PMTCT, HCT) care treatment	Supervisors and Clinicians	2
EPI	Vaccinators and Clinicians	2
Maternal Health (BLSS, FP Counseling, PNC)	Supervisors and CM	2
Clinical Management of Rape	Clinicians and registrars	2
Quality Assurance	Supervisors	2
Integrated management of malnutrition	Clinicians and registrars	2
Solar fridge maintenance	Cold chain technicians	3
IEC/BCC Strategies	Supervisors, DHOs, Clinicians, gCHVs, Health promotion focal persons	3
Community Case management	gCHVs	3
Community based family planning	TTMs and RH supervisors	3
Community mobilization	Supervisors and DHOs	3
STI management	Supervisors and Clinicians	3

4.7 LOFA CHSWT TRAINING NEEDS

Training area	Target staff	Priority
Data management including analysis and presentation	M&E staff, supervisors, DHOs	1
Performance-based contracting and target setting	All senior management	1
IMNCI	Supervisors and Clinicians	1
Malaria Case Management	Supervisors and Clinicians	1
Family Planning	Supervisors and Clinicians	1
Maternal Health (BLSS, FP Counseling, PNC)	Supervisors and CM	1
EmONC	CM and RH supervisor	1
EPI – vaccine management	Supervisors and vaccinators	1
RED/ REP approach strategies	Supervisors and vaccinators	1
HR database management	CHSA, Accountant	1
Vehicle management	Logistician, Accountant, and CHSA	1
Essential Nutrition Action	Supervisors and Clinicians	2
HIV/ AIDS (PMTCT, HCT) care treatment	Supervisors and Clinicians	2
TB/ Leprosy case management	Supervisors and Clinicians	2
Infant resuscitation	Supervisors, clinicians, and CM	2
Counseling for survival of post conflict trauma	Social Welfare supervisor	2
Sexual and gender based violence	Social Welfare supervisor, CM, and RH supervisor	2
LMIS	Pharmacist, Drug Depot focal person, Logistician, all vertical program focal persons, M&E staff	2
Logistics/ procurement	Logistician, Accountant, and CHSA	2
Leadership skills	All senior management	2
Medical waste management	CHSA, CHDD, supervisors, and clinicians	3
Performance management	All senior management	3
Driving	Drivers	3

4.8 NIMBA CHSWT TRAINING NEEDS

Although Nimba CHSWT did not respond to multiple requests for training needs, the CAT was able to put together a proposed training needs list based on findings during the assessment.

Training area	Target staff	Priority
Procurement/ Logistics	Logistician, Accountant, CHSA	1
Data management	Data manager, M&E officer, Clinicians, DHOs, and Supervisors	1
Supervision skills	All Supervisors	1
Financial management	Accountant, CHSA, CHO	1
IMNCI/ Community IMNCI	Supervisors and Clinicians	1
TB/ Leprosy Case management	Supervisors and Clinicians	1
Malaria Case Management	Supervisors and Clinicians	1
HIV/ AIDS (PMTCT, HCT) care treatment	Supervisors and Clinicians	1
EPI	Vaccinators and Clinicians	1
Maternal Health (BLSS, FP Counseling, PNC)	Supervisors and CM	1
Vehicle management	CHSA and Accountant	1
Leadership training skills	Clinicians and supervisors	2
Quality Assurance	Supervisors	2
Community Case management	gCHVs	2
Community based family planning	TTMs and RH supervisors	2
Community mobilization	Supervisors and DHOs	3

Capacity Assessment – Quantitative Instrument Central MOHSW level

Introduction and Instructions

This tool was developed by the Liberia Ministry of Health and Social Work (MOHSW) with technical assistance from Rebuilding Basic Health Services (RBHS). Its purpose is to help the MOHSW determine priority areas for capacity building to help strengthen the Liberian health system. The tool is based on the World Health Organization (WHO) Health Systems Framework that focuses on six building blocks of a health system.

Use of the tool is meant to be collaborative in nature, with members of the assessment team working through each component of the tool together. A copy of the tool should be shared with all assessment participants ahead of time, to help participants prepare for the assessment (i.e., to have a sense of what questions will be discussed, and to locate any relevant documents that will be useful in answering the questions). During the assessment process, participants from the MOHSW, and the RBHS should read through the response options under each standard (component) together, and through discussion, come to a consensus on the appropriate score to assign for each standard.

The tool is meant to be used in conjunction with the qualitative interview guide, and has similar tools available for use at the County level.

Capacity Assessment – Quantitative Instrument Central MOHSW Level

Summary Scoring

Capacity Building Assessment Quantitative Tool – Central MOHSW		Score
Building Block 1: Delivering Essential Health Services		/20
Indicator 1.1: Capacity of central MOHSW to engage CHSWTs in delivering health and social welfare services		
	Standard 1.1.1: Extent of interaction between the central MOHSW and CHSWTs	/4
	Standard 1.1.2: Capacity of the central MOHSW to develop and distribute (to the CHSWTs) policies, plans, and standards for key health areas	/4
Indicator 1.2: Capacity of central MOHSW to ensure appropriate use of policies and standards related to health service delivery for the Essential Package of Health Services (EPHS) areas and subareas		
	Standard 1.2.1: Capacity of central MOHSW to supervise CHSWTs in the use of health service delivery standards	/4
	Standard 1.2.2: Number of operational public health facilities as compared to those projected in the National Health and Social Welfare Plan	/4
Indicator 1.3: Capacity of central MOHSW to deliver health care in priority areas		
	Standard 1.3.1: Capacity of central MOHSW to develop and implement priority health programs	/4
Building Block 2: Health Workforce		/16
Indicator 2.1: Central MOHSW capacity in workforce recruitment and deployment		
	Standard 2.1.1: Ability to recruit human resources for health worker positions	/4
	Standard 2.1.2: Capacity of central MOHSW to staff health facilities as per national staffing guidelines	/4
Indicator 2.2: Capacity of central MOHSW to strengthen the existing health workforce		
	Standard 2.2.1: Capacity of central MOHSW to review health worker staff performance	/4
	Standard 2.2.2: Capacity of central MOHSW to coordinate capacity development of health staff	/4
Building Block 3: Health Information Systems (HIS)		/16
Indicator 3.1: Capacity of central MOHSW to plan for and systematically collect health information		
	Standard 3.1.1: Capacity of central MOHSW to develop and roll out HMIS policies and forms	/4
	Standard 3.1.2: Capacity of central MOHSW to collect quality data	/4
	Standard 3.1.3: Capacity of central MOHSW to manage data	/4
Indicator 3.2: Capacity of central MOHSW to promote evidence-based decisions and policy making		
	Standard 3.2.1: Capacity of central MOHSW to use collected data for planning and policy making	/4
Building Block 4: Access to Essential Medicines		/16

Indicator 4.1: Capacity of central MOHSW to ensure access to essential medicines for the population		
	Standard 4.1.1: Capacity of the central MOHSW to develop a Logistics Supply Chain Master Plan	/4
	Standard 4.1.2: Central MOHSW's capacity to estimate commodity needs, develop a supply plan and procure/source these commodities	/4
	Standard 4.1.3: Central MOHSW's capacity to develop and use a Logistics Management Information System (LMIS)	/4
	Standard 4.1.4: Central MOHSW and CHSWT's capacity to effectively store and distribute commodities	/4
Building Block 5: Health Systems Financing		/16
Indicator 5.1: Capacity of the central MOHSW to ensure that adequate funds are allocated to health expenditures within the overall Government of Liberia budget		
	Standard 5.1.1: Capacity of the central MOHSW to ensure that adequate funds from the total government budget are allocated to health and social welfare	/4
Indicator 5.2 Capacity of central MOHSW to formulate, distribute, and monitor financing for the health sector		
	Standard 5.2.1: Capacity of central MOHSW to plan for, create and allocate a sustainable budget	/4
	Standard 5.2.2: Capacity of central MOHSW to effectively distribute finances	/4
	Standard 5.2.3: Capacity of central MOHSW to monitor finances at the National and County levels	/4
Building Block 6: Governance and Leadership		/16
Indicator 6.1: Capacity of central MOHSW to lead efforts aimed at improving the health of all Liberians		
	Standard 6.1.1: Capacity of central MOHSW to develop and implement a National Health Policy and Plan	/4
Indicator 6.2: Capacity of central MOHSW towards intra and inter agency communication		
	Standard 6.2.1: Capacity of central MOHSW to communicate within the central MOHSW and other Ministries within the Government of Liberia	/4
	Standard 6.2.2: Capacity of the central MOHSW to lead and engage with CHSWTs	/4
	Standard 6.2.2: Capacity of central MOHSW to hold responsibility and ownership for the health system	/4
TOTAL SCORE		/100

Questions by Building Block⁹

Building Block 1: Delivering Essential Health Services

Indicator 1.1: Capacity of central MOHSW to engage County Health and Social Welfare Teams (CHSWTs) in delivering health and social welfare services

Standard 1.1.1: Extent of interaction between the central MOHSW and CHSWTs	
0	No interaction with CHSWTs.
1	Central MOHSW interacts at least once a year with CHSWTs, but only on budget-related activities.
2	Central MOHSW interacts at least once a year with CHSWTs on budget and other health service planning activities.
3	Central MOHSW interacts at least once a year with CHSWTs on budget and other health service planning activities, and maintenance and coordination of facilities.
4	Central MOHSW interacts multiple times a year with CHSWTs on budget and other health service planning activities, maintenance and coordination of facilities, and assessing and planning community health needs.
Comments:	

Standard 1.1.2: Capacity of central MOHSW to develop and distribute (to the CHSWTs) policies, plans and standards for key health areas	
0	No National Health Plan exists.
1	Central MOHSW has a National Health Care Plan, but clinical standards for key areas within the EPHS have not been developed.
2	Central MOHSW has clinical standards and they have been distributed to CHSWTs.
3	Central MOHSW has clinical standards that have been distributed to CHSWTs, and trained at least 50% of CHSWTs on at least 50% of the EPHS subareas ¹⁰ within the last two years.
4	Central MOHSW has clinical standards that have been distributed to CHSWTs, and trained at least 80% of CHSWTs on at least 80% of the EPHS subareas within last two years.
Comments:	

⁹ The five building blocks included in this tool are taken from the World Health Organization's six Building Blocks of a Health System (see <http://www.who.int/healthinfo/systems/monitoring/en/index.html> for details).

¹⁰ "Subareas" refers to the components of the EPHS outlined on pages 50-52 of the National Health and Social Work Plan, such as Antenatal care as a subarea within Maternal and newborn health services

Indicator 1.2: Capacity of central MOHSW to ensure appropriate use of policies, plans and standards related to Health Service Delivery for the Essential Package of Health Services (EPHS) Areas and Subareas (Subareas refers to the components of the EPHS outlined on pages 50-52 of the National Health and Social Work Plan, such as Antenatal care as a subarea within Maternal and newborn health services)⁴

Standard 1.2.1: Capacity of MOHSW to supervise CHSWTs in the use of Health Service Delivery Standards	
0	No systems exist at central MOHSW to monitor adherence of CHSWT to standards.
1	Some elements of a basic system exist for monitoring of adherence to standards. Specifically, the MOHSW has guidelines for one or two of the following areas: lines of responsibility, supervision schedule, supervision guidelines/checklists for health facilities.
2	A system of monitoring of adherence to standards exists with guidelines for all of the above stated areas, but use of these guidelines is not consistent by the central MOHSW or the CHSWTs.
3	Central MOHSW monitors capacity of CHSWT to monitor adherence to standards at the County Health level, and provides support to CHSWTs to monitor adherence at the facility level, but not consistently.
4	Central MOHSW routinely monitors adherence to standards at the County Health level, and provides support to CHSWTs to monitor adherence at the facility level.
Comments:	

Standard 1.2.2: Number of operational public health facilities as compared to those projected in the National Health and Social Welfare Plan	
0	Central MOHSW does not have a list of the number of public health facilities.
1	Central MOHSW has a list of the number of public health facilities, but there is no system to determine and report which facilities are operational (An operational facility is one that provides EPHS at least three days a week, with at least two clinical staff members).
2	Central MOHSW has a list of the number of operational public health facilities, but the number of operational facilities is basically unchanged (within 5%) from the 2011 levels reported in the National Health and Social Welfare Plan (page 61).
3	The number of operational public health facilities is at least 75% ¹¹ of the projected public network 2021 ¹² in at least 60% of counties.
4	The total number of operational public health facilities is at least 80% of the projected public network 2021 ¹³ in at least 75% of counties.
Comments:	

¹¹ The 2011 numbers (i.e., the baseline) are 73% of the 2021 numbers

¹² Please see page 59 of the National Health and Social Welfare Plan, 2011-2021

¹³ Please see page 59 of the National Health and Social Welfare Plan, 2011-2021

Indicator 1.3: Capacity of central MOHSW to deliver health care in identified priority areas

Standard 1.3.1: Capacity of central MOHSW to implement health programs. NOTE: This question will be asked of representatives from each program in the Division of Health Services. Scores from each program will be recorded in the small table below, and the average score entered in this table. The programs being considered are: National Leprosy and Tuberculosis Control (NLTC) program, National Malaria Control Program (NMCP), National AIDS Control Program (NACP), Expanded Program on Immunization (EPI), Neglected Tropical Diseases (NTD), and National Eye Care Program (NECP)	
0	Program does not have capacity to identify priority areas for implementation
1	Program has capacity to identify priority health areas and develop standards for health programs.
2	In addition to criteria #1, the program has capacity to develop an implementation plan for priority health programs.
3	In addition to criteria #2, the program has capacity to conduct periodic Monitoring and Evaluation (M & E) of priority health programs.
4	In addition to criteria #3, the program has capacity to promote data sharing, communication, and collaboration within individual priority health programs.
Comments:	

Scoring of Standard 1.3.1

a) Scores from each individual program for standard 1.3.1 above:

Program	NLTC	NMCP	NACP	EPI	NTD	NECP			
Score /4									

b) Total score from above table (a) = _____

c) Total number of programs included = _____

d) Average score (b/c) = _____ Please enter this score for Standard 1.3.1 above.

