

**DECENTRALIZATION AND SERVICE DELIVERY: A COMPARATIVE CASE
STUDY OF THE HEALTH AND SOCIAL WELFARE DEPARTMENTS IN LIBERIA**

BY

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DECLARATION

I, Patricia Nueni Togba, hereby declare that this dissertation entirely consists of my own work except for the references used and that no part of this publication or the whole has been presented elsewhere for another degree.

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DEDICATION

This dissertation is solely dedicated to Almighty Jehovah, the Alpha and Omega, for His love and faithfulness to me and for giving me the strength and wisdom to complete this dissertation. And I would like to thank my dearest mom, I hope I have made you proud of me. Finally, I dedicate this work to my beloved children, Angel, Courage, Darren, Sarkis and Shadrach. I love you all.



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List of Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
CHSWT	County Health and Social Welfare Team
CHVs	Community Health Volunteers
CM	Community Member
DSW	Department of Social Welfare
EPHS	Essential Package of Health Services
EPI	Expanded Program on Immunization
EPR	Emergency Response Program
EPSS	Essential Package of Social Services
FHD	Family Health Division
GoL	Government of Liberia
HHPs	Household Health Promoters
HIV	Human Immunodeficiency Virus
HE	Health Education
HP	Health Promotion
HO	Health Officer

JFKMC	John F. Kennedy Medical Center
LAC	Liberian Agricultural Company
LAMCO	Liberian American Mining Company
LIBINC	Liberian oil palm plantation Incorporated
LIMINCO	Liberian Mining Company
LISGIS	Liberia Institute of Statistics and Geo-Information Services
MOHSW	Ministry of Health and Social Welfare
MoLG	Ministry of Local Government
NACP	National AIDS and STI Control Program
NDPC	National Development Planning Commission
NDU	National Diagnostic Unit
NGO	Non-Governmental Organisation
NHU	National Health Promotion Unit,
NLTCP	National Leprosy and Tuberculosis Control Program
NMCP	National Malaria Control Program
NTDs	Neglected Tropical Diseases

OPD	Out Patient Department
OTC	Oriental Timber Company
PBC	Performance-Based Contracting
PCU	Program Coordination Unit
PHC	Primary Health Care
SWO	Social Welfare Officer
TB	Tuberculosis
TTMs	Trained Traditional Midwives
UNDP	United Nations Development Programme

ABSTRACT

Decentralization has been viewed widely by many in Liberia as the panacea to the challenges of development in Liberia. With close to five years of the decentralization of the Ministry of Health and Social Welfare, the study sought to examine the services delivery of the Departments of Health and Social Welfare; comparing the progress chalked by both Departments and the challenges that are experienced in the process of decentralization in the Departments. Employing a qualitative research method, in-depth interviews were held with selected participants which included Ministry officials and Community Leaders. The study found that even though the Ministry had started the implementation of the decentralization program, the Department of Health had advanced far greatly than the Department of Social Welfare. There were great disparities in the implementation of the decentralization program between the two Departments. The Health Sector was better funded, had more logistics and staff than the Social Welfare Sector. The study also found that Health officials tended to lead in every sphere of the Ministry's operations, relegating the welfare staff to the background. There was very minimal collaboration between the Departments of Health and Social Welfare. Overall, even though the decentralization program has had some positive impact on the service delivery in the Ministry of Health and Social welfare, there is much to be done in order for the people at the local level to have the real benefits of the program. It is therefore recommended that the government takes steps to stem the fragmentations in social services delivery in the country, provide the needed funding for Social Welfare service delivery and in the medium to long term, detach the Department of Social Welfare from the Ministry of Health and create an all new Ministry to encompass Social Welfare and allied agencies in the country.

CHAPTER ONE

Introduction

1.0 Background of the Study

Decentralization is one of the essential institutional reform efforts pursued in developing countries and is intended to bring numerous improvements. It is considered that decentralization can contribute to further democratization, more efficient public administration, to more effective development, and to good governance, (Saito, 2001). Decentralization therefore, allows for the reconsideration of local government as more than just a technical or administrative extension of the central government and/or a bureaucratic structure with new autonomous powers and functions, (McCarney, 1996 as cited Hope, 2000).

“Decentralization is the process whereby management support systems are de-concentrated so that national government is relieved of a variety of repetitive tasks and functions which can be more effectively accomplished at the local levels where those tasks and functions are occurring”, (Ministry of Health and Social Welfare [MOHSW], 2008:1). When Decentralization takes place, it gives the central government or institution time to concentrate more on policy formulations, carry out strategic planning, mobilize resources that will facilitate implementations, conduct effective monitoring and evaluations of policy implementations and ensure coordination between the county government and its citizens, (MOHSW, 2012).

The United Nations Habitat Agenda (1996) recognizes the fact that in order for any country to obtain successful human settlements development, it should be done through an effective decentralization of management, policy, responsibilities, decision making authority and allocation of sufficient resources inclusive of revenue collection authorities to the local authorities who are believed to be closest to the people and also representatives of constituencies.

The trend towards the development of elected forms of local government that do not just have vertical accountability, but also whose public service delivery role and direct accountability to its citizens are effective has become a global issue. Akpan, (2007) presumes that lower levels of government, for example, a local government, is better placed at perceiving the desires and demands of its constituents for public services than a distant centralized government.

Liberia being a developing country has had the administration and governance of the country controlled by institutions and structures through a centralized process, as far as its history is concerned. This kind of system hindered the participation of the local government in helping in the formulation and implementation of policies that will meet the needs of the vulnerable population. It also led to the gaps in equal access in the provision of public goods and services throughout the country, (Governance Commission, 2010).

The war which ended after fourteen years in 2003, left a lot of destruction and social problems behind. The Governance Commission (2010) reports some of the social problems to include poverty, rape, high levels of alcohol and drug abuse among youth, neglect of children, and teenage prostitution and pregnancy. According to the National Health and Social Welfare Policy, (2011), 63% of the population lives in poverty and 48% lives in absolute poverty. The Essential Package of Social Services, [EPSS], (2012), estimates that 9,640 homes are headed by children; 42,640 children are involved in child labor, 719 cases of substance abuse reported at health facilities; 4,300 children placed in orphanages; 5% of the total population in Liberia form the elderly of which 7,001 are heads of homes. The emergence of these and other problems led to the formulation of the National Social Welfare Policy in 2008 which was revised in 2011.

According to the Liberia National Policy on Decentralization and Local Governance (2010), the absence of decentralization has slowed the overall economic growth and development and democratization processes. This has effectively led to underinvestment in human resources and human wellbeing throughout the country. The Government of Liberia, thus, realized that there was a need for the Liberian people themselves to participate in any process of development that will yield equal distribution of public goods and services. This can be achieved through the promotion of the use of the country resources and international contributions. This realization by the Government of Liberia through the administration of President Ellen Johnson-Sirleaf, deemed it necessary to formulate the National Policy of Decentralization and Local Governance, with the intent to share political, administrative and fiscal powers with the county authorities in the fifteen counties. Five governmental institutions were named as the first agencies to initiate the decentralization processes, amongst which was the Ministry of Health and Social Welfare.

The Ministry of Health and Social Welfare is divided into two main service delivery departments namely: the Department of Health Services and the Department of Social Welfare. They both benefit from the functions of the Department of Administration and the Department of Planning, Research and Development. While it is true that the Ministry emphasizes decentralization, the Department of Social Welfare is yet to decentralize its services as compared to the Department of Health. Through observation, it is seen that the Department of Health has advanced in terms of human resources, funding and logistics as compared to the Department of Social Welfare. The Department of Health is found to be functioning in all fifteen counties through its County Health and Social Welfare Teams, which is the decentralized administrative branch. On these Teams, there is one slot allocated for the Department of Social Welfare occupied by the Social Welfare Supervisor. The Social Welfare Supervisor presently is responsible to carry out all functions of

the Department. The Department of Health on the other hand has over twenty-one staff on each of the fifteen County Health and Social Welfare Teams excluding staff assigned to facilities and communities, with specific functions.

