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IMPROVING CHILD HEALTH IN LIBERIA

BASICS III

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BACKGROUND

Post Conflict Liberia

In 2003, Liberia emerged from a 14-year civil war that was characterized by continuous civil unrest and violence; destruction of infrastructure; large population shifts; and a lack of access to basic necessities such as shelter, food, water, and medicine. The visible vestiges of war still exist in the form of crumbled buildings, widespread poverty, a heavy presence of United Nations Peace Keeping Forces and heavy reliance on generator power throughout the country.

The health system was decimated by the war. In 2006, the Ministry of Health and Social Welfare (MOHSW) estimated that only 40% of the population had access to care (iPRS 2006). Sixty five percent of all health facilities were functional (Rapid Health Sector Assessment, 2006) and population displacement resulted in a severe shortage of trained human resources to ensure the delivery of quality services. A 2005 EPI Cluster Survey found that DPT3 coverage was 40% or below in the most of the country. The 2007 DHS reported that maternal mortality was a shocking 994/100,000 live births.

The Ministry of Health and Social Welfare was barely functional and prior to 2006 provided minimal leadership, coordination and oversight of the health sector. As a result, the health system was extremely fragmented. Eighty percent of functional health facilities and were being funded through international assistance and many partners worked apart from any governmental structure (USAID/BASICS Transition Analysis, Oct 2006) There were few policies or guidelines to direct and standardize the implementation of health services. Finally, the Liberian health sector was moving rapidly towards the post conflict transition. Humanitarian assistance donors were making plans to withdraw funding. Liberia was still considered to be a fragile state and the nascent MOHSW was extremely concerned about having sufficient resources to maintain the existing access to health care.

The Challenges of Health in Fragile States

Fragile states experience the worst health indicators in the world. A third of all maternal mortality occurs in these countries and half of the children who die before the age of five also live in fragile states. In addition, a higher proportion of populations in fragile states are malnourished and malaria-related morbidity is higher. Given the fact that 15% of the world's population live in these environments, global efforts to meet the MDGs by 2015 will remain contingent on progress made to improve health status in fragile states (Department for International Development. 2004. Working Paper 2: How important are difficult environments to achieving the MDGs. Policy Division, Poverty Reduction in Difficult Environments DRAFT).

Conflict and immediate post-conflict periods are considered to be fragile environments, yet they have their own set of unique challenges that result from extended periods of war. One of the greatest challenges is the lack of capacity to manage and deliver quality health services. During

periods of conflict, skilled medical and management professionals often flee while few new staff is available due to education limitations. Those who remain, particularly during prolonged conflicts, are often providing services in difficult conditions due to the destruction of health facilities and lack of basic supplies and drugs. In addition, most do not have access to continuing education or other skills enhancement activities and may therefore experience a decline in skills.

In addition, post conflict periods are often marked by an abundance of donors and implementing partners providing humanitarian services, such as health care. However, once the immediate post-conflict period ends, perceived stability may lead to the withdrawal of relief donors. These groups are likely to re-direct limited resources to active conflict environments with the expectation that development-focused stakeholders will assume the responsibility for post-conflict support, including the establishment of a unified health system. This period between the withdrawal of humanitarian assistance stakeholders and the initiation of development donor funding is called the transition period. Gaps in health services can occur if there is not sufficient funding, coordinated planning, and human capacity development to ensure a smooth transition and this can threaten the perceived legitimacy of nascent governments striving to move beyond the crisis.

The health care crisis in post conflict countries must be addressed through a coordinated, nationally-driven process that is committed to resolving local priorities and health burdens. Critical to accomplishing this, is the development of a strong national health policy and implementation plan that will achieve broad consensus by the national government, health sector partners and other stakeholders. The implementation of the plan must be accompanied by on-going review of accomplishments and challenges and adjustments to the plan when necessary. Simultaneous capacity building at central and district levels is also critical to ensure that skilled managers and clinicians are in place to guide partners and oversee the implementation of quality services. Obvious needs such as infrastructure development must be balanced by skills development (including training and supportive supervision), the definition of support systems, and partner coordination efforts. Multiple priorities contribute to sometimes chaotic, but exciting opportunities in post conflict situations. Success is possible through the empowerment of national governments to identify their own needs and direct their priorities with the support of dedicated partners who bring external perspective and expertise.

Overview: USAID/BASICS in Liberia

Soon after President Ellen Johnson Sirleaf was elected, in 2006 USAID invited USAID/BASICS to assist the Ministry of Health and Social Welfare (MOHSW) in rebuilding the health system.

The assistance provided through USAID/BASICS was two-fold. From August 2006 through December 2007, USAID/BASICS received funding from Africa Bureau and USAID's Office for Foreign Disaster Assistance (OFDA) to assist the MOHSW to lay the foundation for the health system through the development of the **National Health Plan**, **National Health Policy** and the **Basic Package of Health Services**(BPHS). USAID/BASICS also assisted the MOHSW to coordinate donors to support specific components of the National Health Plan and ensure the continuous provision of essential services during the relief-to-development period.

In December 2007, USAID/BASICS was awarded a 22-month Task Order Contract through September 2009, to provide support to the central MOHSW to roll out the BPHS and strengthen the Ministry's capacity to implement decentralized support systems. The key accomplishments are provided in Box 1.

Box 1: Key BASICS Accomplishments, 2006-2009

Through BASICS, USAID supported the MOHSW to:

- Develop the building blocks of the Liberian Health System including the National Health Policy, National Health Plan and the Basic Package of Health Services (BPHS)
- Advocate for donor assistance to address the critical post conflict funding gap and ensure continuity of services to mothers and children.
- Develop and introduce five policies and guidelines to guide the implementation of the BPHS including:
 - Child Survival Strategy
 - Community Health Policy and Strategy
 - In-Service Training Strategy and Plan
 - Decentralization Guidelines and Decentralized Management Support Systems Strategy
 - HMIS Policy and Strategy.
- Encourage task shifting to community health volunteers by working with the MOHSW to incorporate community case management into national policy.
- Train 18 master trainers to improve the skills of health workers.
- Produce three sets of job aids for community health volunteers to treat three key health problems: malaria, ARI and diarrheal disease.
- Design the framework for the national HMIS system.
- Build the capacity of 73 MOHSW staff members to implement the HMIS.
- Develop training materials and standard operating procedures for decentralization of health services by building the capacity of CHTs to manage priority decentralized support systems.

Laying the Foundation: August 2006-December 2007

The key technical activities of BASICS that resulted in the above accomplishments are summarized in Box 2.