*Standard 1.3.1 will be measured as an average of responses from each individual program. Criteria 2, 3, and 4 will be modified for each program and all responses will be aggregated to arrive at a score for 1.3.1. For example, applying standard 1.3.1 to the National Malaria Control Program (NMCP):

Criteria 2: NMCP has capacity to develop an implementation plan for objectives identified in the program

Criteria 3: In addition to criteria 2, NMCP has capacity to conduct periodic M&E of the program

Criteria 4: In addition to criteria 3, NMCP has capacity to share data with fellow health programs in the division, communicate progress and obstacles, and collaborate when needed.

Building Block 2: Health Workforce

Indicator 2.1: Central MOHSW capacity in workforce recruitment and deployment

Standard 2.1.1: Ability to recruit and retain human resources for health worker positions	
0	Job descriptions do not routinely exist, and there is not a consistent way for staff to be paid.
1	Health partners recruit and develop job descriptions for health workers.
2	CHSWTs have input into the recruitment of staff, and the development of job descriptions, however health partners are still heavily involved in this process.
3	CHSWTs and health partners recruit staff based on jointly identified needs. Central MOHSW job descriptions and pay scale are routinely used.
4	Central MOHSW and CHSWT coordinate the recruitment and payment of staff. Staff are provided central MOHSW job descriptions, and are paid by the MOHSW/CHSWT. As necessary, health partners support this process.
Comments:	

Standard 2.1.2: Capacity of central MOHSW to staff health facilities as per National Staffing Guidelines	
0	Standards for appropriate staffing for each level of the health system do not exist.
1	National staffing standards have been developed, but CHSWTs do not have a system to track staffing levels within facilities.
2	National staffing standards (including staffing requirements for each level of health facility) exist and a system has been developed to track staffing levels, but use of the system is not consistent.
3	Adequate staffing data exist, but less than 75% of CHSWTs report staffing levels of at least 75% of staffing requirements across each cadre of staff (within health facilities within the county) for the last reporting period.
4	At least 75% of CHSWTs report staffing levels of at least 75% of staffing requirements across each cadre of staff (within health facilities within the county) for the last reporting period.
Comments:	

Indicator 2.2: Capacity of central MOHSW to strengthen the existing health workforce

Standard 2.2.1: Capacity of central MOHSW to monitor CHSWT staff performance	
0	There are no guidelines or policies at the central MOHSW to review CHSWT staff performance.
1	Health partners monitor CHSWT staff performance (e.g. staff meetings, performance assessment) based on health partner processes. Timing of supportive supervision/performance monitoring visits is ad hoc, and information from these visits.
2	In partnership with central MOHSW, health partners assess CHSWT staff performance using national guidelines and tools (e.g. standardized staff performance checklists). Timing of supportive supervision/performance monitoring visits is ad hoc.
3	Central MOHSW takes the lead in assessing CHSWT staff performance using central MOHSW guidelines and tools (e.g. standardized staff performance checklists). Timing of supportive supervision/performance monitoring visits is ad hoc.
4	Central MOHSW and CHSWT coordinate and support staff performance process utilizing central MOHSW developed guidelines. Staff performance is monitored at least annually. Staff performance is tied to annual reviews and promotions.
Comments:	

Standard 2.2.2: Capacity of central MOHSW to coordinate capacity development of health staff	
0	No in-service training is provided for health staff, or training is completely ad hoc.
1	Health partners coordinate necessary training on EPHS based on health partner curricula and processes.
2	Health partners coordinate necessary training based on health partners' guidelines and processes and provide information to central MOHSW and CHSWT.
3	Health partners coordinate training utilizing curricula approved by central MOHSW/CHSWT. Training schedules are not fully coordinated/ communicated to all relevant stakeholders.
4	Central MOHSW and CHSWT coordinate in-service training, utilizing central MOHSW approved curricula. Training follows a coordinated schedule that enables the appropriate staff to attend appropriate trainings, in a manner that prevents excessive loss of clinical service delivery time.
Comments:	

Building Block 3: Health Information Systems (HIS)

Indicator 3.1: Capacity of central MOHSW to plan for and systematically collect health information

Adapted from the WHO's *Monitoring the Building Blocks of Health Systems*, key components of a HIS include: health surveys, birth/death registration, routine health information (usually from health facilities), surveillance, and census data (this last one may not be the responsibility of the central MOHSW).

Standard 3.1.1: Capacity of central MOHSW to develop and roll out HIS policies and forms	
0	The central MOHSW does not have a health information system (HIS) policy and plan.
1	Central MOHSW has an HIS policy and plan outlining the key components of the HIS; however data collection tools/systems for all key components have not been developed.
2	Central MOHSW has an HIS policy and plan outlining the key components of the HIS, and has developed and printed data collection tools for most of these components. Distribution to counties has been inconsistent.
3	Central MOHSW has an HIS policy and plan outlining the key components of the HIS, and has developed and distributed data collection tools for most of these components to all counties. Annual training on use of these forms has not reached at least 75% of key staff in 75% of counties.
4	Central MOHSW has an HIS policy and plan outlining the key components of the HIS, and has developed and distributed data collection tools for most of these components to all counties. Training on use of these forms has been conducted at least annually to at least 75% of key county staff in at least 75% of counties.
Comments:	

Standard 3.1.2: Capacity of central MOHSW to collect health data	
0	There are no national data collection systems in place.
1	National data collection systems exist, but data are not routinely collected using national data collection forms.
2	Data collection systems exist, and data collection forms are routinely distributed, however, the central MOHSW received timely and complete reports from less than 75% of counties.
3	For the last reporting period, the central MOHSW received timely and complete health data from at least 75% of the counties.
4	For the last reporting period, the central MOHSW received timely and complete health data from at least 75% of the counties and has provided regular feedback to all counties.
Comments:	

Standard 3.1.3: Capacity of central MOHSW to manage data	
0	No central storage exists for health information data.
1	Separate storage systems (paper or electronic) exist for the various components of the HIS, but it is difficult or impossible to manipulate or extract data from the system.
2	Electronic storage systems (databases) exist at the central MOHSW for the various components of HIS; however data are not routinely extracted for reports and other use.
3	Electronic storage systems (databases) exist at the central MOHSW for the various components of the HIS, and data are routinely extracted (at least annually) for use. However, integration of information from other health management systems (i.e., financial, human resource, logistics information, and physical assets data systems) is generally not done.
4	In addition to the above (#3) criteria on data storage and extraction, some integration of information from other health management systems (i.e., financial, human resource, logistics information, and physical assets data systems) is evident.
Comments:	

Indicator 3.2: Capacity of central MOHSW to promote evidence-based decisions and policy making

Standard 3.2.1: Capacity of central MOHSW to use collected data for planning and policy making	
0	The central MOHSW does not use data for strategic planning and decision making.
1	The central MOHSW analyses available HIS data quarterly and distributes reports containing these analyses to key members of the central MOHSW and to CHSWTs. Use of these data is unknown.
2	The central MOHSW analyses available HIS data quarterly and distributes reports containing these analyses to key members of the central MOHSW and to CHSWTs. In addition, presentation and discussion of data are part of central MOHSW meetings.
3	The central MOHSW analyses available HIS data quarterly and distributes reports containing these analyses to key members of the central MOHSW and to CHSWTs. The central MOHSW can identify at least two examples of how data have been integrated into a decision-making process in the past year.
4	The central MOHSW analyses available HIS data quarterly and distributes reports containing these analyses to key members of the central MOHSW and to CHSWTs. The central MOHSW can identify at least four examples of how data have been integrated into a decision-making process in the past year.
Comments:	

Building Block 4: Access to Essential Medicines

Indicator 4.1: Capacity of central MOHSW to ensure access to essential medicines for the population

Standard 4.1.1: Capacity of the central MOHSW to develop a Logistics Supply Chain Master Plan	
0	The central MOHSW does not have a Logistics Master Plan.
1	A Logistics Supply Chain Master Plan has been developed to define inventory control system, LMIS, procurement responsibilities, quantification responsibilities, but it has not been operationalized for implementation.
2	The Logistics Supply Chain Master Plan has been adopted by the central MOHSW and appropriate organizational mechanisms have been set up for operationalization and implementation.
3	The Logistics Supply Chain Master Plan has been adopted by the central MOHSW and implemented in at least 50% of CHSWTs.
4	The Logistics Supply Chain Master Plan is being implanted in all CHSWTs.
Comments:	

Standard 4.1.2: Central MOHSW's capacity to estimate commodity needs, develop a supply plan and procure/source these commodities (Quantification and Procurement)	
0	No capacity (external or internal to the country) available to conduct a quantification exercise (estimate commodity needs, develop a supply plan, and procure essential commodities).
1	Central MOHSW is reliant on external technical assistance to estimate commodity needs, and develop a supply plan, but is unable to fully procure or source (i.e. buy or secure donations of) essential commodities.
2	Central MOHSW is reliant on external technical assistance to estimate commodity needs, and develop a supply plan, but is partially able to procure or source (i.e. buy or secure donations of) essential commodities.
3	Central MOHSW is able to estimate commodity needs, and develop a supply plan, and is partially able to procure or source (i.e. buy or secure donations of) essential commodities, with minimal technical assistance.
4	Central MOHSW has the capacity to estimate commodity needs (forecast), develop a supply plan and fully procure/source essential commodities at least annually.
Comments:	

Standard 4.1.3: Central MOHSW's Capacity to Develop and Use a Logistics Management Information System (LMIS)	
0	No LMIS exists.
1	Central MOHSW has developed an LMIS that includes at least two of the four following components: stock keeping record, consumption/usage register, transaction record, and has system for distributing/resupplying these records. The LMIS is not implemented.
2	An LMIS has been developed (including all four of the above components) and most staff have been trained in use of the LMIS. However, reporting of LMIS data is below 50% for all facilities annually.
3	Central MOHSW has access to limited logistics data including: stock on hand within the system and consumption/usage for the past reporting period and demonstrates reporting rates of less than 70% from the CHSWTs.
4	Central MOHSW has access to logistics data including stock on hand within the system and consumption/usage for the past reporting period and demonstrates reporting rates of at least 70% from the CHSWTs.
Comments:	

Standard 4.1.4: Capacity of Central MOHSW to effectively store and distribute commodities	
0	Storage and distribution of commodities, including essential medicines, is haphazard. Special storage requirements of pharmaceuticals and other items are not followed.
1	National Warehouse(s) for commodity storage exists, with some accommodation for items requiring special storage. Maintenance, cleanliness and size of the national warehouse may be insufficient. Distribution to CHSWTs is not sufficient.
2	The national warehouse meets at least two of the following four criteria: warehouse size is adequate, storage space is well maintained and clean (including pest control), has designated storage equipment for special storage needs, and distribution to CHSWTs follows a consistent schedule.
3	The national warehouse meets at least three of the following four criteria: warehouse size is adequate, storage space is well maintained and clean (including pest control), has designated storage equipment for special storage needs, and distribution to CHSWTs follows a consistent schedule.
4	National Warehouse(s) is adequate (i.e. large enough, regularly cleaned, dry, well organized) with all special needs storage areas clearly designated with correct signage, and established delivery intervals from national warehouse to CHSWTs exist and are routinely followed, including the use of protocols (such as first expired, first out).
Comments:	

