THE MINISTRY OF HEALTH AND SOCIAL WELFARE

GUIDELINES FOR NATIONAL DECENTRALIZATION

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**Decentralized Management Support Systems**

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Introduction

Decentralization is a process whereby management support systems are deconcentrated so that national government is relieved of a variety of repetitive tasks and functions which can be more effectively accomplished at the local level where those tasks and functions are occurring. A major and desired result of the decentralization process is that it allows much more time for the national government to accomplish its policy-making and strategic planning responsibilities. In a decentralized organizational structure the role of national government is directed primarily at policy formulation, strategic planning, resource mobilization and monitoring and coordinating the actions of county level managers to ensure that national policies are appropriately and effectively implemented.

These Decentralization Guidelines are presented to guide the Ministry of Health and Social Welfare in establishing decentralized management systems. It is not intended that these Guidelines function as detailed step-by-step procedures, but rather as guiding principles to assist with the establishment of policies. The Guidelines should not be viewed as rigid doctrine, but as flexible principles by which to make judgments in determining policy. Major issues in the decentralization process are discussed, with suggestions and recommendations provided as appropriate. The first section of this document deals with decentralization issues of a broad, general nature, while the latter part of the document presents issues pertaining to the decentralization of specific management support systems.

Revision of Decentralization Guidelines

The original Decentralization Guidelines were developed in 1985 as part of the South East Region Primary Health Care (SERPHC) project. The SERPHC project was implemented by the MoHSW with assistance from the MEDEX Group, University of Hawaii, through funding from the United States Agency for International Development. The project operated in Grand Gedeh and Sinoe counties. A total of eight separate decentralized management systems were developed and implemented in those two counties, with county level staff trained in their operationalization. During the intervening twenty years from the time of that project and the present, significant changes, both positive and negative, occurred in Liberia. Civil war and unrest destroyed much of the health infrastructure and debilitated national and local institutions. Nevertheless, a powerful rededicated spirit to rebuild and decentralize the health system has emerged from this turmoil, with a strong level of determination on the part of national and local leaders. As part of this resurgent effort an interest in revising these Decentralization Guidelines has been expressed. This current version, developed in late 2008, updates the 1985 document and has the advantage of knowledge of advanced ways to deliver health services and contemporary methods of decentralization that have been in operation in other countries. As with the original version, this revised version of the Guidelines is intended to provide suggestions and recommendations to guide MoHSW leadership in setting policy.
Progress towards Decentralization

Since the original version of the Decentralization Guidelines was developed and endorsed in 1985, considerable progress has been made toward decentralizing management support within the MoHSW. Indeed, decentralization on the part of the Government of Liberia has become a broadly supported theme that impacts on all sectors, not just the health sector. This progress has been made in spite of years of conflict, unrest and hardship over the past twenty years. A National Decentralization Policy has been drafted and is under review. In the MoHSW five-year National Health Policy and Plan created in July 2007 decentralization features prominently, with a clear call to action. The gravity of commitment to decentralize presented in these documents attests to the seriousness of the GOL and the MoHSW to implement these policies with all deliberate speed. Nevertheless, the ambition to move rapidly is tempered by the reality of limited human and material resources. Supplementing the GOL’s obligation of resources to promote decentralization, several donors and non-governmental organizations have provided resources to enhance the pace of decentralization. As will be discussed further below, policies need to result in a clear and adequately resourced plan of action to be of any real value. The MoHSW has demonstrated its commitment to implementation of its decentralization policies in a number of ways. Presented here is a brief summary of a few examples of actions that have been implemented in the recent past:

Support Systems

Following the creation of the current five-year National Health Policy and Plan in July 2007 the MoHSW has been fully engaged in implementing crucial decentralized modules:

Planning and Budgeting: counties were provided technical assistance and templates to create county plans and budgets for FY 2008-09.

Financial Accounting: The Ministry’s Office of Financial Management has planned with PriceWaterhouseCoopers to conduct county level financial accounting training in February 2009; county bank accounts have been established and funds are ready to disburse: county-level accountants have been deployed to most counties.

Human Resources: A Human Resources (HR) Department has been established at central MoHSW; Human Resources for Health Policy, Standard Procedures (SOP) and Job Descriptions drafted; forms designed and printed; HR database developed and being updated; HR “focal points” have been assigned to counties as members of the County Health Team.

HMIS: Computers have been distributed to counties; GIS/mapping training conducted; databases being populated; overall structure and function of HMIS being organized.

Infrastructure: An Infrastructure Unit has been established at central MoHSW; new construction and renovation of damaged facilities in progress; plans for future work developed.

Drugs and Medical Supplies: The National Drug Service is being revitalized and improved procedures that enhance the ability of counties to order and receive drugs and medical supplies are being developed and utilized.
Capacity Building
The Ministry of Health and Social Welfare has been engaged in a number in-house capacity building activities. Notably, in 2007 the MoHSW, assisted by BASICS, conducted training and technical assistance activities in each of the 15 counties to assist the County Health Teams to develop their own county-level annual plans and budgets. The training was based around a planning and budgeting template developed by the Ministry, and resulted in comprehensive plans and budgets for each county. These county health plans are available on the Ministry’s web site ([http://liberiaMoHSW.org/County_Health_Plans.html](http://liberiaMoHSW.org/County_Health_Plans.html)). Similar activities conducted by separate Departments of the Ministry have built capacity at the county level.

In 2007 the Mother Patern College of Health Sciences in Monrovia, the Clinton Foundation and Yale University teamed up to provide an excellent general management skills training course. This course was spread over a four month period in three one-week sessions to provide participants the opportunity to practice what they learned and to bring back their practical experiences to subsequent sessions. A wide range of skills was taught. The Mother Patern College plans to continue offering this course on a regular basis and provides a much coveted certificate to those successfully completing the course. A review of previous course materials shows considerable depth in the content of the course. The management skills learned by county-level participants will be a great asset to them in providing leadership in their counties as they oversee the installation of specific support systems. The MoHSW should maintain a relationship with the Mother Patern College and continue to send new CHT members to this course.

In 2006, UNICEF and Merlin assisted the MoHSW in developing a week-long training for County Health Teams. The training is well documented with job descriptions, supervision checklists, financial management tools, and drug ordering procedures that could be easily integrated into Standard Operating Procedures for specific support systems.

