Ministry of Health and Social Welfare

NATIONAL DECENTRALIZED MANAGEMENT SUPPORT SYSTEMS IMPLEMENTATION STRATEGY & PLAN

November 2008

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FROM THE AMERICAN PEOPLE

BASICS

"The confident new atmosphere in Liberia gives us the opportunity to create strategies and programs that will help our nation not only recover, but also flourish.

"The time is now to capitalize on this momentum, using our collective knowledge, energy, and optimism to propel our dreams into reality."

Honorable Walter T. Gwenigale, M.D.
Minister of Health & Social Welfare
In his Foreword to the National Health Policy & Plan, 2007-2011

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Acknowledgements

On behalf of the senior management of the Ministry of Health and Social Welfare (MOH/SW), I would like to extend our heartfelt thanks and appreciation to all institutions and individuals that made the development of the Decentralized Management Support Systems (DMSS) Strategy and Plan possible.

While it would be impossible to list each contributor by name, I want to mention some key partner organizations without whose support we would not have achieved the development of the DMSS Strategy. The BASICS Project with funding from USAID fielded the consultants who worked with the Ministry of Health and Social Welfare and other health partners to develop and refine this document.

Again, my gratitude goes to all individuals and organizations that supported the process.

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Executive Summary

This document contains proposals and recommendations for establishing a program within the Ministry of Health and Social Welfare to roll-out Decentralized Management Support Systems to the county level in Liberia. The Ministry is committed to the decentralization process and plans to move with deliberate speed in accomplishing this vision. The National Health Plan strongly promotes decentralization through deconcentration of appropriate responsibility and authority from the central level to the county level. County Health Teams are pivotal in this process and work to empower people at the service delivery and community levels. The National Health Plan identified nine management support systems that need to be decentralized.

BASICS was requested by the Ministry to recommend ways to utilize methods and materials that have been previously employed in Liberia and propose a strategy for developing a clear way forward. The strategy proposed in this document advocates a process of building on existing capacity building programs by supplementing such programs with detailed operational level procedures and tools.

The strategy recommended can be summarized as follows:

Phasing of implementation: Recognizing that the roll-out of a large number of management systems cannot all happen at the same time, there is a need to prioritize and phase in the deployment of these systems to the county level.

Formation of a Decentralization Working Group: A team of professionals should be formed within the Department of Planning to facilitate the roll-out of decentralized systems.

Develop Standard Operating Procedures: Standard operating procedures are called for to provide detailed steps for consistent and effective functioning of decentralized systems.

Build on past management training: Numerous programs to teach management skills to County Health Teams and others have been conducted, and are still ongoing. Supplementing these skills with detailed training in standard operating procedures will produce strong results.

Partner/coordinate with existing capacity building initiatives: The Ministry should form strong relationships with institutions and groups offering management training.

Practical, Competency Based Training: Training of County Health teams in the procedures required to operate decentralization should be learner-centered, hands-on, emphasize mastery of required competencies and skills, and based on adult education principles.

System Renewal through Continuous Quality Improvement: As decentralized systems are installed and operational, tools should be developed to assess the performance of teams in accomplishing objectives and achieving results. Improvement of procedures and processes and enhancement of team performance is based on feedback generated from such assessments.

Each of these points in the proposed strategy is explained in greater detail in this document.

The implementation of this strategy is presented in a plan that enables the accomplishment of the goal of having all nine decentralized management support systems rolled-out to and operational in Liberia's 15 counties by the end of the current National Health Plan: June 2011.

Decentralized Management Support Systems

Implementation Strategy and Plan

Introduction

The decentralization mandate of the Ministry of Health and Social Welfare (MoHSW) is to deconcentrate responsibility, authority and resources from the central MoHSW to the county level to effectively manage the systems that most significantly impact on the day-to-day operation of the County Health Services in delivering health care to their communities. The Central MoHSW will retain those management functions that are concerned with broad policies, guidance, regulation, resource mobilization and support to the counties in facilitating the delivery of health services to the nation. The long term goal is to create a synergistic health care delivery system that calls upon the appropriate level to manage the support systems required to deliver services.

The focus of the decentralization strategy at this point is on building the capacity of County Health Teams (CHTs) to effectively adopt and implement the Decentralized Management Support Systems (DMSS). In doing so, CHTs will be in a position to roll-out decentralization further to health facilities they manage and the communities they serve. This is in recognition that the CHTs are close to and can measure the pulse of their county's professional and community constituents. A "middle-out" rather than a top-down or bottom-up approach is the most appropriate process in implementing the DMSS. County Health Teams are strategically poised to accomplish this.

It is noteworthy that considerable progress has been made in recent years due to concerted efforts of the MoHSW and NGOs. A number of management system development and training initiatives have taken place by the MoHSW in the area of County-level Planning and Budgeting, Human Resources and Drugs and Medical Supplies, as well as by NGOs such as the Clinton Foundation, Merlin and the Mother Patern College of Health Sciences, to name a few.

At this point the strategy calls for a consolidation of efforts to provide a comprehensive framework that encompasses all required support system modules. Building on initiatives such as those described above it is time to engage in action that goes beyond general management training and produces detailed standard operating procedures (SOPs). Documentation of these management systems, especially the SOPs, will provide an enduring legacy that will allow those who follow a complete guide of how to install and operate decentralized systems. The weaving together of general management training in leadership, decision-making, resource management, planning and problem solving, and specific training for appropriate cadres in detailed SOPs will provide a strong fabric. By partnering with existing institutions and NGOs that provide such training, the MoHSW can offer a comprehensive course of study covering general to specific support system topics.

A number of detailed Policy and Procedure Manuals were developed between 1984-88 by the MoHSW with assistance from the MEDEX Group of the University of Hawaii as part of the

South East Region Primary Health Care (SER PHC) Project and are available for upgrading and adaptation.[1]

This *Proposed Implementation Strategy and Plan* sets forth, within the framework of the *National Health Policy and Plan 2007-2011*, an implementation strategy and plan to achieve the overall vision of the MoHSW to decentralize the management of health care in Liberia. After a background summary, the document is presented in six major sections:

- Decentralized Management Support Systems
- Strategic and Tactical Considerations
- Priority System Modules
- Priority System Module Descriptions
- Implementation Plan
- Resources Required

This is a practical guide to the steps necessary to achieve decentralization both in the short-term through 2009, and the medium-term through the remaining period of the *National Health Policy and Plan, 2007-2011*.

Based on a request from the MoHSW, this *Implementation Strategy and Plan* has been produced by the BASICS Project in collaboration with the MoHSW, funded by the United States Agency for International Development (USAID).

[1] Unfortunately, during the civil war most of these manuals were lost. To date, four of the eight system manuals have been located and are being used for updated adaptation. The search for the remaining four manuals continues.

Background

The decentralization of management support systems in Liberia is a well-established vision of the Government of Liberia (GoL) and the MoHSW. Emerging from years of devastating national and personal suffering, conflict and crisis, Liberia is firmly rededicated to bringing the vision of decentralization to fruition. While this vision has been articulated for almost 30 years, it now has the potential to become reality.

The mandate for this vision is clearly defined in the *National Health Policy 2007-2011*:

> "Decentralization, adopted as policy before the war, has been chosen by the new government as a key driver of reconstruction." [p. 6]
>
> "The Government of Liberia is committed to decentralization. Within the health sector, decentralization will include de-concentration of management responsibilities at the county level and effective support systems at the central level. The local level shall be responsible for primary health services, while the central level will focus on policies, aggregate planning, and standard settings. The Ministry will assign responsibilities to County." [p 9]
>
> "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 will manage county health facilities. They will be responsible for financial management and personnel and will be fully accountable to local constituencies, as well as to overseeing public bodies. The Ministry will focus on health legislation and law enforcement; policy formulation, revision and enforcement; resource mobilization and allocation, national and long-term planning; broad health sector programming; monitoring and evaluation; and technical oversight of service delivery, regulation, major research and development initiatives. The Ministry will work collaboratively with a diverse set of public, private and NGO health sector partners to ensure full coverage of health services to the Liberian people." [Executive Summary]

As mentioned earlier, decentralization is not a new policy, but rather one that had begun implementation in the 1980's and was interrupted by the civil war of the 1990's. In a defining document adopted by the MoHSW, this policy was clearly established:

> "Decentralization is a process whereby management systems are restructured 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 the 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 effectively accomplish its policy-making responsibility. In a decentralized organizational structure the role of national government is directed primarily at policy formulation, and then monitoring and coordinating the actions of county level managers to ensure that national policies are appropriately and effectively implemented." [*Decentralization Guidelines*, SER PHC Project, 1986]

Four Pillars define the policy and plan of the MoHSW [*National Health Plan 2007-2008*]:

- Basic Package of Health Services

"A Basic Package of Health Services (BPHS) … defines the services that the MOHSW assures will be available to each and every Liberian. The BPHS standardizes prevention and treatment services throughout the health system to ensure that all individuals, wealthy or poor, living in urban or in rural areas, receive the same package of care." [p. 6]

- Human Resources for Health

"The human resource component of the National Health Plan strives to ensure that the right numbers of health workers are in the right places at the right time, and with the right skills. This workforce, with support from community partners, will ensure delivery of the BPHS to meet client and community needs." [p. 9]

- Infrastructure Development

"The infrastructure component of the National Health Plan … make[s] Primary Health Care and the Basic Package of Health Services geographically accessible to [the nation] via a decentralized system of health clinics, health centers, and hospitals." [p. 13]

- Support Systems

"The support systems component outlines the strategies and means for de-concentrating the planning, management, and other key support functions to deliver the Basic Package of Health Services." [p. 15]

The Support System Pillar further defines the decentralization policy:

> "The de-concentration of management responsibilities calls for the building of performing systems at county level, as well as of effective support systems at central level. The mandates of central and county authorities, and their mutual relationships, have to be clearly spelled out. De-concentration will be pursued in an incremental and pragmatic way, by assigning to county authorities the 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." [p. 15]

Additional clarification is provided in the *National Health Plan 2007-2011* [p 17]*:*

> "The priority and primary objective of the support systems component will be to develop the capacity of County Health Teams (CHT) to take charge of the planning process and resource coordination of development partners to shift from the humanitarian to development model before the end of 2008. To this end, the support systems capacity-building process will begin with Planning & Budgeting; Health Management Information System; Supervision; Drugs & Medical Supplies; and Stakeholder Coordination."