Block 5: Health Systems Financing

Indicator 5.1: Capacity of the central MOHSW to ensure that adequate funds are allocated to health expenditures within the overall Government of Liberia budget

Standard 5.1.1: Capacity of the central MOHSW to ensure that adequate funds from the total government budget are allocated to health and social welfare	
0	Central MOHSW has no input into the development of the national budget.
1	Central MOHSW has input into the Government of Liberia’s overall budget, but health expenditures are not systematically calculated on an annual basis and do not total at least 10% of the overall government budget.
2	Central MOHSW budget is calculated annually, and is less than 10% of the overall government expenditure.
3	Central MOHSW budget is calculated annually, and is between 10% and 15% of the overall government expenditure.
4	Central MOHSW budget is calculated annually, and is at least 15% of the overall government expenditure.
Comments:	

Indicator 5.2 Capacity of central MOHSW to formulate, distribute, and monitor financing for the health sector

Standard 5.2.1: Capacity of central MOHSW to plan for, create and allocate a sustainable budget	
The four criteria necessary in a <i>sustainable budget</i> are as follows:	
<i>Planning:</i> Central MOHSW has a realistic and sustainable budget given past experience/expenses, donors and projections.	
<i>Input:</i> All key stakeholders are involved (including central MOHSW and CHSWTs, and as necessary, donors/partners).	
<i>Allocation:</i> Central MOHSW compiles an adequate budget to support facilities and services, with specific line items for key areas outlined in the National Health and Social Welfare Policy and Plan.	
<i>Initiative:</i> Process for collection of budget information is led collectively by the central MOHSW and CHSWTs and the system is standardized across all CHSWTs.	
0	No sustainable budget exists (planning, input, allocation, and initiative).
1	Three of the budget sustainability criteria need improvement (planning, input, allocation, and initiative).
2	Two of the budget sustainability criteria need improvement (planning, input, allocation, and initiative).
3	One of the budget sustainability criteria needs improvement (planning, input, allocation, and initiative).
4	All of the budget sustainability criteria are completed and sustainable, with the central MOHSW/CHSWTs taking the lead on developing the budget (planning, input, allocation, and initiative).
Comments:	

Standard 5.2.2: Capacity of central MOHSW to effectively distribute finances

The four factors necessary to *effectively distribute finances* are as follows:

Financial System: A system exists within the central MOHSW to distribute funds among its activities. This includes differentiating by funding source (e.g., donors, national revenue, etc.) and by funding recipient (e.g., by line item, and by CHSWT).

Tracking: Central MOHSW has a system to track its distributed funds against its total budget, the CHSWTs distributions against total budgets, manage cash flow and segregate expenses.

Policies: Policies for allowable expenses exist and are distributed among central MOHSW staff and CHSWTs. These policies are implemented on a regular basis.

Responsibility: Monthly review of internal expenses versus revenue (both for the MOHSW budget and each CHSWT's budget) is designated to an employee(s) as a responsibility.

0	No system to distribute funds exists (financial system, tracking, policies, and responsibility).
1	Three of the budget distribution factors need improvement (financial system, tracking, policies, and responsibility).
2	Two of the budget distribution factors need improvement (financial system, tracking, policies, and responsibility).
3	One of the budget distribution factors needs improvement (financial system, tracking, policies, and responsibility).
4	All of the budget distribution factors are completed and sustainable (financial system, tracking, policies, and responsibility).

Comments:

Standard 5.2.3: Capacity of central MOHSW to monitor finances at the National and County levels

The four factors necessary to *effectively monitor finances* are as follows:

Documentation: Central MOHSW keeps financial documentation in a secure place, has a policy for keeping receipts and requirements for documentation kept with each type of payment. These policies are flowed down to CHTs and adherence is monitored.

Review: Central MOHSW reviews expenses monthly to ensure applicability and allowability according to the budget and internal policies. Exceptions are documented.

Reporting: A reporting system exists both for the central MOHSW to report to the Liberian government and for the CHTs to report to the central MOHSW. Reports are completed and submitted according to applicable deadlines.

Audit: Central MOHSW either has an internal review of its, and the CHSWTs, accounting systems, or hires external auditors on an annual basis.

0	No tracking/monitoring system exists.
1	Three of the factors necessary to effectively monitor finances need improvement (documentation, review, reporting, and audit); this includes monitoring of finances at the CHSWT.
2	Two of the factors necessary to effectively monitor finances need improvement (documentation, review, reporting, and audit); this includes monitoring of finances at the CHSWT.
3	One of the factors necessary to effectively monitor finances needs improvement (documentation, review, reporting, and audit); this includes monitoring of finances at the CHSWT.
4	All of the factors necessary to effectively monitor finances are completed and sustainable (documentation, review, reporting, and audit); this includes monitoring of finances at the CHSWT.
Comments:	

Block 6: Governance and Leadership

Indicator 6.1: Capacity of central MOHSW to lead efforts aimed at improving the health of all Liberians

Standard 6.1.1: Capacity of central MOHSW to develop and implement a National Health Policy and Plan	
0	Central MOHSW does not have a current National Health Policy and Plan adopted into use.
1	The current National Health Policy and Plan has been adopted by the central MOHSW.
2	Within the central MOHSW, specific individuals are responsible for overseeing and coordinating the implementation of each component of the National Health Policy ¹⁴ .
3	Evidence of at least one Operational Plan developed for less than 50% of the Policy Orientations in the National Health and Social Welfare Policy.
4	Evidence of at least one Operational Plan developed for at least 80% of the Policy Orientations in the National Health and Social Welfare Policy.
Comments:	

Indicator 6.2: Capacity of central MOHSW towards intra and inter agency communication

Standard 6.2.1: Capacity to communicate effectively within the central MOHSW and other Ministries within the Government of Liberia	
0	No evidence of communication plan and protocols for information to flow within the central MOHSW (central level) and to other Ministries within the Government of Liberia.
1	There is an internal communication plan, and protocols are clearly established to guide the plan.
2	At least 50% of key central MOHSW staff are aware of the internal communication plan and protocols but use of the plan and protocols is inconsistent.
3	More than 50% of key staff are aware of the internal communication plan and protocols but use of the plan and protocols is inconsistent.
4	More than 50% of key central MOHSW staff are aware of the internal communication plan and protocols AND use the plan and protocols more than once a year.
Comments:	

¹⁴ Please see section 4 of the National Health and Social Welfare Policy: Policy Orientations, pages 15-27

Standard 6.2.2: Capacity of the central MOHSW to lead and guide CHSWTs	
0	No evidence of information flow between the central MOHSW and CHSWTs.
1	Occasional meetings are held between the central MOHSW and CHSWTs, but these are irregular, and do not involve all CHSWTs. CHSWT has no or limited engagement with central MOHSW to be an advocate for county health service needs.
2	Regular meetings are held between the central MOHSW and all CHSWTs. Central MOHSW receives no input from CHSWTs regarding decisions affecting county health services.
3	Meetings are regularly held between the central MOHSW and all CHSWTs, and key relevant information is shared through these meetings. Central MOHSW receives regular input (in the form of reports) from less than 50% of CHSWTs.
4	Meetings are regularly held among the central MOHSW and all CHSWTs, and key relevant information is shared through these meetings. Central MOHSW receives regular input (in the form of reports) from all CHSWTs. All CHSWTs are fully involved in decision making and policy development affecting the county health services.
Comments:	

Standard 6.2.3: Capacity of central MOHSW to hold responsibility and ownership for the health system	
0	The Liberian health system is predominantly run by health partners, with gaps existing where partners are not implementing services. The central MOHSW has little input into leadership and governance over the system.
1	The health system is predominantly run by health partners, with input from the central MOHSW and/or CHSWTs.
2	Leadership and a sense of ownership of the Liberian health system is generally held by the central MOHSW, with significant input from donors and health partners.
3	The central MOHSW and CHSWTs demonstrate clear leadership (as defined by organized roles, responsibilities, and communications – within central MOHSW and between central and county level) over less than three of the six WHO building blocks of the health system. Donors and health partners are reasonably clear on their role within the system.
4	The central MOHSW and CHSWTs demonstrate clear leadership over each of the six WHO building blocks of the health system. Donors and health partners are reasonably clear on their role within the system (if any).
Comments:	

4.10 CAPACITY ASSESSMENT TOOLS: Central MOHSW qualitative

Capacity Assessment – Qualitative Interview Central MOHSW level

Introduction and Instructions

This tool was developed by the Liberia Ministry of Health and Social Work (MOHSW) with technical assistance from Rebuilding Basic Health Services (RBHS). Its purpose is to help the MOHSW determine priority areas for capacity building to help strengthen the Liberian health system. The tool is based on the World Health Organization (WHO) Health Systems Framework that focuses on six building blocks of a health system.

Use of the tool is meant to be collaborative in nature, with members of the assessment team working through each component of the tool together. A copy of the tool should be shared with all assessment participants ahead of time, to help participants prepare for the assessment (i.e., to have a sense of what questions will be discussed, and to locate any relevant documents that will be useful in answering the questions). During the assessment process, participants from the MOHSW, and the RBHS should read through the response options under each standard (component) together, and through discussion, come to a consensus on the appropriate score to assign for each standard.

The tool is meant to be used in conjunction with the quantitative interview guide, and has similar tools available for use at the County level.

Introduction:

Thank you for agreeing to participate in the capacity assessment of central Ministry of Health and Social Welfare (MOHSW). The assessment is designed to understand current capacity within central MOHSW and identify areas that require capacity building. Findings from this discussion will influence the capacity building strategy. We anticipate the discussion to last between 1.5-2 hours.

Contextual questions:

1. What are the three major health problems in Liberia? How did you identify these problems?
2. What is the MOHSW role in developing and implementing the National Health Plan?
3. What is the MOHSW role in implementing decentralization?

Building Block 1: Delivering essential health services

1. What mechanisms are in place to involve community stakeholders and partners in planning for service delivery?
2. What guidance does MOHSW provide the County Health and Social Welfare Teams (CHSWTs) towards service delivery?
 - a. Is there a policy/ operational plan to guide CHSWTs in service delivery?
3. Has the MOHSW conducted an exercise to plan for health services?
 - a. How often is planning conducted?
 - b. Do you have a general Work Plan (or Annual Operational Plan – AOP)
 - c. Do you have unit-specific Work Plans? How were the work plans developed/ disseminated?
 - d. Who is involved in the planning process?
 - e. How is the planning process organized?
4. How are priority service areas identified?
 - a. Is service delivery reflective of priority health needs?
 - b. What policies do you have in place to ensure service delivery targets priority health needs? Please describe
5. Who decides what services need to be provided at the county and district level?
 - a. What mechanisms exist in place for supervision of county and district health facilities?
 - b. Is supervision focused on medical audits or coaching and performance improvement or both? What approach to supervision is used?
 - c. How often is supervision conducted?
 - d. How are supervision needs determined? (needs-based or regularly scheduled?)
 - e. Who conducts the supervision visits?
 - f. Is there clarity about levels of supervision (who supervises who) and reporting?
 - g. What tools are used to conduct supervision?
 - h. Are supervision results linked to any type of rewarding/recognition/incentives system?
 - i. What are the challenges to conducting supervision?

6. What mechanisms exist for improving quality of care through the health system? What are the gaps in quality of care in the system?
 - a. What indicators are used to measure service quality?
 - b. What kind of mechanism exists to assess quality of care regularly and who are in charge to monitor this (QI teams)?
7. What is central MOHSW's capacity towards delivering Essential Package of Health Services (EPHS)?
 - a. Maternal and newborn services
 - i. How do you identify targets? Please list some of your targets.
 - ii. Where are you with your targets for maternal and newborn services?
 - iii. Do you anticipate reaching all your targets for the year? If no, please explain why
 - iv. What assistance do you need to reach your targets?
 - b. Child health services
 - i. How do you identify targets? Please list some of your targets.
 - ii. Where are you with your targets for child health services?
 - iii. Do you anticipate reaching all your targets for the year? If no, please explain why
 - iv. What assistance do you need to reach your targets?
 - c. Family Planning and Reproductive health (FP/RH)
 - i. How do you identify targets? Please list some of your targets.
 - ii. Where are you with your targets for reproductive health services?
 - iii. Do you anticipate reaching all your targets for the year? If no, please explain why
 - iv. What assistance do you need to reach your targets?
 - d. Communicable disease prevention and control
 - i. How do you identify targets? Please list some of your targets.
 - ii. Where are you with your targets for communicable disease prevention and control services?
 - iii. Do you anticipate reaching all your targets for the year? If no, please explain why
 - iv. What assistance do you need to reach your targets?
8. What is central MOHSW's capacity towards implementing National Malaria Control Program (NMCP)?
 - a. What are the activities of the NMCP?
 - b. How do you identify targets? Please list some of your targets.
 - c. Where are you with your targets for NMCP?
 - d. Do you anticipate reaching all your targets for the year? If no, please explain why
 - e. What assistance do you need to reach your targets?
9. What is central MOHSW's capacity towards implementing Expanded Program on Immunization (EPI)?
 - a. What are the activities of EPI?
 - b. How do you identify targets? Please list some of your targets.
 - c. Where are you with your targets for EPI?
 - d. Do you anticipate reaching all your targets for the year? If no, please explain why
 - e. What assistance do you need to reach your targets?

