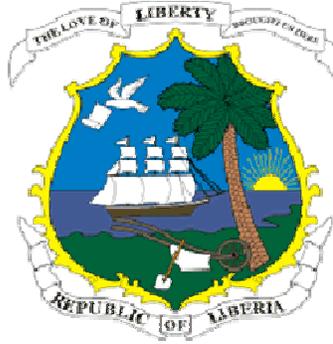




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 **BASICS**

ASSESSMENT OF DECENTRALIZED HEALTH SERVICE MANAGEMENT DURING THE POST-CONFLICT TRANSITION IN LIBERIA

August 2009

This publication was produced for review by the United States Agency for International Development. It was prepared by Chavanne Peercy & Megan Shepherd-Banigan on behalf of USAID/BASICS.

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Chavanne Peercy & Megan Shepherd-Banigan

ACRONYMS

BASICS	Basic Support for Institutionalizing Child Survival
BPHS	Basic Package of Health Services
CHC	Community Health Committee
CHO	County Health Officer
CHT	County Health Team
DHIS	District Health Information System
ECDPM	European Center for Development and Policy Management
gCHV	General Community Health Volunteer
HCC	Health Coordination Committee
HISP	Health Information System Project
HMIS	Health Management Information System
ITN	Insecticide Treated Net
MOH	Ministry of Health
MOHSW	Ministry of Health and Social Welfare
MOU	Memorandum of Understanding
MTOT	Master Training of Trainers
NGO	Non-Governmental Organization
NDS	National Drug Store
NMCP	National Malaria Control Programme
OFDA	Office of Foreign Disaster Assistance
OIC	Officer in Charge
PMI	President's Malaria Initiative
PCT	Program Coordination Team
RBHS	Rebuilding Basic Health Services
SCM	Supply Chain Manager
SOP	Standard Operating Procedure
TA	Technical Assistance
TOR	Terms of Reference
USAID	United States Agency for International Development

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Executive Summary

As part of its technical assistance program to address child survival in the context of humanitarian crises, USAID/BASICS developed a tool to assess decentralized management of health services in post-conflict environments during the transition from relief assistance to development aid. The tool is designed to assess the capacity of health systems to facilitate effective management of health service provision. This is accomplished by gathering information about factors—such as skills, resources and organizational and political structures—that support the devolution of management from the central to the county or district level, and enable health authorities to effectively manage a decentralized system.

The assessment tool was piloted in Liberia in July 2009 in six out of fifteen counties. A module was added to specifically examine the ability of County Health Teams (CHTs) to manage malaria activities. This report details the development of the tool as well as the findings and recommendations from the assessment in Liberia.

The Decentralized Management Framework is built upon six health system components that have emerged from health systems literature and USAID/BASICS Post-Conflict Transition Assessments in Southern Sudan and Liberia: oversight and coordination of the health sector, human resource management, resource management (medical and non-medical), health financing, community involvement and information.

The assessment methodology is based on an endogenous process that considers internal perspectives (i.e. of the Health Team members) of capacity-related factors. The tool consists of four different instruments designed to enable the gathering and verification of information about the six components. They include a Relief to Development Transition Stage Questionnaire, a semi-structured interview, a document review and a guided group discussion.

The CHTs understand their role in planning and coordinating partners. However, coordination with the central MOHSW needs to be strengthened by increasing the involvement of CHTs in planning and decision-making occurring at the central MOHSW. The CHTs' role in providing oversight of partners and facilities is also somewhat limited. Mechanisms need to be put in place so that partners have some accountability to CHTs for county level activities. Resource constraints and a lack of emphasis on downward communication channels are the cause for weak facility engagement and oversight.

The management of human resources is fairly strong across all counties assessed in that there are clear procedures in place that would allow decentralization and a Human Resource Unit has been established in each county. Training is one aspect of human resource management that has not been decentralized. Training activities are paid for and required by the central level need to be incorporated into the county health plans.

Drug stock outs are a major problem. This is caused by a lack of involvement of the CHTs in determining quantities needed and delays attributed to an overly centralized system that is not aligned with county needs. The same is true for the management of other resources such as

supplies, equipment and infrastructure. Centralized procurement and infrastructure processes have negative impacts on the CHT's ability to manage decentralized activities because they inhibit activity implementation.

Centralized financial management places a clear burden on the CHTs' ability to manage and on their credibility as the MOHSW champion of the county health system. Lack of human resources and procedures at the county level must be addressed, but until then some provisions must be put in place so that the CHT has regular access to funding to support planned activities and ensure consistent implementation of the BPHS.

Mechanisms to facilitate community participation exist, but are not being fully utilized nor are the roles and responsibilities of the CHTs and CHCs and their relationship to one another completely understood. The National Policy and Strategy on Community Services has clarified how community services will be managed, however CHTs will need to be trained on their role in community mobilization to strengthen community involvement and facilitate the exchange of information at all levels and ensure that community needs are addressed.

Information exchange processes are in place through the roll out of the HMIS system and the quarterly review meetings. However, information generally flows from bottom (facility) to top (central MOHSW). Lower levels requested more feedback about health decisions, outcomes of supervision visits, and feedback regarding the performance of the county health system.

Recommendations

1. Oversight and Coordination

1.1 **Action: Finalize Planning and Budgeting SOPs.** Support the MOHSW to establish process to define and empower CHT role and tasks across various system components by finalizing the Planning and Budgeting Standard Operating Procedures (SOP) and to roll out the training of these systems to county level.

Responsible: USAID/RBHS to roll out the training of these systems in 7 counties.

1.2 **Action: Define CHT role and tasks in providing oversight and monitoring of partner activities.** For example, develop mechanisms to support the implementation of the decision regarding oversight and monitoring. This could include developing a template for an MOU between CHTs and partners in which oversight and monitoring role of CHT is clearly defined.

Responsible: Central MOHSW to lead process of defining CHT role and tasks with input from CHTs.

Suggested Timeframe: within 6 months

1.3 **Action: Harmonize central level and county operational planning processes.** The product should be one operational planning document for the health sector that is based on county-level health priorities and includes all activities taking place at the county level regardless of whether they are initiated by the central-level, vertical programmes or CHTs.

Responsible: 1) Central MOHSW to approve process; 2) USAID/RBHS to complete Planning Standard Operating Procedure to establish process; 3) Central MOHSW and NMCP to

participate in joint planning process with CHTs.

Suggested Timeframe: within one year

- 1.4 **Action: Place management technical assistance (TA) with the CHT.** Currently there is no on-going capacity building taking place at the county level. Such support would assist the CHTs in the development of management processes and in the implementation of decentralization.

Responsible: 1) Central MOHSW to request assistance from donors and partners and input from CHTs regarding management needs; 2) Donors and partners to provide TA in counties.

Suggested Timeframe: within one year

2. Human Resource Management

- 2.1 **Action: Decentralize the training process.** Include all training sessions in county-specific health plan and use trained county level master trainers as primary facilitators.

Responsible: Central MOHSW and NMCP to ensure training activities are included in county planning documents and train master trainers in county in relevant topics (i.e. malaria case management). Master trainers can be trained by central level staff during upcoming trainings avoiding the need for special Master Training of Trainers (MTOT) sessions.

Suggested Timeframe: within 6 months

- 2.2 **Action: Identify one focal department at the central level to coordinate with the CHTs.** Currently key CHT members are overburdened by requests from several departments in the central MOHSW. The CHTs should have primary contact with one focal department, such as Health Services, through which all joint central and county activities are coordinated, including vertical program activities.

Responsible: Central MOHSW to determine (or establish) focal point department and to institute process for the coordination of activities through this department.

Suggested Timeframe: within 6 months

3. Resource Management (medical and non-medical)

- 3.1 **Action: Prioritize the finalization of the Procurement SOP.** MOHSW partners are currently working on Standard Operating Procedures (SOPs) to decentralize procurement. Procurement is one of the greatest challenges for the CHT to successfully manage the county health system. It is recommended that procurement SOPs be finalized by December 2009 so that central and county level procurement officers can be trained and the system can be rolled out to the counties.

Responsible: 1) Central MOHSW (through Decentralization Working Group) to provide oversight to partners accountable for developing this SOP

Suggested Timeframe: within 3 months

- 3.2 **Action: Establish Supply Chain Management and Procurement systems that respond to county needs.** For example, do not rely on the receipt of monthly reports from the county

to issue drugs and supplies to ensure that counties have sufficient anti-malarial drugs, particularly during the rainy season. Also, CHTs should be responsible for drug forecasting and determining the quantity of drugs needed.

Responsible: National Drug Supply (NDS), USAID/Deliver, and UNDP to coordinate and develop Supply Chain Management and Procurement SOPs.