Looking at the situation in Liberia, the Department of Health has attracted much attention as compared to the Department of Social Welfare. Interestingly, the Ministry is called, The Ministry of Health and Social Welfare, but both have separate policies and plans. The Department of Health has decentralized its services unlike the Department of Social Welfare which is yet to decentralize its services. The budget of both Departments of Health (Preventive and Curative Services) and Social Welfare from 2009/2010 to 2013/2014 are stipulated below in United States Dollars, (National Health Budget, 2013/2014).

Table 1.1: National Health Draft Budget, 2013/2014

Department	Years and Amount			
	2009/2010	2010/2011	2011/2012	2012/2013
Health	\$11,260,891	\$23,034,717	\$32,281,119	\$48,351,281
Social Welfare	\$703,717	\$682,901	\$948,690	\$936,819

Source: MOHSW, 2012

In the case of human resources, the Department of Health has many staff ranging from medical doctors to community health volunteers and the Department of Social Welfare has staff with limited qualifications and also insufficient staff. Logistically, the Department of Health has many vehicles to help in its service delivery unlike the Department of Social Welfare that barely has three.

Decentralization of services and sustainability of development are important in addressing the issues of rebuilding and governing in a country like Liberia which has gone through a devastating fourteen years of civil war. The civil war left behind poverty, destruction of infrastructure and huge social problems. According to the Liberia National Policy on Decentralization and Local Governance, (2010), centralization limits the functions of the local authorities, thus creating an environment wherein they have to depend wholly and solely on central government for both policy formation and the implementations,

1.2 Statement of the Problem

At this stage of development in Liberia, decentralization has become a priority for all government ministries and agencies. The National Decentralization Policy of Liberia was formulated in 2009, highlighting Ministry of Health and Social Welfare as one of the first Ministries to decentralize its service delivery. Up to date, the Department of Health has been able to establish offices in each of the fifteen counties, has community staff carrying out community outreach to the people, health facilities being built in catchment areas so as to improve access to these services, and other activities. The Social Welfare on the other hand has just formulated its decentralization services in the document called the Essential Package of Social Services in 2012, but it still has not decentralized.

The Health and Social Welfare Departments have the mandates to provide health care and social services to the vulnerable population within the Republic of Liberia. Up to present, the services and operations of the Department of Health are decentralized while the Social Welfare Department services and operations are still centralized. The Department of Health has the Bureau of Curative Services, responsible for the supervision of county health care delivery services in communities and at health facilities. The Bureau of Preventive Services, also under

the Department of Health, has the oversight responsibilities to oversee national programs associated with the prevention and control of diseases. Under the Bureau of Preventive, there are programs like:

- 1) Expanded Program on Immunization, (EPI);
- 2) National Health Promotion Unit;
- 3) National Malaria Control Program, (NMCP);
- 4) National Diagnostic Division;
- 5) National Leprosy and Tuberculosis Control Program, (NLTCP);
- 6) National AIDS and STIs Control Program, (NACP);
- 7) Division of Mental Health;
- 8) Environmental and Occupational Health;
- 9) Community Health Services;
- 10) Emergency Response Program;
- 11) Neglected Tropical Diseases;
- 12) Eye Care Program;
- 13) Pharmacy Division,
- 14) Program Coordinating Unit and
- 15) Epidemiology

SOURCE: MOHSW Organizational Chart, 2007

These units are some of the subdivisions of the Bureau of Preventive Services. The Social Welfare Department has six divisions that are responsible for its service provisions. The Divisions are:

- 1) The Family Welfare Division;
- 2) The Rehabilitation Division;

- 3) The Community Welfare Division;
- 4) The Aging Division;
- 5) The Juvenile Division and
- 6) The Training Division.

It also has two programs that are sponsored by United Nations organizations which are the Psychosocial and Community Support Program and the De-institutionalization Plan Program.

There is a need to understand the decentralization strategies used by the Department of Health to meet its service delivery. It is also necessary to identify the gaps and constraints within the Social Welfare Department that is causing delays in its decentralization policy implementations. It is also important to identify a point of collaboration and coordination between the Health and Social Welfare Departments along with other implementing partners to improve service delivery in Liberia.

1.3 Research Questions

The above problem was examined with the hope of addressing the following research questions:

1. How does decentralization promote service delivery?
2. Why do some state institutions decentralize earlier than others?
3. How can the Departments of Health and Social Welfare collaborate and coordinate to improve service delivery

1.4 Objectives of the Study

The research specifically aimed at addressing the following objectives:

1. To describe how decentralization can promote service delivery at the local level
2. To identify the reasons for some state institutions being decentralized earlier than others

3. To identify areas of collaboration and coordination between the Departments of Health and Social Welfare in the provision of services

1.4 Significance of the Study

This research looked at how the Republic of Liberia can have an effective decentralized health and social welfare system that will help in alleviating some of its social problems left behind by the civil war. It also intends to identify the point at which the Departments of Health and Social Welfare can collaborate their services for the best interest of its population. The inability of the Social Welfare to reach the vulnerable population in the fifteen counties has the tendency to increase the rates of social problems within the country, thus having an unhealthy country. The findings from this research will add to the stock of knowledge on decentralization and service delivery specifically taking into account the importance of the level of collaboration and coordination between the Departments of Health and Social Welfare. This study also gives strength to the definition of health by the Constitution of World Health Organization (2006) emphasizing that health is not only the absence of diseases but also the state where one has physical, mental and social wellbeing. In most cases the Social Welfare Department is ignored by politicians not taking into consideration that when the social issues are handled, it has the tendency to improve economic growth and sustainable development. This study has intend to inform and influence policy makers of the importance of social welfare service provision to the nation. It will also help non-governmental organizations and community-based organizations focus on the total wellbeing of the vulnerable population. This study will also provide knowledge to other countries in helping to strengthen their health and social welfare services to meet the wellbeing of the population for a sustainable development.

1.5 Theoretical Framework

The Sequential Theory of Decentralization propounded by Tulia Falleti (2004) is used as the guiding framework to negotiate the curves in conducting this study. According Falleti (2004) the concept of decentralization is a set of state reforms which involves exclusively only state actors from the central government to the lowest government agencies at the grassroots. Falleti argues that the sequencing of different types of decentralization-fiscal, administrative, and political- is a key determinant of the evolution of intergovernmental balance of power.

Falleti (2004) espouses administrative decentralization as comprising the set of policies that transfer the administration and delivery of social services such as education, health, social welfare, or housing to subnational governments. This type decentralization entails the delegation of decision-making authority over government policies (The World Bank, 2001).

On the other hand, Falleti (2004) characterizes fiscal decentralization as referring to the set of policies designed to increase the revenues or fiscal autonomy of subnational governments. She further opines that fiscal decentralization policies can assume different institutional forms and may include an increase of transfers from the central government, the creation of new subnational taxes, and the delegation of tax authority that was previously national. This is aimed at increasing the financial capacity of the lower authorities to enhance their service delivery.

The final type of decentralization according to Falleti (2004) is political decentralization. She defines this type as the set of constitutional amendments and electoral reforms designed to open new or activate existing but dormant or ineffective spaces for the representation of subnational polities. She acknowledges also that political decentralization policies are also designed to transfer electoral capacities to subnational actors. She cites the popular election of mayors and

governors who otherwise were appointed as the creation of subnational legislative assemblies or constitutional reforms that strengthen the political autonomy of subnational governments.

The center of Falleti (2004) argument is the flow among the types of decentralization. She argues that administrative decentralization should have either a positive or negative impact on the autonomy of subnational executives. In her opinion, administrative decentralization improves local and state bureaucracies, foster training of local officials or facilitates learning through the practice of delivering new responsibilities. She further argues that administrative decentralization will likely increase the organizational capacities of subnational governments. However, she acknowledges that if administrative decentralization takes place without the transfer of funds, this reform may decrease the autonomy of subnational officials, who will be more dependent on subsequent national fiscal transfers or subnational debt for delivery of public social services. On another hand, fiscal decentralization can have either a positive or negative degree of autonomy of the subnational level.

Falleti (2004) opines that where there are higher levels of automatic transfer of fiscal resources due to fiscal decentralization, there is an increase in the autonomy of subnational officials. This she argues is because the subnational official will benefit from higher levels of resources without being responsible for the political and bureaucratic costs of collecting those revenues. It is also espoused by the author that should taxing authority be delegated by the central government to subnational units that lack the administrative capacity to collect new taxes, this can set serious constraints on the local budgets and increase the dependence of the local transfers from the central government.