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 1 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;
- Accounting;
- Procurement; 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.

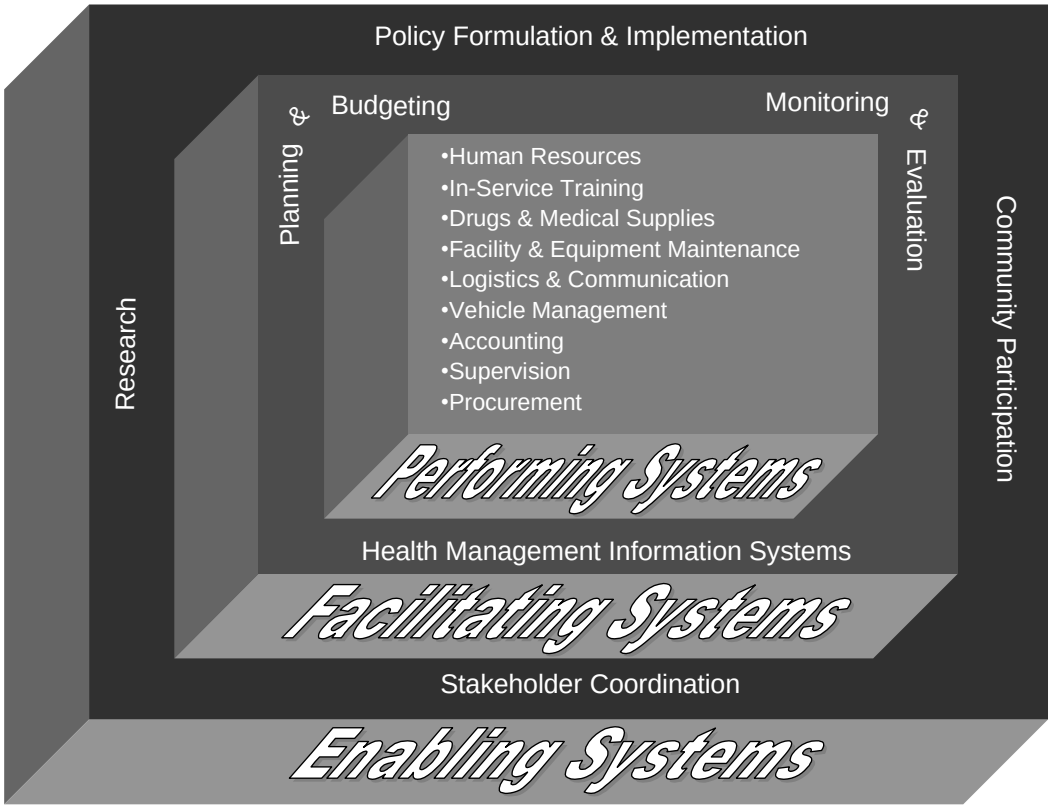

Figure 1: Levels of Management Support Systems

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.

Strategic and Tactical Considerations

This section provides guidance in implementing decentralized management support systems, as broadly defined by the MoHSW in the *National Health Policy and Plan, 2007-2011*. The strategy calls for a rapid first phase short-term roll-out (in 2009) of priority system modules that provide an enabling environment for other support systems. Subsequent medium-term phases (through July 2011, the end of the current 5-year national health plan) are also presented that will allow implementation of all DMSS modules, with a strategy to enable continual evaluation and renewal of those system modules.

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Phasing of implementation

As noted above, it is not possible to implement all modules of all systems immediately. This necessitates a phasing of the DMSS roll-out

- Prioritized by system module: Prioritization is needed to establish an incremental sequencing of system modules.
  - *Criteria for prioritization*: Several criteria can be recognized that can assist with decisions of how to prioritize. There is a need to consider whether the module is:
    - Critical: MOHSW cannot perform basic functions without it. If a system module is critical it needs to be rapidly operationalized regardless of other considerations. Less critical elements can be phased in later. Examples of critical system modules: financial management; local procurement; transportation.
    - Complex: Is it relatively easy or difficult to describe the policies and procedures required to operate the system? The simpler the system is, the easier it is to rapidly operationalize. Examples of complex system modules: financial management, drugs and medical supplies.
    - Controversial: Are there major differences of opinion about the system module that make it difficult to come to consensus over the policies that drive it? Or, are there policies or laws that make changes in the system difficult? System modules that are highly controversial will be difficult to rapidly operationalize
    - Documented: Are there existing materials that adequately describe the policies and procedures required to operationalize the system module? If so, it is possible to move quickly to distribute and develop the required training materials. If not, delay in operationalization can be expected while adequate system documentation is being created and/or adapted.

- *Decide on content of first phase:* Following the criteria mentioned above, the following system modules should be implemented in the first phase due to their critical nature (further explanation of these modules can be found in the next major section of this document):
  - Accounting: CHTs need tools and training to manage and account for funds granted to them by the Central MoHSW.
  - Procurement: With higher level of funding under their direct management, CHTs will engage in greater direct procurement of commodities and services. They need training in GoL regulations and procedures to effectively accomplish this.
  - Vehicle Management: Functioning vehicles are needed to support critical support systems such as supervision and service administration.
  - Supervision: CHT supervisors need further training in methods of planning and conducting supportive supervision of facilities using well-developed tools such as checklists.

- *Suggested second and third phase content to be determined during implementation of first phase*: Using the criteria listed above, during the first phase of roll-out a final determination will be made after discussion with MoHSW decision-makers as to the system modules to include in subsequent phases. Experience gained in the implementation of the first phase will also inform this decision. Some suggestions for the second phase might be made at this time concerning the following system modules that are of a critical nature:
  - Drugs and Medical Supplies: CHTs need to refine their skills in quantifying, ordering and storing these critical commodities.
  - Planning and Budgeting: County Health Services plans and budgets for FY 2009-2010 must be developed by the CHT in each county before July, 2009. Central level staff will need to provide guidance to the counties to update their FY 2008-2009 plans and budgets using the template supplied by MoHSW.
  - Human Resources: Performance appraisal, effective feedback and communication strategies, employee records, recruitment and selection process, new hire orientation.

- <u>Prioritized by county</u>: Just as all system modules cannot be rolled-out at once, the same is true for counties. Some counties will have to precede others in a phased manner to avoid overwhelming the capabilities of those providing capacity building. Based on County Health Team (CHT) staff capacity, decisions will be made as to which counties should first receive training and system roll-out. An assessment of the human resources capacity of each CHT needs to be conducted in order to make this determination. Where staff shortages or inappropriately qualified CHT members are detected, corrective actions should be taken. The following criteria are suggested in determining capacity:
  - Availability of CHT staff: The roll-out of some systems will have to wait until key county-level staff are available. For example, the Financial Management system cannot be rolled-out until there is an accountant on board.

- Qualifications of CHT staff: Do the key CHT staff possess the required education and other professional preparation required to hold the position they are occupying?
- Experience of CHT staff: Do key CHT staff have an adequate amount of experience in their position to take up the duties that will be required of them?
- Judgment concerning their level of cooperativeness: Based on previous experience of Central level supervisors and trainers, are the CHT staff seen as easy to work with and accepting of new ideas and responsibilities, or are they difficult and resistant to change?

While there is an understandable tendency to sympathize with the plight of counties that may be understaffed or have other problems as noted above, it is generally unwise to select such counties for the first phase of roll-out. They will be better served by the central level devoting its energy to help them recruit and place required staff, or to overcome other such problems. It is normally wise to start with high-capacity counties and make sure the program works there before moving on to others that may have difficulties. There is truth in the old adage that "nothing succeeds like success."

Formation of DMSS Working Group

To accomplish the required roll-out tasks in implementing the Decentralized Management Support System (DMSS), 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.