Suggested Timeframe: within 6 months

- 3.3 **Action: Use the Decentralized Working Group as a forum to address the issue of the centralization of infrastructure.** This group could make recommendations about how to increase the active involvement of the CHT in all aspects of infrastructure development, construction and renovation. The two counties which had successfully managed facility renovation projects could serve as a model to establish this process.

Responsible: Central MOHSW (through Decentralized Working Group).

Suggested Timeframe: within 6 months

4. Health Financing

- 4.1 **Action: Prioritize the finalization of the Financial Management SOP utilizing county systems that are already in place.** Financial Management is a priority system for roll out according to the Decentralized Working Group. Our analysis confirms this and urges the MOHSW and its partners to develop SOPs, perhaps based on the procedures developed in Bong, and roll out decentralized financial management without delay. CHTs should provide significant input into the process of developing the SOPs.

Responsible: Central MOHSW (through Decentralization Working Group) to provide oversight to partners accountable for developing this SOP; 2) USAID/RBHS to support roll out of training to 7 counties.

Suggested Timeframe: within 6 months

5. Community Involvement

- 5.1 **Action: Use the experience of Grand Cape Mount as an example for other counties in community engagement and participation.** For example, arrange study tours to Grand Cape Mount to share experience.

Responsible: 1) Central MOHSW could organize future quarterly meeting in Grand Cape Mount and focus meeting on community engagement; 2) USAID/RBHS to orient other CHTs on principles of community involvement using study visit to Grand Cape Mount.

Suggested Timeframe: within 6 months

- 5.2 **Action: Define roles and specific tasks in facilitation of community engagement for CHT, health partners, and community structures.** For example, clarify the kind and frequency of contact (i.e. coordination meetings, planning meetings, data collection, supervision, etc.) that the CHT is supposed to have with CHCs, gCHVs, community leaders, and community members.

Responsible: 1) Central MOHSW (through Community Health Division) to disseminate Policy document to CHTs and work with CHT and partners to develop Terms of Reference (TOR); 2) USAID/RBHS to work through partners in 7 counties to implement structure based on principles outlined in National Community Services Policy and Strategy that

reinforce the role of the CHT and district officers in implementing community services; 3) CHT to include community mobilization activities beyond outreach in county health plan.
Suggested Timeframe: within 1 year

6. Information

- 6.1 **Action: Increase information exchange between NMCP and CHTs during existing activities.** For example, existing activities such as supervision could be used to increase information exchange. Supervision visits could be used to discuss activities, provide feedback about what was supervised during the previous visit, and share information about operational processes and procedures at the central and county level.
Responsible: NMCP to coordinate with CHT to schedule and structure supervision visits to achieve outcomes above.
Suggested Timeframe: within 3 months
- 6.2 **Action: Utilize the implementation of HMIS to strengthen the downward flow of information.** The roll out of the HMIS is an opportunity to improve downward information flow. Institutionalizing the use of data for decision-making at all levels with built in top to bottom and bottom to top communication and data monitoring procedures will improve the quality of data collected and how that data is used. To this end, continue to build on District Health Information System (DHIS) and Data for Decision-Making Training started by Health Information Systems Project (HISP) and USAID/BASICS. For example, as part of the Quarterly Review Meetings, hold a half day in-service training with the HMIS Officers to continue to refine the analysis and use of facility data. Involve the facility staff in Data for Decision-Making training sessions so that they understand the importance of accurate capture of information and can also analyze the information to make adjustments at the facility level.
Responsible: 1) Central MOHSW to request this assistance; 2) RBHS to train county and facility staff in application of health information for programming in 7 counties.
Suggested Timeframe: within 6 months
- 6.3 **Action: Put in place additional strategies to strengthen downward information flow.** One successful strategy is the Epidemiological Bulletin. Additional information that could be shared over the internet or through county supervision visits includes the minutes from central MOHSW meetings including the PCT and HCC Meetings, aggregated monthly health facility information, and supervision reports (from previous visit).
Responsible: Central MOHSW and NMCP to transmit this information to counties on a regular basis over email or through supervision visits.
Suggested Timeframe: within 1 year

Background

a. Health System Capacity in Fragile States

One of the greatest challenges faced by fragile states in the post-conflict period is the lack of capacity to manage and deliver quality health services. During periods of conflict, skilled medical and management professionals often flee while few new health workers are trained. Those who remain, particularly during prolonged conflicts, often provide services in challenging conditions due to the destruction of health facilities and lack of basic supplies and drugs. In addition, most do not have access to training or other skills enhancement activities.

A significant feature in post-conflict settings is the transition from relief to development in which clinic-focused, emergency-funded services evolve to a province-focused system that is supported by the national government and development-funded assistance. Gaps in health services can occur if there is not sufficient funding, coordinated planning and capacity to ensure a smooth transition, and this can threaten the perceived legitimacy of governments striving to move beyond the crisis. In his recent work on the development of capacity in fragile states, Derick Brinkerhoff cites security, the delivery of public goods and services, and political legitimacy as the core set of functions that states (i.e. post-conflict governments) must provide to build sufficient resilience into the system to deal with the shocks of fragility.¹

In addition, the recent trends towards decentralization and performance-based contracting seen in post-conflict countries such as Liberia, Southern Sudan and Afghanistan require that the capacity of health management personnel at the central and provincial levels also be quickly developed to ensure province-wide adherence to National Health Policies and the implementation of the Basic Package of Health Services. Therefore, as health systems and state-run services are re-established in the aftermath of humanitarian crises, one of the critical tasks is to develop sufficient capacity among managers to deliver and monitor services and coordinate with health partners and communities.

Brinkerhoff defines *capacity* as “having the aptitudes, resources, relationships and facilitating conditions that are necessary to act effectively to achieve some intended purpose. *Sustainable* capacity involves the *endogenous* processes that exist within a country, apart from whatever donors do.”² *Capacity development* is a process by which the abilities of individuals, organizations, institutions, and nations are improved to function more efficiently and effectively.³

1 Brinkerhoff, D., 2007. *Capacity Development in Fragile States- Discussion paper No 58D*, European Centre for Development Policy Management, Maastricht (May)

2 Brinkerhoff, D., 2007. *Capacity Development in Fragile States- Discussion paper No 58D*, European Centre for Development Policy Management, Maastricht (May)

3 Land, T., Hauck, V., and Baser, H., 2009. *Capacity Change and Performance- Capacity development: between planned interventions and emergent processes - Implications for development cooperation. Policy Management Brief 22*. European Centre for Development Policy Management, Maastricht (March)

b. USAID/BASICS: The Relief to Development Transition

Much of USAID/BASICS' work in fragile states, such as Liberia and Southern Sudan, focused on addressing the relief-to-development transition, which is often subject to withdrawal of humanitarian assistance before sufficient planning and capacity building occurs for nascent governments with limited experience in service delivery. USAID/BASICS developed and conducted an assessment of the relief to development transition in Liberia and Southern Sudan to inform strategic funding decisions that preserve health care access during the transition. Factors that influence access to care were identified and explored, including the capacity of health personnel and managers, functioning support systems, community participation, and the role of implementing partners.

Rationale for the Decentralized Management in Post-Conflict Transitions Assessment

Few efforts have focused on evaluating the capacity of provincial health teams to guide planning and align programming with national policies in the often chaotic post-conflict period. While the components of health systems in fragile states are similar to those in other countries, levels of system capacity are often much lower. Moreover, in many post-conflict countries, health systems are being completely rebuilt and reformed by new approaches, including decentralization and performance-based contracting. In addition, the shift from relief to development requires an emphasis on the changing and expanding role of provincial level health managers. Finally, post-conflict situations are highly politicized and interplays between newly established governments and populations impacted by war can create unrealistic expectations for the restoration of services and can threaten security which makes a realistic assessment of the capacity important.

Decentralized Management in Post-Conflict Transition Framework and Assessment Tool

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

Three primary approaches frame the Decentralized Management in Post-Conflict Transition Framework and Tool. First of all, the Framework is based on a systems approach. A recent study by ECDPM⁴ (European Center for Development Policy Management) describes capacity and capacity development within a complex adaptive systems perspective. This perspective suggests that, "...systems that are made up of a diverse set of actors whose multiple interactions

⁴ ECDPM published the OECD/DAC Study on Capacity, Change and Performance. This was financed by the Australian Government's Overseas Aid Program (AusAID), the Canadian International Development Agency (CIDA), the UK Department for International Development (DfID), the Dutch Ministry of Foreign Affairs (DGIS), the Japanese International Cooperation Agency (JICA) and the Swedish International Development Agency (Sida).

produce behaviors in the whole system not found in any of the actors. They generate adaptation by changing both intentionally and indirectly, in the face of new circumstances in order to sustain themselves.”⁵

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

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

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

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

1. Determine stage of transition of the decentralized provincial health system along six health system components.
2. Identify the enabling and constraining factors that influence the provincial health teams ability to manage (plan, implement, and evaluate) a decentralized health system.
3. Determine the gaps that need to be addressed to increase the ability of the health teams to manage the provincial health system and malaria activities.
4. Propose recommendations to strengthen the ability of the health teams to manage the decentralized provincial health system and malaria activities.