Efforts such as those of the MoHSW, the Mother Patern College and UNICEF/Merlin described above, need to continue to build general management skills among CHT members. In addition to these general skills, training in specific skills at the operational level need to be planned and conducted as detailed operational procedures are developed. It is important to link this specific level training with general management skills training activities to maximize effectiveness. This topic will be addressed further later in this document.

Decentralized Management Support System Development
The MoHSW should engage in a logical, stepwise process to fully develop and document the nine Decentralized Management Support Systems identified in the National Health Plan. This stepwise process begins with the establishment of policies to generally address fundamental problems and constraints. After policies are set, general procedures describing the implementation of actions to solve those problems and remove constraints drafted. Next, specific procedures, called Standard Operating Procedures are developed. Finally, learning materials are created that contain details on how to train CHTs and Central managers in the general and specific policies and procedures required to operationalize the system. The following describes the flow of the development of properly functioning decentralized management support systems, and how those systems are documented.
Policy Formulation

In the context of the Decentralization Guidelines, policies are defined as formal normative statements used to guide and determine present and future decisions about actions to implement in providing health care to the people of the nation. National policies are usually developed through a political process, whereas the implementation of those policies is usually guided by managers within a hierarchical organization and carried out by technical staff. Although implementation of policies is carried out by technical staff, it is important for high level stakeholders and leaders to continue championing and supporting such implementation to ensure adequate motivation of the staff and availability of resources. Consequently, it is important to involve a wide range of persons in policy formation – from politicians and their constituents to those within implementing ministries and their technical staff at all levels, as well as members of the communities they serve. The MoHSW is at great advantage in this regard since it has provided opportunities for broad stakeholder involvement in an extensive dialogue in 2007 when the five-year National Health Policy and Plan was developed.

The breadth and scope of policies follow the level of the system to which they apply and address problems that are appropriate to that level. The broadest policies related to decentralization are those at the national level. The mandate to decentralize is itself a broad national policy. Policies need to be established to deal with each level of the health sector: ministerial, departmental, county, district, and service delivery point. As examples: there are national policies such as to whether to charge fees for services, intermediate levels policies such as the need for counties to develop annual plans, and health facility policies such as the number of days per week to conduct community outreach visits.

Policies can be compulsory or flexible -- in a decentralized system local authorities should be allowed more latitude in developing their own policies to address local needs. In the interests of the public, however, some policies need to be set at the national level and made compulsory. For example, a county should not be permitted to set a policy that excludes immunization from its array of services.

Policies may be momentous or simple -- for instance, to establish revolving drug funds compared to whether to provide refreshments at County Health Team meetings. Obviously the former is more far-reaching than the latter, but they both have their place.

In each case policies need to be formulated that have a realistic chance of being implemented. Those that are overly ambitious, no matter how noble their intent, may become counterproductive if there is no possibility they will be implemented – people will be frustrated by the promise of something that never happens.

Consideration of the ability to mobilize adequate resources is crucial in policy formation: if there is no hope of finding the required resources, policies demanding certain actions should not be enacted. For example, although it would be an excellent policy of the Ministry to deploy a medical doctor at every clinic, the promulgation of such a policy would be unrealistic and meaningless at this time due to the lack of funds and human resources.

Once realistic policies are set it is important during the implementation of those policies to ensure that the resulting procedures are related to those policies, and that this relationship is clearly articulated. Procedures must not go off on their own without being firmly tied to a policies.

Later in this document several national level policies dealing with decentralization, articulated in the National Health Policy and Plan will be examined, with a view to ensuring ways that they can be realistically implemented.
**System Structure**

A first necessary step to developing the details of decentralized support systems is to concisely define and outline the expected functional contents of the system. The outline should follow the basic structure of the system, starting with the major functional areas and then providing an adequate amount of detail to identify where specific operations take place. The focus of the outline should be on the county level, but where appropriate also show the support functions of the central Ministry. The following is a partial outline of the Supervision Management Support System presented here as an example:

- **Supervision**
  1) Supervision structure
     a) Chain of authority
     b) Supervisory responsibilities
  2) Supervisory skills
     a) Types of supervisory skills
     b) Supportive supervision
     c) Planning
     d) Teamwork and leadership
     e) Motivation
     f) Communication
     g) Problem solving
     h) Conducting meetings
     i) Managing change
  3) Supervisor capacity building
     a) Orientation of new supervisors
     b) Training in supervisory skills
  4) Planning and scheduling
     a) Annual plan
     b) Monthly/quarterly work schedule
     c) Coordination of supervisors’ activities
     d) Scheduling Supervisory Support Visits
     e) Transportation
  5) [continued]…

**Standard Operating Procedures**

To fully operationalize decentralized management systems, standard operating procedures (SOPs) are required that document the policies, regulations, operating steps, tools and forms, with details on who is responsible for each step. A standard template for SOPs should be developed and used to promote consistency and efficiency in operations. SOPs follow the system outlines mentioned above. There should be at least one SOP for each of the lowest levels of the outline of the system. These SOPs, organized according to the system outline and introduced by general policy statements and general procedures, will form the documentation required to operationalize each of the management support systems. In the interests of expediency and efficiency, SOPs for selected priority modules of these support systems can be fully developed in an incremental manner. Development of the SOPs required for an entire support system can be accomplished in subsequent roll-out phases. When all the SOPs are available they can be bundled into a complete system document as described below.
System Documentation
System Documentation is required to describe how to install and maintain decentralized systems. This documentation consists of:

- **Policies**, succinct and comprehensive, with reference to authority, regulations and mandates;
- **Guidelines** required to implement policies;
- **Standard Operating Procedures** containing:
  - **Specific detailed steps** that need to be performed to operate the system;
  - **Responsibilities** clearly identified - who needs to accomplish each step;
  - **Resources** needed to accomplish the procedures;
  - **Forms** to record information for repetitive tasks;
  - **Formats** for less repetitive tasks where more flexibility is required;
  - **Tools** such as checklists; and
  - **Job Aids** to provide practical instructions.

As the above documentation is developed for each part of a decentralized management support system, it can be be bundled into manuals, handbooks or instruction booklets that collectively describe all of the policies and procedures, and contain the forms and tools required to install the system and keep it functioning effectively. This type of documentation provides an enduring legacy that will allow those who follow a complete guide of how to install and operate decentralized systems. Documentation will greatly benefit new employees entering the Ministry’s service. Lack of documentation often results in “new” employees learning informally from “old” employees, who often pass on bad habits instead of best practices.