Box 2: Key BASICS Activities

1. Facilitation of the National Health Workshop
2. Development of the National Health Policy
3. Development of the National Health Plan
4. Development of the Basic Package for Health Service Document
5. Creation of the Health Facility Database
6. Identification of the Post Conflict Transition Gap
7. Post Conflict Transition Assessment
8. Transition Planning
9. Liberia Health Sector Forum and Donor Coordination

I. Development of the Framework of the Health System

In August 2006, USAID/BASICS assisted the MOHSW to design the health system framework. This included achieving broad consensus about key health sector guiding principles and implementation strategies, such as decentralization. In addition to "laying the foundation" this process was also intentionally designed to "uncover the existing foundations" of the health system for rebuilding and reform. The key existing elements that were uncovered through the work of the BASICS consultants included:

- Historical Memory of PHC (1978);
- Decentralization Guidelines (1986);
- Draft Health Policy (2000); and
- iPRS and Budget (2006).

The first National Health Policy workshop (Aug 1-3, 2006) also provided an opportunity to "outline priorities, gaps, and early thinking on the national health policy and strategies for its implementation." The workshop format included the six break-out discussion groups that ultimately evolved into the six "pillars" of the health policy and plan:

- 1) Health Interventions (Basic Package of Health Services)
- 2) Health Infrastructure
- 3) Human Resources & Training
- 4) Health Systems Management
- 5) Health Financing
- 6) Stakeholders and Partnerships

The recommendations from the national workshop were subsequently "embedded" directly into the 2000 draft health policy. This approach provided a way to jump start the health policy process. Within two months a first complete draft of the National Health Policy was produced

along with the Basic Package of Health Services (BPHS) and a draft National Health Plan. The National Health Policy establishes the MOHSW's vision for the health sector. The Basic Package of Health Services (BPHS) document describes the preventive and curative services that should be offered at each level of the health system. The National Health Plan is broken into six pillars: BPHS, Human Resources, Support Systems, Infrastructure, Health Financing, and Stakeholder Coordination and outlines a series of activities to be accomplished during the two year transition period. These documents were subsequently refined and finalized through USAID/BASICS Technical Assistance. Box 3 identifies the element of each pillar.

Box 3: Six Pillars of the Liberian National Health Plan

- **Basic Package of Health Services:** Equitable access to an integrated “minimum package” prevention and treatment
- **Human Resources:** The right number of health workers in the right place, at the right time, and with the right skills.
- **Infrastructure Development:** Reinforce and develop health infrastructure to increase geographic accessibility.
- **Support Systems:** Reinforce and decentralize essential planning and management functions to the county level.
- **Health Financing:** \$12-18 per capita per year will require a total of \$50-75 million per year.
- **Partnerships:** Geographic and programmatic coordination of funding and implementing partners.

The development of the policies provided the foundation for MOHSW leadership and have served as a reference point to coordinate and align donor inputs with national priorities and ensure a coherent approach to service delivery. Further, the policies have supported the Liberian MOHSW to fulfill its vision of becoming a “model of post conflict recovery in the health field” (Liberia National Health Policy 2006). They have remained the cornerstone of the national health system.

The process of health policy development in Liberia in 2006 was unique in several respects.

- The commitment to a participatory approach was key to the wide-range agreement that was reached and is important, though often not accomplished, in post conflict countries. As a result, the MOHSW at all levels has remained committed to the intentional implementation of guiding principles, such as decentralization and primary health care.
- The specific focus of decentralization at the county level is also important. The commitment to decentralization encouraged a fairly rapid roll out of the National Health Plan to the county and built the capacity of county health officials. In addition, it encouraged an integrated approach to service delivery and health programming in-line with the BPHS.
- The organization of the health sector around the 6 pillars was another distinctive aspect that brought continuity and integration to the health sector. These pillars evolved into a framework for the National Health Plan and subsequent planning and national health plan reviews.

The National health Plan had seven guiding principles (see Box 4).

The MOHSW's small size, openness, flexibility and commitment to the guiding principles in the National Health Policy, especially decentralization, has continuously provided an opportunity for innovation. The MOHSW's motto is "paradigm shifting" and they have been eager to consider and rapidly implement such advances as task shifting to address the human resource gap.

Box 4: Guiding Principles of the Liberian National Health Policy

- Health as a Basic Human Right
- Equity, Gender and Poverty Focus
- Efficiency and Sustainability
- Accountability,
- Decentralization
- Primary Health Care
- Partnerships

II. Post Conflict Transition Gap

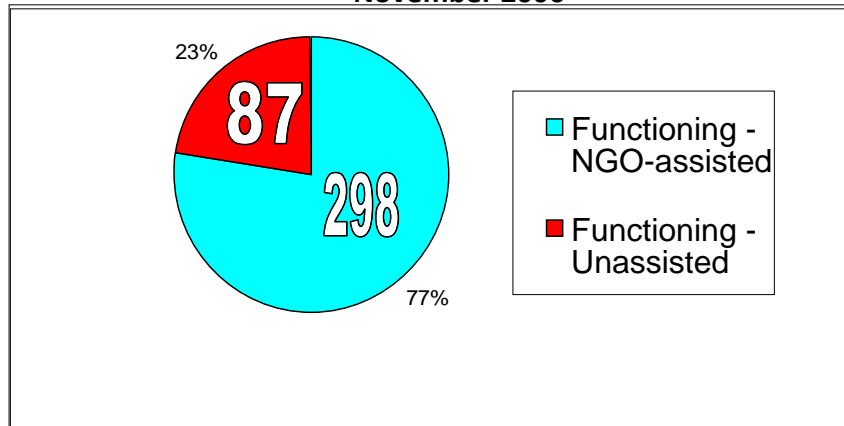
a. Identifying the Post Conflict Transition Gap

The Liberian health sector entered the transition phase in the middle of 2006. Relief partners had already started to withdraw support and the MOHSW had no timeline of donor funding flows to fully understand the impact of this on access to health. In a few sites where humanitarian assistance donors had left, (hospitals and health clinics) the facilities were barely functional. This situation gave the MOHSW reason for concern about the well-being of existing and returning populations.

One of the major achievements of USAID/BASICS work in Liberia was to compile facility-level information to understand the potential Partner "Transition Gap" in October 2006. That is, the financing gap for health facilities that would result from discontinuing humanitarian-based funding through NGOs before development-based funding begins. BASICS found that 77% of functioning facilities were being supported by NGOs that were primarily funded by humanitarian assistance donors and that the majority of these contract awards were due to end by December 2008. Without alternative funding, only 30% of existing facilities would remain functional. This situation could have led to a reduction in access to health services

The transition gap analysis resulted in a facility database which BASICS continued to refine and update and which provided the foundation for the HMIS and a series of other health sector activities including the facility accreditation, the development of an infrastructure plan, and improved donor coordination. In addition, a series of time-sequenced digital maps (dubbed the "10 Million Dollar Maps) were developed to demonstrate the transition gap and these later aided in the transition planning process and served as a strong advocacy tool that led directly to a commitment by the World Bank to earmark \$10 million USD for the Liberian Health sector. Box 5 provides the key finding that over three quarters of facilities had no assistance.