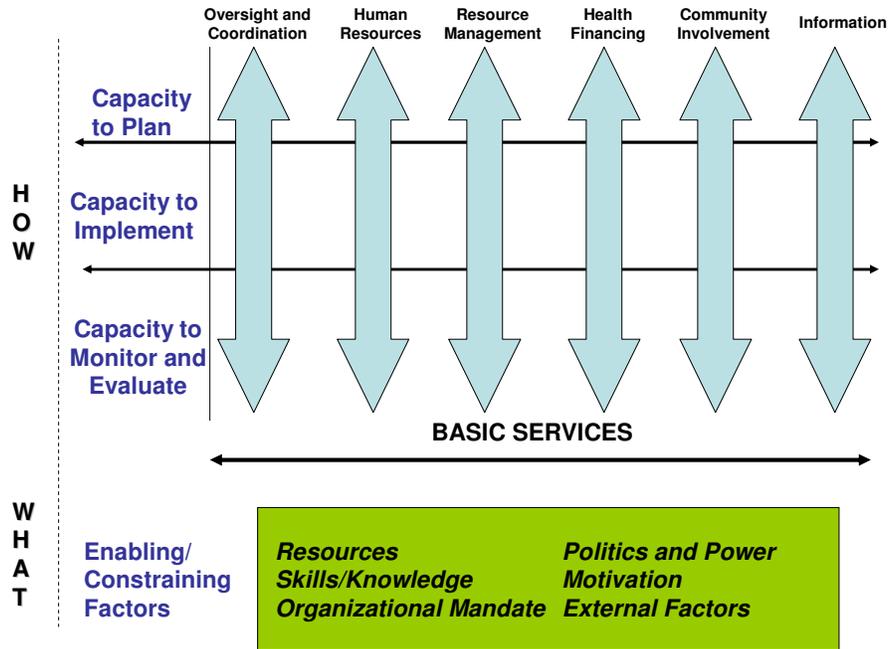
b. Framework Model

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

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

⁵ P.3, Morgan, H. and P., *Capacity, Change and Performance-Study Report. Discussion Paper No 59B*. European Centre for Development Policy Management, Maastricht (April)

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



The framework and tool evaluate the ability of the provincial health management teams to carry out the functions of: 1) planning, 2) implementation, and 3) monitoring of the six health system components above. The terminology of two of Brinkerhoff’s elements has been slightly adapted, though the definitions remain the same. Resources, skills and knowledge, organizational mandate, politics and power, and motivation are the factors that influence the capacity of the Health Teams. These factors are used to understand the Health Teams’ success in performing the three functions cited above.

c. Methodology

The assessment methodology is based on an endogenous process that considers internal perspectives (i.e. of the Health Team members) of capacity-related factors. The tool consists of four different instruments designed to enable the gathering and verification of information about the six components.

1. **Relief to Development Transition Stage Questionnaire:** Relevant provincial stakeholders (NGOs, Health Teams, and central MOH) describe the current transition stage across the different components.
2. **Semi-Structured Interview:** Health Teams and Central Ministry of Health answer questions about the relationship between various actors in the county, and existing guidelines and information that support coordinated service delivery.
3. **Document Review:** A checklist of important documents, such as policies, guidelines, tools and other information utilized by Health Teams in order to plan, monitor and manage provincial health activities.

4. **Guided Group Discussions:** A guided group discussion with Health Teams, partners and community members to further explore findings from the questionnaire and semi-structured interviews in order to:
 - a. Determine the enabling and constraining factors
 - b. Identify strengths to build on and weaknesses to address.

Table 1
Definition of Health System Components

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

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

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

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

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

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

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

Decentralized Management in Post-conflict Transition Assessment: Liberia

In 2006, the Liberian Ministry of Health and Social Welfare developed a National Health Policy that placed heavy emphasis on the decentralization of health sector management to the county level. Since then, the MOHSW has worked with donors and health partners to transfer various functions and responsibilities to the County Health Teams (CHT). USAID/BASICS Decentralized Management in Post-conflict Transition Assessment, conducted in Liberia in July 2009, is an opportunity to understand the extent to which the CHTs are enabled to carry out health sector management functions (planning, implementation and monitoring and evaluation) and to identify gaps in management ability across the six health system components.

USAID/BASICS, on behalf of USAID/Liberia's bilateral, Rebuilding Basic Health Services (RBHS), assessed the ability of CHTs in six counties (Nimba, Bong, Grand Cape Mount, Bomi, Lofa and River Gee) to manage a decentralized system. These counties represent six of seven catchment areas supported by RBHS. In response to RBHS's Presidential Malaria Initiative (PMI) programmatic needs, USAID/BASICS created a special module to explore the CHTs' involvement in the management of NMCP malaria activities at the county level of the CHT to the NMCP's malaria activities. As previously discussed, the assessment did not simply focus on the capacity of the CHTs, but rather on the confluence of factors (resources, skills and knowledge, organizational mandate, politics and power, and motivation) that enables or constrains the CHTs' ability to effectively manage the county health system and malaria activities.

The USAID/BASICS team initially met with stakeholders from USAID/PMI, the central MOHSW, RBHS, and the NMCP to review the goals and objectives of the assessment. A working session was held with a team from NMCP to review and refine the tools with special emphasis placed on the Malaria Semi-Structured Interview. In addition, a representative from the NMCP was selected to be part of the assessment team.

a. Data Collection

i. Semi-Structured Interview

The assessment team met with a representative from each of the six county health teams to administer the semi-structured interview. These interviews provided useful information about how specific aspects of management, such as planning and reporting, were being conducted and by whom. This information provided a baseline for understanding the data gathered through the other tools. A semi-structured interview was also administered to the assessment team's NMCP counterpart.

ii. Relief to Develop Transition Stage Questionnaire

The assessment team explained and distributed the Relief-to-Development Transition Stage Questionnaires to the CHTs, health partners and the NMCP. Completed questionnaires were received from five CHTs, 11 health partners, and one from the NMCP (total of 17). The information gathered from this tool provided an overview of the CHTs' and partners' perceptions of progress being made to decentralized management functions to the county. The

tool also highlighted gaps and strengths across the components and discrepancies among the perceptions of the CHTs and partners.

iii. Guided Group Discussion

The completed Relief-to-Development Transition Stage Questionnaires and Semi-Structured Interviews were used to tailor questions for each group discussion. The results provided information about existing management systems and processes that assisted the assessment team to identify areas that required further exploration. The USAID/BASICS team and a representative from the NMCP traveled to four USAID-supported counties (Bomi, Nimba, Bong, and Grand Cape Mount) to conduct guided small group discussions with representatives from the CHT, partners, and community. Each discussion lasted for approximately three hours and was attended by 10 to 15 people. One USAID/BASICS assessment team member facilitated the discussion based on questions chosen for that county while the other team member took notes to capture the discussion, noting whether the speaker was a CHT member, partner representative, or community member. The information gathered from the group discussions allowed for further exploration of key gaps and strengths in the management of the county health system. In addition, it highlighted how the six factors (resources; skills and knowledge; organizational mandate; politics and power; motivation, and external factors) impacted the CHTs ability to manage.

iv. Document Review

After the group discussions, one member of the assessment team sat with the CHT in each of the four counties to review the existence and location of policy and planning documents, health information (HMIS), procedural guidelines, and treatment guidelines. The purpose of the review was to verify the existence of documents that assisted the CHTs to plan and manage the health system.

The final version of all tools can be found in Annex 1.

Table 2
Tools Completed During Liberia Decentralized Management Assessment

County	Semi-Structured Interview	Relief to Development Transition Stage Questionnaires	Group Discussion	Document Review
Bomi	Yes	Yes	Yes	Yes
Bong	Yes	Yes	Yes	Yes
Grand Cape Mount	Yes	Yes	Yes	Yes
Lofa	Yes	Yes	No	No
Nimba	Yes	Yes	Yes	Yes
River Gee	Yes	No	No	No
NMCP	Yes	Yes	Yes	Yes

b. Constraints

The assessment in Liberia was implemented within a set of certain constraints. First of all, due to time and logistical limitations created by the rainy season, the assessment team was unable to conduct a small group discussion in two of the more inaccessible RBHS counties, Lofa and River Gee. In addition, the assessment methodology was designed to be implemented over a two-day period in each county, with all information collection occurring at the county level. Given some scheduling issues, the semi-structured interviews were conducted in Monrovia at least 5 days apart from the group discussion, which affected the cohesion of the process.