Capacity Building Guides
Practical learning materials for participants and facilitators, consisting of session plans with exercises, simulations and role-plays can be developed from the system documentation described above. These materials should be useful in both workshop settings as well as on-the-job training, depending on the type of knowledge and skill development required. Links between specific system operations and general management skills need to be pointed out so that trainers can ensure both a broad understanding of the policies, principles and strategies that guide the system, and the specific day-to-day actions required to operate the system. Further description of the requirements for support system training and capacity building is presented in the following section.

Capacity Building for Decentralization
Implementing decentralized systems demands extensive training of personnel at the county level, as well as training of central level managers. As will be discussed below, there are training resources and experienced trainers at the MoHSW as well as other government institutions and non-government organizations. The Liberian Institute of Public Administration (LIPA) is an example of such an organization that may be able to provide training for decentralization. LIPA is rebuilding itself as an effective training organization and should be able to provide training services to the MoHSW. The training strategy will
examine options for providing most of the decentralization trainers from the health system and/or from local institutions. One possibility, for example, might be the creation of a pool of trainers. Some trainers would be Support Systems specialists who would provide training assistance in their respective domains, e.g., procurement, financial management, and HIS. Other trainers, perhaps from local training institutions, would be "Generalists" trainers/facilitators. For each support system training event a team (or teams) of two or three trainers (combining one Generalist and one or two Specialists) would be selected to conduct the training process (and perhaps to also provide part of the follow-up support supervision). The key to managing such a pool of trainers will be the ability of the MoHSW to effectively coordinate and match training needs with appropriate trainers. The pool of could be formed from MoHSW staff, staff of other Government Ministries and Agencies, institutional staff at organizations such as Mother Patern College and LIPA, and skilled independent consultants and experts as may be available.

**Linking management training and operations training**

A considerable amount of general management skills training has taken place, conducted by the MoHSW such as during annual planning and budgeting initiatives and by non-governmental organizations (NGOs), such as the Mother Patern College of Health Sciences. General management skills training has focused on topics such as leadership, strategic planning, budgeting, problem solving, team building, giving/receiving feedback, resource mobilization and change management.

Departing from general skills and moving into the realm of day-to-day operations, it is essential to link training in standard operating procedures to the higher order of skills that CHT members must acquire to manage the overall system the SOPs are part of. As SOPs are developed, attention must be paid to the general skills that managers, supervisors and workers should be trained in to increase their capacity to manage the system in which those using the SOPs function. Likewise, whenever general management skills training is conducted, trainers must be cognizant of the specific SOPs that those management skills serve to facilitate. As examples, an SOP covering checklists for supervisory visits to clinics requires skills in leadership and team building; an SOP dealing with employee performance evaluations calls for skills in human resource management and giving/receiving feedback.

In designing training in SOPs and general management skills, those developing the curricula must find ways to link coordinate and integrate these two types of skills and knowledge. Wrapped into the larger management picture is the need to shape appropriate attitudes. As will be discussed in the following section, healthy team attitudes are necessary for a properly functioning system. Attitudes that separate managers and workers into rigid “us-them” categories are not healthy. Cross-training, where those at the operations level receive training in a reasonable amount of management skills training can help to avoid such counterproductive attitudes. Similarly, managers need to have a basic understanding of the procedures that those they supervise are performing, and have a chance to occasionally perform those procedures themselves, to ensure an appreciation of the challenges their employees face.

**Promoting Teamwork**

Old fashioned methods of management called for managers who had general management skills and were isolated from the detailed work of those they supervise; detailed work was performed by operations level workers who were not involved in larger management issues to prevent them from being distracted from their day-to-day functions. A more modern approach to management emphasizes teamwork, where the managerial and operational
functions more closely interact, with managers and workers in frequent contact and communication; managers need to understand and at times participate in the detailed work of those they supervise; operations level workers are encouraged to understand the bigger picture to enhance their value to the organization and to help provide greater opportunities for upward career mobility.

In a decentralized organization, County Health Teams need to engage in this new type of management by encouraging a team approach, not just among the CHT’s senior members, but in the broader sense that all of the health workers within the county form a team. Management and operations level team members need to share a common vision and be committed to work towards mutually understood goals and objectives.

**Competency Based Training (CBT)**

Traditional training approaches based on participants putting in time at workshops produce diminishing results in providing the ability to actually gain new skills. Awareness can be raised and knowledge can be gained at tradition workshops, but skill development is sometimes elusive.

On the other hand, CBT methodology focuses on mastery of specific knowledge and skills and is participant-centered. Participants are required to demonstrate competency by successfully performing the skills required to operate the requirements of the module in which they are being trained. By definition, such training is practical and hands-on in nature, focusing on best practices, with participants progressing at their own pace as they gain competency in specific skills.

It is essential that adequate preparation of learning materials take place, with the competencies to be gained fully identified. Such materials can be efficiently developed if there are well prepared SOPs. The use of CBT methodology is highly recommended for skill development training, especially at the Sop level.

**Central Level Support**

**Decentralization Directives from the Central MoHSW**

To give proper weight to and create an appropriate mandate for decentralization, the central MoHSW should issue clear directives to communicate that the responsibility and authority for specific actions are to be deconcentrated and delegated. Circulars or memoranda that spell out the exact scope and limits of the authority being delegated should be sent out to the counties, all MoHSW departments, related ministries and relevant organizations to ensure official recognition. As policies and SOPs are being issued for implementation they should carry high level certification indicating approval for use and implementation. Whenever revisions to such policies and SOPs are made, they should also have clearly indicated high level approval. Without such clear directives there will be questions as to whether a particular action is actually decentralized.

**Responsibility, Authority, Resources**

A key feature of decentralization is to deconcentrate responsibility and delegate authority to peripheral levels of the organization. Unfortunately, too often inadequate authority is delegated and the peripheral level becomes frustrated because they do not have sufficient decision-making ability. Making a peripheral level responsible for certain actions, but then requiring them to continually check back with the central authority does not accomplish decentralization.
Let’s look at some examples of responsibility without authority. If a CHT, supposedly in the spirit of decentralization, is given responsibility for mounting an immunization campaign in their county, but is not provided decision-making authority and has to check with a department in the central office for decisions about which vaccines to use, the objectives and targets of the campaign, scheduling of the districts and communities to include, how many vaccinators to deploy, etc., then it can be said that they had responsibility without authority. The failure to adequately delegate authority is a failure to decentralize.