10. What is the MOHSW's capacity towards implementing National Leprosy and Tuberculosis Control Program (NLTC)?
 - a. What are the activities of NLTC?
 - b. How do you identify targets? Please list some of your targets.
 - c. Where are you with your targets for NLTC?
 - d. Do you anticipate reaching all your targets for the year? If no, please explain why
 - e. What assistance do you need to reach your targets?
11. What is the MOHSW's capacity towards implementing National AIDS Control Program (NACP)?
 - a. What are the activities of NACP?
 - b. How do you identify targets? Please list some of your targets.
 - c. Where are you with your targets for NACP?
 - d. Do you anticipate reaching all your targets for the year? If no, please explain why
 - e. What assistance do you need to reach your targets?
12. What is the MOHSW's capacity towards implementing Neglected Tropical Diseases (NTD)?
 - a. What are the activities of NTD?
 - b. How do you identify targets? Please list some of your targets.
 - c. Where are you with your targets for NTD?
 - d. Do you anticipate reaching all your targets for the year? If no, please explain why
 - e. What assistance do you need to reach your targets?
13. What is the MOHSW's capacity towards implementing National Eye Care Program (NECP)?
 - a. What are the activities of NECP?
 - b. How do you identify targets? Please list some of your targets.
 - c. Where are you with your targets for NECP?
 - d. Do you anticipate reaching all your targets for the year? If no, please explain why
 - e. What assistance do you need to reach your targets?
14. What is the MOHSW's capacity towards addressing mental health problems?
 - a. What are the activities of the Mental Health Unit?
 - b. Have you identified focus areas in mental health? Please explain the process.
 - c. Have you developed an operational plan to address these focus areas? Please explain.
 - d. Have you set targets for the Mental Health Unit? Please explain.
 - e. What do you think are the major mental health problems in Liberia?
 - f. What are the major challenges facing the Mental Health Unit?
 - g. What assistance do you need to address issues facing the Mental Health Unit?
 - h. What are the major accomplishments of the Mental Health Unit?
15. What is the MOHSW's capacity towards addressing issues facing the nutrition unit?
 - a. What are the activities of the Nutrition Unit?
 - b. Have you identified focus areas in nutrition? Please explain the process.
 - c. Have you developed an operational plan to address these focus areas? Please explain.
 - d. Have you set targets for the nutrition unit? Please explain.
 - e. What do you think are the major nutrition problems facing Liberia?
 - f. What are the major challenges facing the Nutrition Unit?
 - g. What assistance do you need to address issues facing the Nutrition Unit?

- h. What are the major accomplishments of the Nutrition Unit?
16. What is central MOHSW's capacity towards addressing issues facing family health?
 - a. What are the activities of the Family Health Unit?
 - b. Have you identified focus areas in Family Health? Please explain the process.
 - c. Have you developed an operational plan to address these focus areas? Please explain.
 - d. Have you set targets for the Family Health unit? Please explain.
 - e. What do you think are the major Family Health problems facing Liberia?
 - f. What are the major challenges facing the Family Health unit?
 - g. What assistance do you need to address issues facing the Family Health unit?
 - h. What are the major accomplishments of the Family Health Division?
 17. What is central MOHSW's capacity towards addressing health promotion issues?
 - a. What are the activities of the National Health Promotion (NHP) Unit?
 - b. Have you identified focus areas in Health Promotion? Please explain the process.
 - c. Have you developed an operational plan to address these focus areas? Please explain.
 - d. Have you set targets for the NHP unit? Please explain.
 - e. What do you think are the major Health Promotion areas for Liberia?
 - f. What are the major challenges facing the NHP Unit?
 - g. What assistance do you need to address issues facing the NHP Unit?
 - h. What are the major accomplishments of the NHP Unit?
 18. What is central MOHSW's capacity towards addressing community health issues?
 - a. What are the activities of the Community Health Unit?
 - b. Have you identified focus areas in Community Health? Please explain the process.
 - c. Have you developed an operational plan to address these focus areas? Please explain.
 - d. Have you set targets for the Community Health Unit? Please explain.
 - e. What do you think are the major Community Health problems facing Liberia?
 - f. What are the major challenges facing the Community Health Division?
 - g. What assistance do you need to address issues facing the Community Health Division?
 - h. What are the major accomplishments of the Community Health Division?
 19. What is the MOHSW's capacity towards addressing problems with health care infrastructure?
 - a. What are the activities of the Infrastructure Unit?
 - b. Have you identified focus areas in improving infrastructure across central, county, and district levels? Please explain the process.
 - c. Have you developed an operational plan to address these focus areas? Please explain.
 - d. Have you set targets for the Infrastructure Unit? Please explain.
 - e. What do you think are the major health care infrastructure issues facing Liberia?
 - f. What are the major challenges facing the Infrastructure Unit?
 - g. What assistance do you need to address issues facing the Infrastructure Unit?
 - h. What are the major accomplishments of the Infrastructure Unit?
 20. What is the MOHSW's capacity towards addressing environmental health problems?
 - a. What are the activities of the Environmental Health Unit?
 - b. Have you identified focus areas in improving environmental health across central, county, and district levels? Please explain the process.

- c. Have you developed an operational plan to address these focus areas? Please explain.
 - d. Have you set targets for the Environmental Health Unit? Please explain.
 - e. What do you think are the major environmental health issues facing Liberia?
 - f. What are the major challenges facing the Environmental Health Unit?
 - g. What assistance do you need to address issues facing the Environmental Health Unit?
 - h. What are the major accomplishments of the Environmental Health Unit?
21. What information/ data do you wish you had when it comes to planning for service delivery?
22. What are the major challenges facing service delivery?
23. What are the major accomplishments of service delivery?

Building Block 2: Health Workforce

1. Briefly describe MOHSW strategy to strengthen health workforce at all levels?
 - a. Do you have an operation plan to recruit new workforce? Please describe
 - b. Do you have an operation plan to identify pre and in-service training needs of health workforce? Please describe
 - c. Has central MOHSW reached any agreements/ contracts with TNIMA and/ or other institutions to train and recruit new workforce? Please describe
 - d. Has MOHSW conducted periodic assessments of workforce needs and priorities? Please describe
2. Briefly describe the MOHSW strategy to mobilize and distribute health workforce based on county needs
 - a. How are the needs assessed?
 - b. Who is involved in the needs assessment?
 - c. How often is a workforce needs assessment conducted?
3. What are the MOHSW training needs towards each area listed in the Essential Package of Health Services (EPHS)?
 - a. Maternal and newborn health services
 - b. Child health services
 - c. Family Planning and Reproductive health
 - d. Communicable disease prevention and control
4. What are your training needs towards each vertical program?
 - a. NMCP
 - b. EPI
 - c. NLTC
 - d. NACP
 - e. NTD
 - f. NECP
 - g. Mental Health
 - h. Nutrition

- i. Family Health
 - j. Health Promotion
 - k. Community Health
 - l. Training Unit in the Department of Planning
 - m. Environmental Health
 - n. Infrastructure
5. Briefly describe mechanisms in place to review staff competencies and performance
 - a. What is the course of action after a performance review?
 - b. Do you have any strategies for continuous performance improvement? Please explain
 6. Briefly describe the mechanisms in place to promote accountability and transparency in the workforce
 - a. Are there clear guidelines in the job descriptions about staff roles and responsibilities? Please describe one or more
 - b. How often are these guidelines reviewed and implemented?
 7. What mechanisms are in place to address workforce absenteeism and poor productivity?
 8. Describe any agreements made with institutions of higher learning to provide in-service training for staff
 - a. How are these training needs identified?
 - b. How often is a training needs assessment conducted?
 - c. Is there a formal mechanism to engage institutions of higher learning to provide training?
 - d. What institutions have been engaged so far?
 9. What types of trainings have been provided by MOHSW/ vertical program in the past year?
 - a. Who were trained?
 - b. Who determines the staff to be trained?
 - c. How were the training needs identified?
 - d. Who initiated/ requested the training?
 - e. Who conducted the training? (CHSWT, MOHSW, partner?)
 - f. How was the training funded?
 10. Please describe MOHSW's/ each vertical program's policy to strengthen existing workforce
 - a. Is there an operational plan for in-service training?
 - b. How are in-service training needs identified?
 - c. How often are in-service trainings delivered?
 - d. Is there an operation plan to retain existing workforce?
 - e. Do MOHSW staff that complete requisite in-service trainings get incentives?
 11. What is the capacity of the Training Unit in the Department of Planning to address training needs for MOHSW?
 - a. What are the activities of the Training Unit?
 - b. Have you identified focus areas for the Training Unit? Please explain the process.
 - c. Have you developed an operational plan to address these focus areas? Please explain.
 - d. Have you set targets for the Training Unit? Please explain.
 - e. What do you think are the major pre-service training problems facing MOHSW?

- f. What do you think are the major in-service training problems facing MOHSW?
 - g. What are the major challenges facing the Training Unit?
 - h. What assistance do you need to address issues facing the Training Unit?
 - i. What are the major accomplishments of the Training Unit?
12. What is the capacity of MOHSW towards granting accreditation to health facilities?
 - a. Is there an operational plan to grant accreditation?
 - b. How often is accreditation conducted?
 - c. Are accreditation standards comprehensive and up to date?
 - d. Who conducts accreditation? How is this team formed?
 - e. What kind of assistance does MOHSW need towards implementing accreditation?
 13. Identify three priority areas where you need training within the next 6 months (ask for each vertical program and Central MOHSW as a whole)
 14. What are the major challenges for strengthening health workforce? (ask for each vertical program and central MOHSW as a whole)
 15. What are the major accomplishments of MOHSW/ vertical programs towards strengthening workforce?

Building Block 3: Health Management Information Systems

Will be assessed separately using PRISM tools

Building Block 4: Access to essential medicines

1. Briefly describe the central MOHSW strategy to ensure access to essential medicines
 - a. Where do your medicines come from?
 - b. What mechanisms are in place to assess needs of medicines for central MOHSW?
 - c. What mechanisms are in place to ensure proper distribution based on need?
2. What is MOHSW's capacity towards assessing commodity needs in the EPHS areas?
 - a. Do you have a plan to assess current needs? Please describe
 - b. Do you have a plan to assess future needs? Please describe
 - c. Do you seek input from CHSWTs in assessing medicine needs? Please describe
3. To what extent is the national essential medicines plan implemented by central MOHSW?
 - a. What guidance does MOHSW provide CHSWTs and/ or partners towards implementing the national essential medicines plan in counties?
 - b. Who is responsible for the county level implementation?
4. Is there an inventory to monitor stocks of essential medicines?
 - a. What is maintained in the inventory? (medicines, equipment, supplies)
 - b. Who manages the inventory?
 - c. What is the procedure to report stock imbalances?
5. Describe the mechanisms used by central MOHSW to implement the Supply Chain Logistics plan.

- a. Who is responsible for implementing individual portions of the plan?
 - b. How is the process organized?
6. Describe the procedures adopted by central MOHSW for proper storage of essential medicines.
7. How are commodity needs identified at the county level?
 - a. How are county needs assessed?
 - b. What role does MOHSW play in assessing commodity needs at the county level?
 - c. What happens after commodity needs are identified? How do the counties request for commodities identified based on need?
8. Describe the procedures adopted by central MOHSW for proper and fair distribution of essential medicines to counties
 - a. How is distribution handled?
 - b. How is equity ensured in distribution? In other words, what procedures are used to make sure essential medicines are distributed according to need?
9. What is the role of partners in procuring essential medicines?
10. What is the role of partners in managing the supply chain management system?
11. What is the role of community-based groups and networks in community commodity distribution?
12. What is the role of private sector in commodity distribution?
13. What are the major challenges in ensuring access to essential medicines in Liberia?
14. What are the major accomplishments of central MOHSW in ensuring access to essential medicines?