Findings

A. Strengths and Gaps of System Components

i. Oversight and coordination

In a decentralized health system it is important that the CHT provide leadership through the oversight and coordination of all health activities in the county. This is accomplished through three main actions for which CHTs should have full responsibility: 1) planning, 2) coordination with partners and the central MOHSW, and 3) supervision and monitoring.

In Liberia, each CHT is given the mandate to develop a county health plan annually. The county health plan is developed with input from health partners and in some cases local authorities, facilities and communities. This plan is to be reviewed on a regular basis (i.e. monthly or quarterly) with the results used to develop the next year’s plan. Presently all 6 CHTs have a plan in place, although there is variance across counties in the timeliness of their review and revision processes.

One major obstacle faced by CHTs in the management of county health activities is the lack of coordination with central MOHSW. Many decisions regarding health policies and activities are made at the central level without input from the CHTs. In fact, the discussion participants reported that CHTs must rely on partners to transmit information from the central MOHSW. Furthermore, despite the existence of a county health plan, central level departments and vertical programs often carry out centrally planned activities in the county without sufficient notice to the CHTs. In these cases, activities previously planned by the county are either delayed or left incomplete.

Partner coordination is an area where the CHTs demonstrate strength. All CHTs assessed have highly collaborative relationships with health partners active in their county. The teams reported that they have Memoranda of Understanding (MOU) with the majority of partners and remain apprised of their programs through regular monthly meetings where partner activities are reported and discussed. Still, most CHTs and partners reported that the CHT did not hold the partners completely accountable to meeting county health goals. CHTs seemed unclear of their role and/or disempowered in this aspect of partner coordination. This may be due to the fact that partners are not held accountable to the CHTs, but instead to their donors and the central level ministry. For example, the central MOHSW assigns partners to work in specific counties and may not consult with the CHTs regarding their needs. Furthermore, the CHTs must be involved in partner programs from planning stage through implementation and monitoring. Some CHTs reported that they are often unaware of a partner's planned activities until the proposal has been submitted and funded.

Finally, CHT engagement with the facility needs to be increased. Oversight and coordination of health facility activities are accomplished through regular supervision visits, facility involvement in planning county health activities and the provision of feedback to facilities about major decisions and outcomes of supervision. Although the CHTs recognize the importance of supervision and have a system in place to conduct supervision, they are unable to supervise every health facility on a regular basis because of a lack of resources, such as transportation and fuel, or inaccessibility due to distance and road disrepair. These resource constraints and lack of clarity about the role of CHTs in providing oversight to and coordinating with facilities also inhibit the provision of feedback to facilities.

Summary: The CHTs understand their role in planning and coordinating partners. However, coordination with the central MOHSW needs to be strengthened by increasing the involvement of CHTs in planning and decision-making occurring at the central MOHSW. The CHTs' role in providing oversight of partners and facilities is also somewhat limited. Mechanisms need to be put in place so that partners have some accountability to CHTs for county level activities. Resource constraints and a lack of emphasis on downward communication channels are the cause for weak facility engagement and oversight.

ii. Ability to manage human resources

Human resource management is the most decentralized component of the health system. Each county assessed has a Human Resource Officer who is responsible for maintaining personnel files, identifying staffing needs and initiating recruitment. There also seem to be clear procedures in place and the CHTs reported that they are aware of their roles and responsibilities

in the recruiting and hiring process. In addition, most counties have staff members who have participated as trainers in central level training workshops.

One gap in the management of human resources is that training continues to be driven by the central level. Virtually all training is initiated, planned and facilitated exclusively by the central MOHSW, particularly the vertical programmes. The CHT has no input in the planning or scheduling training activities and they feel that the topics and timing are determined for them. Furthermore, the CHTs and partners reported that, in many instances, they are only informed of trainings days prior to their start date and these training activities often conflict with previously planned activities. Part of this challenge is created by donor requirements and targets which mandate that a certain number of people be trained within a specific timeframe. Despite these issues, most training activities do involve the CHTs as facilitators and this could be built on to decentralize the management and facilitation of training programs in the future.

The availability of human resources strongly affects the decentralization process in that county health teams and the facilities they oversee are understaffed. This impacts the county staff. As identified in previous decentralization assessments, the members of the CHT are overburdened by multiple roles and responsibilities. For example, most County Health Officers (CHOs) maintain a second role of Hospital Administrator, either of which represents full time responsibilities.

Summary: The management of human resources is fairly strong across all counties assessed in that there are clear procedures in place that would allow decentralization and a Human Resource Unit has been established in each county. Training is one aspect of human resource management that has not been decentralized. Training activities are paid for and required by the central level need to be incorporated into the county health plans.

iii. Medical resources (drugs and supplies)

Currently, five of the counties assessed have a county-wide system in a place to control all drugs and medical supplies. However the system is basic in that it only monitors drug inventories and remaining stock levels. The actual management of drugs and medical supplies, including drug selection and determination of need, is carried out at the central level. Each month the county submits an inventory report to the central level which indicates quantity available in the health facility store rooms. The Supply Chain Managers (SCM) at the National Drug Store (NDS) use this information to determine which drugs will be distributed to the county. Once the determination is made the NDS is responsible for delivering the drugs and supplies to the county (or regional) drug depot on a quarterly basis. All of the counties assessed have experienced multiple stock outs in the past six months. They attribute this to central level stock outs, delays due to NDS's logistical processes and their attempt to minimize the number of trips. Furthermore, it was reported that the quantity determination for each drug is based on a system of replenishing what was utilized, as opposed to forecasting actual needs.

The drug management process for vertical programs, specifically NMCP, differed among counties. For example, some counties reported that they give no input about the quantity of malaria drugs and supplies (i.e. ITNs) needed in the county. Those counties that provided input through monthly reports did not receive drugs if the report was delayed.

Summary: Drug stock outs are a major problem. This is caused by a lack of involvement of the CHTs in determining quantities needed and delays attributed to an overly centralized system that is not aligned with county needs.

iv. Non-medical resources

The management of supplies and equipment is divided between the county and central level. The CHT is involved in determining need and inventory control. If the county is in need of supplies they must submit a formal request to the central ministry. This requires technical and financial approval from two different offices within the central ministry and is then forwarded to the procurement department which completes all purchasing. All counties assessed reported that this was a major obstacle in the implementation of their activities. Firstly, the procurement process is the same regardless of the item (i.e. generator versus light bulb). Often the process becomes lengthy due to the fact that both the approval and the procurement processes can only be completed by specific departments leading to a high volume of requests and resulting in a backlog. Furthermore, most purchases are made in Monrovia from specific vendors. This requires that a representative of the CHT travel to the capital to pick up the purchased items and may require a significant amount of time, especially for those living in remote counties.

The management of infrastructure is also heavily centralized. In the interest of standardization, it was decided at the central level that all facilities must comply with the same building design. This resulted in a significant delay in infrastructure improvement while the central MOHSW developed a nationally approved health facility design. Secondly, the CHTs reported that there is a fee to use the plan and that specific individuals must supervise the project. This has increased the cost of facility construction and renovation and creates a delay as counties must wait until the specific individuals are available to supervise the project. One county reported that the extra financial burden produced by these requirements led to a significant increase in the cost of one facility, forcing them to look for additional funding. Furthermore, they felt that “over” standardization led to a loss of innovation and the ability to improve facility design for specific county contexts. The centralization of infrastructure may not be necessary. Two counties reported that they had successfully managed their own facility infrastructure projects. In both instances they used this as an example of the CHTs ability to manage. Such experiences could be built upon and used as a model for additional projects.

Summary: Centralized procurement and infrastructure processes have negative impacts on the CHT’s ability to manage decentralized activities because they inhibit activity implementation.

v. Health financing

Financial management is almost entirely centralized. This finding is consistent with other decentralization assessments, which focused on financial management processes and skills at the county level and found that most counties do not have standardized accounting policies and procedures in place⁶. Although each county assessed has its own bank account, only one CHT in Liberia has signatory power. As was mentioned earlier, if CHTs need funds, even to support planned activities, they must make a request to the central ministry. Once approved, the money

⁶ Ministry of Health and Social Welfare and BASICS. Decentralized Management Support System Pre-Assessment Survey. 2009.

is drawn down from the bank account and the CHT must go to Monrovia to collect the check. The CHTs reported that there is a petty cash system in place (\$2000USD per quarter), but it is not fully functional. Normally the fund is at a zero balance because the monies must be fully liquidated before the CHT can request more and the process for requesting and receiving these funds is lengthy. In addition, one county reported that they did not have a petty cash fund and therefore had no access to any money. This challenges the ability of the CHTs to manage and oversee the health system because they do not have the resources to make small, but significant purchases, including drugs and fuel, which are essential to the implementation of basic services.