Likewise, even with both responsibility and authority decentralized to a peripheral level, if adequate resources to implement services are not provided, decentralization is also meaningless. Local implementers who are attempting to implement programs must command the resources required to carry out their responsibility. Continuing with the above example, even if the responsibility and authority is given to a CHT to mount a vaccination campaign, without the funds, vaccines, vehicles and human resources available, the effort cannot be viewed as adequately decentralized. To require the CHT to wait for, and perhaps beg for, such resources from the central level would undermine their ability to function, and result in a failure to decentralize.

**Decentralization Working Group**

To accomplish the required roll-out tasks in implementing Decentralized Management Support Systems, a group of dedicated professionals working within the authority of the MoHSW will be needed. It is recommended that a Decentralization Working Group (DWG) be formed to facilitate the process of rolling out decentralized modules. The DWG should be comprised of members of the Ministry Central staff, plus some participation from the County level. To supplement and extend the capabilities of these key members, some level of short-term consultant assistance may be of value. A summary of the suggested main responsibilities of the DWG would include:

- Prepare work plans to implement decentralized management support systems;
- Gather information to design system modules;
- Prepare and/or adapt Standard Operating Procedures;
- Prepare and/or adapt learning materials;
- Conduct/facilitate workshop training and follow-up On-the-Job Training;
- Coordinate the inputs and activities of Government departments, NGOs, FBOs, and others involved in the decentralization process;
- Assure the integration of system modules to create a holistic decentralization package;
- Identification and mobilization of resources;
- Monitor and evaluate the performance of decentralized systems.

**Technical Assistance**

For systems that may require a specific technical expertise to ensure that the right policies and procedures are established, the Ministry may need to enlist help from technical assistants, either international or local. Examples of such technical assistance would be accounting systems, health management information systems, and monitoring and evaluation. In addition to such expertise, there may be times when the Ministry needs to supplement its workforce with short-term technical consultants who can dedicate themselves to a specific piece of work from beginning to end without the distractions that permanent employees face in dealing with multiple tasks. Where either particular expertise is not available, or time is not available of permanent staff, it is recommended that technical assistance be engaged. Often
donors will respond to such needs and provide technical assistants, or funds for the Ministry to secure technical assistants.

**Material Resources**

In addition to considerable human resources to design and document management systems and learning materials, there will also be extensive need for material assistance during the decentralization process. Examples of such material assistance include vehicles and running costs to provide transportation for system rollout, training and supervision; paper and printing costs for system documentation and learning materials; funding for workshop venues, travel costs and per diem for participants; additional equipment (such as computers) and supplies to operationalize some systems, maintenance tools and/or funds for outsourcing facility and equipment maintenance.

**Organizational Issues**

**Organizational Levels: Skills Sets and Functions**

Three organizational levels of decentralized management can be identified: Executive, Managerial and Operational. Each has its specific function within the decentralized system, and requires a somewhat different set of skills to perform those functions. They can be described as follows:

- **Executive level:** Comprised of the Minister, Deputy and Assistant Ministers, and heads of key special programs at Central level. Emphasis is on conceptual skills. They require a set of skills to perform the following functions:
  - Establishing policies
  - Monitoring and evaluating results
  - Strategic planning (vision, goals)
  - Mobilizing resources
  - Leadership

- **Managerial level:** Comprised of heads of Central level Bureaux, Divisions, and key sections, and County Health Team members. Emphasis is on both conceptual and technical skills. They require a set of skills to perform the following functions:
  - Implementing of policy
  - Developing procedures
  - Designing and conduction training
  - Supervision
  - Monitoring and evaluating technical outputs
  - Technical supervision
  - Strategic planning (tactics, goals and objectives)
  - Identifying and securing resources
• **Operational level**: Comprised of County and District level staff concerned with day-to-day direct work output and delivery of services. Emphasis on technical skills. They require a set of skills to perform the following functions:
  o Implementation of procedures,
  o Activity planning (objectives),
  o Use of resources
  o Technical inputs
  o Work output
  o Reporting of data used in monitoring

While each level has its own area of exclusive functions and skills, there are places where these skills and functions overlap, or intersect, as can be seen in Figure 1 below.

• The Executive and Managerial levels share a considerable number of skills in dealing with common functions. These skills include strategic planning, mobilizing and securing resources, policy formulation and implementation.
• The Managerial and Operational levels also share extensive overlap in skills required to deal with their common functions, including work planning, developing and implementing procedures, monitoring outputs and securing and using resources.
• To a certain degree, all three levels share a set of skills and functions, including an understanding the vision and long range goals of the Ministry, the need to monitor accomplishments, placing high value on results.
• The Executive and Operational levels do not exclusively share any common functions or skills; where there is overlap or intersection, such skills and functions are also shared by the Managerial level.
Recognition that there are shared functions and skills helps to promote the concept that there are shared values and vision within the entire organization. As mentioned earlier, teamwork is essential in a well-functioning organization, and an understanding of areas of intersection of skills and functions helps promote teamwork. A worker performing menial and relatively unskilled tasks has to share the vision and values of co-workers, up to the highest level in the Ministry, to build a functional team capable of coordinated outcomes in service to the public.

**Health Districts**

As stated in the draft National Decentralization Policy and promoted in the National Health Plan and Policy 2007-2011, health districts are being established to provide an additional layer of management and support for the delivery of health services. The addition of Health Districts provides opportunity for support of services at a level that is closer to the community than the County level, especially in geographically large counties. With fully functioning Health Districts, headed by District Health Officers (DHOs), CHTs will be aided in their task of supervising health centers and clinics since DHOs will be geographically closer to those facilities and can spend a greater amount of time giving supportive supervision to their staff. However, the addition of this layer also presents challenges in locating additional resources to provide the necessary personnel and secure office space and transportation for them. The pace of implementation of functional Health Districts will be constrained by the availability of resources.
Rollout of Decentralized Systems

Given the large number of decentralized systems to be rolled out, an incremental approach is needed. This is recognized in The National Health Policy:

The Ministry will pursue de-concentration in an incremental and pragmatic way, by assigning to County Authorities responsibilities they are equipped to assume and progressively expanding these responsibilities. (p 15)

A phased rollout is recommended, with systems of highest priority rolled out first. As mentioned early in this document, there has been considerable progress made to date in decentralizing the Ministry’s support systems, yet much is left to do. A phased plan can be developed that allows for the complete rollout of all support systems by the completion of the current National Health Plan in 2011.