- Location of DWG: The suggested placement of the DWG would be within the Department of Planning, Research & Development, under direction of the Assistant Minister for Planning.
- Terms of Reference (TOR): Suggested Terms of Reference for the DWG-
  - Prepare work plans to implement the DMSS program;
  - Identify consultants and others needed to assist the DWG;
  - Gather information to design system modules;
  - Prepare and/or adapt system module Standard Operating Procedures (SOPs);
  - Prepare and/or adapt training materials;
  - Identify county level participants to attend workshops;
  - Conduct/facilitate workshop training and follow-up OJT;
  - 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 DMSS package;
  - Identification and mobilization of resources to support the implementation of the DMSS;
  - Monitor and evaluate the performance of the systems.
- Membership of the Decentralization Working Group: The professionals who make up this DWG will need to devote sufficient time to this work. Given the demanding schedules of most MoHSW officials, it is likely that technical consultants will need to be engaged to join and assist the DWG. Membership from staff of County Health Teams would also be excellent, but could cause problems since they would then be absent from counties that are already facing staff shortages. BASICS can possibly provide short term technical

assistance (STTA) consultants, either local or external, to join the DWG on an as-needed basis to accomplish specific tasks required for the DMSS roll-out. It may also be possible that additional local consultants could be engaged by the MoHSW or perhaps provided by NGOs. Suggested membership might include:

- Assistant Minister for Planning (Chair)
- MoHSW responsible officers from the following sections (both central and county) who would be brought into the Working Group on an as-needed basis depending on the specific system module being developed at the time:
  - Human Resources & In-service Training
  - HMIS
  - Procurement
  - Transport
  - Financial Management (OFM)
  - Infrastructure
  - Supervision
  - Pharmacy
  - County Health Officer(s)
  - County Health Services Administrator(s)
- BASICS (could function as secretariat to the DWG)
  - System Strengthening Officer
  - Technical Consultants
- NDS (DELIVER)
- WHO Planning Officer
- NGO and FBO participants
- Others

- Qualifications of DWG members: It would be most desirable if DWG members have had prior training in management, or have functioned as managers. In most cases, detailed knowledge of specific management systems may not required, since such content knowledge and expertise can be obtained on a short-term basis from STTA consultants or from knowledgeable individuals in the MoHSW or elsewhere through information gathering interviews by the DWG. What is important is that DWG members must be capable of clear, logical thinking. They also should have the ability to reduce to writing information gathered through interview, observation and document review. Such writing does not need to be beautifully crafted prose, but must contain the essential points. Others can help with editing and final written products.
- Orientation and Training of DWG: Appropriate orientation should be arranged after the formation of the DWG to apprise them of their anticipated duties and responsibilities, and to provide them a common understanding of the DMSS strategy and plans. Further specific training, such as in Management Analysis, may be arranged.
- Frequency of Meetings: The full DWG should have a set monthly meeting date, with other meetings called as necessary during periods of intensive activity. There is also the possibility of forming technical sub-groups or task forces to meet as required to accomplish specific pieces of work.
- Timing of formation of DWG: The DWG should be formed as soon as possible so that they might engage in orientation and DMSS work planning in January 2009.

- Management Analysis training: In addition to the basic orientation described above, further intensive training in Management Analysis could be offered. This type of training has been successfully provided to MoHSW staff in the 1980's as part of the SER PHC Project.
- Resources required for Decentralization Working Group:
  - Funds will be required to print SOPs and training materials;
  - Support for a considerable amount of travel to the counties will be needed. This will be in the form of per diems for DWG members as well as one or two vehicles for a period of several months to enable county visits for OJT, follow-up and monitoring and evaluation.
  - Logistical support costs for workshop participants will be required.
  - To provide technical assistance to the DWG in writing and editing SOPs, as well as the preparation of training materials, conducting a TOT, and facilitating CHT training, it is recommended that one or more short term technical assistants (STTA) be engaged. These STTA may be found locally or internationally. STTA will have the ability to dedicate themselves full-time to assisting the DWG during intensive activity periods.
- Long-term disposition of the Working Group. Roll-out and continuing support of the DMSS is really not a one-off activity. The MoHSW should consider the establishment of a DMSS Support Unit, probably within the Planning Department, to provide continuing support for this program. The work of this Unit would largely involve monitoring and evaluation, conducting continuous quality improvement (described in greater detail below), taking corrective actions at the county level through supportive OJT to ensure proper functioning of decentralized systems, and safeguarding the decentralization process from any form of "creeping re-centralization."

Develop Standard Operating Procedures (SOPs)

As mentioned above, SOPs that document the policies, regulations, operating steps, tools and forms, with details on who is responsible for each step, are required to fully install the DMSS. 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 and can be bundled into a complete system document.

- SOPs must contain detailed policies, procedures, tools, forms and step-by-step usage instructions: It is recommended that a consistent format for the documentation of SOPs be developed and used for each support system module. Generally, the format of the SOP document should include:
  - A *Policy* statement that provides broad guidance as to the purpose of the module and what it is intended to accomplish;
  - *Regulations* of the GoL and/or the MoHSW that spell out mandated requirements are often quoted as a foundation on which policies are based. Regulations often have the force of law behind them. Examples of regulations can be found in the "Standing Orders of the Civil Service."
  - *Procedures* that show the sequential steps required to fully implement the policy;

- *Responsibly* of different persons in the organization who need to accomplish each of the steps identified (who does what, who gives what to whom, who oversees/supervises what is being done, etc.).
- *Forms* developed and available to record information for repetitive tasks with clear instructions concerning what/who/how/when things need to be done. Completed samples of completed forms provide a good guide of how to use them.
- *Formats* for less repetitive tasks where more flexibility is required, such as composing a letter requesting something or instructing someone to take certain actions.
- *Tools* such as a supervisory checklist to provide guidance.
- *Job Aids*, often presented in poster format suitable for hanging on the wall, where the procedures to take place are listed and illustrated, are also useful tools to help remind workers of their responsibilities. Such job aids are not for the purpose of displaying general information such as slogans, announcements or other exhortations, but rather procedural steps to get a specific job or activity accomplished.

❖ Analyze current requirements and achieve consensus as to policies and procedures: The basis for any system rests on what is currently being practiced. A review and analysis of existing practices within a management system is a starting point for further development. Analysis considers whether the system is serving the goals and objectives it was designed for, how efficiently it functions, whether there are redundancies or gaps, and whether people understand what needs to be done and actually do it. The intention is to recommend improvements: strengthen what is working and change what is not. Once an analysis has been conducted and recommendations for change formulated, those recommendations need to be reviewed by a wide range of interested parties at different levels of the system. Not everyone may agree fully with proposed changes, but the nature of consensus building is that there is an opportunity for divergent opinions to be heard, and then a workable compromise reached.

❖ Adapt existing materials: In most cases there are existing materials (SOPs, forms, etc.) that can be gleaned from within Liberia or from other countries and organizations. These can serve as the basis for brainstorming about how to put together an improved system. As an example, the SER PHC Policy and Procedure Manuals that have been located can be used as a good starting point, but need updating since they were developed over twenty years ago (as of this writing copies of manuals covering Finance, Communications, General Supplies and Personnel have been found). There are also generic system materials available. The MEDEX Group developed generic SOPs for eleven different management systems. A complete set of these is available electronically. These materials, and other generic materials, or materials successfully used in other countries or by other Liberian Ministries, can be adapted for use. A search of the internet completed by BASICS revealed that there are district health management team specific materials that can be adapted into developing or complementing SOPs. For the details see the recent October 2008 trip report by Franklin Baer. A complete set of most of these materials is available electronically. Many of these materials have been successfully used by Liberian Ministries or in other decentralized health systems. What is required is a detailed and dedicated look at these materials to select the best pieces for adaptation. The adaptation process is labor intensive, requiring attention to detail, analysis of current procedures, ability to clearly document the SOPs and management principles in writing, and the technical means to reproduce forms, tools, case studies, conceptual frameworks, and exercises.

- Develop system performance indicators: As part of the process to develop SOPs, a clear and limited set of indicators should be developed. Such indicators need to be measurable and point to whether the system is actually accomplishing its intended results. These indicators will be used in monitoring and evaluation the performance of the system.

Build on past management 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. It is the firm intention of the DMSS strategy to acknowledge and build upon this training

> *In a development setting,*
>
> Theory without practice is pointless;
> Practice without theory is meaningless
>
> *Another way to say it…*
>
> Ideas without actions are ineffectual;
> Actions without ideas lack vision & direction

Having said that, it is important to note that the strategy being proposed holds that management support systems are not truly installed and operational until detailed SOPs have been documented and promulgated. No amount of management theory will result in operational systems until the detailed regulations, operating steps, tools and forms have been designed, described and deployed. Conversely, detailed SOPs need to be implemented within an environment that is governed by higher levels of understanding by those in leadership positions – the "big picture" context.

❖ General management training: Over the past few years a number of management training courses have been conducted by the MoHSW and its partners. These courses covered topics such as (not an exhaustive list):

- Leadership and Decision-making
- Strategic Management
- Strategic Planning and Work Planning
- Budgeting
- Problem Solving
- Building Consensus
- Team Building
- Human Resource Management
- Manpower Assessment
- Monitoring and Evaluation
- Change Management
- Performance Evaluation
- Giving/Receiving Feedback
- Resource Mobilization
- Communication Styles and Skills
- Financial Management
- Supervisory skills

All of these are essential skills for managers at central and county level, especially those in higher level leadership positions. Training in these skills should continue to be promoted, especially if coordinated with specific system training, as described later in this section.

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 SOPs for specific support systems.

In 2007, as part of the implementation of the National Health Plan, BASICS assisted the MOHSW in the development of a county planning process. This began TA to develop county planning templates and to introduce the planning process for five CHTs. The

MOHSW then scaled up the process to all counties. The DMSS process will build on this past management training to consolidate a yearly planning/budgeting and quarterly review processes. This process would also address selected planning issues such as the designation of health facility catchment areas and strategies for partner coordination as part of the county health plan, especially through the new RBHS project.