In addition, counties have limited information about the cost of running health activities in their county. This is due to the fact that they do not coordinate county-level health financing and receive no information about the cost of vertical program activities or partner financial inputs. This does not give them the opportunity to prioritize resources which is a key component of health system management.

One county has been given the mandate to manage their own finances. The CHT Administrator is an accountant and developed county-specific accounting and financial management policies and procedures after attending a management training provided by AMREF. This CHT undergoes an annual audit by a chartered firm, which they have regularly passed. The CHO of this county is a signatory on the bank account and can cash checks. As a result, the CHT can purchase drugs and supplies. This could be used as an example of how financial management has been successfully decentralized. Several of the other counties have strengths, including an accountant on the CHT staff and a process for budgeting the county health plan, which will aid the decentralization of financial management.

Another strength in the area of financial management is the support from partners and communities. Partners and community representatives stated that they would prefer that the CHTs have greater financial responsibility because it would increase transparency and trust between the CHTs and communities. Furthermore, it would directly improve the availability of drugs and supplies and increase access to quality services. Most CHTs and partners felt that the lack of skills and capacity to manage funding were not the reason that financial management remained centralized, but that it was due to existing government policies.

Summary: Centralized financial management places a clear burden on the CHTs' ability to manage and on their credibility as the MOHSW champion of the county health system. Lack of human resources and procedures at the county level must be addressed, but until then some provisions must be put in place so that the CHT has regular access to funding to support planned activities and ensure consistent implementation of the BPHS.

vi. Community involvement

Community involvement was repeatedly mentioned by all six CHTs as an important aspect in the management of the health system. The foundation for appropriate community involvement is currently being strengthened through two important community structures that are addressed in the recently developed National Policy and Strategy on Community Services, Community Health Committees (CHC) and the general Community Health Volunteer (gCHV). Some CHCs were organized in all counties assessed and are responsible for community mobilization and ensuring that the health facilities are accountable to the community. In many counties the CHCs

are participating regularly in the planning process. The gCHV program is in early stages of implementation. The community is heavily involved in this process in that they actively participate in the recruitment and supervision of the volunteer. The gCHV's presence in the community will act as a direct link to the facility, and therefore the formal health system.

Despite these two structures, active community participation remains insufficient in most counties assessed. Oftentimes, the CHCs' involvement ends at the planning stage or is limited to contact at the facility level. Currently, there is not a formal mechanism to facilitate exchange between the CHT, facility and CHC regarding health services and community needs. This may change when the national policy is fully implemented. Many of the CHTs place the responsibility on the community stating that they are reluctant to participate due to the former culture of top down administration as well as the expectation of remuneration common during the relief stage. Nonetheless, the CHT has an important role in engaging the community. For instance, regular meetings and outreach activities can be used to elicit input and provide information on opportunities to participate. The lack of acknowledgement of the CHTs' role in community involvement and the overburdened CHT staff may be barriers to engaging the communities. Currently there is no framework to guide the counties in encouraging community involvement. Clarifying the roles and responsibilities of the CHTs and community members will facilitate full participation of the community.

A relatively strong example of effective community involvement has been established in Grand Cape Mount. In this county the CHCs are extremely involved in various aspects of health activities in their community with their participation extending far beyond the planning stage and through the monitoring stage. For example, in some communities a community member is present when drugs or supplies are delivered to a facility in order to supervise and ensure quantities are correct. Furthermore, they provide important feedback to the CHT concerning community needs and perceptions of facility staff to which the CHT gives strong consideration. Although the organization of all CHCs is not complete, there is a successful process to follow. This system has flourished under strong partner support as well as the acknowledgement of roles and responsibilities by both the community and CHT members. The value placed on strong community participation has led to a highly functional system which can serve as a model to other counties.

Summary: Mechanisms to facilitate community participation exist, but are not being fully utilized nor are the roles and responsibilities of the CHTs and CHCs and their relationship to one another completely understood. The National Policy and Strategy on Community Services has clarified how community services will be managed, however CHTs will need to be trained on their role in community mobilization to strengthen community involvement and facilitate the exchange of information at all levels and ensure that community needs are addressed.

vii. Information

The current situation of information exchange has a considerable impact on the CHT's ability to manage health activities. Presently, the system has several strengths that can be built upon, but no information processes are fully functional. The main source of programmatic information exchange is the quarterly review meetings, during which county teams and their central level counterparts review and discuss the status of their county health plans. However, all counties reported that aside from the verbal comments provided at the meeting, there is no

feedback provided to the CHTs in a written and/or practical format. This is also true in the case of supervisory visits. The CHTs stated that they needed input from the central MOHSW regarding their performance and would welcome additional input to help them improve. The CHTs also reported that they did not receive information about central MOHSW Health Coordination Committee (HCC) or Program Coordination Team (PCT) meetings. Therefore, information about critical decisions is relayed to them by the partners in the county.

One positive factor is the implementation of the Health Management Information System (HMIS) and the potential to use this information to monitor health activities each quarter. Regular health system data is being collected monthly in all six counties assessed. All CHTs are aware of this system and the roles and responsibilities of the CHT and facilities in compiling, analyzing and transmitting this information to the central level. Still, some counties have not completed recruitment of the HMIS Officer and the CHTs reported that there are major gaps in reporting as some facilities do not send their reports each month. Therefore, the reporting process is inadequate. While the responsibility for the collection and, in some cases the analysis of data, is clear the CHTs are not using the information on a monthly basis to make adjustments to health activities. This could be due to insufficient skills, the absence of an HMIS Officer, or the lack of clear mandate from the central MOHSW about the use of the data at the county level.

One system of information exchange repeatedly pointed out as a successful process for the dissemination of important health information is the Epidemiology Report, which is provided via email on a weekly basis. This Bulletin provides an overview of weekly health (information about outbreaks and priority diseases) statistics broken down by county. The CHTs reported that they review this information to assess the health needs in their county versus other counties, but again this information did not seem to be used to plan or monitor health activities. The main limitation of this reporting process is the lack of internet in several counties

The primary problem with the current information system is that all information flow is upward. At no point in the process is there regular provision of feedback to subordinate levels (i.e. CHT to facility or community). This affects the CHTs ability to manage in two ways. First, apart from the Epidemiology Bulletin, they are not receiving information from the central level ministry. As discussed above, no written feedback is provided to the CHT, an issue that was repeatedly reported as being a major obstacle to management. The same is true for data collected at the facility and filtered up to central level ministry. Once the data is processed, the aggregated results are not shared with the individuals responsible for the implementation of health activities including the CHTs, partners and Officers in Charge (OIC). Similarly, information is not flowing down from the CHT to the facility level, minimizing the support for addressing gaps in health services that the CHT can provide to the health clinic and community. This lack of information exchange or availability of feedback occurs in all aspects of the health system; data collection and analysis, decision-making, supervision, and so forth.

Information exchange between the partners and CHTs was fairly strong. Partners generally share work plans and in some cases transmit facility-level health information to the CHTs. However, this can be strengthened as it was reported by CHT members and partners that there is information being provided to donors that is not shared with the CHT on a regular basis.

Summary: Information exchange processes are in place through the roll out of the HMIS system and the quarterly review meetings. However, information generally flows from bottom (facility) to top (central MOHSW). Lower levels requested more feedback about health decisions, outcomes of supervision visits, and feedback regarding the performance of the county health system.

Table 3
Summary of Management Ability, by County and Health System Component

Component	Grand Cape Mount	Bomi	Bong	Nimba
Oversight and Coordination	Some	Some	Some	Some
Human Resources	Some	Some	Some	Some
Resources	Less	Less	Less	Less
Health Financing	Less	Less	More	Less
Community Participation	More	Less	Less	Less
Information	Some	Some	Some	Some

The above table provides an overview of findings about **county-level management ability** (based on the enabling/constraining factors) broken out by county and health system component. For example, Bong County was assessed to have *more* management ability in health financing because the CHT manages their own funds, has established accounting procedures and guidelines, and regularly passes annual audits. Detailed information regarding the factors that influence ability to manage can be found in the Findings Section.