In furthering the discourse, Falleti (2004) posits that when it comes to decentralization, both the national and subnational executives have their territorial interests that they strive to protect beside their partisan interests. She posits that territorial interests are defined by the level of government either by the national, state, or municipal and the characteristics of the territorial unit. Such characteristics may include, whether the provinces is rich or poor, big city or small town. In this regard, Falleti indicates that in most cases, the national executives would prefer administrative decentralization to fiscal decentralization and that fiscal decentralization is in turn preferred to political decentralization. In other words, Falleti implied that should the central government be forced to choose between surrendering fiscal or political authority, it will choose to give away fiscal authority and to retain political control, which may serve to influence the expenditure decisions made by subnational officials. From the angle of subnational executives, Falleti (2004) indicates that they will prefer first and foremost, political decentralization then fiscal decentralization and then administrative decentralization. In other words, subnational executives would prefer political autonomy, money and responsibility in that order.

Sequentially therefore, Falleti (2004) shows that the level of government whose territorial interests prevail at the outset of the decentralization process will likely dictate the first type of decentralization that is pursued. This she indicates will in turn, produce policy feedback effects that account for the order and characteristics of the reforms that will eventually follow. Therefore, in negotiations where subnational interests prevail in the first round, the most likely sequence will be political decentralization which will enhance the power and capacities of subnational actors for the next rounds of reforms: fiscal and administrative. However, if national interests prevail at the beginning of the decentralization process, administrative decentralization

will likely occur first, then fiscal decentralization and perhaps political decentralization, (Falleti, 2004).

Besides the competing interests that tend to dictate the flow of decentralization according to Falleti (2004), Garman, Haggard and Willis (2001) argues that the structure of the political party rather than the interest can dictate the flow of decentralization. The authors opine that where political parties are centralized, intergovernmental fiscal relations will tend to favor the center and thus, the fiscal structure of the state will be centralized. On the other hand, Garman et al (2001) indicate that in event that the party derives its strengths from regions, they will favor decentralization in order to retain power.

Juxtaposing the situation of decentralization in the Ministry of Health and Social Welfare to the theory of decentralization, it is clear that the Department has more or less attained administrative and fiscal decentralization, which are the only type that can be attained per the structure of the Liberian governance system which is a unitary state. There are adequate office structures at the local levels and budget is substantial to meet a greater extent of the needs of the department. However, when it comes to the situation of the Department of Social Welfare, despite the policy provision and the recognition on paper that the Department has been decentralized, the real situation is a far cry of decentralization. The operations of the Department are largely been run from the National Head Office with only a single officer assigned to an entire country. There are no regional officers and budgetary allocations are woefully inadequate. This has a great extent disabled the Department to from performing effectively.

This study will use the Sequential Theory of Decentralization to ascertain the reasons for which decentralization has taken place in the Department of Health whereas true decentralization has yet to take place in the Department of Social Welfare despite policy provisions in that regard.

1.6. Organization of the study

The study is organized into five chapters. Chapter one of the study introduces the study. It outlines the introductory background to the study, the statement of the problem, the aims and objectives of the study, the significance of the study, the theoretical framework and the definition of key concepts. The second chapter is devoted to a review of relevant literature. The third Chapter is a presentation of the research methodology employed in the conduct of the study. The fourth chapter on the other hand comprises the presentation of the findings and discussions. Chapter five is the final chapter of the study and entails the summary of findings, conclusion and recommendations of the study.

CHAPTER TWO

Literature Review

2.0 Introduction

This chapter of the study focuses on the review of relevant literature. The review is conducted under themes which have been formulated in line with the objectives of the study and in a bid to seek answers to questions that have been raised by the study. The review begins by looking at the concept of decentralization, its challenges and solutions. This is followed by a consideration of decentralization as implemented in various countries across the world with special emphasis on developing countries. There is then a review of literature on decentralization on health care and social welfare service delivery in Liberia. The chapter ends with a conclusion by the researcher.

2.1 Conceptualizing Decentralization

Even though decentralization is not a new concept, having been used since the 1950s (European Commission, 2007); According to Crawford (2004), it has become an increasingly widespread and significant dimension of political and administrative reform in many developing countries. The coming into prominence of the concept according to Crawford (2004) began in the late 1980s and has been strongly supported by a variety of actors ranging from international development agencies through national governments to non-governmental and grassroots organizations.

Decentralization is invariably defined by various authorities. Though the definitions vary, at the core of the concept is devolution of power from the center to the local levels. The World Bank (2001) characterized decentralization as a complex multifaceted concept embracing a variety of perceptions which must be carefully analyzed in any particular country before determining if projects or programs should support reorganization of financial, administrative, or service

delivery systems. The World Bank (2001) defines the concept as “the transfer of authority and responsibility for public functions from central government to intermediate and local government or quasi-independent government organizations and/or the private sector”. On the other hand, the UNDP (2004) defines the concept of decentralization as a restructuring of authority so that there is a system of co-responsibility between institutions of governance at the central, regional and local levels according to the principle of subsidiarity. This definition by UNDP connotes a sharing of power between the central government and the local authority which otherwise was a preserve of the central government. This diverts slightly from the World Bank’s definition which seems to suggest an outright transfer of power from the central to the local government. The UNDP (2004) espouses that based on the principle of decentralization functions or tasks are transferred to the lowest institutional or social level that has the potential of completing them. The French Corporation (2009) characterizes decentralization as being part of democratic governance which is intended to give local authorities their own resources and responsibilities separate from those of central government. The French Corporation concurred that the concept of decentralization relates to the role of and the relationship between central and subnational institutions, whether they are public, private or civic. This definition by the French Corporation (2009) corroborates the earlier definitions by the World Bank (2001) and the UNDP (2004) because it does not only indicates a transfer of power from central government to the local government, but it indicates a continuous relationship between the central and the local governments.

The above definitions of the concept of decentralization can be summarized as any act in which a central government formally relinquishes powers to actors and institutions at lower levels in a

political-administrative and territorial hierarchy (Mawhood 1983; Smith 1985, as cited by Ribot 2001)

2.2 Types of Decentralization

Generally, there are three types of decentralization, which are fiscal, political and administrative decentralization (Falleti, 2004; Scott, 2009; World Bank, 2001). Fiscal decentralization entails the transfer of financial resources in the form of grants and tax-raising powers to the sub-national units or local governments (Scott, 2009; World Bank, 2001). This kind of decentralization gives the local level authorities autonomy to appropriate the resources in manners deemed necessary.

On the other hand, administrative decentralization, which may be sometimes be referred to as de-concentration, connotes a situation where the functions performed by the central government are transferred to geographically distinct administrative units (European Commission, 2007; French Corporation, 2009; Scott, 2009; World Bank, 2001). The European Commission (2007) indicates that this type of decentralization seeks to transfer decision-making authority, resources and responsibilities for the delivery of a select number of public services or functions from the central government to other levels of government, agencies or field offices of central government line agencies.

Shah and Thompson (2004) concurs with the definition of administrative decentralization but also simplifies it by stating that an effective administrative decentralization requires lack of any ex ante controls over the decision to hire, fire and set terms of employment of local staff. To improve tax collection or the delivery of local public services, local government should have the freedom to contract own taxing and spending responsibilities. Furthermore, local governments should have the authority to pass bylaws in their spheres of responsibility without having to

obtain prior clearance from the higher level government. The European Commission explains that administrative decentralization has three possible variants which come with different characteristics. These variants include de-concentration, delegation and divestment. De-concentration refers to “a process in public administration in which a field office or official or a central department or ministry acquires some degree of delegated authority to make decisions or otherwise regulate operations” (European Commission, 2007, p.17).

Delegation on the other hand is said to refer to a more extensive form of administrative decentralization and involves a redistribution of authority and responsibility to local units of government or agencies that are not always necessarily branches or local offices of the delegating authority (European Commission, 2007). The final variant of administrative decentralization is divestment which the European Commission posits is a finance term but has been co-opted into the field of public administration. According to the European Commission (2007), divestment “occurs when planning and administrative responsibility or other public functions are transferred from government to voluntary, private or non-governmental institutions” (p.17).