<p>Building Block 5: Health systems financing</p>
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1. Briefly describe the mechanisms for funding health services in Liberia?
 - a. Where does funding come from?
 - b. What percentage of funding comes from MOHSW vs. external donors?
2. Briefly describe the mechanisms in place to determine budget needs of individual counties?
 - a. Who is responsible for determining county budgetary needs?
 - b. How often is the budget review conducted?
 - c. How is the process organized?
3. How is the overall MOHSW budget monitored?
 - a. Who monitors/ manages the MOHSW budget at the central level?
 - b. What input do individual departments provide towards managing the overall MOHSW budget?
4. What is central MOHSW's capacity towards developing and implementing Performance-based contracts (PBC)?
 - a. How are performance indicators identified? What is MOHSW's process for identifying the indicators?
 - b. How are contractors identified? What is MOHSW's process for identifying the contractors?

- c. Is there a policy/ operational plan to guide the PBC process?
 - d. How is performance evaluated and recognized?
 - e. What kind of assistance does MOHSW provide to CHSWTs in implementing PBC?
5. What resources and support does central MOHSW need to implement PBCs across all counties?
 - a. Financial needs
 - b. Procurement and logistic needs
 - c. Training needs
6. Briefly describe the mechanisms in place to ensure fair and adequate distribution of funds to the county health teams.
 - a. How is the process set up?
 - b. How are needs determined?
7. Briefly describe the mechanisms in place to ensure transparency in revenue collection and distribution
 - a. What policies and procedures are in place?
 - b. What is the course of action when a discrepancy is identified?
8. Briefly describe your procurement policies and procedures?
 - a. Do you have different thresholds for procurement?
 - b. What do you keep as documentation in your files?
 - c. How do you ensure transparency in procurement?
9. What are the major challenges to receiving and disbursing funds for county health teams?
10. What are the major accomplishments towards receiving and disbursing funds for county health teams?

<p>Building Block 6: Governance and leadership</p>

1. Briefly describe the national strategy to implement the National Health and Social Welfare Policy and Plan (NHSWPP)
 - a. Do you have an operational plan to implement NHSWPP?
 - b. What challenges have you experienced in implementing NHSWPP?
 - c. What capacity/ information do you wish you had to implement the National Health Plan?
2. Briefly describe the MOHSW supervision process
 - a. Is there an operation plan to guide supervision of CHSWTs? Please describe
 - b. What kind of supervision is promoted (e.g. supportive supervision)?
 - c. How often is supervision conducted?
 - d. Who conducts the supervision?
 - e. What happens after supervision? What steps are taken to identify and address issues?
3. Briefly describe the communication strategy of MOHSW
 - a. What mechanisms exist for communication within central MOHSW?
 - b. What mechanisms exist for communication between MOHSW and CHSWTs?
 - c. What mechanisms exist for communication between MOHSW and partners?

4. Briefly describe the policies and procedures in place to promote collaboration between MOHSW and partners?
 - a. Is there a policy to guide collaborations? Please describe
5. Does the health system have an executive leadership development or training program?
6. What are the strategies to build the leadership capacity of health care managers and practitioners?
7. What are the major challenges in terms of governance?
8. What are the major accomplishments in terms of governance?

4.11 CAPACITY ASSESSMENT TOOLS: CHSWT quantitative

Capacity Assessment – Quantitative Instrument CHSWT Level

Introduction and Instructions

This tool was developed by the Liberia Ministry of Health and Social Work (MOHSW) and the County Health and Social Work Team (CHSWT) with technical assistance from Rebuilding Basic Health Services (RBHS). Its purpose is to help the MOHSW determine priority areas for capacity building to help strengthen the Liberian health system. The tool is based on the World Health Organization (WHO) Health Systems Framework that focuses on six building blocks of a health system.

Use of the tool is meant to be collaborative in nature, with members of the assessment team working through each component of the tool together. A copy of the tool should be shared with all assessment participants ahead of time, to help participants prepare for the assessment (i.e., to have a sense of what questions will be discussed, and to locate any relevant documents that will be useful in answering the questions). During the assessment process, participants from the MOHSW, CHSWT, and the RBHS should read through the response options under each standard (component) together, and through discussion, come to a consensus on the appropriate score to assign for each standard.

The tool is meant to be used in conjunction with the qualitative interview guide, and has similar tools available for use at the National (Central MOHSW) level.

Capacity Assessment – Quantitative Instrument CHSWT Level

Summary Scoring

Capacity Building Assessment Quantitative Tool – CHSWT		Score:
Building Block 1: Delivering Essential Health Services		/28
Indicator 1.1: Capacity of CHSWTs to engage with central MOHSW Health Facilities (HF) in delivering the health and social welfare services		
	Standard 1.1.1: Extent of interaction between CHSWTs and central MOHSW	/4
	Standard 1.1.2: Extent of Interaction between CHSWTs and Health Facilities	/4
Indicator 1.2: Capacity of CHSWTs to ensure appropriate use of policies and standards related to health service delivery for the EPHS areas and subareas		
	Standard 1.2.1: Capacity of CHSWTs to Supervise Health Facilities in the Use of Health Service Delivery Standards	/4
	Standard 1.2.2: Number of operational public health facilities as compared to those projected in the National Health and Social Welfare Plan	/4
	Standard 1.2.3: Capacity of CHSWT to safely handle and dispose of medical products and bi-products	/4
Indicator 1.3: Capacity of CHSWTs to deliver health care in priority areas		
	Standard 1.3.1: Capacity of CHSWT to implement programs developed by the Division of Health Services at the central MOHSW level	/4
	Standard 1.3.2: Capacity of CHSWT to address community health needs	/4
Building Block 2: Health Workforce		/16
Indicator 2.1: Capacity of CHSWT in workforce recruitment and deployment		
	Standard 2.1.1: Ability to recruit human resources for health worker positions	/4
	Standard 2.1.2: Capacity of the CHSWT to staff health facilities as per National Staffing Guidelines	/4
Indicator 2.2: Capacity of the CHSWT to strengthen existing health workforce		
	Standard 2.2.1: Capacity to review staff performance	/4
	Standard 2.2.2: Capacity of CHSWTs to coordinate capacity development of health staff	/4
Building Block 3: Health Information Systems		/16
Indicator 3.1: Capacity of the CHSWT to plan for and systematically collect health information		
	Standard 3.1.1: Capacity of the CHSWT roll out HIS policies and forms	/4
	Standard 3.1.2: Capacity of CHSWT to collect health data	/4
	Standard 3.1.3: Capacity of CHSWT to report health data to the MOHSW and back to health facilities	/4
Indicator 3.2: Capacity of CHSWT to promote evidence-based decisions and policy making		
	Standard 3.2.1: Capacity of CHSWT to use collected data for planning and policy making	/4

Building Block 4: Access to Essential Medicines		/12
Indicator 4.1: Capacity of CHSWT to ensure access to essential medicines for the county		
	Standard 4.1.1: Capacity of the CHSWT to estimate commodity needs and request these commodities from the central MOHSW	/4
	Standard 4.1.2: The CHSWT's capacity to use a Logistics Management Information System (LMIS)	/4
	Standard 4.1.3: CHSWT's capacity to effectively store and distribute commodities	/4
Building Block 5: Health Systems Financing		/12
Indicator 5.1 Capacity of CHSWT to formulate, distribute, and monitor financing for the health sector		
	Standard 5.1.1: CHSWT capacity to plan for, create and allocate a sustainable budget	/4
	Standard 5.1.2: Capacity of CHSWT to effectively distribute finances	/4
	Standard 5.1.3: Capacity of CHSWT to monitor finances at the County and facility levels	/4
Building Block 6: Governance and Leadership		/16
Indicator 6.1: Capacity of CHSWT to implement activities aimed at improving the health of all people within the county		
	Standard 6.1.1: Capacity of CHSWT to implement the National Health and Social Welfare Policy and Plan	/4
Indicator 6.2: Capacity of CHSWT to communicate and share best practices with the central MOHSW and with other CHSWTs		
	Standard 6.2.1: Capacity to communicate and share reports, documents and plans with the central MOHSW and other CHSWTs	/4
	Standard 6.2.2: Capacity of the CHSWT to lead and engage with DHSWT and health facilities	/4
	Standard 6.2.3: Capacity of CHSWT to hold responsibility and ownership for the health system within their county	/4
TOTAL SCORE		/100

Questions by Building Block¹⁵

Building Block 1: Delivering Essential Health Services

Indicator 1.1: Capacity of CHSWTs to engage with central MOHSW and Health Facilities (HF) in delivering the health and social welfare services

Standard 1.1.1: Extent of interaction between CHSWTs and central MOHSW	
0	No interaction between the CHSWTs and the central MOHSW.
1	CHSWTs interact with central MOHSW at least once a year, but only on budget and finance related activities.
2	CHSWTs interact with central MOHSW at least once a year on budget, finance, and health service planning activities.
3	CHSWTs interact with central MOHSW at least once a year on budget, finance, health service planning activities, and maintenance and coordination of facilities.
4	CHSWTs interact with central MOHSW at least quarterly on budget, finance, health service planning activities, maintenance and coordination of facilities, and assessing and planning community health needs.
Comments:	

Standard 1.1.2: Extent of interaction between CHSWTs and Health Facilities (HF)	
0	No interaction with HF.
1	Health facilities exist, but interaction between the CHSWT and HF is sporadic.
2	CHSWTs interact at least monthly with HF, but the oversight and sharing of key information is sporadic.
3	CHSWTs meet at least monthly with HF to do some, but not all of the following: share key information and policies, conduct supervisory visits, obtain health and logistics data, and provide feedback to facilities on data submitted.
4	CHSWTs meet more than monthly with HF to share key information and policies, conduct supervisory visits, obtain health and logistics data, and provide feedback to facilities on data submitted.
Comments:	

¹⁵ The five building blocks included in this tool are taken from the World Health Organization's six Building Blocks of a Health System (see <http://www.who.int/healthinfo/systems/monitoring/en/index.html> for details).

Indicator 1.2: Capacity of CHSWTs to Ensure Appropriate use of Policies and Standards Related to Health Service Delivery for the Essential Package of Health Services (EPHS) Areas and Subareas (Subareas refers to the components of the EPHS outlined on pages 50-52 of the National Health and Social Work Plan, such as Antenatal care as a subarea within Maternal and newborn health services)⁴

Standard 1.2.1: Capacity of CHSWTs to supervise health facilities (HF) in the use of health service delivery standards	
0	No existing systems in place to distribute or monitor adherence to policies, guidelines and standards.
1	The CHSWT distributes policies, plans and standards to HF, but does not have a system in place to monitor adherence to these standards. If health partners are monitoring adherence to standards, it is using their own separate systems.
2	The CHSWT distributes policies, plans and standards to HF. Some elements of a basic system are used for monitoring of adherence to standards. Specifically, the CHSWTs use guidelines for one or two of the following areas: lines of responsibility, supervision schedule, supervision guidelines/checklists for facilities and/or health workers.
3	The CHSWT distributes policies, plans and standards to HF. Some elements of a basic system are used for monitoring of adherence to standards. Specifically, the CHSWTs use guidelines for more than two of the following areas: lines of responsibility, supervision schedule, supervision guidelines/checklists for facilities and/or health workers. No feedback is provided to central MOHSW regarding supervision of HF.
4	The CHSWT routinely distributes and monitors HF regarding adherence to standards as per the previous (#3) and provides feedback to the central MOHSW.
Comments:	

Standard 1.2.2: Number of operational public health facilities as compared to those projected in the National Health and Social Welfare Plan	
0	CHSWT does not have a list of the number of public health facilities within the County.
1	CHSWT has a list of the number of public health facilities, but there is no current documentation if these facilities are operational (an operational facility is one that provides EPHS at least three days a week, with at least two clinical staff members).
2	CHSWT has a current list of the number of operational public health facilities, but the number of operational facilities is basically unchanged (within 5%) from the levels reported in the National Health and Social Welfare Plan (page 61).
3	The number of Government of Liberia (GOL) operational health facilities is at least 75% ¹⁶ of the projected public network 2021 ¹⁷ within the county.
4	The total number of GOL operational health facilities is at least 80% of the projected public network 2021 within the county.
Comments:	

¹⁶ The 2011 numbers (i.e., the baseline) are 73% of the 2021 numbers

¹⁷ Please see page 59 of the National Health and Social Welfare Plan, 2011-2021

Standard 1.2.3: Capacity of CHSWT to safely handle and dispose of medical products and bi-products

A comprehensive medical products and bi-products disposal policy should include all of the following: waste minimization, segregation, handling, storage, transport, treatment and disposal. The policy should also include a pictorial representation of waste segregation and standard operating procedures for the different steps to handle various categories of waste.