**Box 5: NGO Health Facilities Funding Gap
November 2006**



b. Post Conflict Transition Assessment

As a follow up to the Transition Gap Analysis in January and February 2007, BASICS conducted a Transition Assessment with support from the U.S. Government's Office of Foreign Disaster Assistance (OFDA). Funding for the Liberian health sector from OFDA and the U.S. State Department's Bureau of Population Refugee Migration (BPRM) was being phased out and therefore the objective of the assessment was to make recommendations about the best use of remaining funds to avoid cessation of vital health services, maximize the public health impact of existing facilities, and support the implementation of the National Health Plan. BASICS designed and tested this first-ever evidenced-based approach to assessing the transition period in post-conflict situations to contribute to a smoother handover between relief and development donors and partners (see [Health System Transition and the Transition Gap in Liberia, A Report to the Office of Foreign Disaster Assistance](#)). As a result of the recommendations, OFDA and BPRM continued to fund facilities that had the greatest influence on the health of the Liberian population. In addition, the methodology was applied in other post conflict situations, such as Southern Sudan.

c. Planning for the Transition Period

The Transition Assessment provided an opportunity to begin working with the County Health Teams (CHT) in the 5 counties funded by OFDA and BPRM to conduct short term transition planning and longer term planning for development at the county level. In June 2007, USAID/BASICS designed a county level transition planning process which included the collection of additional information about health facility types, staffing, program implementation and community-based programs and planning workshop with CHTs and partners. Each county developed its health plan in which they identified steps needed to begin implementing the BPHS and shifting to a decentralized health system. This was significant because it was one of the first steps taken to implement decentralization by giving power to the CHTs to lead and conduct health sector planning.

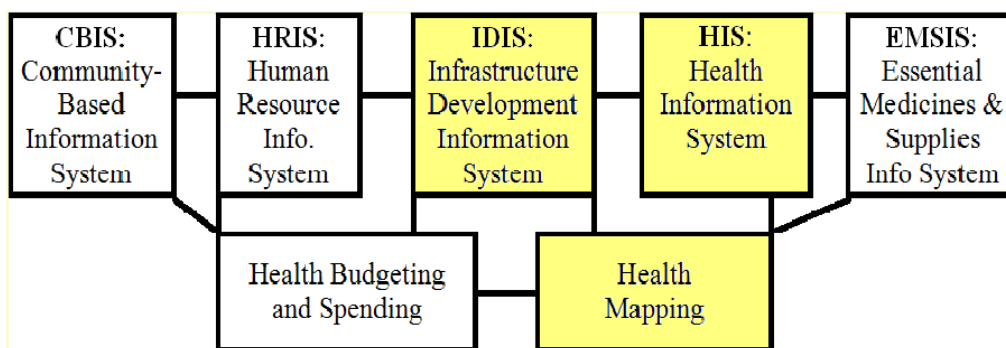
d. Bridging the Post Conflict Transition Gap

In response to the outcomes of the Transition Gap Analysis, USAID, USAID/BASICS and the World Bank partnered with the MOHSW to organize a day-long Health Sector Forum as part of the Liberia Partners Forum in Washington, DC in February 2007. The purpose of the Health Sector Forum was to present the National Health Policy and Plan and identify potential resources and funding mechanisms to support the implementation of the plan and cover the transition gap. The participants expressed a high level of interest to support Liberia and the MOHSW outlined several next steps including identifying areas of needs and gaps that required additional partner support and begin capacity building at the national and county levels, particularly in management and leadership functions. As a result of the information from the transition gap analysis and transition assessment, including the time sequenced digital maps, donors, including the World Bank, committed sufficient funding over a period of several years to avoid any cessation of health services thereby effectively bridging the post conflict transition gap.

e. Creating the Framework for the Health Management Information System

In September 2007 the MOHSW expressed an interest in establishing a consensus among donors and partners regarding the development of information systems. BASICS helped to facilitate this discussion by developing and presenting a conceptual framework for an integrated Health Management Information System (HMIS). This conceptual framework (see Box 6) helped to clarify that the MOHSW information system should be defined as inter-linking set of databases rather than being limited to health services statistics from health facilities. The discussion also agreed that the three elements to begin developing the HMIS would be the Infrastructure, HIS and health mapping. Based on this approach the MOHSW with assistance from Merlin engaged the services of the Health Information System Program (HISP) to begin developing the HIS component. BASICS assistance continued to assist the MOHSW in developing the infrastructure database and mapping capabilities.

Box 6: Framework for a National Health Management Information System



Implementing the National Health Plan: December 2007-September 2009

In December 2007, BASICS was awarded a 22-month contract with USAID/Liberia to assist the Ministry of Health and Social Welfare to develop and roll-out a decentralized, county-focused health system which supports the delivery of the Basic Package of Health Services (BPHS). Under this contract, BASICS focused on strengthening the delivery of the BPHS at the county level, with special emphasis on the essential components of Maternal, Newborn and Child Health services. The key accomplishments of BASICS are summarized in Box 7.

Box 7: Key BASICS Activities, 2007-2009

1. Conducted BPHS Orientation Workshops for Family Health services supervisors throughout the country
2. Developed the **Strategy for National In-Service Education** for mid-level facility-based health workers
3. Developed four of the six BPHS in-service training modules
4. Revised Physician Assistant Pre-Service Training Curriculum
5. Developed the **National Strategy and Policy for Community Health Services**
6. Updated Child Survival Strategy
7. Conceptualized and developed the National Health Information Management System framework.
8. Developed the **Strategy for the National Health Management Information System and Implementation Plan**
9. Updated facility database and conducted health sector mapping
10. Developed the **Guidelines for National Decentralization**
11. Developed training modules and SOPs for four of the MOHSW nine management support systems
12. Supported the MOHSW to coordinate partners and donors

I. Operationalizing the Basic Package of Health Services

The Basic Package of Health Services is the cornerstone of the health system. It establishes the minimum prevention and curative services to be offered at each level of the health system and serves as a guide to the MOHSW, donors and implementing partners to ensure that national priorities continue to be addressed. The BPHS is organized according to six components: Maternal and Newborn Health, Child Health, Reproductive and Adolescent Health, Communicable Diseases Control, Mental Health and Emergency Care.

a. BPHS Orientation Workshops

One of the strengths of the Liberian MOHSW is its commitment to decentralization. The dissemination of information to the county level is key. As part of this effort, a series of BPHS Orientation Workshops were organized and facilitated for 105 national and county level supervisors of Family Health Services. These workshops ensured that supervisors understood the content of the BPHS to enable them to appropriately supervise health workers.

b. BPHS In-Service Training

One of the MOHSW's key priorities to address the human resource limitation and roll out quality BPHS services was the rapid establishment and implementation of an In-Service Training program for mid-level health workers based at facilities. USAID/BASICS assisted the MOHSW to develop a framework and implementation plan for the In-Service Training Program. Through this effort, the MOHSW established an In-Service Training Unit within the central MOHSW to serve as the focal point for all activities related to In-Service Training.