- Specific system training: Management system training can be considered *specific* when it includes instruction in the detailed steps and materials required to actually operate a system. Regulations, operating steps, tools and forms, with details on who is responsible for each step of the system need to be documented and used as the basis for training those who will actually operate the system. Participants in such training, whether in workshops or OJT, need to leave the training with written instructional materials in hand to which they can refer in future as they do their jobs at their work sites. The development of SOPs, as described above, is a first step in identifying the details that make systems operational. Example: Managers can learn the theory and general principles of Performance Appraisal in order to bring them into full awareness of the need to evaluate the work of employees they manage. However, without specific guidance embodied in a standard form that they can complete, with instructions on how to fill in the different sections of the form, their appraisals are likely to be inconsistent and vague, if the appraisal actually happens at all. Moreover they need instructions on how to store the forms for future reference and how to use the information in the Appraisal to make decisions about the advancement of the persons appraised. The use of forms and other such tools is particularly useful when performing repetitive tasks. A manager who has to write many Performance Appraisals per year will be well served by having a properly designed form with adequate instructions on how to use it.

  The MoHSW, at times with assistance of partners, has engaged in specific system training. Of note, the Human Resources (HR) department has designed detailed procedures and forms for a number repetitive HR tasks such as requests for leave, transfers, appraisals, etc.

- Linking management training and operations training: 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. 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.

Partnering and coordinating with existing capacity building initiatives

There are many ways to form relationships with groups that are providing management training, both within and external to Liberia.

- *Partnering* implies working side-by-side throughout the development of a program;
- *Collaborating* means participating jointly in significant portions of program development;
- *Coordinating* involves information sharing about program activities to avoid duplication and gaps.

The depth of the relationship required depends on the needs of the program and the relevance of what the group has to offer. At a minimum, where either general management or specific system training is being accomplished by institutions, the MoHSW should be fully cognizant of their training content, materials and methods. The following presents an example of management training conducted by a local institution and how the MoHSW might coordinate with that institution..

- Mother Patern College of Health Sciences: In 2007 the Mother Patern College, the Clinton Foundation and Yale University teamed up to provide an excellent management skills 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 close coordination with the Mother Patern College to ensure that additional central- and county-level managers attending the course understand the relationship between the management skills they acquire and the program of specific systems training planned for their program areas. The Mother Patern College should be encouraged to keep the MoHSW fully apprised of their upcoming courses, and the MoHSW should likewise keep them informed of related management system roll-out initiatives.
- Developing a pool of trainers: One method of coordinating training resources would be to form a pool of trainers that can be drawn upon as need arises. There are training resources and experienced trainers at the MoHSW as well as other government institutions. 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. Other trainers could be brought in from NGOs such as Mother Patern College. In addition, skilled independent consultants and experts may also be recruited needed. In developing this 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. Others, 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.

Practical, Competency Based Training (CBT)

- Competency Based Training (CBT): Traditional training approaches based on participants putting in time at workshops produces diminishing results in providing the ability to actually gain new skills. Awareness can be raised and knowledge 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 training materials take place, with the competencies to be gained fully identified. Such materials can be efficiently developed if there are well prepared SOPs.

- Adult education principles: As a pioneer in *Androgogy* (adult education), Malcolm Knowles developed four basic principles:
  - Adults need to be involved in the planning and evaluation of their instruction (Self-concept and Motivation to learn).
  - Experience (including mistakes) provides the basis for learning activities (Experience).
  - Adults are most interested in learning subjects that have immediate relevance to their job or personal life (Readiness to learn).
  - Adult learning is problem-centered rather than content-oriented (Orientation to learning)[2]

  These principles are still valid and should guide the development of adult learning programs.

- Workshops + OJT: In keeping with the principles of adult education and competency based training, a blend of group training at workshops covering an introduction to the skills to be mastered, plus follow-up on-the-job training is recommended. After a brief workshop to set the context in which the skills are to be performed and

> I hear and I forget;
> I see and I remember;
> I do and I understand.

[2] Knowles, M. S., *et al.* (1984). *Andragogy in action: Applying modern principles of adult education*. San Francisco: Jossey-Bass.

an initial opportunity to participate in exercises and case studies, trainers need to visit participants on their actual work sites. During such OJT visits trainers can observe how well participants are performing the skills they learned. Strengths are to be praised, weaknesses corrected. Hands-on practical mentoring will provide realistic learning opportunity and effectively reinforce and enhance performance.

- Cascade training: In a cascade training scheme, central level trainers would provide learning opportunities for CHTs to prepare them to train health facility staff. Their preparation should include information about the content of management systems, as well as adult learning methodology. Health facility staff, in turn, may train community level workers and volunteers. This scheme establishes an efficient training network and empowers CHTs with useful skills that will serve them well in their supervisory functions.

System Renewal through Continuous Quality Improvement

During the conclusion of the Third Phase of DMSS roll-out, a Continuous Quality Improvement (CQI) program should be initiated. CQI focuses on a team approach to improvement and offers praise and rewards to teams that improve and excel, rather than focusing on blaming individuals for poor performance. Using 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. Focus is on eliminating internal competition between individuals and building a cooperative workforce. DWG members should have responsibility for applying the 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 advocated.

Management Analysis

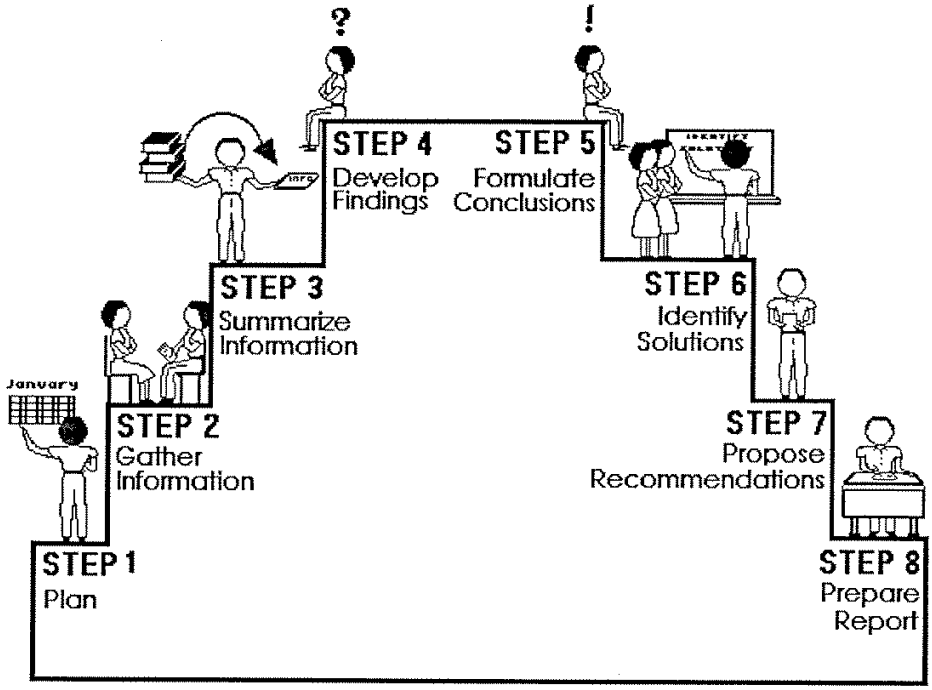
Management Analysis is systematic study of the causes of and solutions to management problems. Management analysis studies are conducted by trained management analysts. The resulting studies identify problems and recommend improvements in management systems. The MEDEX group developed and conducted numerous courses in Management Analysis is various developing countries during the 1980's and 1990's. All of the course materials are available:

- *Management Analysis: Manual for Improving Health Management Systems*
- *Management Analysis: Training Workbook*
- *Management Analysis: Instructors Guide*

The course was of five weeks duration (including an internship) and produced a cadre of management analysts. These analysts conducted management studies, reducing dependency

on foreign management consultants. It is believed that this course could be shortened to two weeks of classroom time followed by one or two weeks of field study as an internship.

It is recommended the course be conducted for members of the Decentralization Working Group and others to help them understand the analysis and assessment process that informs the Continuous Quality Improvement program. The illustration below shows the steps that Management Analysts use to produce an analysis.