Continuous Quality Improvement

Once management support systems have been rolled out and are operational, a process of ensuring that they can be refreshed and improved needs to be put in place. To address this, a process called Continuous Quality Improvement (CQI) will help to maintain momentum in seeking renewal of management systems. CQI focuses on a team approach to improvement and offers praise and rewards to management teams that improve and excel, rather than focusing on blaming individuals for poor performance. Based on skills and competencies that were learned during training, tools are developed that assess the performance of teams in accomplishing objectives and achieving results. The CQI assessment tool measures the processes that drive the system and helps determine how to remove barriers that prevent teams from doing a better job. Emphasis is on eliminating internal competition between individuals and building a cooperative workforce. The Ministry should apply a CQI assessment tool to CHTs on a quarterly basis. Based on the findings of the assessment, feedback is shared with CHTs to engage them in discussions about how their team performance might be enhanced by improving the systems they are operating. Changes are proposed and implemented by modifying SOPs and providing additional training as necessary. This continuous cycle allows the renewal of support systems and ensures that a fresh approach to problem solving is promoted.

Policies Governing the Decentralization of Health Services

National Decentralization Policy

The draft National Decentralization Policy of the Republic of Liberia states:

Liberia shall remain a unitary state with a system of local government and administration which shall be decentralized with the county as the principal focus of the devolution of power and authority. (Section1.1)

County governments shall be established within the geo-political boundaries of the fifteen political sub-divisions of Liberia with political, fiscal, and administrative devolution of authority granted to them by legislative actions and constitutional amendments. The strategy for decentralized governance shall be to empower the Liberian people to participate in all dimensions of local self-governance and facilitate
equal political participation in the process of national democratic governance. (Section 1.3)

This draft Policy further states that:

The national government shall prescribe the first administrative agencies to be established concurrently in each county upon implementation of this national policy. These shall include [among others]:

- Department of Health and Social Welfare

The title of the chief administrative officer or head of each county agency shall be called Director; the mission, purposes and powers of administrative agencies shall be prescribed in the enabling acts passed by the National Legislature for the creation of such agencies. (Section 5.1)

All heads of county administrative agencies shall be appointed by the Governor with the consent of the County Legislative Assembly (CLA) from the nationally established civil service list of eligible officers. They shall serve in any county as long as they have the confidence of the Governors. These heads shall administer county and national programs in their respective counties and facilitate monitoring, and evaluation of county conditions and of national programs for the relevant national ministries. (Section 5.2)

National ministries shall develop national goals in consultation with county technical personnel, shall design and provide robust programs of technical assistance, outreach and training useful to the-counties, analyze and develop policies and programs appropriate for county development, and monitor and evaluate the performance of counties in achieving national goals in their respective sectors. The national Civil Service Agency and the Liberia Institute for Public Administration shall provide administrative assistance and guidance in the development of county personnel systems, human resources management, training and capacity building for county development. The Governance Commission shall assist county governments in crafting and reviewing sub-national institutions and policies. (Section 5.3)

National Health Policy

Policies of the MoHSW that concern the decentralization are clearly spelled out in the National Health Policy and Plan 2007-2011:

3.3.5 Decentralization

The Government of Liberia has stated its intention to proceed towards decentralization. While the overall characteristics of the future decentralized public structure are being specified, the health sector will work hard to prepare the ground for the reform. The de-concentration of management responsibilities requires the building of performing systems at county level, as well as effective support systems at central level. The Ministry will pursue de-concentration in an incremental and pragmatic way, by assigning to County Authorities responsibilities they are equipped to assume and progressively expanding these responsibilities. Caution will be exerted in the process, to ensure that health services are delivered without major disruptions.
3.4 Policy Objectives
From the preceding, the scope and rationale of the health policy may be articulated as follows:

Overall goal To improve the health status of an increasing number of citizens, on an equal basis...

Main strategy …through expanded access to effective basic health care, backed by adequate referral services and resources.

Adopted means The overall policy goal will be attained through the improved management of expanded resources, provided by the state, donors, international agencies, nonprofit health care providers, economic actors and communities. Strong, structured partnerships around shared objectives and approaches, within and outside the health sector, will be required to improve health status.

Organization of Health Services at the County Level

At the county level, the County Health Team (CHT), is responsible for delivering health and social welfare services on behalf of the MoHSW to the people within its respective county.

Relevant section from the draft National Health Policy:

1.2 Operational Levels
County Level
The County Health and Social Welfare Service Administration is the operational management structure, which includes the County Health and Social Welfare Team (CH&SWT). County health authorities manage county health facilities, including county hospitals. Proper administrative structures and management tools will be introduced at county level, to make health authorities truly autonomous. They will be responsible for financial and asset management and personnel, and will be fully accountable to local constituencies, as well as to overseeing public bodies. The relationships of county health authorities with local government structures shall be clearly spelled out. ¹

County Health Team (CHT)
To ensure a more seamless integration of the management of service delivery, a team made up of members of the MoHSW county level management is organized in each county. This cross-cutting County Health Team is empowered to provide integrated management of the key functions of the Ministry at the county level.

¹ The terminology used in the draft National Decentralization policy differs from that commonly used by the MoHSW at this time. Since that terminology is not yet fully developed, this document will use County Health Team (CHT) as the administrative organization responsible for implementing the MoHSW’s programs and services at the county level.
The CHT is headed by a County Health Officer (CHO) and is comprised of three Departments.

Community Health Department: Headed by a Community Health Department Director (CHDD), this Department supervises the operation of all primary health care facilities and personnel in the county and provides support services to these facilities and personnel to enhance their functioning.

Hospital Department: Headed by a Hospital Medical Director (HMD), this Division provides in-patient, or secondary level, health services. Serves as a referral point for all primary health care facilities to which more complicated cases may be sent. The Out Patient Unit of the hospital functions as a primary health care facility.

Administration Department: Headed by a County Health Services Administrator (CHSA), this Department provides administrative support for all divisions and units of the County Health Team.