Once the Training Plan was complete, USAID/BASICS supported the development of four of the six BPHS training modules: Tropical and Communicable Diseases, Mental Health and Adolescent Sexual Health and Reproductive Health. The content for the complete training underwent an extensive review and validation process lead by the MOHSW and facilitated by USAID/BASICS.

In collaboration with other MOHSW partners, including RBHS and Peace Corps, USAID/BASICS finalized the training materials and conducted the initial TOTs training for 18 master trainers. With the establishment of the In-Service Training Unit, the MOHSW is committed to the process and will continue to utilize the inputs developed by USAID/BASICS to roll out the training to the health workers in the county.

c. Physician Assistant (PA) Pre-Service Training

At special request of the Minister of Health, USAID/BASICS assisted the Tubman National Institute of Medical Arts (TNIMA) to review the Physician Assistants pre-service training curriculum. The updating the PA curriculum will improve PA training in Liberia—it is another important strategy to improve the human resources for health gap.

d. Community Health Services Program

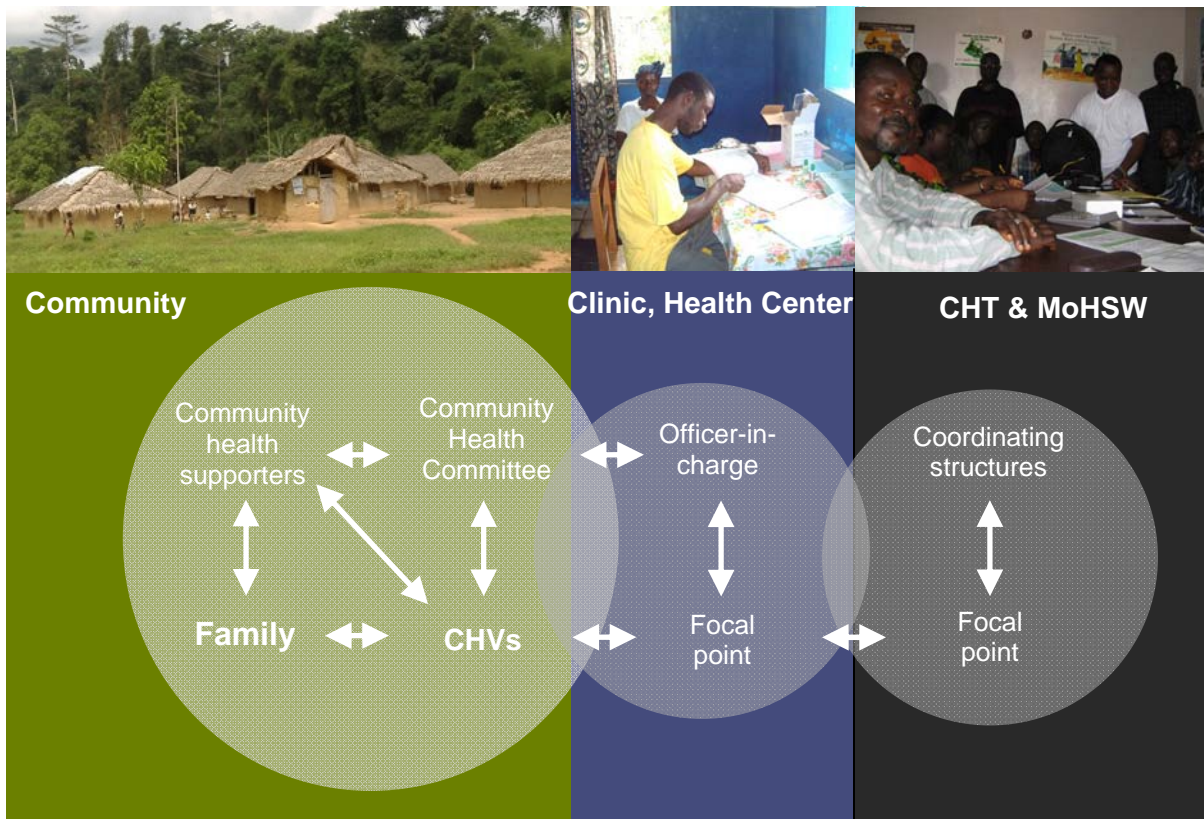
Despite the fact that Liberia is a fairly small country, geographic access to services remains a major challenge. The MOHSW recognizes the critical role that community-based workers play in improving access to health care. In addition, the MOHSW is committed to meaningful participation of communities in the health sector. Therefore, another priority activity for BASICS was to provide technical leadership and coordinate partners' effort for the design and establishment of a harmonized community health volunteer program. Throughout the war, many NGOs had utilized community volunteers, but programs were not active in all communities and distinct differences between the programs lead to varying parameters for General Community Health Volunteer (gCHV) selection, tasks, incentives and training.

USAID/BASICS first undertook an assessment of the existing community health services programs to establish baseline information for existing activities and provide a set of recommendations to guide the development of a national program.

Drawing on the successful experiences of others, such as the expertise offered by NGOs in Liberia and the Female Community Health Volunteer Program in Nepal, USAID/BASICS assisted the MOHSW to develop a Policy and Strategy for General Community Health Volunteers (gCHV). The policy established the components of the program including community health worker cadres, programmatic focus, selection criteria, and motivational incentives. The strategy

suggests a strategic approach for phasing in community health services based on priority health needs to encourage visible gains and not overwhelm the system. One of the major policy implications addressed in the strategy was that of task shifting and allowing gCHVs to perform community case management by administering the first dose of anti-malarial medication and antibiotics to sick children. As is the case in much of Africa, this was a new approach in Liberia. the MOHSW quickly endorsed the policy, demonstrating its commitment to considering alternative solutions outside of exclusively facility-based care. The framework for community-based health care is shown in Box 8.

Box 8: Conceptual Framework for the Liberian National System of Community Health Services



The MOHSW established a Community Health Division (CHD) within the MOHSW to provide leadership for the implementation of the Community Health Services Strategy. The development of a set of indicators and training program materials were two of the first activities undertaken to launch the implementation of the strategy. USAID/BASICS worked with the CHD and other partners to develop gCHV training materials. These materials including a facilitators' guide, classification cards, community register and job aids, on ARI, diarrheal disease and malaria case management. These diseases were chosen because of their significance for under-five morbidity and mortality. As part of the decentralization process, USAID/BASICS facilitated a workshop to orient district health officers from six counties to the Community Health Service Policy and Strategy. The MOHSW, through the CHD, and health partners will continue to train and monitor gCHVs in all 15 counties.

According to the Chief Medical Officer, the National Community Services Policy is the policy counterpart to the BPHS. The development of this policy is of strategic importance in regards to assisting the MOHSW to improve access to health services.

e. Child Survival Strategy

USAID/BASICS facilitated a collaborative process with the MOHSW to update the child health policy. The policy has been approved by the MOHSW.