Rollout of Priority System Modules

Through discussion with key persons at the MoHSW, NGOs and others, combined with judgments based on previous experience in Liberia and elsewhere, a prioritization of selected modules from within the nine Support Systems described earlier in this document is recommended. The total content of the nine systems represents a vast array of policies and procedures. The enormity of the task of rolling out all of these systems necessitates prioritization to govern the sequencing of implementation. In this regard it must be noted that health services are obviously being delivered now and that in one way or another the delivery of these services is being managed by community, district, county and central levels. The intention of the DMSS implementation is to provide revised and improved guidelines to county and central MoHSW managers to better accomplish what they are already doing. The following list represents an extraction from the nine systems of high priority modules to be rolled out in the First Phase:

- **Priority modules recommended for First Phase implementation:**
  - Financial Management (part of Planning & Budgeting system)
    - County level accounting system consistent with generally accepted accounting principles:

        - Recording/documenting of banking and cash transactions
        - Authorized spending limits
        - Expenditures consistent with budget
        - Segregation of responsibilities
        - Internal controls
        - Reconciliation of accounts
        - Transparency
    - Central level oversight and auditing

- Procurement
    - Local procurement procedures
    - Allowable categories
    - Authorized limits
    - Oversight from Central

- Vehicle Management
    - County level maintenance and repair of vehicles
    - GSA certification of local private maintenance and repair facilities
    - Maintenance contracts/Fee schedule
    - MoHSW-NGO vehicle sharing

- Supervision
    - Supervisory checklists/service standards
    - Supportive supervision
    - Facility level on-the-job training

Following the First Phase of rollout, a selection of priority modules needs to be made from among the following list of the Second and Third Phases:

❖ **Priority modules for Second and Third Phase implementation:**

- 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

- Stakeholder Coordination and 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

- Planning and Budgeting
  - Review use of MoHSW template
  - Preparation for fiscal year 2009/2010

- Health Management Information System
  - Coordination & integration of data management
  - Data capture
  - Data quality
  - Transmittal of data
  - Electronic data entry
  - Data processing
  - Data storage, archiving and retrieval
  - Data analysis and interpretation
  - Feedback and dissemination to horizontal stakeholders
  - Electronic data processing hardware & software
  - Electronic data transmission equipment
  - Data processing supplies

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

- Research
  - Surveys
  - Data mining
  - Publishing research results

- 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

- 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

➢ 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

Priority System Module Descriptions

Financial Management

Financial Management (FM) at the County level is a critical, enabling support system required to make other support systems operational. The current Financial Management decentralization proposal 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 based 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 manage their own finances is essential in giving such managers direct control over resources. Decentralizing responsibility without decentralizing resources is a frustrating experience for County Health Services (CHS) 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 Financial Management as one of those systems. It is suggested that FM be specifically named in the Planning and Budgeting system (i.e., Planning, Budgeting and Financial Management), or FM be listed as a separate tenth system (although FM is closely related to planning and budgeting, it is a significant system in its own right.)

- 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 CHS 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 FM when the banks are close to them.

Current County-Level Capacity

Eleven counties have Accountants deployed as members of the County Health Services. Four additional Accountants need to be hired so each county will be adequately covered. The actual skill levels of these Accountants needs to be assessed. Each Accountant must have skills in basic accounting principles before participating in training in the MoHSW county

FM system. A questionnaire that assesses their skill level should be developed to send out to each county-level Accountant to complete and submit to the central office. The questionnaire should be reviewed and verified by the County Health Officer before submitting.

Priority System Modules

- County level accounting system consistent with generally accepted accounting principles:
    - Authorized spending limits
    - Expenditures consistent with budget
    - Segregation of responsibilities
    - Internal controls
    - Reconciliation of accounts
    - Transparency
- Central level oversight and auditing

Standard Operating Procedures (SOPs)

County-level FM SOPs are not yet available. Clearly documented SOPs covering the detailed steps, forms and responsibilities for operating this system must be and available before FM training commences and the system is installed at county level. The MoHSW plans to continue using technical assistance provided through a FfID funded arrangement with PricewaterhouseCoopers (PwC) to develop the required SOPs. These SOPs need to include detail on the following:

- **Accounting Control Procedures**-Any procedures written should comply with generally accepted accounting principles (GAAP) and characteristics relating to good internal control.
    - Standard Chart of Accounts
    - General Journals
    - Subsidiary Journals
    - Recording transactions
    - Payment Vouchers
    - Procurement procedures (role of financial personnel –related to Procurement SOP)
    - Adjusting Journal Vouchers
    - Cash Disbursement procedures
    - Month-end and year end balancing procedures
    - Bank Accounting procedures
        - Signatories
        - Banking policies
        - Bank reconciliations
        - Check controls
        - Transfer funding procedures from Central MOHSW.
    - Documentation of transactions
    - Filing documentation
    - Petty cash procedures
- **Monitoring/Reporting**
    - Internal County level reports
        - Expenditures Compared to budget (monthly)
        - Bank reconciliation report

        - Petty cash report
    - Reports to Central MOHSW
        - Request for funds (quarterly?)
        - Expenditures Compared to Budget (monthly?)
        - Other reports (TBD)
- **Auditing**
    - Internal auditing (County level)
    - Internal auditing (Central Level)
    - External auditing (Accounting firm)

Relationship to Other Support Systems

The FM system is closely related to the Planning and Budgeting system, which sets out on an annual cycle the funding levels required and approved to provide resources for service delivery activities. The FM system is related to any other support system that requires funds to provide resources.

Overall Leadership and Management Capability Required of the CHS

Honesty, integrity and transparency are critical leadership skills in operating an effective FM system. Ability to follow a financial plan (budget) is also an essential leadership skill. The CHO needs to routinely share information about budgets and expenditures with the CHT so they can assist in adequately monitoring the availability of resources to accomplish their planned activities.

Human Resources Required

At the county level the primary person required to operate the system is the CHS Accountant. The County Health Officer and the County Health Services Administrator will also play a significant role in approving expenditures and tracking expenditures compared to budget. All members of the CHS must be informed of the SOPs required for expenditure approval. The central MoHSW Controller will lead efforts to oversee and audit county-level FM operations.

Training Materials/Methodology

SOPs and training materials need to be developed prior to installation of the county-level FM system. Successful completion of training needs to be competency-based. The principle of competency based training is that participants need to demonstrate that they have acquired the required skills before they are provided a certificate of completion. Training materials should include numerous case studies and exercises to ensure more than an academic understanding of the system. A workshop of several days duration at a central location attended by each county CHO, CHSA and Accountant will be required at the initial roll-out of the FM system. Soon after the initial workshop the central MoHSW must begin a follow-up program that provides at least quarterly visits to each county to assess their implementation of the FM system. Central MoHSW providing this function should provide additional on-the-job training as necessary to ensure complete understanding and performance of the SOPs. All other members of the CHS will also need brief training on how the FM system works and how they request allowable resources. The Accountant, with assistance from the CHO and CHSA, should provide this training after they return to their county from the FM workshop. Simple training aids should be developed and provided to them to help them deliver this brief training to the CHS.

Suggested Indicators for Monitoring and Evaluation

Indicators (and Targets) from "Draft Framework for the County Health Plan":

- Cumulative % of the yearly budgeted county allotment that has been drawn down.
- County Health Office maintains an active financial ledger.

Additional suggested indicators:

Percent of County Health Services (CHS) accomplishing the following-

- Monthly CHS bank reconciliations prepared and balanced in a timely manner.
- Monthly CHS financial status reports submitted in timely manner.
- Quarterly CHS expenditure within approved budget.
- Annual CHS budget submitted in a timely manner.
- Annual CHS budget approved.

Next Steps

Based on discussions during the national health plan review the following actions were proposed for year two concerning decentralized financial management (*National Health and Social Welfare Plan (2007-2011) Update For Year Two Implementation, p. 7):*

Year Two [Support Systems] Implementation Plan	**Quarters ('08-'09)**					
	3	**4**	**1**	**2**	**3**	**4**
8. Decentralization of financial management to the counties.						
a) Assess financial management capacity		**x**	**x**			
b) Develop financial management procedures, guidelines and implementation plans			**x**			
c) Conduct training in financial management			**x**	**x**		
d) Disburse funds to counties based on their capacity to manage and their needs			**x**	**x**	**x**	**x**
e) Monitor, evaluate and audit financial system			**x**	**x**	**x**	**x**

Procurement

Procurement management at the County level is a critical, enabling support system required to make other support systems operable. The proposal to decentralize this system is tied to the Financial Management system and empowers the County Health Services (CHS) to perform its own direct purchasing of commodities and services. It is crucial that the CHS follow established legal GOL procurement regulations. Procurement is part of the *Logistics and Communication System.*

Implementation Issues

- Outside of Monrovia the availability of vendors of commodities is limited at this time, which will result in the CHS 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 will be limited to approved categories, such as cleaning supplies, construction materials, firewood, stationery supplies, simple medical supplies, etc.
- Labor will be procured locally by the CHS to accomplish simple required services such as cleaning, food preparation, maintenance and repair, etc.
- Monetary limits will be set that the CHS must stay within. Procurement that may exceed such limits will be referred to the Central Ministry to manage on behalf of the CHS.
- The CHS, through their Financial Management system must ensure availability of funds in their bank account before engaging in direct procurement.
- Drugs and Medical Supplies will not be procured directly by the CHS, 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).
- A number of CHS staff will be involved in the direct procurement function, including the County Health Services Administrator (CHSA), and other staff within the CHS 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.
- The Central Ministry must develop procedures to ensure adequate oversight of procurement performed by the CHS's.

Current County-Level Capacity

The CHSA has in his/her department one or more logistics staff to perform procurement functions under his/her supervision. Training in the relevant local procurement policies and procedures will need to be undertaken to ensure understanding of and compliance with GOL and MOHSW procurement regulations and limitations.

Priority System Modules

- Local procurement procedures
- Allowable categories
- Authorized limits
- Oversight from Central

Standard Operating Procedures

Detailed procedures need to be developed that will provide guidance to accomplish the following:

- Local market survey to identify vendors and availability of goods and services
- Developing specifications of required commodities and services
- Quantification of required commodities
- Determining authorization level
- Obtaining quotes from vendors
- Evaluating quotes and decision making
- Approving and issuing purchase orders or contracts
- Receiving and evaluation of products or deliverables
- Approving and making payments to vendors
- Management and retention of records and documentation

Relationship to Other Support Systems

As mentioned above, monetary limits will be set that the CHS must stay within. Procurement that may exceed such limits will be referred to the Central Ministry to manage on behalf of the CHS. The CHS annual budget will itemize the anticipated expenditure on local procurement.