Political decentralization is the third type of decentralization and refers to the situation where powers and responsibilities are devolved to elected local governments (Scott, 2009; World Bank, 2001). The European Commission (2007) corroborates the definition of political decentralization by Scott and World Bank and further explains that political decentralization normally involves a partial transfer of power and authority with the central government reserving greater amount of power and control.

On outlining differences between administrative and political decentralization is the fact that the former involves a transfer of responsibility to units which are extensions of the central government, who are usually non-government, who are usually non-elected (European Commission, 2007; French Corporation 2009). On the other hand, political decentralization involves the transfer of power and responsibilities to local authorities who are elected by the people (European commission, 2007; French Corporation, 2009; World Bank, 2001).

Although, it is widely accepted that there are three types of decentralization, there are a few instances of divergence. The French Corporation (2009) in its clarification of decentralization, presents the original three, fiscal, administrative and political decentralization, but goes to add a fourth, divestment. This is in sharp contrast to the views of the European Commission (2007) who indicates divestment as a variant of administrative decentralization. Therefore, according to the French Corporation, there are four types of decentralization: fiscal, administrative, political and divestment which involves the devolution of public functions to voluntary, private or non-governmental institutions. Another diverging view on the types of decentralization is presented by Ribot (2001). Though not explicit in rejecting fiscal decentralization as a type of decentralization on its own, Ribot argues for the existence of two independent types of decentralization-administrative and political decentralization.

2.3 Challenges of Decentralization

Decentralization despite the fact that it has certain repercussions has generally been touted as presenting very important impetus for development at the local level. However, implementing decentralization is often bedeviled with several challenges. Among the major challenges to decentralization according to Scott (2009) include constraints in performance and accountability of local governments. Such constraints according to Scott are occasioned by limited resources,

weak institutional capacity, inadequate mechanisms of accounting and accountability and limited availability of information.

Devas (2005) and Scott (2009) opines that Decentralization may be detrimental to a local authority that is characterized by extreme constraints such as too few staff, inexperienced personnel and/or inadequate financial resources (Devas, 2005; Scott, 2009). The economic development at the local level according to Devas (2005) is dependent on the efficient and reliable service provision and these in turn are very much dependent on the right and adequate number of personnel as well as the availability of financial and logistical support. In the event that there is decentralization in a local area that is not effectively equipped with such human and logistical resources, decentralization may become a bane to the progress of such an authority. Devas (2005) opines that local governments in most countries have limited local taxing powers from which to finance the services assigned to them. As a result, service level falls short of what is required. Local revenues are often limited to a few visible taxes that are difficult and expensive to collect, inequitable in impact, and economically distorting.

As indicated by Falleti (2004), in the ideal situation, the preference of central governments in decentralization is to first ensure fiscal decentralization. However, fiscal decentralization has great implications for tax increases and so Devas (2005) concurs with Fjeldstad (2001) that increased local revenue mobilization often involves coercive extraction from the poor. Therefore, considering the importance of financial and its related resources to the decentralization process, it is apparent that limited resources serves as a significant barrier to decentralization. In situations where countries have to defy the odds to decentralize, Scott (2009) posits that local governments often have to operate in environment characterized by very severe resource

constraints. In the end, therefore, the purpose of decentralization- improvement in the quality of life at the local level-is greatly thwarted because life becomes more unbearable for the people.

The European Commission (2007) indicates that decentralization may be too costly a process for most countries with smaller economies and has a potential of bringing about fiscal indiscipline. This may lead to elite capture (Bardhan, 2004). Bardhan accepts that local government may have better local information and accountability but they are highly vulnerable to being captured by the local level elites which in turn, negatively influences local level development as decisions tend to be made in favor of the elites and not the local populace.

Devas (2005) adds that local government activities that could benefit economic development, such as planning, regulation and business licensing, become ineffective in protecting the public interest and are exploited as rent-seeking activities due to elite capture. Elite capture is closely related to weak structures at the local levels especially in regard of inexperienced personnel, and inadequate funds. These allow for the elites to influence the structures of the local level in their favor. Information plays a serious role in decentralization and may be serious hindrance to decentralization. Scott (2009) espouses that information irregularities makes it difficult for central officials to actually be informed of the true state of affairs at the local level. This according to Scott (2009) stems from the tendency for local officials to conceal the true picture in their bid to remain in the good books of the central authorities.

Devas (2005) further indicates that decentralization without good road networks and utilities such as electricity and water supply hinders local level development. This by implication means that once the local level is decentralized, especially with fiscal decentralization, transport becomes key to the local level's ability to generate revenues for development. The same applies

for electricity and water supply as these are very useful for small and medium level industrial development.

In extending the discourse on decentralization, the European Commission (2007) indicates that decentralization has the potential to lead to a clash between different sources of power and legitimacies. This is possible as many local level outfits scramble to find their places and fits. This demands lots of tact and the scrambles may escalate into deep rooted internal conflicts among local authorities and agencies and create various layers of inefficiencies and strife development (European Commission, 2007). In response to the effect that decentralization can be implemented as a response to potential or actual regional conflict (Aspinall et al, 2003), Devas (2005) indicates that decentralization can actually serve as a catalyst to conflict and to reducing social cohesion. Devas argues that decentralization can heighten the differences between regions and can easily leads to situations where local leaders are elected along ethnic lines and continue to mobilize ethnic identities to consolidate power. This creates the situation where resources tend to be channeled towards one area of the decentralized area to the neglect of others and stands to worsen the poverty or underdevelopment of the regions or local areas.

According to the White Paper for Social Welfare (1997) it stated that internationally, the strategy that has proven most effective in improving economic and social well-being consists of three elements: labor-absorbing growth, equitable investments in education, health care and social support for poor and vulnerable groups. It further opines that when social welfare services are spread out to other agencies, the result is fragmentation, duplication, inefficiency and ineffectiveness as it relates to meeting the needs of the vulnerable, as each agency, organization, etc. have their own procedures, styles of work, approaches and priorities. Stange (2009) supports

White Paper for Social Welfare (1997) concerning fragmentation by stating that it is at the heart of the ineffectiveness of our increasingly frantic efforts to nurture improvement.

2.4 Combating the Challenges of Decentralization

Despite the enormous challenges that confront decentralization efforts, there have been quite a number of suggestions to avert such challenges. World Bank (2001) indicates that in most instances, successful decentralization is related closely to four key governance principles, including the assignment of clear financial functions, insuring informed decision making, adherence to local priorities, and prioritizing accountability. Despite such theoretical prescriptions by the World Bank, the global financial institution recognizes that in practice, applying the named principles have not proven to be simple. The difficulties the World Bank indicates are as a result of the fact that circumstances differ from country to country and therefore suggests that for decentralization to be successful, policies and institutional instruments should be crafted to the specific conditions of individual countries (World Bank, 2001).

Widespread corruption has been associated with the challenges of decentralization and Devas (2005) posits that international experience suggests that central governments can always help to put the local governments on track by instituting reforms to accounting systems to simplify accounts and make them more transparent. As important revenue generation is to decentralization, one of the most pragmatic way to overcoming the challenges of decentralization is the improvement in methods of collecting revenue. In this regard, Devas (2005) suggest that central governments should support the computerization of revenue collection and accounting systems, with appropriate safeguards, so that these can facilitate cross-checking and therefore reduce opportunities for individual discretion and manipulation.

On another hand, Dehn et al, (2002) suggest that to ensure that local authorities manage funds effectively and for that matter, the success of decentralization, central government should require the publication and display of information about resources for particular facilities, services or projects. The authors further suggest that central governments should always require the submission of photographic records of project implementations.

Devas (2005) suggests that there must be clear rules about public procurement, and the specification of codes of conduct for all officials at the local levels. Devas further suggests that at all points in time, government representative should be elected and proper arrangements be made for all elected representative to declare their assets (Devas, 2005) in order to ensure accountability and to prevent incidents of corruption. This will effectively allow for the resources to reach the populace at the local level.