II. Building Capacity through the Development and Strengthening of Support Systems

The National Health Plan outlines nine support systems that form the foundation of the decentralized health system and which the MOHSW and partners are actively engaged in strengthening at the central and county levels.

- 1) Policy formulation and implementation**
- 2) Planning and Budgeting**
- 3) Human Resources Management and 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 and Community Participation**

The **highlighted** components are those on which USAID/BASICS activities were focused.

a. National Health Management Information System

Given the importance of data in planning and decision-making and the determination of health priorities, one of USAID/BASICS major priorities within the support systems was the development of a national Health Information Management System (HMIS) USAID/BASICS assisted the ministry to develop a conceptual framework that defines the components of the HMIS (see Box 6).

Building on the consensus and conceptual framework for HMIS established in September 2007, USAID/BASICS subsequently worked with the HMIS Unit within the MOHSW to develop a national HMIS Policy and Strategy. The policy established the mission and guiding principles of the HMIS and the role of various actors at all levels of the health system in its implementation. The strategy laid out the architecture of the HMIS, including the flow of information and hardware and software needs, and a detailed implementation plan. The Policy and Strategy provide a strong foundation for the gradual implementation of the HMIS to ensure timely provision of quality data to inform policy development, planning and management of health services and programs.

Once the HMIS Policy and Strategy was endorsed by the MOHSW, USAID/BASICS worked with the HMIS Unit to begin implementing the Strategy. A set of national indicators was agreed to

and the facility-level integrated reporting forms were aligned with the indicator dataset. Building consensus around a common set of indicators was a challenge and required on-going collaboration and dialogue with national programs and health partners. Notwithstanding, the final set of indicators allowed BASICS and the HMIS Unit to develop a streamlined, integrated reporting system at all levels.

USAID/BASICS also purchased 15 sets of computers to establish HMIS Units in each county. One year after purchase, the computers continued to be functional and used by county data managers to implement the HIS component of the HMIS.

b. Health Information System (HIS)

While USAID/BASICS provided assistance to develop the HMIS framework, the focus of HMIS implementation was primarily on the Health Information System (HIS). The HIS is operated through the District Health Information System (DHIS) database that was developed by the Health Information System Project (HISP) from South Africa. Building on the work of HISP in Liberia, USAID/BASICS engaged their assistance to update the DHIS with the revised list of national indicators and train data managers to use the DHIS and improve the quality of information collected. In addition, through USAID/BASICS a set of Standard Operating Procedures (SOPs) and training materials for county-level data managers were developed to standardize the process of data generation, analysis, and flow.

Through the provision of the hardware, software, guidelines, tools and on-going training, the MOHSW has all the elements needed to run the HIS at the county level. While the use of data for decision-making and planning requires some improvement, the MOHSW staff is gaining experience in the collection and generation of information and has started to produce weekly Epidemiological Bulletin and quarterly health service bulletins to disseminate information to stakeholders

Population catchment area estimates for defined geographic areas are necessary for planning, decision-making and resource allocation. Obtaining reliable catchment population estimates for health facilities in Liberia have been difficult which means it is difficult to then calculate service coverage. USAID/BASICS and the Rebuilding Basic Health Services Project (RBHS), collaborating with the Liberia Institute for Statistics and Geo-information Services (LISGIS) are assisting the MOHSW to define the catchment population for every health facility in the country. USAID/BASICS assisted with financial resources for this effort, which will be completed by RBHS including the catchment populations and maps.

i. Community-Based Information System—CBIS

The CBIS is one of the components of the HMIS. Community level indicators were developed during the formation of the community health services policy and strategy. The data elements derived have subsequently being incorporated into the DHIS. USAID/BASICS working along with the CHD developed reporting forms and visualized the reporting link between the community and the health facility.

ii. Infrastructure Development Information System—IDIS

The information collected during the Transition Gap Assessment about the location and functionality of health facilities had been compiled into a database that became the

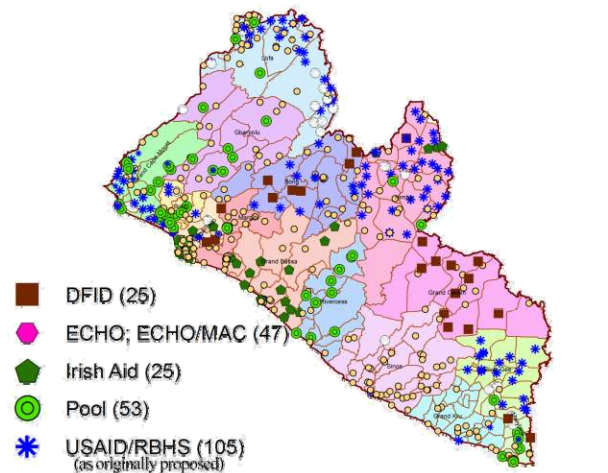
Infrastructure Development Information System (IDIS). This database has several key reference sources for a number of important initiatives including the transition gap analysis, the accreditation of the health facilities, and the development of the HIS/DIS system. The formation was also shared with the Infrastructure Unit when it became operational and is updated bi-annually. The information is used to assess and plan for infrastructure construction and renovation needs. BASICS has continued to support the improvement in the quality of the information. For example, 30 GPS Units were purchased to collect facility-specific GPS coordinates to improve the accuracy of facility locations. Additionally the GPS units are being used by the county health teams for the collection of information on other services and facilities including wells and latrines.

iii. Health Mapping

Regular and digital mapping played an important role in assisting with early planning decisions and later to demonstrate findings from assessments and other information gathering (see Box 9). For example, USAID/BASICS assisted the MOHSW to create digital maps to visually depict the post conflict transition gap, donor and implementing partner inputs, facility accreditation status, and health sector infrastructure and infrastructure needs to support planning efforts.

In an effort to build capacity within the central MOHSW to create and use digital health sector maps, USAID/BASICS purchased and installed 5 sets of GIS software. In addition, a hands-on training program was developed and conducted for 16 central MOHSW staff from each of the 4 pillars (Health Services/BPHS, Planning/Support Systems, Infrastructure, and Human Resources) and other national programs to enable them to create and produce digital maps for their own needs.