B. National Malaria Control Programme

Although the above discussion of the six components provides generalized information pertaining to the management of all programs carried out by the county health team, findings specific to the National Malaria Control Program (NMCP) emerged as well. Many of the CHTs and partners felt that malaria activities are proceeding fairly well in their counties. The NMCP has significant financial resources for malaria activities, allowing them to fulfill their national malaria goals. This assists the county to meet their goals as well in that ITNs are readily available and training for health staff in malaria control takes place on a regular basis.

The main obstacle to malaria programming at the county level occurs in the planning phase. Activity preparation and funding allocation takes place at the central level without input from the CHTs. In addition, the central level schedules malaria training with minimal coordination with the CHTs and these activities are not part of the county health plan. The only role that the CHTs play in this process is selection of trainees and at times support in the facilitation of training sessions. They have no input on timing, agenda or subject. Counties reported that the training plan was developed in response to donor requirements rather than county needs.

Another important point discussed by the CHTs was the lack of involvement in the supply chain process. In fact, some CHTs reported that they were unaware of the system used to quantify malaria drugs and supplies sent to the county. Furthermore, based on information from the CHTs, malaria drugs and supplies are still being delivered directly by the NMCP and have not been added to the central stock. These are serious issues for many of the counties due to the large number of malaria drug stock outs over the past six months.

Lastly, county officials felt that the NMCP was not providing sufficient feedback on malaria programs. Although supervision is carried out by the NMCP on a regular basis, no report or other feedback is provided to the CHT. In addition, they do not receive community specific information on malaria which would assist the health team in program planning.

Summary: The CHTs report being very happy with malaria activities. In fact, the CHTs would like more feedback from NMCP after supervision visits so that they can improve their involvement in malaria activities in their counties. The planning and implementation of non-facility based malaria activities remains very centralized. CHTs are not involved in determining how funds are allocated or in scheduling and planning training and other malaria activities, such as campaigns. Finally, most CHTs reported that they provided limited input regarding the amount of malaria drugs and supplies needed in the county.

Conclusions

a. Clarity on roles and functions of county health teams

The National Health Plan states the importance of devolution of power to the county level. Specifically, the plan mentions decentralizing training, human resources, planning, management and resource coordination. The CHTs demonstrated that they had a clear vision and understanding of their functions when asked about the roles of different actors in a decentralized system. The most frequent responses for county level responsibilities were planning, implementation of county health services (distribution of drugs and supplies and providing supervision to facilities), training, financial management, and coordination with health partners and stakeholders, including the monitoring of their activities. The CHTs envisioned the central MOHSW creating standards, guidelines and policies to ensure uniform service delivery nationally, providing technical support and monitoring and evaluating county system outcomes. Despite the clear vision and consistency of responses among the CHTs, the CHTs have not been delegated full responsibility to set the agenda at the county level. Their ability to plan and decide, implement, and monitor and evaluate remain constrained by factors, such as lack of an organizational mandate, that gives the CHT the full authority to manage the health system. This control has not been devolved by the central MOHSW, as planned. In addition, the CHTs and they do not have the resources needed to manage the implementation of the health system.

This situation has created some discontent among the CHTs who do not feel that they have full ownership of decisions and activities at the county level.

b. CHT ability to plan and decide

The CHTs have been coordinating county-level actors to conduct planning sessions since 2007. CHTs reported that the county planning process is their responsibility and they demonstrated that they have the capacity to convene stakeholders, organize projected activities into a planning document and some reported that they have submitted a costing of the county health plan to the central MOHSW.

While the capacity to conduct planning is clearly present, their ability to create a realistic work plan and decide on critical county health care issues is limited by several factors. First, the CHTs do not have any control over the amount of funding they receive. According to the CHTs there is no connection between the cost of the activities that should be supported by the county health budget and the funds actually received. Most partners do not share information about the amount of funding they have available to support activities in the county health plans. In addition, at times donor or partner priorities do not align well with county health needs meaning partners either operate in isolation or their activities are not included in the county health plans and information about outcomes are not shared with the CHTs. As a result, the county health plans are not comprehensive documents that take into account all activities in the county and are not based on a known financial context. Several CHT members reported that because of these factors, the county health plans are often not achieved due to insufficient funding. One county reported that this has decreased interest in planning and some CHT members do not see it as a useful functional activity as there are no resources to align with plans that are made.

In addition, several annual plans are created at the central level for various programs and departments. Most of these planning processes do not include CHT input and often central and county health plans are not coordinated and may even conflict. In the cases where planned activities conflict, such as a county-level supervision visit and a program training session, the central level activities take precedent over the county activities. More importantly, several of the CHTs reported that they were often not aware of central level activities, such as training, supervision or campaigns, taking place in the county until days beforehand. They must then delay activities in the county plan and find sufficient people to support or attend the central activity. This further contributes to the sense that the county health plans are irrelevant because decisions about activities are made at the central level since that is where all resource allocation decisions are made without input from the CHTs.

c. CHT ability to implement

The CHTs are fully aware of their role in ensuring that service delivery is aligned with the BPHS and other national policies and guidelines. Most CHTs interviewed reported that they manage a few facilities in their counties, but the implementation of service delivery is primarily funded and managed by health partners. Therefore, the current role of the CHTs is to support implementation through tasks such as monitoring drug supply, providing supervision, and coordinating with health partners and the central level regarding county level activities.

Despite the CHTs' attempt to fulfill these functions, their ability to implement is constrained by several factors. Most importantly, procurement and financial management are totally centralized. This creates substantial delays in the receipt of drugs, supplies and other key resources, such as fuel. This makes it difficult for the CHT to carry out planned activities and support service delivery. Procurement and financial management are two systems that the central MOHSW is working to decentralize. However, according to the CHTs, current Government of Liberia policies and apprehension at the central level about the existence of sufficient skills and capacity at the county level have delayed the decentralization of these systems. Delays by partners responsible for developing these systems contribute to the holdup of the process as well.

The other limiting factors for implementation are logistical and resource constraints. The heavy workload of CHT members and limited fuel availability contribute to the inability of the CHT to fully implement the county health activities. Finally, there is insufficient staff at the facility level to support full implementation.

d. CHT ability to monitor and evaluate

The CHTs are aware of their role in coordinating the partners and central MOHSW activities at the county level. This is distinct from their role during the relief period when, due to the limited functionality of the MOHSW, health partners were responsible for managing all aspects of service delivery without substantial government involvement. As Liberia moves towards development, roles and responsibilities are changing and the central MOHSW, the CHT and the partners need to clarify these roles and adjust to them. As a result, the CHTs have not yet fully assumed responsibility for monitoring and evaluating all health activities in the county.

There are two factors that constrain the ability of the CHTs to monitor and evaluate. First, the CHTs do not have a clear mandate to monitor partners as there is not an agreement in place that holds partners accountable to CHTs and the county health plan. The central level controls the relationship with donors and partners. The CHTs reported that they have activity based MOUs with partners at the county level, but the central level agreements between the health partner organizations and the MOHSW supersede agreements at the local level. This results in a disconnect between the primary agreement and what actually is happening at the county level. Theoretically, the CHTs should be signatories to this agreement, but it is unclear whether this is the case and if so, what authority it gives to the CHTs to monitor and hold partners accountable to county priorities. Another inhibiting factor is that CHTs often are not involved in partner activity planning and may not receive all information about partner activities. Without full awareness of the activities taking place in the county, they are unable to monitor and ensure that these activities are aligned with the county health plan and the BPHS.

Limited resources to undertake supervision and monitoring of partners are another problem for the CHTs. Several partners suggested that the interaction between the CHTs and themselves could be enhanced through more joint activities of supervision, planning, reporting and activity implementation. This should be encouraged as a priority despite the CHTs' existing heavy work loads and limited fuel and vehicles because it is strategic to CHT directing health service delivery in their county. Resource limitations also constrain CHT monitoring and evaluation of facilities and their interface with communities.