**CHT Terms of Reference:**

**Roles and Responsibilities:**

**Coordination & Communication:**
- Submit health services reports (administrative, technical, contingency) quarterly to the office of the Director of Health Services Division, *using the designated reporting formats*
- Conduct monthly County Health Sectoral Coordination meetings with all partners
- Establish the County Health and Social Welfare Board; CHO will attend all quarterly CHSWB meetings, and inform CHSWB members of all ongoing health activities in the county
- Liaise with county line ministries and sectoral agencies (e.g., WHO, UNICEF, NGOs) through regular briefings, including initiating MOUs when necessary
- Ensure effective coordination between all health facilities and the surrounding communities through the CHWs and CDCs

**Provision of Services and Quality Management:**
- Plan, coordinate, and supervise county health services. Health services include curative, preventative, rehabilitative and emergency preparedness response (EPR) activities.
- Oversee all direct patient care in the county. Oversee community health programs and public health clinics to ensure quality health care services are provided in accordance with approved guidelines and protocols from central MoHSW
- Investigate and take action as necessary to maintain the highest possible quality of care; ensure county hospital, health centers, and clinics meet minimum quality of care requirements in accordance with MoHSW policies and guidelines; monitor the quality of care at all health facilities within the county and supervise staff through on-site supervision, HIS and regular appraisals of CHT and facility staff
- Work with Community Health Services Unit to ensure that the concept of PHC is implemented
- Oversee development and maintenance of functional county-wide supply chain and forecasting systems; Ensure availability of all essential medicines at public facilities; Oversee submission of all requisitions for drugs and medical supplies
- Oversee all pharmacy and laboratory services throughout the county; ensure protocols are followed and quality of care at all facilities meets MoHSW standards
Planning, Monitoring and Evaluation:
- Oversee planning and administration of all county health and social welfare services, develop multiyear implementation plans and budgets.
- Oversee implementation of all county health and social welfare plans, including the County Health Plan and longer-range strategies aimed at implementing the National Health Plan.
- Track progress made on implementing CHT and national plans; ensure objectives are achieved and projects do not exceed budget.
- Maintain accurate and updated CHT and County budgets; ensure financial records are correct and financial assets are properly managed at all times.
- Oversee preparation of monthly reports. Analyze data from all county health facilities and develop appropriate responses to address any management issues and/or health outbreaks. Review, analyze and approve all monthly reports from CHT and facility staff before submission to MoHSW, NDS, or other external agencies.

Human Resources:
- Maintain accurate (ghost-free) personnel payrolls for all public health facilities; communicate Human Resource needs and challenges to the Director of Human Resources Management and Development at the central MoHSW in a timely manner.
- Ensure Human Resources and related issues (i.e. distribution of salary/incentives) are managed appropriately throughout the county.
- Identify, recruit and train health facility staff, and manage assignments of all personnel to county health facilities.
- Oversee assessment/evaluation of skill levels in health care management and training needs of health personnel and service providers at primary and secondary levels.
- Develop and ensure that a supervision system for service providers is implemented by all members of the CHT through a comprehensive and approved supervisory checklist.
- Provide support and oversee training of staff, including:
  - Monthly supervisory and monitoring visits to monitor staff performance.
  - Make supervisory schedule for supervisors and conduct in-service training.

Infrastructure and Logistics:
- Maintain up-to-date and accurate database of all health facilities in the County, including status (functional or non-functional) and infrastructure needs.
- Oversee and approve physical rehabilitation of health and related facilities.
- Ensure proper use and maintenance of equipment and vehicles, especially ambulances, etc. Oversee the Maintenance Team; ensure that repairs and construction are completed throughout the county in a timely and appropriate manner.

CHT Composition:
Senior Staff:
- County Health Officer
- County Health Department Medical Director
- County Hospital Medical Director
- County Health Services Administrator
- County Pharmacist
- County Laboratory Supervisor
General Members (not all may be present in every CHT):

- Clinical Supervisor
- Social Welfare Supervisor
- Focal Persons of categorical programs (HIV/AIDS, EPI, EPR, HP/HE, Malaria, TB/Leprosy)
- MCH Focal Person
- Reproductive Health Focal Person
- Surveillance Officer
- Eye care specialist
- Environmental Health Supervisor
- Mental Health Supervisor
- Finance Director/Accountant
- Hospital Administrator
- Diagnostic Services Supervisor
- Logistician
- Human Resources Officer
- Registrar

**CHT Organogram**

Figure 2 depicts the organizational structure of the CHT. An important point to note in the Organogram is that there is an unobstructed chain of authority from the CHO to the CHDD to the Clinical Supervisor to the Officers in Charge of the health facilities. This direct channel of supervision is essential to avoid confusion over who is supervising whom. It also prevents a problematic situation where an employee has more than one supervisor. It is also important to distinguish between Direct Supervision and Indirect Supervision.

Direct Supervision deals with authority and responsibility. Every person in the organizational structure must have only one direct supervisor. Such supervisors provide day-to-day supervision and are the final authority in terms of issuing orders to personnel to perform specific duties. Requests for leave, travel, transfer and all forms of personnel actions are submitted to and channeled through direct supervisors. Indirect Supervision on the other hand, deals with the technical content of employees’ functions. An employee may have more than one indirect supervisor; direct supervisors may also provide indirect supervision. No instruction may be given to an employee by an indirect supervisor without the knowledge and consent of the employee’s direct supervisor.
County Health and Social Welfare Board
To enhance accountability of the CHT to its constituent county community, County Health and Social Welfare Boards (CHSWB) are established. The CHSWB serves as a policy-making structure at the county level. The Terms of Reference for the CHSWB are:  
- Advise the County Health and Social Welfare Officer on health policy within the county;
- Assist the County Health and Social Welfare Team in multi-sectoral coordination;
- Mobilize resources for the implementation of the county health and social welfare plan;
- Review the County Health and Social Welfare Team’s implementation strategy and health and social welfare plan and progress;
- Monitor the use of financial and non-financial resources in the county;
- Ensure activities are coordinated and resources are used for intended purposes;
- Advise on health priorities;
- Review and approve the annual county health plan and budget prior to submission for the MoHSW’s annual budgeting process;
- Meet quarterly; and
- Present a progress report during the biannual national joint review.

2 [Formal source citation required – this text taken from a loose page provided by the MoHSW titled “County Health and Social Welfare Board”]
The board will be chaired by the Assistant Superintendent for Development and will consist of representatives from:

- County Health and Social Welfare Team;
- Implementing partners;
- Private/for-profit organizations;
- The local Ministries of Education, Agriculture, Internal Affairs, Gender and Development, and Public Works; and
- Allied Health Professionals and traditional healers;
- Member of Youth Group;
- Justice Ministry.

The CHO will serve as the secretary to the Board. The CHSWB shall function as a sub-committee of the County Development Council (CDC), to whom it will make semi-annual reports.