0	CHSWT has no policy or practices to support safe handling and disposal of medical products and bi-products.
1	The CHSWT and health facilities have policies in place to support safe handling and disposal of medical products and bi-products, but the policies are not comprehensive (see definition above) and implementation of these policies is inconsistent.
2	The CHSWT and health facilities have comprehensive policies in place to support safe handling and disposal of medical products and bi-products, but the implementation of these policies is inconsistent (either across facilities, or across areas within the policy).
3	The CHSWT and health facilities have comprehensive policies in place to support safe handling and disposal of medical products and bi-products, and are routinely implementing the three minimum steps (waste segregation, waste storage, and waste treatment/ disposal).
4	The CHSWT and health facilities have comprehensive policies in place to support safe handling and disposal of medical products and bi-products, and are routinely implementing all seven steps (Waste minimization, segregation, handling, storage, transport, treatment, and disposal).
Comments:	

Indicator 1.3: Capacity of CHSWTs to deliver health care in priority areas

Standard 1.3.1: Capacity of CHSWT to implement programs identified by the Department of Health Services at the central MOHSW level

The programs being considered are: National Leprosy and Tuberculosis Control (NLTC) program, National Malaria Control Program (NMCP), National AIDS Control Program (NACP), Expanded Program on Immunization (EPI), Neglected Tropical Diseases (NTD), and National Eye Care Program (NECP).

0	CHSWT does not have any capacity to implement the program.
1	CHSWT is completely aware of program policy and guidelines. There are program guidelines in place to guide CHSWT staff implementing the program.
2	In addition to criteria #1, CHSWT has reached at least 50% of program targets.
3	In addition to criteria #1, CHSWT has reached at least 75% of program targets.
4	In addition to criteria #1, CHSWT has reached 100% of program targets.

Comments:

Scoring of Standard 1.3.1

a) Scores from each individual program for standard 1.3.1 above:

Program									
Score /4									

b) Total score from above table (a) = _____

c) Total number of programs included = _____

d) Average score (b/c) = _____ Please enter this score for Standard 1.3.1 above.

* Standard 1.3.1 will be measured as an average of responses from each individual program. All criteria will be modified for each program and all responses will be aggregated to arrive at a score for 1.3.1. For example, applying standard 1.3.1 to the National Malaria Control Program (NMCP):

0: CHSWT does not have any capacity to implement NMCP

1: CHSWT is completely aware of program policy and guidelines. There is a program book in place to guide CHSWT staff implementing the program

2: In addition to criteria #1, CHSWT has reached at least 50% of program targets

3: In addition to criteria #1, CHSWT has reached at least 75% of program targets

4: In addition to criteria #1, CHSWT has reached 100% of program targets

Standard 1.3.2: Capacity of CHSWT to address community health needs	
0	CHSWT has no capacity to identify community health needs.
1	Health partners have conducted a community health needs assessment and CHSWT has access to the findings. CHSWT was not involved in the needs assessment.
2	CHSWT has conducted a community health needs assessment with the help of health partners in the last three years.
3	In addition to criteria #2, CHSWT has identified and prioritized community health problems with the help of health partners.
4	In addition to criteria #3, CHSWT has developed an operational plan to address community health needs with the help of health partners and MOHSW.
Comments:	

Building Block 2: Health Workforce

Indicator 2.1: Capacity of CHSWT in workforce recruitment and deployment

Standard 2.1.1: Ability to recruit human resources for health care workforce	
0	CHSWT has no authority towards recruiting staff. In cases where CHSWT has authority, job descriptions do not routinely exist.
1	Health partners recruit and develop job descriptions for health workers.
2	The CHSWT has input into the recruitment of staff, and the development of job descriptions, however health partners are still heavily involved in this process.
3	The CHSWT and health partners recruit staff based on jointly identified needs. Central MOHSW job descriptions are routinely used.
4	The CHSWT coordinates the recruitment and payment of staff. Staff are provided MOHSW job descriptions. As necessary, health partners support implementation.
Comments:	

Standard 2.1.2: Capacity of the CHSWT to staff health facilities as per National Staffing Guidelines	
0	Standards for appropriate staffing for each level of the health system do not exist.
1	National staffing standards have been developed, but the CHSWT are not able to track staffing levels within facilities.
2	National staffing standards exist and a system has been developed to track staffing levels, but use of the system by the CHSW/ is not consistent.
3	Adequate staffing data exist. Less than 50% of reported health facilities have both key clinic staff – Officer in Charge (OIC) and Certified Midwife (CM).
4	Adequate staffing data exist and at least 75% of the reported health facilities have both key clinic staff (OIC and CM).
Comments:	

Indicator 2.2: Capacity of the CHSWT to strengthen existing health workforce

Standard 2.2.1: Capacity of CHSWT to monitor staff performance	
0	There are no policies or guidelines in place to review staff performance.
1	With minimal assistance from the CHSWT, health partners monitor staff performance based on health partner processes. Timing of supportive supervision/performance monitoring visits is less than yearly.
2	In partnership with the CHSWT, health partners assess staff performance using national guidelines and tools (e.g. standardized staff performance checklists). Timing of supportive supervision/performance monitoring visits is less than yearly.
3	The CHSWT takes the lead on assessing staff performance using MOHSW guidelines and tools (e.g. standardized staff performance checklists). Timing of supportive supervision/performance monitoring visits is annual.
4	The CHSWT coordinates and support staff performance process utilizing MOHSW developed guidelines. Staff performance is monitored at least annually. Staff performance is tied to annual reviews and promotions.
Comments:	

Standard 2.2.2: Capacity of CHSWTs to coordinate capacity development of health staff	
0	No in-service training is provided for health staff, or training is completely ad hoc.
1	Health partners provide training on EPHS based on health partner curricula and processes.
2	In partnership with the CHSWT, health partners provide training on EPHS using curricula and processes developed by health partners. Training information is provided to MOHSW and CHSWT.
3	The CHSWT and health partners provide training on EPHS using MOHSW-approved curricula and processes. Training schedules are not fully coordinated/ communicated to all relevant stakeholders.
4	CHSWT coordinates in-service training, utilizing MOHSW approved curricula. Training follows a coordinated schedule that enables the appropriate staff to attend appropriate trainings, in a manner that prevents excessive loss of clinical service delivery time.
Comments:	

Building Block 3: Health Information Systems

Indicator 3.1: Capacity of the CHSWT to plan for and systematically collect health information

Adapted from the WHO's *Monitoring the Building Blocks of Health Systems*, key components of a HIS include: health surveys, birth/death registration, routine health information (usually from health facilities), surveillance, and census data (this last one may not be the responsibility of the central MOHSW).

Standard 3.1.1: Capacity of the CHSWT to roll out HIS policies and forms	
0	The CHSWT has not been informed of a health information system (HIS) policy. Neither the CHT nor the HF have national HMIS forms.
1	The CHSWT is aware of the national HIS policy but has inconsistent access to the national data collection tools. Key staff members at the county and facility level have not been provided training on HMIS data collection.
2	The CHSWT is aware of the national HIS policy and has consistent access to the national data collection tools. Health workers are aware of the national HIS policy, but have limited access to the national data collection tools and no trainings on the use of these tools.
3	CHSWT awareness and access as per #2. Health workers are aware of the national HIS policy and have consistent access to the national data collection tools. Annual training on use of these forms has reached less than 75% of health workers within the county.
4	CHSWT and health worker awareness and access as per #3. Annual training on use of these forms has reached at least 75% of health workers within the county.
Comments:	

Standard 3.1.2: Capacity of CHSWT to collect health data	
0	CHSWT does not collect health data from health facilities. Health partner data collection is irregular.
1	Health partners routinely collect data from health facilities using systems and forms developed by the health partner. Data collected by health partners is not routinely shared with the CHSWT.
2	Health partners routinely collect data from health facilities using national data collection systems and forms. The CHSWT receives timely and complete reports from less than 75% of health facilities for the last reporting period.
3	Health partners routinely collect data from health facilities using national data collection systems and forms. The CHSWT receives timely and complete health data from at least 75% of the health facilities.
4	For the last reporting period, the CHSWT received timely and complete health data from at least 75% of the health facilities and has provided regular feedback ¹⁸ to all health facilities.
Comments:	

¹⁸ Feedback should include identification of errors, discussion around ways to improve data collection

Standard 3.1.3: Capacity of CHSWT to manage data	
0	No storage systems exist at the CHSWT for health data.
1	Separate storage systems (paper or electronic) exist for the various components of the HIS, but it is difficult or impossible to manipulate or extract data from the system.
2	Electronic storage systems (databases) exist at the CHSWT for various components of HIS; however data are not routinely extracted for reports and other use.
3	Electronic storage systems (databases) exist at the CHSWT for various components of the HIS, and data are routinely extracted (at least annually) for use. However, integration of information from other health management systems (i.e., financial, human resource, logistics information, and physical assets data systems) is generally not done.
4	In addition to the above (#3) criteria on data storage and extraction, some integration of information from other health management systems (i.e., financial, human resource, logistics information, and physical assets data systems) is evident.
Comments:	

Indicator 3.2: Capacity of CHSWT to promote evidence-based decisions and policy making

Standard 3.2.1: Capacity of CHSWT to use collected data for planning and policy making	
0	The CHSWT does not use data for strategic planning and decision making.
1	The CHSWT analyses available HIS data quarterly and distributes reports containing these analyses to key members of the CHSWT. Use of these data is unknown.
2	The CHSWT analyses available HIS data quarterly and distributes reports containing these analyses to key members of the CHSWT. In addition, presentation and discussion of data are part of CHSWT meetings.
3	The CHSWT analyses available HIS data quarterly and distributes reports containing these analyses to key members of the CHSWTs. The CHSWT can identify at least two examples of how data have been integrated into a decision-making process in the past year.
4	The CHSWT analyses available HIS data quarterly and distributes reports containing these analyses to key members of the CHSWTs. The CHSWT can identify at least four examples of how data have been integrated into a decision-making process in the past year.
Comments:	

Building Block 4: Access to Essential Medicines

Indicator 4.1: Capacity of CHSWT to ensure access to essential medicines for the county

Standard 4.1.1: Capacity of the CHSWT to estimate commodity needs	
0	No capacity (partners or CHSWT) is available within the county to estimate commodity needs (supervise facilities in the reordering and report this information to the central MOHSW).
1	CHSWT is reliant on assistance from partners to estimate commodity needs.
2	CHSWT, with some assistance from partners, is able to estimate commodity needs.
3	CHSWT is able to estimate commodity needs, however the timing of these estimates is haphazard.
4	CHSWT is able to estimate commodity needs according to schedule.
Comments:	

Standard 4.1.2: The CHSWT's capacity to use a Logistics Management Information System (LMIS)	
0	No LMIS exists.
1	An LMIS exists, but the CHSWT and facilities do not have all of the LMIS forms, and use of these forms is inconsistent. Less than 60% of staff involved in the LMIS have been trained on the system.
2	The CHSWT and facilities have the LMIS forms, and at least 60% of staff involved in the LMIS have been trained in use of the forms/system. Reporting of LMIS data is below 50% for all facilities over the past reporting period.
3	The CHSWT and facilities have all of the LMIS forms, and more than 75% of staff involved in the LMIS have been trained in use of the forms/system. Reporting of LMIS data is below 75% for all facilities over the past reporting period.
4	The CHSWT and facilities have all of the LMIS forms, and more than 75% of staff involved in the LMIS have been trained in use of the forms/system. However, reporting of LMIS data is above 75% for all facilities over the past reporting period.
Comments:	

Standard 4.1.3: CHSWT's capacity to effectively store and distribute commodities	
0	Storage and distribution of commodities, including essential medicines, is haphazard with no special storage requirements of pharmaceuticals and other items.
1	County warehouse(s) for commodity storage exists, with some accommodation for items requiring special storage. Maintenance, cleanliness and size of the county warehouse may be insufficient.
2	The county warehouse meets at least two of the following four criteria: warehouse size is adequate, storage space is well-maintained and clean (including pest control), has designated storage equipment for special storage needs, and distribution to health facilities follows a consistent schedule.
3	The county warehouse meets at least three of the following four criteria: warehouse size is adequate, storage space is well maintained and clean (including pest control), has designated storage equipment for special storage needs, and distribution to health facilities follows a consistent schedule.
4	The county warehouse(s) is adequate (i.e. large enough, regularly cleaned, dry, well organized) with all special needs storage areas clearly designated with correct signage, and established delivery intervals from county warehouse to health facilities exist and are routinely followed, including the use of protocols (such as first expired, first out).
Comments:	

Block 5: Health Systems Financing

Indicator 5.1 Capacity of CHSWT to formulate, distribute, and monitor financing for the health sector

Standard 5.2.1: Capacity of the CHSWT to plan for, create and allocate a sustainable budget

The four criteria necessary in a *sustainable budget* are as follows:

Planning: CHSWT has a realistic and sustainable budget given past experience/expenses, donors and projections.