Another way to combat the issue of fragmentation is through integration of care system and services which according to Kodner and Spreeuwenberg (2002) are the fulfilment of system aims in which it necessitates co-operation and collaboration among and between the various parts of the organization or system in which, integration is the “glue” that bonds the entity together, thus enabling it to achieve common goals and optimal results. Collaboration of services as espoused by Sandford and Milward (2007) has benefits especially as more complex, multidimensional problems appear in the public arena, additional knowledge, further tools, and more refined services need to be mobilized. They elaborated further that collaboration offers the promise of accessing more resources and sharing the risks associated with finding a solution to them. This also gave policymakers the argument that such partnerships increase efficiency and allow citizens to receive seamless services. Additionally, there are potential synergies that come from

collaboration that can create opportunities for learning and organizational improvement (Sandford and Milward, 2007).

Taking into consideration that Social welfare is an integrated and comprehensive system of social services, facilities, program and social security to promote social development, social justice and the social functioning of people and that it can bring about sustainable improvements in the well-being of individuals, families and communities when linked to other social service systems such as health, nutrition, education, housing, employment, recreation, rural and urban development and land reform through which people's needs are met, and through which people strive to achieve their aspirations (White Paper for Social Welfare, 1997) emphasizes the importance of coordination and collaboration in order to achieve better service delivery.

2.5 Decentralization in Different Countries

Decentralization is a global phenomenon that has been implemented across the world. In Africa, decentralization is implemented in various forms of governments across the continent. From the political perspective, Okojie (2009) is of the opinion that decentralization is a key strategy for promoting good governance, interpreted as greater pluralism, accountability, transparency, citizen participation and development. Since decentralization enhances the citizens' ability to monitor local officials, there are possibilities of improved transparency and reduction in corruption and an overall improvement in local governance. Notable countries on the continent that have implemented the concept of decentralization include but are not limited to Ethiopia, South Africa, Uganda, Namibia, Nigeria and Ghana (Crawford, 2004). The concept has also gained prominence in recent times in some countries such as Hungary and Slovakia that used to lean towards communist practices (Dethier, 2000). There are also cases of extensive decentralization in Western European countries including France, Belgium, Spain, and Italy.

Asia, Sri Lanka and Philippines are among classical cases of decentralization that is worth mentioning (Dethier, 2000).

Decentralization in almost all countries has been in response to one or the other need to address developmental or political gaps. Aspinall et al, (2003) posit that in some parts of the world, the process of decentralization was predominantly in response to either actual or potential regional conflicts. The researchers cite the case of Indonesia, Russia, Nigeria, Ethiopia, Sudan, Sri Lanka and Philippines, among other joule. In the cases of most Eastern European countries as defined by Coulson (1995), decentralization was in response to persistent demand from the local level for local democratic control and autonomy. Coulson opines that the pressure from decentralization was because central government had failed to deliver to the satisfaction of their citizenries. In the same vein, Menocal (2004) corroborates that there were similar pressure for decentralization in several countries in Latin America and to some extent, some countries in Western Europe such as France, Belgium, Spain and Italy. However, Devas (2005) expresses the opinion that these pressures might have been the result of the activities of certain local elites who professed political opportunities for themselves.

In most, if not all instances where countries have charted the path of decentralization, there have often been the establishment of local level governments, officials of whom are in most instances elected (Steiner, 2006). Across the cases, the most important challenges have often been the matter of fiscal decentralization where local government have often not been able to fiscally sustain themselves and thus, have to rely on the central government to meet a very significant portions of their budgets. For example, Dethier (2000) indicates that in Hungary, 20 percent of public sector expenditures and 35 percent of public sector investment by the central government

has often gone into financing local governments. This Dethier posits is notwithstanding local governments' inability to raise the requisite revenues to ensure their fiscal and economic sustainability. Uganda faces similar situation as Steiner (2006) extends that the central government transfers an approximation of 30 percent of its total budget to local governments as intergovernmental grants. There is also a transfer of about 27 percent of the total public expenditures by central government to local administration in Uganda spend at the local level. Most local governments therefore depend heavily on direct transfers from central government to ensure that they are able to provide the needed service to the people (Steiner, 2006).

In Ghana for instance, the District Assemblies Common Fund is a measure to ensure that funds are made available for the administrative and developmental needs of the very district governments (Crawford, 2004). In the case of Ghana however, Crawford acknowledges that local government are not completely dependent on central government and do themselves have some revenue-raising powers. Nkrumah (2000) corroborates the foregoing assertion by Crawford but adds that the financial position of the local government could have been strong but for the fact that the central government reserves the lucrative tax fields for the center. Dethier (2000) complains that in the case of Hungary and Slovakia, there have been issues with major expenditure management and public accountability despite the specification of expenditure assignments and accountability rules in intergovernmental affairs by legislature.

Despite the inability of most local governments to meet their fiscal targets, the World Bank (1999) indicates that those local governments which met their fiscal target were faced with inefficiencies in the delivery of public services and of strains in local finances. The global financial institution indicates that there were still systemic imbalances in the intergovernmental finance structure and expenditure and revenue assignments were not well matched. The World

Bank attributed the challenges of the system of transfers from the central to the local governments which it indicates created inappropriate incentives, which led many local governments to claim additional deficit grants to manage financial difficulties.

Local governments have not always been wholeheartedly accepted by all in countries where decentralization has been implemented. There have been intentional and unintentional bottlenecks that have been placed in the way of decentralization in many countries. In Uganda, Steiner (2006) espouses that local councils were originally established for political reasons and not for the aim of improving service delivery or reducing poverty. Steiner indicates that with the change in objectives from political to social service delivery, a fertile ground was provided for resistance to decentralization in the country. Such resistance came from within the administrative structures of line ministries (Steiner, 2006). Steiner indicates that the reason was as a result of the requirement of such ministries to relinquish part of their discretions to the benefits of the local governments. The Ministry of Local Government (MoLG) of Uganda (2004) has indicated that there has been evidence in the Ugandan government set up to the effects that the line ministries have retained a lot of power over local policies. It has therefore been proposed to be re-defined. The Ugandan situation indicates a classic case of structural and administrative conflict and so the Ministry of Local Government (2004) calls for a re-definition of the role of the ministries as a cross-cutting one, thereby enabling it to spearhead the decentralization process (MoLG, Uganda, 2004).

Ghana's case has also seen its fair share of opposition as Crawford (2004) indicates that country's decentralization programs are implemented by three state institutions: the Ministry of Local Government and Rural Development, the National Development Planning Commission, and the Office of the Administrator of the District Assemblies Common Fund which is attached

to the office of the President. The first point of contention in the Ghanaian situation is the matter of which the three parallel agencies of government should be the lead agencies for the decentralization process. Even though, Crawford acknowledges that the Ministry of Local Government and Rural Development was touted as a lead agency, he equally acknowledges that there are disagreement from various sources to this claim. The USAID (2003) on its part also indicates that some central government departments have been perceived as resisting the decentralization process for various reasons. Crawford (2004) indicates that in Ghana, it is evident that the autonomy of local government is compromised and undermined in a number of ways, indicating that central government control remains very real. There are elected members to the structure of the local government but Crawford maintains that the central government continues to appoint persons as its representative at the local government level leading to tensions among elected and appointed members of the district assemblies. The ultimate implication of this is a negative effect on service delivery at the grassroots. Ahmed et al (2005) cite evidence from India to the effect that transfers from the center to the local governments are formula-driven but the central government has often influenced the transfer process.

In some countries also, experts are of the view that decentralization has been seen as a way of reconstructing countries that have experienced the destruction of infrastructural and social structures. Crook (2003) opines that in countries like Uganda and Sierra Leone, the concept was introduced to reconstruct the country through a bottom up approach. Crook also give an example of South Africa case after the apartheid as an instance where decentralization was employed as a mechanism for reconstruction.

The overall impression of the discussions by various studies on decentralization has been, the concept is good for several reasons but as far as various countries which have adopted the

concept are concerned, decentralization has tended not to have achieved the purpose of its introduction. In the Ghanaian situation for instance, Crawford (2004) concludes that, “decentralization has not succeeded in entrust[ing] downwardly accountable representative actors with significant domains of discretionary power” (p.3).