Box 9: Mapping of Donor Assistance to Health Facilities



b. Decentralized Management Support Systems (DMSS)

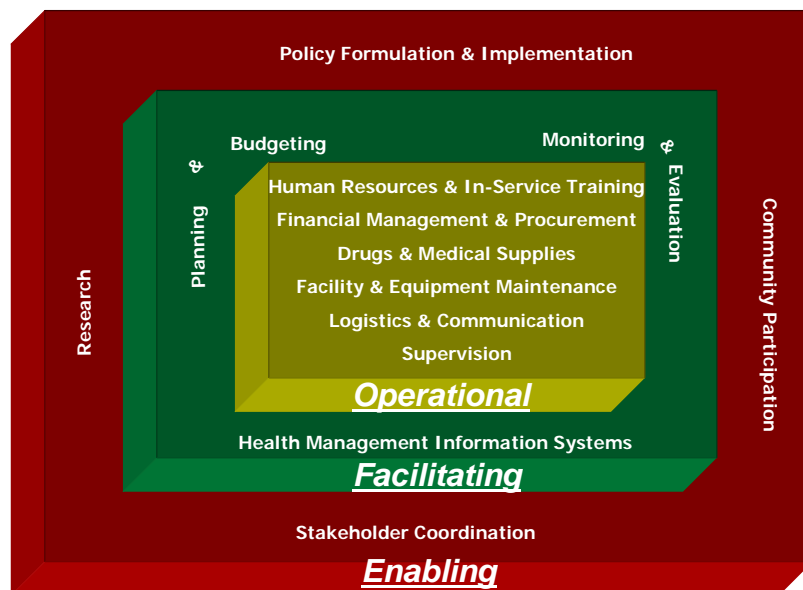
In accordance with the MOHSW's mandate to decentralize the health system, the responsibility, authority and resources will be deconcentrated from the central to the county level. Achieving a system under which the County Health Teams (CHT) can effectively manage requires defining roles and responsibilities and building their capacity to fulfill these roles.

Through the National Health Policy and Plan, the MOHSW had already made significant progress in the implementation of several decentralized support systems including planning and budgeting, infrastructure, human resources, etc. However, part of USAID/BASICS mandate was to further define these modules and the roles of staff at all levels (central and CHTs) through the development of a Decentralized Management Support System Guidelines and Strategy.

Building on the process and materials developed by the MEDEX Project that existed in Liberia in the early 80s, the Strategy proposes to implement the support systems through a combination of documented Standard Operating Procedures (SOPs), management training at central and county levels, a phased implementation approach and continuous quality improvement.

Box 10: Decentralized Management Support Systems

Levels of Management Support Systems



The formation of the MOHSW-led Decentralized Working Group (DWG) was the first result of recommendations from the DMSS Guidelines. This group spearheads the implementation of the strategy. The DMSS roll out was organized into 3 phases of which the first was accomplished with USAID/BASICS support. The first phase consisted of developing written SOPs and training materials for the following modules: Supervision, HMIS, Stakeholder Coordination, Planning and Budgeting, and Vehicle Management. Prior to the finalization of the training materials, a Rapid Pre-Assessment of the county level support systems was conducted to assess the capacity of CHTs to absorb the required training and operationalize the support systems. Eventually, central staff were trained on Supervision, Vehicle Management, and HMIS. The Decentralized Working Group will continue to lead phases 2 and 3 with support from other partners including UNDP, Price Waterhouse Cooper, and RBHS.

The development of management support systems was unique in Liberia because the basic groundwork for the framework has already been established prior to the war and allowed the rapid development of revised modules. In addition, the MOHSW already recognized the need to

reform existing management systems and actively supported the efforts to honestly evaluate existing systems and adapt proposed changes. As a result of the emphasis on documenting support system implementation and the process that had been put in place by BASICS, the MOHSW and other partners, utilized a similar terminology and guiding documents to detail the implementation of other systems, such as Supply Chain, Financial Management and Procurement.

c. Decentralized Management Assessment Tool for Post Conflict Transition States

At the request of USAID's Office for Foreign Disaster Assistance (USAID/OFDA), USAID/BASICS developed a Decentralized Management Assessment Tool for Post Conflict Transition States to examine the management capacity of a county health system and team and explore the factors that influence their ability to transition from relief to development.

The purpose of this tool is to assist MOHs and donors to determine gaps and make recommendations to support the decentralization of health program management to the county level. This would be accomplished through the following objectives:

- Determine stage of transition of the decentralized county health system along six health system components.
- Identify the enabling and constraining factors that influence the health teams' ability to manage (plan, implement, and evaluate) a decentralized health system.
- Determine the gaps that need to be addressed to improve the ability of the health teams to manage the county health system.
- Propose recommendations to strengthen the ability of the health teams to manage the decentralized county health system.

As depicted in Figure 1, the tool is used to evaluate the ability of a county health management teams to plan, implement, and monitor six essential health system components (which are shown across the top of the figure, and have emerged from health systems literature and USAID/BASICS Post Conflict Transition Assessments in Southern Sudan and Liberia). The green shaded area at the bottom of the figure also shows factors identified by Derick Brinkerhoff¹ that enable or constrain the capacity of the Health Teams to perform its functions.

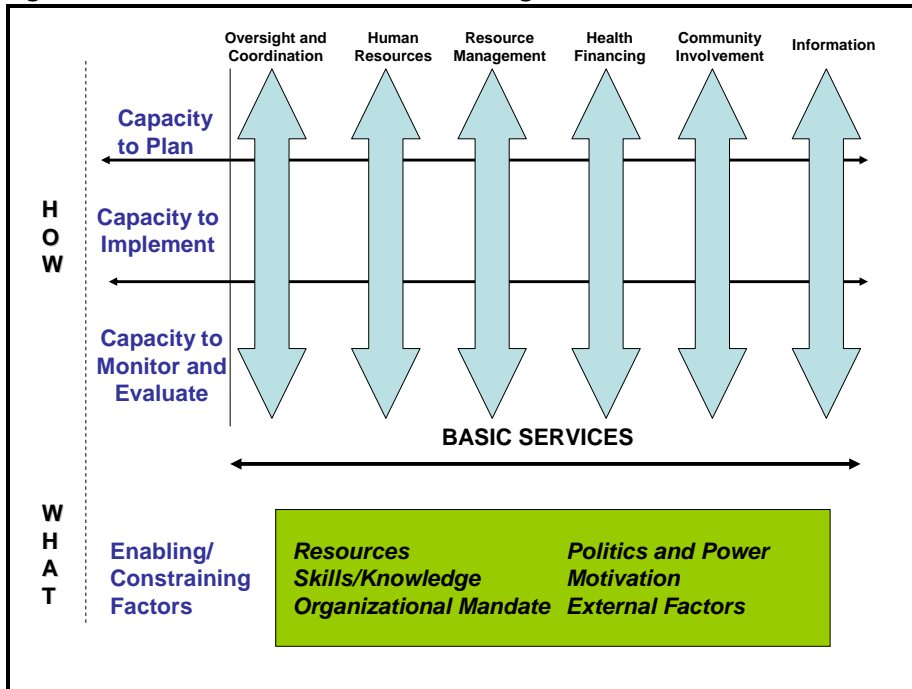
The Decentralized Management Assessment Tool in Post Conflict States consists of four different instruments designed to gather and verify information along the six components:

1. Relief to Development Transition Stage Questionnaire: Relevant county stakeholders (NGOs, health teams, and central MOH) describe the current transition stage across the different components.
2. Semi-Structured Interview: Health teams and Central Ministry of Health answer questions about the relationship between various actors in the county and existing guidelines and information that support coordinated service delivery.