Input: All key stakeholders are involved (including MOHSW and CHSWTs, and as necessary, donors/partners).

Allocation: CHSWT compiles an adequate budget to support facilities and services, with specific line items for key areas outlined in the National Health and Social Welfare Policy and Plan.

Initiative: Process for collection of budget information is led collectively by the MOHSW and CHSWTs and the system is standardized across all CHSWTs.

0	No sustainable budget exists (planning, input, allocation, and initiative).
1	Three of the budget sustainability criteria need improvement (planning, input, allocation, and initiative).
2	Two of the budget sustainability criteria need improvement (planning, input, allocation, and initiative).
3	One of the budget sustainability criteria needs improvement (planning, input, allocation, and initiative).
4	All of the budget sustainability criteria are completed and sustainable, with the MOHSW/CHSWTs taking the lead on developing the budget (planning, input, allocation, and initiative).
Comments:	

Standard 5.1.2: Capacity of CHSWT to effectively distribute finances

The four factors necessary to *effectively distribute finances* are as follows:

Financial System: A system exists within the CHSWT to distribute funds among its activities. This includes differentiating by funding recipient (e.g., by line item, and by facility or district).

Tracking: CHSWT has a system to track its distributed funds against its total budget, the facility distributions against total budgets, manage cash flow and segregate expenses.

Policies: Guidelines for allowable expenses exist and are distributed among CHSWT. These policies are implemented on a regular basis.

Responsibility: Monthly review of internal expenses versus revenue (both for the CHSWT budget and each facility's budget) is designated to an employee(s) as a responsibility.

0	No system to distribute funds exists (financial system, tracking, policies, and responsibility).
1	Three of the budget distribution factors need improvement (financial system, tracking, policies, and responsibility).
2	Two of the budget distribution factors need improvement (financial system, tracking, policies, and responsibility).
3	One of the budget distribution factors needs improvement (financial system, tracking, policies, and responsibility).
4	All of the budget distribution factors are completed and sustainable (financial system, tracking, policies, and responsibility).
Comments:	

Standard 5.1.3: Capacity of CHSWT to monitor finances at the County and facility levels¹⁹

The four factors necessary to *effectively monitor finances* are as follows:

Documentation: CHSWT keeps financial documentation in a secure place, has a policy for keeping receipts and requirements for documentation kept with each type of payment. These policies are flowed down to county health facilities and adherence is monitored.

Review: CHSWT reviews expenses monthly to ensure applicability and allowability according to the budget and internal policies. Exceptions are documented.

Reporting: A reporting system exists both for the CHSWT to report to the central MOHSW and for the county health facilities to report to the CHSWT. Reports are completed and submitted according to applicable deadlines.

Audit: CHSWT either has an internal review of its, and the county health facilities, accounting systems or hires external auditors on an annual basis.

0	No tracking/monitoring system exists.
1	Three of the factors necessary to effectively monitor finances within the CHSWT need improvement (documentation, review, reporting, and audit); this includes monitoring of finances at facilities.
2	Two of the factors necessary to effectively monitor finances within the CHSWT need improvement (documentation, review, reporting, and audit) this includes monitoring of finances at facilities.
3	One of the factors necessary to effectively monitor finances within the CHSWT need improvement (documentation, review, reporting, and audit) this includes monitoring of finances at facilities.
4	All of the factors necessary to effectively monitor finances within the CHSWT are completed and sustainable (documentation, review, reporting, and audit) this includes monitoring of finances at facilities.
Comments:	

¹⁹ This applies only to facilities that have their own budget

Block 6: Governance and Leadership

Indicator 6.1: Capacity of CHSWT to implement activities aimed at improving the health of all people within the county

Standard 6.1.1: Capacity of CHSWT to implement the National Health and Social Welfare Policy and Plan (NHSWPP) and County Health and Social Welfare Policy and Plan (CHSWPP)	
0	CHSWT is not aware of the NHSWPP and CHSWPP.
1	CHSWT is aware of both plans; however no systems of communication exist between CHSWT and the central MOHSW to implement the plans.
2	CHSWT is aware of the both plans and systems of communication exist between CHSWT and the central MOHSW to implement the plans. Central MOHSW takes the lead in implementation of both plans at CHSWT and HF level.
3	CHSWT awareness and communication as per #2. MOHSW and CHSWT jointly implement activities listed in both plans, with CHSWT taking the lead.
4	CHSWT awareness and communication as per #3. CHSWT takes the lead in implementing the plans with input from HF and guidance from central MOHSW.
Comments:	

Indicator 6.2: Capacity of CHSWT to communicate and share best practices with the central MOHSW and with other CHSWTs

Standard 6.2.1: Capacity to communicate and share reports, documents, and plans with the central MOHSW and other CHSWTs	
0	No evidence of communication plan and protocols for information to flow within the CHSWT and to either the central MOHSW or other CHSWTs.
1	Communication, meetings and sharing of reports, documents and plans happen in an ad hoc manner.
2	Representatives from the CHSWT attend meetings with the central MOHSW, but meetings and attendance is ad hoc. Reports, documents, and plans are submitted on time less than 50% of the time.
3	Representatives from the CHSWT attend meetings with the central MOHSW, but meetings and attendance is ad hoc. Reports, documents, and plans are submitted on time at least 50% of the time.
4	Representatives from the CHSWT attend regular meetings with the central MOHSW, and submit reports and plans on time at least 75% of the time.
Comments:	

Standard 6.2.2: Capacity of the CHSWT to lead and guide health facilities (HF)	
0	No evidence of information flow between CHSWT and HF.
1	Occasional meetings are held between the CHSWT and HFs, but these are irregular, and do not involve all facilities. CHSWT has no or limited engagement with HF to be an advocate for county health service needs.
2	Regular meetings are held between the CHSWT and HF. The CHSWT receives no input from HF regarding decisions affecting county health services.
3	Meetings are regularly held between the CHSWT and all HF, and key relevant information is shared through these meetings. CHSWT receives regular input (in the form of reports) from at least 50% of HF.
4	Meetings are regularly held between the CHSWT and all HF, and key relevant information is shared through these meetings. CHSWT receives regular input (in the form of reports) from all HF. All HF are fully involved in decision making and policy development affecting the county health services.
Comments:	

Standard 6.2.3: Capacity of CHSWT to hold responsibility and ownership for the health system within their county	
0	The county health system is predominantly run by health partners, with gaps existing where partners are not implementing services. The CHSWT has little input into leadership and governance over the system.
1	The health system is predominantly run by health partners, with input from the CHSWT and/or the central MOHSW.
2	Leadership and a sense of ownership of the county health system is generally held by the CHSWT, with significant input from donors and health partners.
3	The CHSWT demonstrates clear leadership (as defined by organized roles, responsibilities, and communications – within central MOHSW and between central and county level) over at least three of the six WHO building blocks of the health system ²⁰ . Donors and health partners are reasonably clear on their role within the system.
4	The CHSWT demonstrate clear leadership over each of the six WHO building blocks of the health system. Donors and health partners are reasonably clear on their role within the system (if any).
Comments:	

²⁰ Please see WHO’s publication *Monitoring the Building Blocks of Health Systems*. As per this publication, the six building blocks are health service delivery, health workforce, health information systems, access to essential medicines, health systems financing, and leadership and governance.

4.12 CAPACITY ASSESSMENT TOOLS: CHSWT qualitative

Capacity Assessment – Qualitative Interview County Health and Social Welfare Team (CHSWT) level

Introduction and Instructions

This tool was developed by the Liberia Ministry of Health and Social Work (MOHSW) and the County Health and Social Work Team (CHSWT) with technical assistance from Rebuilding Basic Health Services (RBHS). Its purpose is to help the MOHSW determine priority areas for capacity building to help strengthen the Liberian health system. The tool is based on the World Health Organization (WHO) Health Systems Framework that focuses on six building blocks of a health system.

Use of the tool is meant to be collaborative in nature, with members of the assessment team working through each component of the tool together. A copy of the tool should be shared with all assessment participants ahead of time, to help participants prepare for the assessment (i.e., to have a sense of what questions will be discussed, and to locate any relevant documents that will be useful in answering the questions). During the assessment process, participants from the MOHSW, CHSWT, and the RBHS should read through the response options under each standard (component) together, and through discussion, come to a consensus on the appropriate score to assign for each standard.

The tool is meant to be used in conjunction with the quantitative interview guide, and has similar tools available for use at the National (Central MOHSW) level.

Introduction:

Thank you for agreeing to participate in the capacity assessment of [insert name of county here] CHSWT. The assessment is designed to understand current capacity within your CHSWT and identify areas that require capacity building. Findings from this discussion will influence the capacity building strategy. All responses are confidential. We will not cite any respondent names or titles in the reports.

Contextual questions:

1. What are the three major health problems in your county? How did you identify these problems?
2. What is the County Health and Social Welfare Team (CHSWT) role in developing and implementing the National Health and Social Welfare Policy and Plan (NHSWPP)?
3. What is the CHSWT role in promoting decentralization? How well do you think you are equipped to implement decentralization activities within the year?
4. What is the role of County Health and Social Welfare Board in your county? Please elaborate on the Board's involvement in CHSWT's activities.

Building Block 1: Delivering essential health services

1. What health services do you currently provide?
2. What are the priority health needs in your county?
 - a. How were the priorities assessed?
 - b. Who conducted the assessment?
 - c. Are your services delivered based on priorities? If not, please explain.
3. Who manages health services at the county level?
4. What mechanisms are in place to involve community stakeholders and partners in planning for service delivery?
 - a. Do you convene regular community stakeholder meetings?
 - b. What is discussed in these meetings?
5. Has the CHSWT conducted an exercise to plan for health services?
 - a. How often is planning conducted?
 - b. Have you developed a general work plan for the CHT? Please explain
 - c. Have you developed unit-specific work plans? Please explain.
 - d. Who is involved in the planning process?
 - e. How is the planning process organized?
6. Who decides what services need to be provided at the county and district level?
 - a. How is supervision conducted at county health team?
 - b. How do you conduct supervision at district health facility level?
 - c. Is supervision focused on medical audits or coaching and performance improvement or both? What approach to supervision is used?
 - d. How often is supervision conducted?

- e. How are supervision needs determined? (Needs-based or regularly scheduled?)
 - f. Who conducts the supervision visits?
 - g. Is there clarity about levels of supervision (who supervise who) and reporting?
 - h. What tools are used to conduct supervision?
 - i. Is supervision results link to any type of rewarding/recognition/incentives system?
 - j. What are the challenges to conducting supervision?
7. What guidance do you receive from central MOHSW level towards service delivery?
8. What is the CHSWT's capacity towards delivering Essential Package of Health Services (EPHS)?
- a. Maternal and newborn services
 - i. Where are you with your targets for maternal and newborn services?
 - ii. Do you anticipate reaching all your targets for the year? If no, please explain why
 - iii. What assistance do you need to reach your targets?
 - b. Child health services
 - i. Where are you with your targets for child health services?
 - ii. Do you anticipate reaching all your targets for the year? If no, please explain why
 - iii. What assistance do you need to reach your targets?
 - c. Family Planning and Reproductive health
 - i. Where are you with your targets for reproductive health services?
 - ii. Do you anticipate reaching all your targets for the year? If no, please explain why
 - iii. What assistance do you need to reach your targets?
 - d. Communicable disease prevention and control
 - i. Where are you with your targets for communicable disease prevention and control services?
 - ii. Do you anticipate reaching all your targets for the year? If no, please explain why
 - iii. What assistance do you need to reach your targets?
9. What is the CHSWT's capacity towards implementing National Malaria Control Program (NMCP)?
- a. What are the activities of NMCP in your county?
 - b. Are you involved with identifying targets for NMCP in your county? If yes, what is your level of involvement?
 - c. Where are you with your targets for NMCP?
 - d. Do you anticipate reaching all your targets for the year? If no, please explain why
 - e. What assistance do you need to reach your targets?
10. What is the CHSWT's capacity towards implementing Expanded Program on Immunization (EPI)?
- a. What are the activities of EPI in your county?
 - b. Are you involved with identifying targets for EPI in your county? If yes, what is your level of involvement?
 - c. Where are you with your targets for EPI?