2.6 Decentralization and Service Delivery

Akpan (2007) opines that decentralization may result in better service delivery. He also stressed that the decentralization of the provision of social services such as education, health, water and sanitation may improve service delivery. Ahmed, Devarajan, Khemani and Shah (2005) also corroborates with Akpan that a country can have a successful and sustainable service delivery if the government intervenes and provide the necessary resources and technical assistance to lower-tier governments. (Republic of Rwanda, 2006) emphasizes that a sound intergovernmental system is grounded on a clear definition of spending and revenue responsibilities between each level of government. Failing to clarify assigned responsibilities will surely result in inefficiency and instability of service delivery.

Darmawan (2008) opines also that decentralization and service delivery can be achieved if financial resource autonomy is given to local authorities and later intergovernmental transfers and grants are established to address some specific problems such as fiscal gap or vertical imbalance between expenditure and revenue at sub-national government level. Furthermore, the transfers are important to correct fiscal inequality among the sub-national governments, improve the fiscal efficiency across jurisdictions, overcome spill overs and establish fiscal harmonization.

2.7 Decentralization, Health Care and Social Welfare Service Delivery in Liberia

The Liberian governance and public administration has since the country's independence in 1847 remained highly centralized in the country's capital, Monrovia (Governance Commission, 2010). Thus, the governance and public administration of Liberia had been controlled largely by institutions and structures of the central state. This situation according to the Governance Commission indicates that it did not allow adequate legal opportunities for the establishment of a system of participatory local governance.

Further, the Governance Commission espouses that the centralized nature of the governance and public administrative structures of the country had impeded popular participation and local initiatives, especially in regards to the provision of public goods and services. The consequent effects of this system as hinted by the Governance Commission include potential gaps in economic growth and development, equal access to social and economic opportunities and human wellbeing between the center, Monrovia, and the rest of the country. Ultimately, the Governance Commission laments that the situation had contributed greatly to a slowdown in the country's overall economic growth and development, as well as the democratization processes and underinvestment in human resources and human wellbeing throughout the Republic. Such challenges with a centralized system of governance and administration as gaps in development and service delivery, are factors that informed the formulation and implementation of the decentralization program in Liberia.

One of the Ministries of the Republic of Liberia that was selected as pioneer for the implementation of the decentralization program in the country was the Ministry of Health and Social Welfare. The Essential Package of Health Services (2011) indicates that the Ministry of Health and Social Welfare (MOHSW) has the mandate to reform and manage the health sector to

enable it effectively and efficiently deliver comprehensive, quality health and social welfare services that are equitable, accessible and sustainable for the people of Liberia. The National Health Policy and Plan, (2008-2011) states that the Liberian decentralization program is guided by the Liberian National Decentralization Policy. However, the Ministry of Health and Social Welfare as a pioneer in the decentralization process has formulated its own guiding principles for the successful implementation of the decentralization program and launched the National Health and Social Welfare Decentralization Policy and Strategy. One way that the National Health and Social Welfare Decentralization Policy/Strategy (2011) ensured an effective implementation of decentralization within the Ministry as speculated by its decentralization policy, was to make provision for the appointment of a Director of Decentralization Unit who works within the office of Planning, Research and Development Department

The new National Health and Social Welfare Policy and Plan which covers a ten year span, starting 2011 and ending 2021 entrusts the responsibility of the execution of the Ministry's decentralization program in the hands of the County Health and Social Welfare Teams (CHSWT)-a combined team of health and social welfare personnel. This Team is responsible for the delivery of services to the people of Liberia at the grassroots level. According to the Liberian National Health Policy and Plan (2008-2011), the County Health and Social Welfare Teams was responsible to manage all Ministry-owned facilities, Ministry-employed human resources and Ministry-provided material resources. The National Health Policy and Plan, (2008-2011, p.10) intended that the center will gradually allocate and transfer resources to the county It is expected that the County Health and Social Welfare Teams were to strategize and respond to the local health and social welfare issues within their communities.

2.7.1 Social Welfare Service Delivery in Liberia

The Government of Liberia's Social Welfare Policy (2009) describe social welfare services as the cornerstone of the new Liberian National Social Welfare case delivery strategy. The Department of Social Welfare, under the Ministry of Health and Social Welfare has the mandate to deliver social welfare services in the Republic of Liberia (Ministry of Health and Social Welfare, Essential Package of Social Services, 2011-2021). The Essential Package of Social Services indicates that the Department of Social Welfare is charged with the responsibility to provide "equitable and high quality services targeting persons, families and communities, and strengthen the modalities to enhance the voice of the vulnerable in defining priority needs and influencing the character and content of service delivery" (p.7). However, the National Health Policy and Plan (2007) portrays the Social Welfare Department as fragmented and under resourced, and thus, unable to address the enormous needs of the Liberian population. According to the National Health Policy and Plan, (2007) the result of the fragmentation and the inability of the Department to deliver essential services to the people of Liberia is one of the reasons for major reviews

According to the Essential Package of Social Services, (2011-2021), in order to ensure the effective social welfare service delivery in Liberia, the Department of Social Welfare introduced the Social Welfare Policy in 2011 to provide direction for reforming the Social Welfare Department in line with the principles of the National Decentralization Policy. The objectives of the reforms in the Social Welfare Department focus on improved efficiency and effectiveness among the various actors in the Department, increased accountability and probity, and an enhanced ability to support vulnerable persons. The main aim of the reforms in the Social Welfare Department in particular was to redirect the operations of the Social Welfare

Department “towards a developmental social welfare approach” which would focus specifically on the establishment of a demand-driven, community-focus social welfare response with strengthened institutions capable of delivering quality services (Social Welfare Policy, 2009).

Three key achievements are targeted by the Social Welfare Department with regards to the reform efforts and these include the ability of the Department of Social Welfare to enable a better coordination of social welfare service delivery; the ability of the Department to strengthen the influence of vulnerable groups in decision-making in society; and finally, the ability of the Department to enhance the socio-economic conditions of vulnerable groups in the country (Social Welfare Policy, 2009). Thus, at the heart of the Social Welfare Policy that was formulated in 2009, is a two-point aim of strengthening the Social Welfare Department as well as protecting vulnerable groups. In the long term, however, the Social Welfare Policy aimed at three things: the first being the decentralization of social welfare services and the reinforcement of partnerships to effect the decentralization process; the second, the strengthening of community social capital and family and extended family networks; and finally, the enabling systems and structures that allow the effective and equitable access to social services among the populace who are most vulnerable and in need (Social Welfare Policy, 2009). It is important to note that the policy defines *long term* as any time after 2011. Considering the current study was conducted three years into the anticipated take off of the projected realization of the long term goals of the Department of Social Welfare as spelt out in the Social Welfare Policy, it is expected that much should have been achieved by the Department.

The delivery of social welfare services in Liberia should be organized into four divisions according to the Essential Package of Social Services (2011-2021). The first of the divisions is the Community Welfare Division which entails basic community services, psychosocial support

and services for the elderly. The second is the Family Welfare Division which involves the promotion of family-base care, family reunification, and services for separated or orphaned children, and children in contact with the law. The third division is the Rehabilitation Division which encompasses physical, mental health, and substance abuse support services. The fourth division is the Institutional and Organizational Development Services which include services for the professional development of staff (MOHSW's EPSS 2011-2021, p.8).

There are four tiers of care delivery in the Liberian social service delivery system (EPSS, 2011-2021). These follow the political structure of the country. The first tier is the community level which is the lowest level. This is the level that involves community case workers, community outreach volunteers and trained social service providers. Staff at this level are supposed to work directly with the people and thus, the direct link between the people and the chain of authorities. The second tier is the district level workers who at this level serve as facilitators for case workers at the community level. The social welfare supervisors at this level are responsible for the supervision and monitoring of the community level. County level officers form the third tier officers of the Department of Social Welfare. Officers at this level are supervisors and case managers. They provide supervision for all county social welfare activities and are responsible for the training and retraining of staff of the Department of Social Welfare in their respective counties.