Overall Leadership and Management Capability Required of the CHS

As mentioned above, the County Health Officer has ultimate authority over and responsibility for local procurement. The CHO must provide oversight of this function to ensure that all procurement policies and procedures are followed. As with other systems, honesty, integrity and transparency are critical leadership skills in operating an effective procurement system. This is an area that is universally fraught with lucrative temptations in the form of kick-backs from vendors, disappearance of procured commodities, nepotism in selecting vendors of commodities and services, etc. To guard against such irregularities, diligent oversight by the CHO and the Central Ministry must be maintained.

Human Resources Required

Logistics staff to assist the CHSA in performing procurement. A minimum of a high school education should be required for such staff.

Training Materials/Methodology

SOPs and training materials need to be developed prior to installation of the county-level Procurement system. Training materials should include numerous case studies and exercises to ensure more than an academic understanding of the system. A workshop of several days duration at a central location attended by each county CHO, CHSA and key logistics staff will be required at the initial roll-out of the Procurement system. Soon after the initial

workshop the central MoHSW must begin a follow-up program that provides at least quarterly visits to each county to assess their implementation of the Procurement system. Central MoHSW providing this function should provide additional on-the-job training as necessary to ensure complete understanding and performance of the SOPs. All other members of the CHS will also need brief training on how the Procurement system works. The CHSA, with assistance from the CHO, should provide this training after they return to their county from the Procurement workshop. Simple training aids should be developed and provided to them to help them deliver this brief training to the CHT.

Suggested Indicators for Monitoring and Evaluation

- Percentage of local procurements with complete documentation.

Vehicle Management

Vehicles are a critical part of the *Logistics and Communication* support system that enable other crucial functions to operate. 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 post-conflict 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.
- It is proposed that County Health Services 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.
- County Health Services must establish and adhere to strict vehicle usage and preventive maintenance policies to ensure continuous operation of vehicles under their responsibility.
- Where County Health Services 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 lack their own private vehicle, and in counties where public transportation is required.. This must be discouraged in order to protect these valuable assets.

Current County-Level Capacity

The County Health Services Administrator is responsible for managing vehicles. He/she has staff to deal with logistics and driving of such vehicles. Administrative staff capabilities in this regard needs assessment. Administration of transportation resources is a general management skill level task and does not require specialized technical skills. Preventive maintenance of vehicles should be simplified by using a checklist that can be used by anyone qualified to drive a vehicle.

Priority System Modules

- County level maintenance and repair of vehicles
- GSA certification of local private maintenance and repair facilities
- Maintenance contracts/Fee schedule

- Sharing of vehicles with NGOs

Standard Operating Procedures

- Restrictions on vehicle usage
- Ensuring widespread knowledge of vehicle usage policy
- Disciplinary action for vehicle misuse
- Planning transportation needs
- Requesting/authorizing transportation
- Scheduling vehicle usage
- Scheduling vehicle preventive maintenance
- Driver training and supervision
- Maintaining vehicle usage logs
- Maintaining vehicle checklists and records
- Arranging local vehicle maintenance and repair
- Controlling the provision of fuel for vehicles
- Reporting on vehicle usage and maintenance

Relationship to Other Support Systems

Vehicles are a critical requirement of the Supervision system. Logistics and Communication system also require vehicles to function effectively.

Overall Leadership and Management Capability Required of the CHT

CHOs must take a keen interest in the management of one of their most valuable resources: vehicles. Only human resources are a more precious resource than vehicle resources to enable the delivery of health services.

Human Resources Required

In addition to qualified and trained drivers, the County Health Services Administrator should appoint one member of his staff to function as the Vehicle Dispatcher. The Dispatcher should receive requests for transportation, obtain approvals for such requests and ensure that vehicles are available as required. The Dispatcher should also monitor vehicle usage through daily inspection of vehicle logs and prepare reports to submit to the CHSA. The CHSA should appoint a member of staff to schedule and arrange for vehicle preventive maintenance (may be the Vehicle Dispatcher). It is recommended that only one driver be assigned per vehicle rather than rotating drivers among vehicles. It has been shown that this improves vehicle life.

Training Materials/Methodology

Competency based training should be utilized to ensure that skills are understood and can be performed before providing a certificate of completion of any training course. Training in defensive driving and driving in rough conditions, especially proper use of four-wheel drive should be arranged for drivers, probably best done through OJT. Other staff managing vehicle usage will require training in usage logs and procedures to restrict unauthorized use of vehicles.

Suggested Indicators for Monitoring and Evaluation

- Kilometers traveled per vehicle each quarter
- Fuel usage per vehicle
- Days of downtime per quarter

Next Steps

Based on discussions during the national health plan review the following actions were proposed for year two concerning decentralized financial management (*National Health and Social Welfare Plan (2007-2011) Update For Year Two Implementation, p. 7):*

Year Two [Support Systems] Implementation Plan	**Quarters ('08-'09)**					
	3	**4**	**1**	**2**	**3**	**4**
6. Decentralize vehicle and other equipment maintenance to county level.						
a) Examine the feasibility of local maintenance contracts for vehicles and equipment by CHTs			**x**			
b) Examine the feasibility of regional maintenance contracts for vehicles & equipment by CHTs			**x**			
c) Develop procedures and guidelines for decentralized maintenance			**x**	**x**	**x**	

Supervision

The ability of the CHT to provide high quality supervision of health facilities is critical to the smooth functioning of health services. There are definite supervisory skills that can be learned and techniques that can be applied to improve supervision. The basic function of the supervision system is to facilitate the ability of employees to develop and maintain high level work performance and ensure that all employees are consistently working towards planned goals and objectives.

Implementation Issues

- Supervisors must be encouraged to provide supportive supervision. This differs from an orientation that mainly finds faults in employees and criticizes their performance. Supportive supervision promotes team functioning and emphasizes praise for good performance. Feedback is given in order to correct improper or poor performance in a constructive way, to encourage employees to seek solutions to their problems. There are skills that supervisors can learn to enhance their ability to provide supportive supervision, but they must also be encouraged to develop attitudes that reinforce their application of those skills. They must have genuine respect for their employees and value the work that they do. Supportive supervision encourages two-way communication: supervisors must both give feedback to and receive feedback from the employees they supervise.
- There is no escaping the fact that supervisors must also be trainers. A supervisor who is not providing on-the-job training is not fully functioning as a supervisor. Guiding employees in how to improve performance demands the ability to provide learning opportunities for them. Sometimes this type of training can be informal without preparation, when a supervisor observes inadequate performance and demonstrates to an employee how to properly perform a function. Other times supervisors need to prepare brief training exercises to correct performance issues they have detected in their employees.
- To ensure consistent evaluation of system and employee performance, supervisors should have a supervisory checklist to assist them during supervisor visits. Employees should know what the contents of the checklist are. After a supervisor completes a checklist during a supervisory visit, feedback on what was recorded on the checklist should be shared. The checklist should be more than just boxes to check off, but rather should enable to supervisor to write in descriptions of problems, plus recommendations of how to solve those problems. Categorical programs should be included in an integrated checklist to reinforce the need to provide harmonized supervision. The checklist should also be closely related to the health facility accreditation standards.
- Supervising supervisors: there are often situations where a supervisor from a higher level, such as headquarters, makes supervisory visits to CHT supervisors and county health facilities. In such cases they must respect the chain of authority and not undermine the authority of CHT supervisors by circumventing those supervisors and dealing directly with health facility personnel. This is not to say that they should not visit health facilities and interact with their staff, but that they should do this together with CHT supervisors and not by pass them. In particular, higher level supervisors visiting a county should not promise to fix problems at health facilities. Such problem solving needs to be directed to CHT supervisors

who have responsibility to develop the means and manage the resources required to correct problems.

- Communication is critical between supervisors and employees. Not only do supervisors need to communicate to deliver instructions and information, but also to listen and receive feedback. While verbal communication is good to provide human interaction and convey a sense of interest and value in the work of employees, written communication is also essential to ensure clear and consistent understanding and to document instructions and plans.
- Problem solving needs to be directed back to those who are experiencing problems to encourage their participation in finding solutions. A dependency relationship should not develop where supervisors promise to take care of their problems for them. Such promises often remain unfulfilled and results in a disempowering of employees.
- Performance evaluations are a critical part of supervision and must be well documented and shared with employees. Evaluations should lead to the development of a plan to improve performance where appropriate. Constructive criticism should be provided and must be evidence-based, not based on personal opinions.
- Continuous Quality Improvement is a key responsibility of supervisors. CQI was explained earlier in this document. Supervisors will be responsible for assisting in the development of an assessment tool and the application of that tool to enhance and improve system performance.
- Supervisors must be prepared to manage resistance to change that it inevitable when new procedures and functions are introduced. Employees should be provided hands-on training to introduce them to new ways of working. Their opinions should be sought to help them see the purpose of new procedures.
- Team building and maintenance is a critical function of supervisors, who must be able to give employees the sense that they are part of a larger team that shares common values and purpose. Teamwork, however, does not mean everyone doing the same thing at the same time. It is important that supervisors correctly assign tasks and balance workloads to allow teams to function harmoniously.
- Categorical programs at the CHT level can by their nature create supervisory problems if not dealt with in a cohesive team fashion. The head of each categorical program has an agenda to pursue in ensuring implementation of their program. This at times puts them in conflict with the supervisory structure. The CHT Clinical Supervisor is responsible for supervising health facilities. This is direct supervision and must be respected – employees at health facilities must only have one direct supervisor. Categorical program supervisors provide indirect supervision and should not be giving orders to employees. They need to first seek approval from the clinical supervisor and having their instructions passed through the normal chain of authority. This is to allow proper scheduling of events and tasks and avoid overwhelming and/or confusing facility employees with conflicting, unharmonized instructions.