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

3. Document Review: Checklist of important documents such as policies, guidelines, tools and other information utilized by health teams in order to plan, monitor and manage county health activities.
4. Guided Group Discussions: A guided group discussion with health teams, partners, and community members to further explore findings from the questionnaire and quasi-structured interviews in order to: determine the enabling and constraining factors; and identify strengths to build on and weaknesses to address.

Figure 1: Elements of Decentralized Management Assessment Tool



In July 2009 BASICS piloted the Decentralized Management Assessment Tool in Liberia to determine gaps and make recommendations to support the decentralization of health programs to the provincial level (see [Assessment of Decentralized Health Service Management during the Post-Conflict Transition in Liberia](#)). Data was collected from six County Health Teams (CHTs) using the four tools listed above. An additional module was created for the Liberia assessment which focused on national malaria programming. The study provided a current status of decentralization identifying strengths and weakness and factors impacting both. Furthermore, it contained in-depth information gathered from the CHTs themselves that provided a deeper understanding of the realities at the county level. The results can inform the MOHSW and donors on next steps as well as priority areas for capacity building within the CHT and strengthening of the system. The major findings were as follows:

- The CHTs understand their role in planning and coordinating partners. However, coordination with the central MOHSW needs to be strengthened by increasing the involvement of CHTs in planning and decision-making occurring at the central MOHSW. The CHTs' role in providing oversight of partners and facilities is also somewhat limited.

Mechanisms need to be put in place so that partners have some accountability to CHTs for county level activities. Resource constraints and a lack of emphasis on downward communication channels are the cause for weak facility engagement and oversight.

- The management of human resources is fairly strong across all counties assessed in that there are clear procedures in place that would allow decentralization and a Human Resource Unit has been established in each county. Training is one aspect of human resource management that has not been decentralized. Training activities are paid for and required by the central level need to be incorporated into the county health plans.
- Drug stock outs are a major problem. This is caused by a lack of involvement of the CHTs in determining quantities needed and delays attributed to an overly centralized system that is not aligned with county needs. The same is true for the management of other resources such as supplies, equipment and infrastructure. Centralized procurement and infrastructure processes have negative impacts on the CHT's ability to manage decentralized activities because they inhibit activity implementation.
- Centralized financial management places a clear burden on the CHTs' ability to manage and on their credibility as the MOHSW champion of the county health system. Lack of human resources and procedures at the county level must be addressed, but until then some provisions must be put in place so that the CHT has regular access to funding to support planned activities and ensure consistent implementation of the BPHS.
- Mechanisms to facilitate community participation exist, but are not being fully utilized nor are the roles and responsibilities of the CHTs and CHCs and their relationship to one another completely understood. The National Policy and Strategy on Community Services has clarified how community services will be managed, however CHTs will need to be trained on their role in community mobilization to strengthen community involvement and facilitate the exchange of information at all levels and ensure that community needs are addressed.
- Information exchange processes are in place through the roll out of the HMIS system and the quarterly review meetings. However, information generally flows from bottom (facility) to top (central MOHSW). Lower levels requested more feedback about health decisions, outcomes of supervision visits, and feedback regarding the performance of the county health system.

d. Planning

The National Health Plan set a precedent regarding the importance of coordinated planning. Since August 2006, USAID/BASICS has supported the MOHSW in its planning efforts through the development of planning frameworks and processes, design and facilitation of central and county level planning workshops, and creation and generation of information, such as digital maps, to inform planning activities.

The Transition Assessment conducted in January 2007, resulted in the first county-level planning process which brought together five CHTs to look at transition planning and aligning priorities with the National Health Plan. BASICS also provided technical assistance to the MOHSW to plan

and conduct Quarterly Review Meetings. These meetings bring together all central and county MOHSW staff and implementing partners to review information from the past quarter and plan activities to address county health needs for next quarter.

Since 2008, the MOHSW has hosted an annual National Health Sector Review Conference to review macro level health sector activities from the past year, assess the current status against the National Health Plan and Poverty Reduction Strategy and develop plans for each Health Sector Pillar (BPHS, Human Resources, Infrastructure, and Support Systems) for the coming year. As part of these efforts, USAID/BASICS worked with the MOHSW to develop workshop agendas, power point slides, planning templates and matrices, and other materials, such as the National Health Plan Brochure. In June 2008, the MOHSW conducted a National Health Sector Review Assessment to collect information about the progress made towards implementing the National Health Plan. USAID/BASICS participated in this effort as a member of the assessment team.

III. At the Table: Serving as Advisors to the MOHSW

Throughout the three years in Liberia, USAID, through USAID/BASICS has served as a trusted advisor to the MOHSW, beginning with assistance to conceptualize the health system through the development of the National Health Policy and Plan.

Partner Coordination

USAID/BASICS supports an all-Liberian staff whose offices are located within the MOHSW. USAID/BASICS has continually worked with the MOHSW to accomplish local priorities and needs. As a result, these staff members have become integral to the MOHSW team and contribute to policy analysis and decision-making. USAID/BASICS staff members are present at all Health Sector meetings including donor and partner coordination meetings and the bi-monthly Program Coordination Team meeting which is comprised only of high level MOHSW staff members. High level policy decisions are made at these meetings.

Donor Coordination

USAID/BASICS has assisted the MOHSW and donors to undertake multiple analyses of donor and partner assistance in Liberia (see Box 11). During the early post conflict period, donor assistance through INGOs had provided assistance directly to the large majority of functioning health facilities. This has resulted, in some counties, in multiple partners assisting health facilities, and minimal CHT capacity building. As Liberia moves beyond the conflict period, the MOHSW expects donors and partners to adopt a county-wide approach that supports the implementation of the BPHS and support systems development. An analysis of donor assistance in March 2007 found that primary donors (those who were assisting 50% or more of the health facilities) could be identified. USAID/BASICS proposed an approach to identify a primary donor for areas of emphasis within each county. This approach was explored by USAID in an effort to target assistance in five geographic catchment areas and resulted in the definition of USAID-supported catchment areas through the new USAID bilateral, RBHS. RBHS is now responsible for building the capacity of CHTs to implement the National Health Plan and coordinate service delivery in those counties. This is an example that the MOHSW can use to organize other donors within specific geographic areas and will lead to coordinated donor inputs that support the needs identified by the MOHSW.

Box 11: Liberian MOHSW Donor Coordination Map



Additional Perspectives

The MOHSW expressed that they valued the partnership and felt that USAID/BASICS added value to the work of the MOHSW. For example, in 2006 BASICS provided assistance when there was minimal capacity at the MOHSW to develop the National Health Plan and Policy. The experience and ideas from other countries that BASICS consultants provided was especially helpful.