The final tier in the social welfare service delivery in the Republic of Liberia is the national level. This refers to the central administration of the Department of Social Welfare and officers here are senior members of the Department who have the responsibility to ensure that social welfare services are rendered at the community level and it should be done through the county social workers. Officers at this level are responsible for policy formulation and implementation.

They are in charge of developing tools for monitoring and evaluating performance of the staff at the county and other lower levels.

Despite the fact that the Government of Liberia through the Ministry of Health and Social Welfare and for that matter, the Department of Social Welfare has put in place several mechanisms to ensure that social welfare services are delivered to the people as effectively as possible, a myriad of obstacles hinder such realizations. The EPSS, 2011-2021, indicates that a variety of factors have combined to negatively influence interventions, including cultural and geographical factors. The EPSS further indicates that the ability of communities to respond to problems depend largely on the availability of resources and as is characteristic of most developing countries and in the special case of Liberia that is recovering from massive destructions by a fourteen years of civil war, resources are unevenly distributed. This, makes it difficult for welfare officers to implement interventions in especially the most deprived areas of the country. The EPSS indicates that resource constraints in many sectors of the country have prevented institutional transformations to address specific needs of vulnerable populations with specific emphasis on those with disabilities. Furthermore, there is a case of pervasive traditional practices and behaviors, high rates of alcohol and substance abuse, limited community child protection services, minimal disaster intervention services and few community-based intervention programs have combined to count against the delivery of social welfare services in the country.

Irrespective of the above challenges, the EPSS indicates the number of Liberian Government Ministries that have actively supported the Department of Social Welfare to deliver services to the vulnerable to ensure the improvement in their wellbeing. Besides other government agencies that have supported the Department of Social Welfare to deliver welfare services to the people of

Liberia, both local and especially international NGOs have been very instrumental in partnering with the Department of Social Welfare to ensure that essential social welfare services are provided for the people (EPSS, 2011-2021; GoL, Social Welfare Policy, 2009). Abramson (2012) espouses that under the Ministry of Health and Social Welfare Performance-Based Contracting (PBC) Policy, NGOs, both national and international played a crucial role of managing all development-focused contracts.

2.7.2 Health Care Service Delivery in Liberia

The Essential Package of Health Services [EPHS] of the Ministry of Health and Social Welfare, 2011, indicates that the responsibility of ensuring that the Liberian people are healthy and enjoy good quality healthcare is entrusted to the Department of Health Services. Liberia's health services like many other sectors of the economy have been severely disrupted by years of conflict and looting (MOHSW, 2007). Jhpiego (nd), an international NGO in Liberia confirms that the civil war that ended in the country in 2003, left in its wake enormous challenges to rebuild the crippled health care system and provide adequate health services for its people. Jhpiego reiterates that the key among the challenges included weak logistics, transportation and communications systems, as well as insufficient access to care and poor referral networks, particularly in remote rural areas.

The EPHS (2011) indicates maternal health care as one of the priority areas for the MOHSW and Jhpiego (nd) indicates that maternal mortality in Liberia is among the highest in the world and only 40% of the population has access to health services. This calls for frantic and pragmatic efforts at rebuilding the Department through the building of infrastructure, workforce and the utilization of all available services. In this regard, Jhpiego (nd) acknowledges that the efforts so far taken by the Government of Liberia as it opines that within a short period, the MOHSW has

taken bold steps to transition from an emergency relief model of health care to a functioning, decentralized health care system. Jhpiego (nd) acknowledges that there is still a long way to go even though all fifteen counties of the country have begun operational management of health services. It is important to note however that the countries are still operating under the direction and support of the central Ministry of Health and Social Welfare (Jhpiego, nd).

The Government of Liberia's National Health and Social Welfare Policy which was first introduced in 2007, revised in 2011 and billed to span up to 2021, spells out the modalities for the delivery of health care services in Liberia. However, in order to ensure that services reach the lowest level of the Liberian population, and in line with the principles of the National Decentralization program, the EPHS (2011) indicates that the Liberian healthcare sector like the social welfare sector is organized into three levels. The first level is primary is primary level which includes community health care systems. This level is made up of four types of service providers. The first of them is Community Level Services such as set standards for outreach, health promotion and referral services for communities that are more than one hour walk (5km) from the nearest health facility. This activity is the responsibility of the Community Health Volunteers including Household Health Promoters, Trained Traditional Midwives, and general Community Health Volunteers. This category of personnel are responsible for primary health care education at the grassroots level. The second tier within the primary care system is the Primary Health Care Clinic Level 1. This refers to community clinics that operates Out Patient Department services. These clinics are opened eight hours a day from Monday to Friday. This level covers cluster communities that are isolated from major settlement. Such communities usually have a population of up to 3,500. The penultimate tier within the Primary Level health care system is the Primary Health Care Clinic Level 2 which covers catchments that are made up

of populations between 3,500 and 12,000. In addition to providing OPD services eight hours a day from Monday to Friday, PHC Level 2 clinics also provide outreach services to portions of their catchment population outside of a 5km radius. The outreach program constitutes the last but not least of the primary level care and is christened the Integrated Outreach Program (EPHS, 2011).

The next level of health care in Liberia after primary health care is Secondary Care which is referred to as District Level Health Care System. It is the first provider of secondary health care and focuses on maternal and child health care. Secondary health care is the referral point for the community system. This system provides health care services for catchments with populations ranging between 25,000 and 40,000. Facilities that provide services at this level include Health Centers and District Hospitals. County Health System is an advanced health care system in the secondary healthcare system which provides expanded services within the secondary level of care. It consists of county hospitals which are responsible for receiving referrals from the community and district health systems. Such county hospitals provide general surgeries, pediatrics, general medicine, obstetrics and gynecological services and are open twenty-four hours every day. Tertiary Care, that is, the National Health System is the final level. This level consists of two types of hospitals: Regional Hospitals and one National Hospital, John F. Kennedy Medical Center (JFKMC). Regional Hospitals serve a catchment area of three to five counties and receive referrals from County Hospitals. The National Hospital is the final referral point for cases in the country.

Despite such a comprehensive structure of the health care system in the country, the Decentralization Guidelines (2008) empowers county health authorities to manage county health facilities, including county hospitals. The Decentralization Guidelines indicate that proper

administrative structures and management tools would be introduced at county level, to make health authorities truly autonomous. It further iterates that county health authorities would be given responsibility for financial and asset management and personnel, and would be fully accountable to local constituencies, as well as to overseeing public bodies. The Decentralization Guidelines (2008) establishes a County Health Team which is entrusted with the responsibility of management of county health service delivery. The Team is made up of senior staff and general members. Senior staff on the Team include the county health officer, the county health department director, the county hospital medical director, the county health services administrator, the county pharmacist, and the county laboratory supervisor. On the other hand, the general members are made up of the clinical supervisor, social welfare supervisor, focal persons of categorical programs (HIV/AIDS, EPI, EPR, HP/HE, Malaria, TB/Leprosy), MCH focal person, reproductive health focal person, surveillance officer, eye care specialist, environmental health supervisor, mental health supervisor, finance director/accountant, hospital administrator, diagnostic services supervisor, logistician, human resource officer, and the registrar (Decentralization Guidelines, 2011, pp 17-18).

Notwithstanding, the decentralization of the Health Department, the National Health Policy and Plan (2008-2011) foresees several challenges to the realization of effective and efficient health service delivery. The National Health Policy looks at these challenges in two broad categories: the immediate term challenges and the long term challenges. Immediate challenges according to the National Health Policy have to do with the expansion of access to basic health care of acceptable quality. Specific challenges under this include but are not limited to ensuring the availability of funds at the county level to support the continuous delivery of basic services; improving the availability of essential medicines and other critical health commodities;

rehabilitating health facilities in under-served areas; upgrading the skills of health workers and redeploying them to areas where they are most needed; boosting management capacity at all levels to support the delivery of services; and improving availability of safe water and sanitary facilities. On the other hand, long term challenges according to the National Health Policy and Plan include ensuring the availability of adequate resources to sustain the investments needed for the reconstruction of health facilities due to massive destructions by the civil war; restructuring resource allocation patterns, so that underserved communities can benefit adequately from health sector recovery; reducing the present strategic and operational fragmentation, in order to ensure coherence of sector development and attain efficiency gains; and upgrading, streamlining and restructuring the workforce, through a long term training program and the introduction of effective personnel management practices; among others (National Health Policy and Plan, 2008-2011).