Current County-Level Capacity

CHT supervisors have received considerable training in supervisory techniques and are definitely on the right track to forming effectively functioning teams. Consolidating these gains through the introduction of supervisory SOPs and checklists will enhance their capacity.

Priority System Modules

- Supervisory checklists/service standards
- Supportive supervision
- Facility level on-the-job training

Standard Operating Procedures

The following SOPs will need development to fully document the functions of county-level supervisors:

- Reporting
- Monitoring and evaluating health system performance and results
- Monitoring and evaluating health facility performance
- Monitoring the use of equipment and commodities
- Proposing changes to improve work performance
- Continuous quality improvement
- Participating in planning and budgeting
- Work scheduling
- Giving and receiving feedback
- Personnel supervision:
    - Orientation of new personnel
    - In-service on-the-job training
    - Performance evaluation
    - Recognition of outstanding performance
    - Discipline
    - Grievances
    - Delegation of authority
    - Motivation
    - Team building

Relationship to Other Support Systems

Given the number of supervisory visits by CHT supervisors to health facilities, supervision is closely tied to the vehicle management system. Supervisors use information from the HMIS and interpretation methodology from the Monitoring and Evaluations system in their supervisory activities. Also, many supervisory functions are closely related to the Human Resources and In-service Training system.

Overall Leadership and Management Capability Required of the CHT

Supervision is a key responsibility of CHTs and should occupy a great deal of their time. Constant review of supervisory activities should be engaged in by the CHT to ensure that all members are following appropriate supervisory procedures and functioning as a team.

Human Resources Required
CHT supervisors.

Training Materials/Methodology
Supervisors need SOPs and learning materials to orient and train new employees to proper policies and procedures.

Suggested Indicators for Monitoring and Evaluation

- Number of visits per facility per quarter by CHT supervisors

Implementation Plan

The following are the major goals and objectives that provide a framework for the phased implementation of the strategy outlined above:

Goal : All Decentralized Management Support Systems rolled-out and operational by the end of the current National Health Plan – June 30, 2011.

> **Objective 1**: First Phase Roll-out of 4 priority system modules by April 2009.
>
> **Objective 2**: Second Phase Roll-out of 4 additional priority system modules by October 2009.
>
> **Objective 3**: Third Phase Roll-out of all remaining system modules by April 2010.
>
> **Objective 4**: Establish a continuous quality improvement system that commences operation in June 2010 and continues operation through June 30, 2011 (and beyond).

Additional sub-objectives and timelines with more detailed activities will be developed on an annual basis once implementation of the plan commences.

The timelines presented on the following pages are arranged by major activity phases and categories:

- Preparation Phase
- First Phase of DMSS Roll-out
- Management Analysis Training
- Second Phase of DMSS Roll-out
- Third Phase of DMSS Roll-out
- Continuous Quality Improvement Phase

There are *Phases* and *Rounds* in the Implementation Plan:

- System Modules are arranged in Phases;
- Counties are arranged in Rounds.

In some cases the counties are placed in different Rounds to avoid including an overwhelmingly large number of participants in a single workshop (e.g., if there are four participants from 15 counties, then 60 participants would be too many for one workshop; splitting that approximately in half makes it manageable.). In other cases the assignment of a county to a round has to do with their readiness to participate in the training. If key staff are not yet on board the CHT, or existing staff in key positions are considered to lack capacity to understand, the training for that county will be deferred to a subsequent Round. Until a thorough assessment of CHT staff availability and capacity is conducted it will not be possible to name which counties will be placed in a specific Round.

Guide to Reading the Implementation Plan

- The Implementation Plan covers the remaining life of the National Health Plan (through June 30, 2011.

- Each year is divided into 3-month Quarters.

- An activity of any duration (i.e., 1-31 days) is indicated by an "**X**" when it occurs within the quarter (i.e., an "**X**" does not indicate that the activity occurs for the entire month) .
  - An activity that occurs in the first month of the quarter: **X**
  - An activity that occurs in the second month of the quarter: **X**
  - An activity that occurs in the second and third months of the quarter: **XX**
  - An activity that occurs in the all three months of the quarter: **XXX**

- Summary activities are indicated with "**>**" **>>>**

- The person or group having primary responsibility for implementing an activity is indicated in the timetable.

Decentralized Management Support System Implementation Plan, FY 2008-2011

Task	Responsible	FY 2008-09				FY 2009-10				FY 2010-11			
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
		Jul Aug Sep	Oct Nov Dec	Jan Feb Mar	Apr May Jun	Jul Aug Sep	Oct Nov Dec	Jan Feb Mar	Apr May Jun	Jul Aug Sep	Oct Nov Dec	Jan Feb Mar	Apr May Jun
1. Preparation Phase			>>>>										
1.1. Decentralization Working Group			>>>										
1.1.1. Develop TOR	AMP, DMSS-STTA		X										
1.1.2. Approve TOR	DMP		X										
1.1.3. Form DWG	AMP		X										
1.1.4. Notify MoHSW Central and County of DWG TOR	DWG		X										
1.1.5. Preliminary DWG meeting	DWG		X										
1.1.6. DWG Orientation session	AMP, DMSS-STTA			X									
1.1.7. Coordination meeting with relevant partners	DWG			X									
1.2. Standard Operating Procedures (First Phase Modules)			>>>>										
1.2.1. Confirm selection of 4 priority Modules	DMP		X										
1.2.2. Identify & approve required STTA	DWG, DMP		X										
1.2.3. Develop & agree on SOP format	DMSS-STTA, DWG		X										
1.2.4. Gather information: existing procedures, forms, etc.	DMSS-STTA, DWG		XX										
1.2.5. Draft SOPs using format	DMSS-STTA, DWG		XX										
1.2.6. Build consensus on SOPs	DWG			X									
1.2.7. Print SOPs	DWG			X									
1.3. Assess capacity of 15 County Health Teams			>>>										
1.3.1.Gather existing info from HR database	DWG		XX										
1.3.2.Develop CHT capacity assessment tool	DWG		X										
1.3.3. Assess 15 CHTs using assessment tool	DWG			X									
1.3.4. Compile & analyze data	DWG			X									
1.3.5. Use data to divide counties into 2-3 training Rounds	DWG			X									

Task	Responsible	FY 2008-09				FY 2009-10				FY 2010-11			
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
		Jul Aug Sep	Oct Nov Dec	Jan Feb Mar	Apr May Jun	Jul Aug Sep	Oct Nov Dec	Jan Feb Mar	Apr May Jun	Jul Aug Sep	Oct Nov Dec	Jan Feb Mar	Apr May Jun
2. First Phase of DMSS Roll-out			>	>>>	>>>	>							
2.1. Preparation for First Phase Training			>>	>									
2.1.1. Identify Trainer STTA	DWG		X										
2.1.2. Prepare training plan	STTA			X									
2.1.3. Identify & notify participants	DWG			X									
2.1.4. Identify trainers	DWG			X									
2.1.5. Identify venue & arrange logistics	DWG			X									
2.1.6. Develop & print training materials	STTA, DWG			XX									
2.1.7. Orientation of trainers	STTA			X									
2.2. First Phase Workshops				>>	>								
2.2.1. Conduct Workshop for Round One Counties	STTA, Trainers			X									
2.2.2. Conduct Workshop for Round Two Counties	STTA, Trainers			X									
2.2.3. [Conduct Workshop for Round Three Counties]*	STTA, Trainers				X								
2.3. First Phase Follow-up OJT				>	>>>	>							
2.3.1. OJT Orientation	STTA			X									
2.3.2. Conduct OJT for Round One Counties	Trainers				XX								
2.3.3. Conduct OJT for Round Two Counties	Trainers				XX								
2.3.4.[Conduct OJT for Round Three Counties]*	Trainers				X	X							
2.4. First Phase Cascade Training of Facility Teams				>>	>>>	>>							
2.4.1.Develop training plans	CHT			XX									
2.4.2.Prepare & print materials	CHT			XX									
2.4.3.Conduct workshops	CHT			X	XXX								
2.4.4.Conduct OJT	CHT				XXX	XX							

*Third Round required only if all counties not trained in first two Rounds.