The CHSWB provides an opportunity for broader involvement of government and non-government development partners from other sectors, as well as the county community at large. This involvement will increase the county’s “ownership” and responsibility for the activities of the CHT in providing health and social welfare services. A functional relationship between the CHSWB and the Central MoHSW needs to be developed to assist the CHSWB in interpreting and promulgating national health policies. The CHSWB also provides an excellent vehicle for coordinating health and social welfare services at the county level.

**Partnering of Government, Non-Government, and Private Providers**

At the county level, in addition to the CHT, a good portion of health service is delivered by non-governmental organizations (NGO), faith-based organizations (FBO) and private/for-profit providers. The CHT and the CHSWB together share the role of coordinating health and social welfare services within the county delivered by this array of providers. This coordination takes the form of ensuring that MoHSW policies, standards and protocols governing the delivery of health services and protection of the public are followed by all health care providers. Coordination is carried out by having periodic meetings with other providers to make sure they understand national health policy and plans; harmonizing activities to best utilize scarce resources and avoiding both duplication and gaps in service; and synchronizing schedules to provide effective supervision and utilization of transportation resources. Coordination among all county health providers can also be helpful when engaging in intensive campaigns that benefit the community at large.

**Categorical Programs**

Sometimes also known as vertical programs, categorical programs are all contained within the Community Health Department and the heads of those programs report to the County Clinical Supervisor. These programs include:

- HIV/AIDS
- EPI
- TB/Leprosy
- Malaria
- Eye Care
- EPR
- Mental health
It is incumbent upon the Clinical Supervisor to ensure coordination and harmonization among these categorical programs. None of the heads of these programs must be allowed to “go off on their own” to start or engage in activities without the knowledge of the other programs. Often several of these programs rely on one person at a health facility to deliver their program’s services. This can create a situation of confusion for the staff at those facilities resulting in conflicting priorities and schedules. Heads of categorical programs must respect the chain of authority and direct supervision mentioned above, and all instructions and orders to facilities must flow first through the Clinical Supervisor, and if he/she agrees then be communicated to the facility staff. This should not inhibit the flow of information (as opposed to instructions), which is indirect supervision, again as mentioned above and clearly depicted in the organogram.

**Decentralized Management Support Systems**

In the National Health Policy and Plan 2007-2011 nine management support systems were identified:

1) Policy formulation and Implementation
2) Planning, Budgeting and Accounting
3) Human Resources Management & In-Service Training
4) Health Management Information Systems
5) Drugs and Medical Supplies
6) Facility and Equipment Maintenance
7) Logistics and Communication
8) Supervision, Monitoring and Evaluation, Research
9) Stakeholder Coordination & Community Participation

**Levels of Decentralized Management Support Systems**

Each of these nine systems play a role in supporting the delivery of health services. To help understand the respective roles of these systems, they can be arranged into three levels:

- **Enabling Systems**: Support systems that are the foundation and framework upon which all other systems rest.

- **Facilitating Systems**: Support systems that provide information and guidance in maintaining the environment in which performing systems operate.

- **Performing Systems**: Core functions that give direct day-to-day support to the delivery of health services.

This arrangement is depicted in the step pyramid diagram in Figure 3 below. As can be seen in the diagram, the following Enabling Systems form the base upon which the other support systems rest:

- Policy Formulation and Implementation;
- Stakeholder Coordination and Community Participation; and
- Research…
The following Facilitating Systems are in the middle of this arrangement and form a bridge between underlying support systems and daily operational systems:

- Planning and Budgeting;
- Monitoring and Evaluation; and
- Health Management Information Systems

Finally, the following Performing Systems are represented at the top level of the step pyramid, and are enabled and facilitated by the other support systems:

- Human Resources and In-Service Training;
- Drugs and Medical Supplies;
- Facility and Equipment Maintenance;
- Logistics and Communication; and
- Supervision

This representation of the total package of management support systems may assist in forming an understanding of the way these different systems interact. These levels of support systems are linked and interact. Performing Systems cannot operate without their underlying Enabling and Facilitating Systems.

As an example, a policy that enables County Health Teams to procure their own supplies by disbursing funds to them for their direct control, allows CHTs to plan the amount of supplies they require and determine the portion of their budget they allocate, which facilitates their ability to procure and pay for the supplies needed to support the delivery of services.

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**Figure 3: Levels of Management Support Systems**
Issues Impacting the Implementation of Decentralized Systems

The nine management systems contribute to supporting the delivery of the Basic Package of Health Services in Liberia. The extent and pace of decentralization of these systems depends on how soon detailed system materials are developed, and the stage of readiness of the counties to take on deconcentrated responsibilities. Each of these systems will be briefly described below, with an examination of some of the issues that may impact on their decentralized implementation through the life of the National Health Plan.

1) **Policy formulation and implementation**
- Policies must address common problems
- Created by politicians, implemented by technicians
- Consensus building
- Champions and leaders
- Stakeholder involvement
- Levels of policy formation
- Realistic vs overly-ambitious policies
- Relating policies to vision and strategy

2) **Planning, Budgeting, Accounting and Procurement**

**Planning**
- The planning/budgeting/accounting cycle and — an iterative process
- Practical, evidence-based planning — avoiding the overly-ambitious
- Goals and objectives
- Monitoring results
- Planning process vs plans
- Levels of planning: county, program, health facility, individual staff plans, etc.

**Budgeting**
- Linking budgeting to planning goals and objectives
- Budgeting based on costing of activities
- Unit costs
- Revising budgets as plans change or resources are reduced
- Tracking expenditures to budget
- Financial management link to procurement
- Dealing with direct funding and procurement and in-kind contributions

**Accounting**
Financial Accounting at the county level is a critical support system. The current decentralization proposal for financial accounting of the MoHSW requires each county to operate a simple system of banking and cash management of subsidies granted to them by the central Ministry. Funds will be deposited in their county bank account by central basis on approved budgets. The drawdown and expenditure of those funds will be monitored and audited by central on a regular basis. These actions are consistent with the Vision and Approaches articulated in the National Health and Social Welfare Plan (2007-2011) Update For Year Two Implementation (p. 6): “…the health sector will move forward with the community and county as a locus for decision-making in relation to resource management and service delivery.”
Implementation Issues:

- The ability of county-level managers to account for their own funds is essential in giving such managers direct control over resources. Decentralizing responsibility without decentralizing resources is a frustrating experience for CHT managers.