- d. Do you anticipate reaching all your targets for the year? If no, please explain why
 - e. What assistance do you need to reach your targets?
11. What is the CHSWT's capacity towards implementing National Leprosy and Tuberculosis Control Program (NLTCP)?
 - a. What are the activities of NLTCP in your county?
 - b. Are you involved with identifying targets for NLTCP in your county? If yes, what is your level of involvement?
 - c. Where are you with your targets for NLTCP?
 - d. Do you anticipate reaching all your targets for the year? If no, please explain why
 - e. What assistance do you need to reach your targets?
 12. What is the CHSWT's capacity towards implementing National AIDS Control Program (NACP)?
 - a. What are the activities of NACP in your county?
 - b. Are you involved with identifying targets for NACP in your county? If yes, what is your level of involvement?
 - c. Where are you with your targets for NACP?
 - d. Do you anticipate reaching all your targets for the year? If no, please explain why
 - e. What assistance do you need to reach your targets?
 13. What is the CHSWT's capacity towards implementing Neglected Tropical Diseases (NTD)?
 - a. What are the activities of NTD in your county?
 - b. Are you involved with identifying targets for NTD in your county? If yes, what is your level of involvement?
 - c. Where are you with your targets for NTD?
 - d. Do you anticipate reaching all your targets for the year? If no, please explain why
 - e. What assistance do you need to reach your targets?
 14. What is the CHSWT's capacity towards implementing National Eye Care Program (NECP)?
 - a. What are the activities of NECP in your county?
 - b. Are you involved with identifying targets for NECP in your county? If yes, what is your level of involvement?
 - c. Where are you with your targets for NECP?
 - d. Do you anticipate reaching all your targets for the year? If no, please explain why
 - e. What assistance do you need to reach your targets?
 15. What is the CHSWT's capacity towards addressing mental health problems?
 - a. Do you have a mental health program/ unit/ division?
 - b. Have you identified focus areas in mental health?
 - c. Have you developed an operational plan to address these focus areas?
 - d. Have you set targets for addressing mental health issues in your county? Please explain.
 - e. What do you think are the major mental health problems in your county?
 - f. What are the major challenges towards addressing mental health problems in your county?
 - g. What assistance do you need to address issues mental health problems in your county?
 - h. What are your major accomplishments in addressing mental health problems in your county?

16. What is the CHSWT's capacity towards addressing nutrition problems?
 - a. Do you have a nutrition program/ unit/ division?
 - b. Have you identified focus areas in nutrition?
 - c. Have you developed an operational plan to address these focus areas?
 - d. Have you set targets for addressing nutrition problems in your county? Please explain.
 - e. What do you think are the major nutrition problems in your county?
 - f. What are the major challenges towards addressing nutrition problems in your county?
 - g. What assistance do you need to address issues nutrition problems in your county?
 - h. What are your major accomplishments in addressing nutrition problems in your county?
17. What is the CHSWT's capacity towards addressing health promotion issues?
 - a. Do you have a health promotion program/ unit/ division?
 - b. Have you identified focus areas in health promotion?
 - c. Have you developed an operational plan to address these focus areas?
 - d. Have you set targets for addressing health promotion problems in your county? Please explain.
 - e. What do you think are the major health promotion areas for your county?
 - f. What are the major challenges towards addressing health promotion problems in your county?
 - g. What assistance do you need to address issues health promotion problems in your county?
 - h. What are your major accomplishments in addressing health promotion problems in your county?
18. What is the CHSWT's capacity towards addressing community health problems?
 - a. Do you have a community health program/ unit/ division?
 - b. Have you identified focus areas in community health?
 - c. Have you developed an operational plan to address these focus areas?
 - d. Have you set targets for addressing community health problems in your county? Please explain.
 - e. What do you think are the major community health problems in your county?
 - f. What are the major challenges towards addressing community health problems in your county?
 - g. What assistance do you need to address issues community health problems in your county?
 - h. What are your major accomplishments in addressing community health problems in your county?
19. What is the CHSWT's capacity towards addressing problems with health care infrastructure?
 - a. Do you have a focal person to identify infrastructure problems?
 - b. Have you identified infrastructure problems in your county and district facilities?
 - c. Have you developed an operational plan to address these problems?
 - d. Have you set targets for addressing infrastructure issues in your county? Please explain.
 - e. What are the major infrastructure problems in your county?
 - f. What are the major challenges towards addressing infrastructure issues in your county?

- g. What assistance do you need to address infrastructure problems?
 - h. What are the major accomplishments towards improving infrastructure in your county?
20. What is the CHSWT's capacity towards addressing environment health issues?
- a. Do you have a focal person to identify environmental health problems?
 - b. Have you identified environmental problems in your county and district facilities?
 - c. Have you developed an operational plan to address these problems?
 - d. Have you set targets for addressing environmental health problems in your county?
Please explain.
 - e. What are the major environmental health problems in your county?
 - f. What are the major challenges towards addressing environmental health problems in your county?
 - g. What assistance do you need to address environmental health problems?
 - h. What are the major accomplishments towards improving environmental health in your county?
21. What information/ data do you wish you had when it comes to planning for service delivery?
22. What are the major challenges facing service delivery?
23. What are the major accomplishments of service delivery?

<p>Building Block 2: Health Workforce</p>
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1. Briefly describe the CHSWT strategy to mobilize and distribute health workforce based on county needs
 - a. How are the needs assessed?
 - b. Who is involved in the needs assessment?
 - c. How often is a workforce needs assessment conducted?
2. Briefly describe mechanisms in place to review staff performance
 - a. How often are performance reviews conducted?
 - b. What is the course of action after a performance review?
3. Briefly describe the mechanisms in place to promote accountability, and transparency in the workforce
 - a. Are there clear guidelines in the job descriptions about staff roles and responsibilities?
Please describe one or more
 - b. How often are these guidelines reviewed and implemented?
4. What mechanisms are in place to address workforce absenteeism?
5. What mechanisms are in place to address poor productivity?
6. What input do you provide to central MOHSW have towards developing (recruiting and retaining) county level workforce?
7. Describe any agreements made with health training institutions to provide in-service training for staff
 - a. How are these training needs identified?
 - b. How often is a training needs assessment conducted?

- c. Is there a formal mechanism to engage health training institutions to provide training? Please elaborate.
- 8. What types of trainings have been provided in the past year?
 - a. Who were trained?
 - b. How are staff selected to be trained?
 - c. How were the training needs identified?
 - d. Who initiated/ requested the training?
 - e. Who conducted the training? (CHSWT, central MOHSW, partner?)
 - f. How was the training funded?
- 9. What are your training needs towards each area listed in the Essential Package of Health Services (EPHS)?
 - a. Maternal and newborn health services
 - b. Child health services
 - c. Family Planning and Reproductive health
 - d. Communicable disease prevention and control
- 10. What are your training needs towards each vertical program?
 - a. NMCP
 - b. EPI
 - c. NLTC
 - d. NACP
 - e. NTD
 - f. NECP
 - g. Mental Health
 - h. Nutrition
 - i. Health Promotion
 - j. Community Health
- 11. What is your workforce capacity towards providing supervision at the county and district level?
 - a. What kind of trainings have you had to provide supervision?
 - b. What are your training needs towards providing supervision?
 - c. Do you provide feedback after supervision has been conducted? In what form?
- 12. Briefly describe mechanisms in place to review staff competencies and performance
 - a. What is the course of action after a performance review?
 - b. What are the strategies for continuous performance improvement?
- 13. What is your capacity towards ensuring quality health care?
 - a. Please describe the quality assurance trainings your workforce received
 - b. What are your training needs towards ensuring quality assurance?
- 14. What is the CHT's capacity towards retaining existing workforce?
 - a. Do you offer any incentives? Please explain.
 - b. Are there any employment agreements to retain staff? Please explain.
- 15. Identify three priority areas where you need training within the next 6 months
- 16. What are the major challenges for strengthening health workforce?
- 17. What are the major accomplishments of CHSWT towards strengthening workforce?

Building Block 3: Health Management Information Systems

Will be measured separately using Performance of Routine Information Systems Management (PRISM) tools

Building Block 4: Access to essential medicines

1. Briefly describe the CHSWT strategy to ensure access to essential medicines
 - a. Where do your medicines come from?
 - b. What mechanisms are in place to assess needs of medicines in your county?
 - c. What mechanisms are in place to ensure proper distribution based on need?
2. To what extent is the national essential medicines plan implemented in your county?
 - a. Do you receive guidance from MOHSW or partners towards implementing the national essential medicines plan in your county?
 - b. Who is responsible for the county level implementation?
3. Is there an inventory to monitor stocks of essential medicines?
 - a. What is maintained in the inventory? (medicines, equipment, supplies)
 - b. Who manages the inventory?
 - c. What is the procedure to report stock imbalances?
4. What is your capacity towards assessing medicine needs in your county in the EPHS areas?
 - a. Do you have a plan to assess current needs?
 - b. Do you have a plan to assess future needs?
5. What is your capacity towards distributing essential medicines to district health facilities?
 - a. Do you have a distribution plan? Please describe
6. What is the role of community-based groups and networks in community commodity distribution?
7. What is the role of private sector in commodity distribution?
8. What are the major challenges in ensuring access to essential medicines in your county?
9. What are the major accomplishments of your county in ensuring access to essential medicines?

Building Block 5: Health systems financing

1. Briefly describe the mechanisms for funding health services in your county?
 - a. Where does funding come from?
 - b. What percentage of funding comes from the County government vs. MOHSW vs. external donors?
2. Briefly describe the mechanisms in place to determine budget needs of your CHSWT

- a. Who manages the budget?
 - b. How often is the budget review conducted?
 - c. Who reviews the budget?
 - d. How do you request money from central MOHSW?
3. What is your CHSWT capacity towards implementing performance-based contracts (PBC) in your county?
 - a. What is your role in implementing PBC?
 - b. What is your role in selecting performance indicators?
 - c. What is your process for selecting contractors?
 - d. How is the PBC implementation carried out? What is your level of input? Do you have an operational plan?
4. What resources and support does the CHSWT need to implement PBCs across the county?
 - a. Financial needs
 - b. Procurement and logistic needs
 - c. Training needs
5. Briefly describe the mechanisms in place to ensure fair and adequate distribution of funds to the district health teams and health facilities
 - a. How is the process set up?
 - b. How are needs determined?
6. Briefly describe the mechanisms in place to ensure transparency in receiving funds and distributing them
 - a. What policies and procedures are in place?
 - b. What is the course of action when a discrepancy is identified?
7. What is your capacity to implementing “contracting-in” mechanism of PBC?
 - a. What is your understanding of the “contracting in” mechanism?
 - b. What do you see as your role in implementing the “contracting in” mechanism?
 - c. What is your capacity towards implementing PBCs within the next 3 months?
 - d. What is your capacity towards implementing PBCs within the next 6 months?
 - e. What is your capacity towards implementing PBCs within a year?
8. What resources and training do you require if you are required to implement PBCs within the next 3-6 months?
9. Briefly describe your procurement policies and procedures?
 - a. Do you have different thresholds for procurement?
 - b. What do you keep as documentation in your files?
 - c. How do you ensure transparency in procurement?
10. What are the major challenges to collecting and allotting funding for your CHSWT?
11. What are the major accomplishments towards collecting and allotting funds for your CHSWT?

<p>Building Block 6: Governance and leadership</p>

1. Briefly describe the national strategy to implement the National Health and Social Welfare Policy and Plan (NHSWPP) and County Health and Social Welfare Policy and Plan (CHSWPP)?
 - a. Do you have an operational plan to implement the plans?
 - b. What challenges have you experienced in implementing the plans?
 - c. What capacity/ information do you wish you had to implement the plans?
2. Briefly describe the CHSWT supervision process
 - a. Is there an operation plan to guide supervision of Health Facilities? Please describe
 - b. How often is supervision conducted?
 - c. Who conducts the supervision?
 - d. What happens after supervision? What steps are taken to identify and address issues?
3. What kind of support do you receive from central MOHSW towards supervision of Health Facilities?
4. Briefly describe the communication strategy of CHSWT
 - a. What mechanisms exist for communication within CHSWT?
 - b. What mechanisms exist for communication between CHSWT and central MOHSW?
 - c. What mechanisms exist for communication between CHSWT and Health Facilities?
 - d. What mechanisms exist for communication between CHSWT and partners?
5. Briefly describe the policies and procedures in place to promote collaboration between CHSWT and partners?
 - a. Is there a policy to guide collaborations? Please describe
6. What are the strategies to build the leadership capacity of senior management at the CHSWT?
7. What are the major challenges in terms of governance?
8. What are the major accomplishments in terms of governance?