Reflections

- 1) **Building on existing cornerstones.** Working intentionally to "uncover" existing foundations of the health system rather than beginning at zero, provided a way to quickly establish a consensus for rebuilding and reform of the health system and to "jump start" the development of the National Health Policy. Some of the "cornerstones" included the Health Policy from 1996, Decentralized Guidelines from 1986, and the concept of Primary Health Care. This accelerated the finalization the National Health Policy and Plan by avoiding delays associated with developing a common vision and framework.
- 2) **Maintaining the foundation.** During the 2006 August Rapid Health Sector Review Workshop, the MOHSW structured the National Health Plan around 6 "pillar" components which evolved into the framework of the health system. The pillars included the BPHS, Human Resources, Support Systems, Infrastructure, Health Financing and Partnership. The pillars have been used to structure all subsequent planning and health sector review activities. The six pillars of the National Health Plan (now seven including Social Welfare) have provided have a very practical way for the MOHSW to visualize (see Box 12) and implement an integrated approach to rebuilding and reforming the health system. In addition, their use provides a coherency and consistency across health activities and programs.

Box 12: Visualizing the Liberian MOHSW Six Pillars



- 3) **Participatory Management Approach of MOHSW:** Consensus building is central to the Liberian way. The focus on open participation and involvement of the MOHSW and other partners including UN bodies, donors and NGO/FBOs, in all USAID/BASICS activities resulted in sector-wide input and coordination. The MOHSW was accessible, flexible and willing to engage in dialogue. This encouraged joint planning and decision making between USAID/BASICS and the MOHSW and resulted in strong, productive relationships based on mutual understanding and a common vision. This close working relationship enhanced MOHSW ownership and the sustainability of project outcomes because the MOHSW was involved in each USAID/BASICS activity.
- 4) **Technical Assistance versus Development Project Balance.** The USAID/BASICS Liberia model effectively balanced a technical assistance and development project approach. The BASICS all-Liberian team was comprised of people who were familiar to and well respected by the MOHSW. In addition, the office was located in the MOHSW building. As a result, the USAID/BASICS team served as on-site advisors to the MOHSW and provided continual technical support in the areas of BPHS implementation and systems strengthening. However, the USAID/BASICS local team maintained their project identity and this helped to balance the sometimes hectic, fast-paced environment with a focus on the longer-term objectives that were outlined in the National Health Plan and the USAID/BASICS workplan. In addition, the team ensured that program implementation remained adherent to the local context while still addressing donor expectations.
- 5) **Building Institutional Memory.** USAID/BASICS capitalized on institutional memory. To begin, the project was built around a team of external consultants who remained engaged throughout the project. The continuity of this Technical Assistance allowed the project to develop strong and fruitful relationships with counterparts in the MOHSW and provided a sense of stability not generally achieved by other two- year projects. Returning technical assistants were more productive because they understood the context, helped to monitor

the progress of activities and maintained an active focus on the implementation of the National Health Plan. Finally, when the external consultants returned home, they provided on-going technical backstopping to the local USAID/BASICS team and counterparts in the MOHSW. The USAID/BASICS local staff also brought significant institutional memory to the project because they had previously worked in the health sector. Therefore, they could assist the MOHSW to rebuild and not “recreate” the health system in the post conflict period. Finally, USAID/BASICS local staff will transition to the USAID bilateral, RBHS. Thus, USAID/BASICS products will be promoted and utilized to benefit the Liberian health system for many years to come.

- 6) **Transitioning work with clear focus and direction:** During the last six months of the project, USAID/BASICS worked with the MOHSW and partners to identify how to continue supporting project activities, such as HMIS and Community Health Services. USAID/BASICS sought to strengthen coordination and conducted joint planning with other partners. Specifically, the project worked with RBHS to align workplans and ensure the transition of specific activities post BASICS. In addition, as USAID/BASICS technical staff will be transferring to the bilateral they will likely maintain similar roles and continue to serve as advisors to the MOHSW.
- 7) **Rebuilding health systems with a focus on maternal and child health.** Throughout the project, USAID/BASICS maintained a focus on maternal and child health outcomes. In 2006 the Transition Assessment emphasized the impact of reduced maternal and child health services on communities and the results gave the MOHSW the information needed to solicit sufficient donor support to avoid any cessation of services. In addition, USAID/BASICS contributed to MCH through the development of policy documents such as the BPHS, the National Community Services Strategy and Policy, and the Child Survival Strategy. Finally, USAID/BASICS contributed to improving the quality of MCH services by providing technical assistance to develop training materials for CHVs and 4 of the 6 BPHS In-Service training modules.

Next Steps

MOHSW capacity improved substantially from 2006 to 2009. The MOHSW hired new capable staff, established units and working groups to lead the work in key areas of USAID/BASICS' focus including the In-Service Training Unit, the Community Health Division, the HMIS Unit and the Decentralized Working Group. A large amount of central and county level capacity building has also taken place in areas of BPHS and support system implementation, research and data collection, use of equipment including GIS software and the DHIS, and M&E.

The emphasis in all activity implementation has been on partnership and coordination with the MOHSW. Each key activity involved key stakeholders outside of the MOHSW such as the USAID bilateral RBHS, WHO, UNICEF, UNDP, and NGOs. In addition, current USAID/BASICS staff and external consultants will remain involved through the USAID bilateral, RBHS. The USAID/BASICS staff transitioned to the bilateral in after September 2009 and will continue to play similar roles. The institutional memory and some of USAID/BASICS activities will be continued through RBHS. The key transition activities remaining are summarized in Box 13. Improved MOHSW capacity and the substantial involvement of other partners ensures that the work started under

USAD/BASICS will be continued driven by clear leadership from the MOHSW and guided by the priorities stated in the National Health Plan.

Box 13: Key Transition Activities for Post-USAID/BASICS Period

- BPHS In-Service Training: Training Unit will continue to train master trainers and MOHSW partners, such as RBHS will carry out TOTs and health worker training sessions in their geographic areas of emphasis.
- General CHV Program: The Community Health Services Division will continue to implement program activities including training MOHSW partners such as RBHS through NGO grantees will support the CHTs to train gCHVs in the communities.
- Physician Assistant Pre-Service Training Program: TINMA will continue to develop the curriculum and refine training sessions with support from RBHS.
- Updating HMIS databases and training central and county staff in data management, use and analysis: The HMIS Unit will continue this work with support from RBHS staff and other partners.
- Decentralized Management Support Systems: The Decentralized Working Group will continue to lead this effort and coordinate with MOHSW partners, such as RBHS to build the capacity of CHTs using the results of the Decentralized Management Capacity Assessment as a baseline and guide.
- USAID/BASICS Central-Level Technical Assistance: All USAID/BASICS technical staff will continue working in a similar function on the USAID 5-year bilateral, RBHS.