Task	Responsible	FY 2008-09				FY 2009-10				FY 2010-11			
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
		Jul Aug Sep	Oct Nov Dec	Jan Feb Mar	Apr May Jun	Jul Aug Sep	Oct Nov Dec	Jan Feb Mar	Apr May Jun	Jul Aug Sep	Oct Nov Dec	Jan Feb Mar	Apr May Jun
3. Management Analysis (MA) Training					>>>	>>							
3.1. Preparation					>>>								
3.1.1. Identify & approve required MA-STTA	DWG, DMP				X								
3.1.2. Prepare training plan	MA-STTA, DWG				XX								
3.1.3. Identify & notify DWG participants	DWG				X								
3.1.4. Identify venue & arrange logistics	MA-STTA, DWG				XX								
3.1.5. Develop & print training materials	MA-STTA, DWG				X								
3.2. Conduct Management Analysis Workshops						>							
3.2.1. Conduct Management Analysis Workshop	MA-STTA					X							
3.3. Perform Management Analysis Studies						>							
3.3.1. Conduct MA Studies	DWG Trainees					X							
3.3.2. Evaluate MA Studies	MA-STTA					X							
3.3.3.Use Study recommendations for Second Phase training	DWG					X							

Task	Responsible	FY 2008-09				FY 2009-10				FY 2010-11			
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
		Jul Aug Sep	Oct Nov Dec	Jan Feb Mar	Apr May Jun	Jul Aug Sep	Oct Nov Dec	Jan Feb Mar	Apr May Jun	Jul Aug Sep	Oct Nov Dec	Jan Feb Mar	Apr May Jun
4. Second Phase of DMSS Roll-out						>>>	>>>						
4.1. Preparation						>>>							
4.1.1. Confirm selection of 4 additional priority Modules	DMP					X							
4.1.2. Identify & approve required STTA	DWG					X							
4.1.3. Gather information: existing procedures, forms, etc.	SOP-TTA, DWG					X							
4.1.4. Draft SOPs using format	SOP-STTA, DWG					X							
4.1.5. Build consensus on SOPs	DWG					X							
4.1.6. Print SOPs	DWG					X							
4.1.7. Identify Trainer STTA	DWG					X							
4.1.8. Prepare training plan	Trainer-STTA, DWG					X							
4.1.9. Identify & notify participants	DWG					X							
4.1.10. Identify trainers	Trainer-STTA, DWG					X							
4.1.11. Identify venue & arrange logistics	Trainer-STTA, DWG					X							
4.1.12. Develop & print training materials	Trainer-STTA, DWG					X							
4.1.13. Orientation of trainers	Trainer-STTA, DWG					X							
4.2. Second Phase Workshops						>	>>						
4.2.1. Conduct Workshop for Round One Counties	Trainer-STTA, Trainers					X							
4.2.2. Conduct Workshop for Round Two Counties	Trainer-STTA, Trainers						X						
4.2.3.[Conduct Workshop for Round Three Counties]*	Trainer-STTA, Trainers						X						
4.3. Second Phase Follow-up OJT						>	>>>						
4.3.1. OJT Orientation	Trainer-STTA					X							
4.3.2. Conduct OJT for Round One Counties	Trainers						XX						
4.3.3. Conduct OJT for Round Two Counties	Trainers						XX						
4.3.4.[Conduct OJT for Round Three Counties]*	Trainers						XX						
4.4. Second Phase Cascade Training of Facility Teams													
4.4.1.Develop training plans	CHT						XX						
4.4.2.Prepare & print materials	CHT						XX						
4.4.3.Conduct workshops	CHT						X	XXX					
4.4.4.Conduct OJT	CHT							XXX	XX				

Task	Responsible	FY 2008-09				FY 2009-10				FY 2010-11			
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
		Jul Aug Sep	Oct Nov Dec	Jan Feb Mar	Apr May Jun	Jul Aug Sep	Oct Nov Dec	Jan Feb Mar	Apr May Jun	Jul Aug Sep	Oct Nov Dec	Jan Feb Mar	Apr May Jun
5. Third Phase of DMSS Roll-out								>>>	>>>	>>>	>		
5.1. Third Phase Preparation								>>>					
5.1.1. Confirm selection of all remaining priority Modules	DMP							X					
5.1.2. Identify & approve required STTA	DWG							X					
5.1.3. Gather information: existing procedures, forms, etc.	SOP-TTA, DWG							X					
5.1.4. Draft SOPs using format	SOP-STTA, DWG							X					
5.1.5. Build consensus on SOPs	DWG							X					
5.1.6. Print SOPs	DWG							X					
5.1.7. Identify Trainer STTA	DWG							X					
5.1.8. Prepare training plan	Trainer-STTA, DWG							X					
5.1.9. Identify & notify participants	DWG							X					
5.1.10. Identify trainers	Trainer-STTA, DWG							X					
5.1.11. Identify venue & arrange logistics	Trainer-STTA, DWG							X					
5.1.12. Develop & print training materials	Trainer-STTA, DWG							X					
5.1.13. Orientation of trainers	Trainer-STTA, DWG							X					
5.2. Third Phase Workshops								>	>>				
5.2.1. Conduct Workshop for Round One Counties	Trainer-STTA, Trainers							X					
5.2.2. Conduct Workshop for Round Two Counties	Trainer-STTA, Trainers								X				
5.2.3.[Conduct Workshop for Round Three counties]*	Trainer-STTA, Trainers								X				
5.3. Third Phase Follow-up OJT								>	>>>				
5.3.1. OJT Orientation	Trainer-STTA							X					
5.3.2. Conduct OJT for Round One Counties	Trainers								XX				
5.3.3. Conduct OJT for Round Two Counties	Trainers								XX				
5.3.4.[Conduct OJT for Round Three Counties]*	Trainers								XX				
5.4. Third Phase Cascade Training of Facility Teams									>>>	>>>	>		
5.4.1.Develop training plans	CHT								XX				
5.4.2.Prepare & print materials	CHT								XX				
5.4.3.Conduct workshops	CHT								XX	XX			
5.4.4.Conduct OJT	CHT								X	XXX	X		

Task	Responsible	FY 2008-09				FY 2009-10				FY 2010-11			
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
		Jul Aug Sep	Oct Nov Dec	Jan Feb Mar	Apr May Jun	Jul Aug Sep	Oct Nov Dec	Jan Feb Mar	Apr May Jun	Jul Aug Sep	Oct Nov Dec	Jan Feb Mar	Apr May Jun
6. Continuous Quality Improvement (CQI) Phase									>>	>>>	>>>	>>>	>>>
6.1. Preparation									>>	>>>			
6.1.1.Identify & approve CQI STTA	DWG, DMP								XX				
6.1.2.Develop CQI Plan	CQI-STTA, DWG									X			
6.1.3.Approve CQI Plan	DWG, DMP									X			
6.1.4.Develop CQI Tool	CQI-STTA, DWG									X			
6.1.5.Train DWG in CQI Tool & methodology	CQI-STTA									X			
6.1.6.Pre-test CQI program in 2 counties	CQI-STTA, DWG									X			
6.1.7.Revise CQI based on pre-test	CQI-STTA, DWG									X			
6.1.8.Finalize CQI Tool	CQI-STTA, DWG									X			
6.2. Assessments using CQI Tool										>	>>>	>>>	>>>
6.2.1.Quarterly CQI system performance assessments	DWG									X	X	X	X
6.2.2.Review system performance indicators	DWG									X	X	X	X
6.3. Implement Improvements											>>>	>>>	>>>
6.3.1.Evaluate data from Quarterly CQI Assessments	DWG										X	X	X
6.3.2.Design improvements in Support Systems	DWG										X	X	X
6.3.3.Update/revise SOPs	DWG										X	X	X
6.3.4.Implement improvements through workshops & OJT	DWG										XX	XXX	XXX

Resources Required

Action/Function	Requirement
Guidance for DMSS Roll-out: Writing and editing of system documentation and training materials; Conducting/facilitating training	External STTA*
Assistance in specialized decentralized systems: such as Finance, M&E, IST, HMIS, etc.; Writing and editing of system documentation and training materials	External STTA
Training of Trainers: Design TOT; Conduct TOT	External STTA
System Documentation: Assess CHT capacity ; Draft System Documentation; Obtain county level feedback during documentation; Assist with workshops and Follow-up OJT	Local STTA
Training: Assess CHT capacity ; Draft training materials; Obtain county level feedback during material preparation; Assist with workshops and Follow-up OJT	Local STTA + DWG
Decentralization Working Group	Support
Travel to support above functions	Travel costs
Printing, copying and binding of system documentation , training and follow-up materials	Printing services
Workshops	Workshop costs

***STTA=Short Term Technical Assistance**

Glossary[3] & Acronyms

Capacity	The level of knowledge, skills and attitudes that enable a person or team to effectively manage health services
CBT	Competency Based Training
CHS	County Health Services
CHT	County Health Team
CHSA	County Health Services Administrator
CHO	County Health Officer
CHD	Community Health Department
Decentralization	A process that shifts health services management responsibility and authority from the central level to the county, district and community level, as appropriate
Deconcentration	A process of decentralization that incrementally shifts health services management responsibility and authority from the central level to the county, district and community level, as appropriate
DMSS	Decentralized Management Support Systems
Health Facility	A hospital, health center, health post, clinic, or other physical site where health services are delivered
Policy	A statement of what should be contained in a management system
Procedure	A series of detailed steps required to implement a policy
SER PHC	South East Region Primary Health Care
SOP	Standard Operating Procedure
STTA	Short Term Technical Assistant/Assistance
TA	Technical Assistance
WG	Working Group

[3] The definitions presented here should be considered *operation definitions* for use within the context of this document.