Recommendations

1. Oversight and Coordination

- 1.1 **Action: Finalize Planning and Budgeting SOPs.** Support the MOHSW to establish process to define and empower CHT role and tasks across various system components by finalizing the Planning and Budgeting Standard Operating Procedures (SOP) and to roll out the training of these systems to county level.
Responsible: USAID/RBHS to roll out the training of these systems in 7 counties.
Suggested Timeframe: within 6 months
- 1.2 **Action: Define CHT role and tasks in providing oversight and monitoring of partner activities.** For example, develop mechanisms to support the implementation of the decision regarding oversight and monitoring. This could include developing a template for an MOU between CHTs and partners in which oversight and monitoring role of CHT is clearly defined.
Responsible: Central MOHSW to lead process of defining CHT role and tasks with input from CHTs.
Suggested Timeframe: within 6 months
- 1.3 **Action: Harmonize central level and county operational planning processes.** The product should be one operational planning document for the health sector that is based on county-level health priorities and includes all activities taking place at the county level regardless of whether they are initiated by the central-level, vertical programmes or CHTs.
Responsible: 1) Central MOHSW to approve process; 2) USAID/RBHS to complete Planning and Budgeting Standard Operating Procedure to establish process; 3) Central MOHSW and NMCP to participate in joint planning process with CHTs.
Suggested Timeframe: within 1 year
- 1.4 **Action: Place management technical assistance (TA) with the CHT.** Currently there is no on-going capacity building taking place at the county level. Such support would assist the CHTs in the development of management processes and in the implementation of decentralization.
Responsible: 1) Central MOHSW to request assistance from donors and partners and input from CHTs regarding management needs; 2) Donors and partners to provide TA in counties.
Suggested Timeframe: within 1 year

2. Human Resource Management

- 2.1 **Action: Decentralize the training process.** Include all training sessions in county-specific health plan and use trained county level master trainers as primary facilitators.
Responsible: Central MOHSW and NMCP to ensure training activities are included in county planning documents and train master trainers in county in relevant topics (i.e.

malaria case management). Master trainers can be trained by central level staff during upcoming trainings avoiding the need for special Master Training of Trainers (MTOT) sessions.

Suggested Timeframe: within 6 months

2.2 Action: Identify one focal department at the central level to coordinate with the CHTs.

Currently key CHT members are overburdened by requests from several departments in the central MOHSW. The CHTs should have primary contact with one focal department, such as Health Services, through which all joint central and county activities are coordinated, including vertical program activities.

Responsible: Central MOHSW to determine (or establish) focal point department and to institute process for the coordination of activities through this department.

Suggested Timeframe: within 1 year

3. Resource Management (medical and non-medical)

3.1 Action: Prioritize the finalization of the Procurement SOP. MOHSW partners are currently working on Standard Operating Procedures (SOPs) to decentralize procurement. Procurement is one of the greatest challenges for the CHT to successfully manage the county health system. It is recommended that procurement SOPs be finalized by December 2009 so that central and county level procurement officers can be trained and the system can be rolled out to the counties.

Responsible: 1) Central MOHSW (through Decentralization Working Group) to provide oversight to partners accountable for developing this SOP.

Suggested Timeframe: within 3 months

3.2 Action: Establish Supply Chain Management and Procurement systems that respond to county needs. For example, do not rely on the receipt of monthly reports from the county to issue drugs and supplies to ensure that counties have sufficient anti-malarial drugs, particularly during the rainy season. Also, CHTs should be responsible for drug forecasting and determining the quantity of drugs needed.

Responsible: National Drug Supply (NDS), USAID/Deliver, and UNDP to coordinate and develop Supply Chain Management and Procurement SOPs.

Suggested Timeframe: within 6 months

3.3 Action: Use the Decentralized Working Group as a forum to address the issue of the centralization of infrastructure. This group could make recommendations about how to increase the active involvement of the CHT in all aspects of infrastructure development, construction and renovation. The two counties which had successfully managed facility renovation projects could serve as a model to establish this process.

Responsible: Central MOHSW (through Decentralized Working Group).

Suggested Timeframe: within 6 months

4. Health Financing

4.1 Action: Prioritize the finalization of the Financial Management SOP utilizing county systems that are already in place. Financial Management is a priority system for roll out

according to the Decentralized Working Group. Our analysis confirms this and urges the MOHSW and its partners to develop SOPs, perhaps based on the procedures developed in Bong, and roll out decentralized financial management without delay. CHTs should provide significant input into the process of developing the SOPs.

Responsible: Central MOHSW (through Decentralization Working Group) to provide oversight to partners accountable for developing this SOP; 2) Health partners to support roll out of training in geographic areas of coverage.

Suggested Timeframe: within 3 months

5. Community Involvement

5.1 **Action: Use the experience of Grand Cape Mount as an example for other counties in community engagement and participation.** For example, arrange study tours to Grand Cape Mount to share experience.

Responsible: 1) Central MOHSW could organize future quarterly meeting in Grand Cape Mount and focus meeting on community engagement; 2) USAID/RBHS to orient other CHTs in 7 counties on principles of community involvement using study visit to Grand Cape Mount.

Suggested Timeframe: within 6 months

5.2 **Action: Define roles and specific tasks in facilitation of community engagement for CHT, health partners, and community structures.** For example, clarify the kind and frequency of contact (i.e. coordination meetings, planning meetings, data collection, supervision, etc.) that the CHT is supposed to have with CHCs, gCHVs, community leaders, and community members.

Responsible: 1) Central MOHSW (through Community Health Division) to disseminate Community Health Services Policy document to CHTs and work with CHT and partners to develop Terms of Reference (TOR); 2) USAID/RBHS to work through partners in 7 counties to implement and evaluate community structures based on principles outlined in National Community Services Policy and Strategy that reinforce the role of the CHT and district officers in implementing community services; 3) CHT to include community mobilization activities beyond outreach in county health plan.

Suggested Timeframe: within 1 year

6. Information

6.1 **Action: Increase information exchange between NMCP and CHTs during existing activities.** For example, existing activities such as supervision could be used to increase information exchange. Supervision visits could be used to discuss activities, provide feedback about what was supervised during the previous visit, and share information about operational processes and procedures at the central and county level.

Responsible: NMCP to coordinate with CHT to schedule and structure supervision visits to achieve outcomes above.

Suggested Timeframe: within 3 months

6.2 **Action: Utilize the implementation of HMIS to strengthen the downward flow of**

information. The roll out of the HMIS is an opportunity to improve downward information flow. Institutionalizing the use of data for decision-making at all levels with built in top to bottom and bottom to top communication and data monitoring procedures will improve the quality of data collected and how that data is used. To this end, continue to build on District Health Information System (DHIS) and Data for Decision-Making Training started by Health Information Systems Project (HISP) and USAID/BASICS. For example, as part of the Quarterly Review Meetings, hold a half day in-service training with the HMIS Officers to continue to refine the analysis and use of facility data. Involve the facility staff in Data for Decision-Making training sessions so that they understand the importance of accurate capture of information and can also analyze the information to make adjustments at the facility level.

Responsible: 1) Central MOHSW to request this assistance; 2) RBHS to train county and facility staff in application of health information for programming in 7 counties.

Suggested Timeframe: within 6 months

6.3 **Action: Put in place additional strategies to strengthen downward information flow.**

One successful strategy is the Epidemiological Bulletin. Additional information that could be shared over the internet or through county supervision visits includes the minutes from central MOHSW meetings including the PCT and HCC Meetings, aggregated monthly health facility information, and supervision reports (from previous visit).

Responsible: Central MOHSW and NMCP to transmit this information to counties on a regular basis over email or through supervision visits.

Suggested Timeframe: within 1 year

Note: Discussion group participant

Table 4
Recommended actions to enhance management ability of CHTs, by time period

Action in next 3 months	3.1 Prioritize the finalization of the Procurement SOP
	4.1 Prioritize the finalization of the Financial Management SOP utilizing county systems that are already in place
	6.1 Increase information exchange between NMCP and CHTs during existing activities
Actions in next 6 months	1.1 Finalize Planning and Budgeting SOPs
	1.2 Define CHT role and tasks in providing oversight and monitoring of partner activities
	2.1 Identify one focal department at the central level to coordinate with the CHTs
	3.2 Establish Supply Chain Management and Procurement systems that respond to county needs
	3.3 Use the Decentralized Working Group as a forum to address the issue of the centralization of infrastructure
	5.1 Use the experience of Grand Cape Mount as an example for other counties in community engagement and participation
	6.2 Utilize the implementation of HMIS to strengthen the downward flow of information
Actions in next year	1.3 Harmonize central level and county operational planning processes
	1.4 Place management technical assistance (TA) with the CHT
	2.2 Decentralize the training process
	5.2 Define roles and specific tasks in facilitation of community engagement for CHT, health partners, and community structures
	6.3 Put in place additional strategies to strengthen downward information flow

Use of the Results and Methodology

The findings and recommendations of this assessment can be used by the CHTs, the central level MOHSW, and health partners in their continuation of the decentralization process. First, the report provides a current status of decentralization identifying strengths and weakness and factors impacting both. Furthermore, it contains in-depth information gathered from the CHTs themselves that provides a deeper understanding of the realities at the county level. The results can inform the MOHSW on next steps as well as priority areas for capacity building within the CHT and strengthening of the system. The information analyzed in this report can provide guidance in the development of programs and health activities. Partners can draw on information in similar ways, using it as a baseline for management capacity programs and to inform program planning. The CHTs can also employ the results of this assessment to better understand their own strengths and gaps and as an advocacy tool for increased responsibility and support to achieve a decentralized health system.