- Adequate controls and oversight must be established to guard against mismanagement and/or lack of accountability of financial resources. Financial management problems can result in scandalous, perhaps criminal consequences for both the Ministry and the individuals involved.

- The current nine management support systems identified by the MoHSW do not specifically name Accounting as one of those systems. It is suggested that Accounting be specifically named in the Planning and Budgeting system (i.e., Planning, Budgeting and Accounting).

- Banks do not exist in or near many counties, which poses a challenge for counties that are distant from Monrovia. Nevertheless, even if checks are drawn on a Monrovia bank, the ability of the CHT to directly provide payments to vendors will relieve them of dealing with the current bottleneck of having to seek approved requisitions for payment from the central MoHSW.

- Further allowing counties to directly control their own resources while coming to Monrovia to do banking transactions puts them in control of their budget while simultaneously clearing hindrances at the center. This prepares them for the complete de-concentration of financial management when the banks are close to them.

**Procurement**

As with Financial Accounting, Procurement management at the County level is also a critical support system. The proposal is to decentralize procurement the CHT to perform its own direct purchasing of commodities and services. It is crucial that the CHT follow established legal GOL procurement regulations.

Implementation Issues

- Outside of Monrovia the availability of vendors of commodities is limited at this time, which will result in the CHT arranging procurement with vendors in Monrovia. Although this will involve traveling to Monrovia to obtain quotes, make payments and collect goods, it nevertheless, enables counties to arrange their own direct procurement and eliminates the bottleneck of all procurement having to be authorized and arranged through the Central Ministry.

- Commodity procurement should be limited to approved categories, such as cleaning supplies, construction materials, firewood, stationery supplies, simple medical supplies, etc.

- Labor should be procured locally by the CHT to accomplish simple required services such as cleaning, food preparation, maintenance and repair, etc.

- Monetary limits should be set that the CHT must stay within. Procurement that may exceed such limits will be referred to the Central Ministry to manage on behalf of the CHT.
o The CHT, through their Financial Budgeting and Accounting system must ensure availability of funds in their bank account before engaging in direct procurement.

o Drugs and Medical Supplies will not be procured directly by the CHT, but ordered from the National Drug Service (NDS). Exceptions to this may include local procurement of emergency drugs (if not available or accessible at NDS, but available locally) and simple medical supplies (disinfectants, cotton wool, etc.) if the cost of such supplies is competitive with the NDS (factoring in the cost of transportation from NDS to the county).

o A number of CHT staff should be involved in the direct procurement function, including the County Health Services Administrator (CHSA), the Accountant and Logistician and other staff within the CHT who will assist with developing specifications, receiving and evaluation of commodities and services, etc. The County Health Officer has ultimate authority over and responsibility for direct procurement.

o The Central Ministry must develop procedures to ensure adequate oversight of procurement performed by the CHT’s.

3) Human Resources Management & In-Service Training

Human Resources
- Job Descriptions
- Staff database
- Personnel forms
- Recruitment and hiring
- Performance evaluations
- Discipline
- Grievances
- Leave

In-Service Training
- Orientation of new staff
- Continuing education
- Scheduling training
- Training of trainers

4) Health Management Information Systems
- Manual vs computerized
- Geographic Information Systems
- Capturing data
- Reporting data
- Compiling and processing data
- Forms and supplies
- Reporting requirements
- Electronic data transmission
- Feedback
5) **Drugs and Medical Supplies**
- Forecasting and quantification
- Storage
- First expired, first out
- Ordering system
- Issuing, delivering
- Procurement issues
- Avoiding leakage
- Revolving drug funds
- Disposal of damaged, outdated products

6) **Facility and Equipment Maintenance**
- Monrovia vs local maintenance
- Procuring services locally for vehicle and facility maintenance
- Procuring spare parts and construction materials
- Preventive maintenance schedules
- Inspecting facilities and equipment
- Performing preventive maintenance
- Training in the use and maintenance of facilities and equipment

7) **Logistics and Communication**

*Logistics*
- Storage of supplies
- Issuing of supplies
- Avoiding leakage
- Transportation and delivery of supplies

*Communication*
- Communication channels
- Communication devices
- Communication etiquette
- MoHSW web site
- Communication within the CHT
- Conducting and minuting meetings
- Communication with community

*Vehicle Management*

Vehicles are a critical part of the *Logistics and Communication* support system. Having vehicles available and keeping them running is a chronic source of difficulty for all public health systems, where travel to health facilities and the communities they serve is required. Liberia faces considerable challenge in this regard at this time due to the poor condition of roads in many areas of the country, although it is anticipated that road conditions will improve. Finding a reliable local means of maintaining and repairing vehicles is imperative to support supervision, emergency services and general administrative services are to achieve their objectives.
Implementation Issues

- The current policy of the MoHSW and the GoL concerning vehicle maintenance and repair is that all vehicles must be brought to Monrovia for assessment prior to such servicing and Repair. This places an excessive burden on distant counties, necessitating the removal of the vehicle from the county for lengthy periods, plus the expense of fuel and human resources required.
- The CHT should be authorized to manage the local maintenance and repair of vehicles.
- The MoHSW should work with the General Services Agency (GSA) to determine the capability of maintenance facilities at both the county and regional levels.
- Maintenance contracts, or perhaps fixed fee schedules, can be established with accredited maintenance facilities.
- CHTs should establish and adhere to strict vehicle usage and preventive maintenance policies to ensure continuous operation of vehicles under their responsibility.
- Where CHTs lack sufficient vehicles, especially for supervision, they should coordinate with NGOs in their county that have vehicles to partner with them during their planned activities that require transportation.
- There is a chronic temptation to use vehicles for personal, non-official use, especially by staff who do not have their own private vehicle, and in counties where public transportation is limited. This must be discouraged in order to protect these valuable assets.

8) Supervision, Monitoring and Evaluation, Research

Supervision
- Supervising supervisors
- Supportive supervision
- Performance evaluations
- Ensuring quality of services
- Continuous Quality Improvement
- Managing change
- Supervisory skills

Monitoring and Evaluation
- Establishing indicators
- Measuring outputs and outcomes
- Feedback to improve performance

Research
- Surveys
- Data mining
- Publishing research results
9) Stakeholder Coordination & Community Participation
   • County Health Boards
   • Building community trust
   • Coordinating Government, NGO, FBO and Private partners
   • Coordination meetings
   • Community self-help contributions
   • Community outreach from facilities
   • Gathering feedback from communities
   • Giving information to communities
   • Health Districts