The assessment also resulted in the refinement of the tool, making the instruments more specific to the Liberia context. Thus, the tool is now available for use in the remaining counties to assess the decentralization process relative to each. In addition, this tool can be used on a repeating basis to provide updates along the decentralization process. Lastly, the tool can be modified for use in other countries undergoing similar decentralization activities. USAID/BASICS is happy to share this tool with the MOHSW and their partners in order to facilitate future information collection about decentralized management.

County Health Team (CHT) Structured Interview

Name: _____

Job Title: _____

Date: _____

Introduction

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

Guidelines for the Interviewer

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

County Context

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

a. Number and Type of facilities

b. Implementing Partners

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

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

a. How do you come to these conclusions?

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

Oversight and coordination of the health sector

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

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

4. How do you use this information?

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

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

Yes **No**

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

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

Yes **No**

a. If yes, what would that be?

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

Yes **No**

a. If yes, when and by whom?

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

Yes **No**

8. How often do you need to conduct planning?

a. What information do you use for planning?

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

Yes No

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

Yes No

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

12. How do you use those products?

Service Delivery

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

2. Who decides which services to provide?

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

Yes No

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

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

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

Yes No

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

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

Yes No

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

Yes No

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

Yes No

a. If yes, what form of transportation?

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

Human Resources

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

Yes No

a. If yes, how do you participate?

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

Yes No

<p>2. Do you have a register of all health staff in the county?</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>
<p>a. Is it broken down by cadre?</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>
<p>3. How many facilities are adequately staffed according to the BPHS guidelines?</p>
<p>4. Over the last 6 months, what type of training has taken place in your county?</p>
<p>a. Who was trained?</p>
<p>b. Who initiated/required the training (MOHSW, NGO/donor/CHT)?</p>
<p>c. Who conducted the training (MOHSW, NGO/donor/CHT)?</p>
<p>d. Who paid for the training (MOHSW, NGO/donor/CHT)?</p>

<p><i>Resources</i></p>
<p>1. Where do your supplies and drugs come from?</p>
<p>a. Who decides which supplies and drugs, including quantities, are needed and how?</p>

b. How are the supplies distributed to facilities?
2. Is an inventory maintained for the following:
a. Drugs Yes <input type="checkbox"/> No <input type="checkbox"/>
b. Supplies Yes <input type="checkbox"/> No <input type="checkbox"/>
c. Equipment Yes <input type="checkbox"/> No <input type="checkbox"/>
3. Is there a reporting system for stock balances? Yes <input type="checkbox"/> No <input type="checkbox"/>
a. How often is this reported and to who is it sent?
b. Have you experienced any drug stock outs in the past six months? Yes <input type="checkbox"/> No <input type="checkbox"/>

<i>Financial Resources</i>
1. Where does the funding for health services in your county come from (i.e. donors, NGOs, MOHSW)?
2. Are you allowed to allocate this funding or is it determined for you?
3. How much is needed to run the current health services in your county?

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

Yes No

a. To Whom?

Community Involvement

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

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

Yes No

a. If yes, who?

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

Yes No

c. If yes, which ones?

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

Yes No

a. If yes, how?

County Health Team (CHT) Semi-Structured Interview: Malaria Module

Name: _____

Job Title: _____

County: _____

Date: _____

Introduction

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

This module is designed to answer questions specific to the management of county level malaria activities and is directly tied to the general CHT management capacity structured interview.

Guidelines for the Interviewer

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

County Context

1. Tell us about the incidence of malaria in your county for:

a. General population

b. Pregnant women

c. Children under 5

2. Tell us about the malaria activities in your county (community and facility):

Oversight and coordination of the health sector

1. What malaria-related policies and guidelines (i.e. Malaria Guidelines, National Malaria Policy etc.) are available to help you in your role at the County Health Department?

a. Where do they come from (i.e. MOHSWSW, NGO, donor etc.)?

b. How do you use them?

3. What is the key information that you should have about your county to manage malaria services?

a. Where would you find that information?

<p>4. Is there malaria planning for health services done in your county?</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>
<p>a. If yes, when and by whom?</p>
<p>5. How often is planning conducted?</p>
<p>6. What are the products that result from the planning process?</p>
<p>7. How do you use those products?</p>

<p><i>Malaria Service Delivery</i></p>
<p>1. Who provides malaria services (facility and community level)?</p>

<p><i>Human Resources for Malaria</i></p>
<p>1. Over the last 6 months, have any training sessions on malaria interventions taken place in your county?</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>
<p>a. What was the subject of each training (CM, Supply Chain Management)?</p>
<p>b. Who initiated/required the training (NGO/donor/MOHSW/CHT)?</p>

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

Malaria Resources
1. Where do your ITN supplies and malaria drugs come from?
a. Are you involved in the procurement of these drugs and supplies? Yes <input type="checkbox"/> No <input type="checkbox"/>
b. Who decides which supplies and drugs, including quantities, are needed and how?
c. How are the supplies distributed to facilities?
2. Do you maintain an inventory for:
a. Drugs Yes <input type="checkbox"/> No <input type="checkbox"/>
b. Supplies Yes <input type="checkbox"/> No <input type="checkbox"/>
3. Is there a reporting system for stock balances?
Yes <input type="checkbox"/> No <input type="checkbox"/>
a. How often is this reported and to who is it sent?
b. Have you experienced any drug stock outs in the past six months? Yes <input type="checkbox"/> No <input type="checkbox"/>

Financial Resources

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

2. Are you allowed to allocate this funding?

Yes No

a. If no, who allocates the funding?

3. How much is needed to run the current malaria activities in your county?

Community Involvement in Malaria

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

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

Yes No

a. If yes, how? (CHV)

County-Level Relief to Development Questionnaire

Name: _____

Job Title: _____

Organization: _____

County: _____

Introduction

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

Instructions

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

Key

MOHSW = central level MOHSW

CHT = county level MOHSW

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

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

1.1 Ability to adequately engage health facilities

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

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

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

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

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

Component 2: Capacity to manage human resources for health

2.1 Ability to plan and decide on human resources for health

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

2.2 Ability to mobilise human resources for health

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

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

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

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

3.1 Ability to plan and decide on resources for health

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

3.2 Ability to mobilise and distribute resources for health

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

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

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

Component 4: Capacity to finance health services

4.1 Ability to budget for sustainable financial resources

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

4.2 Ability to disburse health financing for the county health sector

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

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

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

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

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

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

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

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

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

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

Component 6: Capacity to manage health information

6.1 Ability to plan and decide on health information to collect

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

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

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

6.3 Ability to utilize health information to improve services

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

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

Introduction

The purpose of this group discussion is to:

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

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

The proposed agenda for the guided discussion is as follows:

Group Discussion Guidelines

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

Group Discussion Questions

Instructions:

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

1. Vision: Setting the Context

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

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

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

2. Ability to plan and decide:

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

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

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

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

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

3. Ability to lead and engage health facilities

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

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

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

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

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

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

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

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

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

6. Ability to Implement

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

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

7. Ability to mobilise human resources for health

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

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

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

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

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

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

9. Ability to disburse financing for the county health services

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

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

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

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

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

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

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

11. Ability to monitor:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Date: _____

County: _____

Observer: _____

Checklist for Record Review

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

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

Date: _____

County: _____

Observer: _____

Check records for:

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

ANNEX 2: Group Discussion Participant Priorities and Recommendations for Next Steps

Participants in the group discussion were asked to list their priorities and to provide their three most important recommendations or “next steps” for the decentralization process. The recommendations are as follows:

1. Clarify roles and responsibilities of central, county, community and partners for all aspects of health system management.
2. Give power and mandate to CHT to manage health system at all levels. This includes managing partners, resources and health services.
3. Formalize a two-way information system that includes feedback, data and means to receive it (i.e. internet).
4. Control of resources for the implementation of the county health plan should be released to the County Health Teams.
5. Capacity building should be decentralized. This includes the decentralization of the training system and technical assistance in management to the county health teams.
6. Identify human resource incentives/motivation (county volunteers salaried, hardship pay) to increase manpower.
7. Ensure that all vacant positions at various levels (county, district, and community) are filled and all people are trained and working under MOHSW guidance (SOPs).
8. Budget must address specific county realities (i.e. population, number health facilities, and geographical factors) and should be based on the county health plan.