Adding to the identified challenges above, Abramson (2012) in an evaluation of the performance based contracting of the Bomi County Health Services indicates that one of the major challenges to the operation of the health services in the county was inconsistent communication flow from line managers to middle management. This according to Abramson (2012) had on occasions resulted in a less participatory county team. It is important to conclude this section by noting that to work effectively at overcoming the challenges that confront health service delivery in Liberia, especially at the county level, non-governmental organizations (NGOs), Faith-based Organizations (FBOs) and private/For Profit Providers of health services have been very instrumental in working with the County Health Teams (Decentralization Guidelines, 2008).

CHAPTER THREE

Methodology

3.0 Introduction

This chapter captures the various methods, instruments and techniques that were adopted in the collection and processing of data for the study. It entails a description of the research design, the area within which the study was conducted, the case selections. The chapter also encompasses the data collection methods that were employed to obtain the relevant information for this study. In addition, this chapter describes how the data collected from the field was handled. The final section of this chapter includes a presentation of the ethical issues that were considered in the conduct of the study.

3.1 Research Design

The study is a comparative case study which used the qualitative approach of Exploratory as the method of enquiry. Comparative case study of organizations according to Berg (2001), may be defined as the systematic gathering of enough information about a particular organization to give the researcher insight into the life of that organization. The choice of a qualitative research design was primarily because the researcher sought to collect rich in-depth information on the experiences of persons who are part of a hidden population and whose voices are hardly heard. The Peninsula Research & Development Support Unit [RDSU] (2009) posits that qualitative research allows the research participants to give ‘richer’ answers to questions put to them. This is corroborated by Sofaer (1999) who espouse that qualitative research methods are valuable in providing rich descriptions of complex phenomena and illuminating the experiences and interpretation of events by research participants with varying stakes. Soafer extended that

qualitative research gives voices to research participants who are hardly heard. The intent of this current study was to solicit the views of various stake holders in the two Departments of the Ministry of Health and Social Welfare of Liberia and therefore the researcher deemed a qualitative method appropriate.

The method of exploratory was preferred for a number of reasons; including the facts that it helps the researcher gain new insights, discover new ideas and/or increase knowledge of a phenomena, Burns and Grove (1998:38). Also, Collins Cobuild English Dictionary for Advanced Learners (2001:540), also state that, “Exploratory actions are done in order to discover something or to learn the truth about something.” Considering the fact that the researcher has some perception of the situation, it is only prudent to use this method to learn the truth about the decentralization process at the Departments of Health and that of Social Welfare.

3.2 Study Area

The study was conducted in the Grand Bassa County in Liberia. The Grand Bassa County is one of the three original counties along with Montserrado and Sinoe, which first formed the Republic of Liberia (Grand Bassa County Development Agenda, 2007). The county was established in 1833 with Buchanan City as its capital. It is located in the area from latitude 6°45' to latitude 5°30' North and from longitude 10°30' to longitude 9°00' West (Grand Bassa County Development Agenda, 2007). The county is bordered to the Southwest by the Atlantic Ocean, to the Northwest by Margibi County and to the North by Bong County. Nimba County borders the County to the east and Rivercess County to the southeast. The total land area of the County is approximately 3,382 square miles [8,759 square kilometers] (Grand Bassa County Development Agenda, 2007).

According to the Liberia Institute of Statistics and Geo-Information Services [LISGIS] (2009), the 2008 Population and Housing Census put the total population of Grand Bassa at 221,693, with a male population of 110,913 (50.03%) and a female population of 110,780 (49.97%). The county has an average House Hold size of 4.6 (LISGIS, 2009). The LISGIS, (2009) indicates that the proportion of the population living in urban areas in the county is 58,956 (26.56%) while there are 162,737 (73.44%) rural dwellers. With such a large proportion of the population in the rural area, decentralizing social welfare services will ensure that the needs of the rural people are well attended to.

Grand Bassa prior to the civil war in Liberia was one of the most vibrant counties in the country. It was the hub of many economic and industrial activities. The county boasted of both local and international companies such as the Liberian American Mining Company (LAMCO), Liberian Mining Company (LIMINCO), the rubber plantation of the Liberian Agricultural Company (LAC), the palm oil plantation Liberian Incorporated (LIBINC), the logging concerns Oriental Timber Company (OTC) and National Milling Company all had operations in the County. There was also the harbor of Buchanan which was the second largest port in Liberia (Grand Bassa County Development Agenda, 2007).

The County Development Agenda indicates that the civil war had disastrous consequences on all the activities above which virtually came to a halt upon the looting and vandalizing of almost all the County's business and industrial establishments. This led to extreme hardships in the County after the war ended. The extensive damages made the rebuilding process difficult and this in turn has and continues to affect the lives of the people of Grand Bassa County.

As part of the recovery measures put in place by the government of Liberia to bring the country back to its once vibrant status, three development priorities were identified including road construction across the county, nationwide development of health facilities and the establishment of educational facilities throughout the country (Grand Bassa County Development Agenda, 2007). The Decentralization of various government Ministries and Departments is one of the additional measures to facilitate the pace of the recovery of Liberia. With the Ministry of Health and Social Welfare being selected as one of the pioneers of the decentralization process, the Department of Health has decentralized quite greatly but that of Social Welfare under the same Ministry is still being run entirely from the central office.

Considering the Grand Bassa exhibits both urban and largely rural features and being one of the hardest hit during the conflict, the research purposively selects the county to study the extent to which the Department of Health has been decentralized and the effects the process has brought about in the lives of the people and to juxtapose it with the Department of Social Welfare.

3.3 Case Selection

The cases for this study comprised of the Department of Health and Social Welfare based on their similarities as government agencies responsible to deliver health and social services to the population of Liberia. As part of the Ministry of Health and Social Welfare, they both share in the Department of Administration and the Department of Planning, Research and Development. The mandate to decentralized services was given but up to date, it is only the Department of Health which has gone ahead and decentralized in the fifteen counties with the Social Welfare Department still operating from its central office. This points the differences in structure and service delivery which called for such study.

As this is a comparative study, cases comprised of 3 staff from the Department of Health who included: an official and staff of Health at the Central Office and the County levels; 2 Officials and staff of the Social Welfare Department both at the Central and County levels. Others included 1 staff of the Decentralization Unit and 6 beneficiaries like 1 Town chief, 1 opinion leader, 1 women leader, and 2 youth leaders, and an NGO Supervisor. These participants comprised of four females and seven males, ranging from age 21-27 years. (*see appendix for demographic profile*). These selections are based on convenience sampling method which looks at availability, accessibility and is also less expensive, (Berg 2001).

The selection of the Health and Social Welfare officials at the Central office was based on the reason that they are responsible for the implementation and supervision and monitoring of activities of the Sectors. The staff of the Decentralization Unit is in the best position to give information on the implementation, strategies, challenges and successes as well as the measures put in place to handle any contingencies with the policy implementation. The Health and Social Welfare staff at the county level was included in the study because they are the individuals responsible for the direct operations of the Departments' activities and can best tell to what extent decentralization is useful to their service delivery.

All other participants were selected because they are the recipients of the services from the sectors and could share their experiences with respect to the effectiveness or otherwise of the ability or inability of the Departments to decentralize. The case selection could have increased or decreased depending on Marshall's (1996) view that the number of required participants for a study usually becomes obvious as new categories of themes or explanations stop emerging from the data that are being collected, but unfortunately, it did not change.

3.4 Data Collection Methods and Tools

The data were gathered through the use of in-depth interviews and key informant interviews. Primary data for the study was gathered through in-depth interviews with participants. A list of questions were designed targeting two sets of participants-officials of the Ministry of Health and Community Leaders- and their knowledge and experiences with the decentralization policy and process. Interview sessions were scheduled and interviews recorded using an audio recorder which was transcribed into Word document.

The use of key informant interview was used for the official of Social Welfare Department with the expectation of responding to the delay in the decentralization process looking at challenges and constraints and the way forward. The official of Health was expected to give responses as to the trend and success of the decentralization process and the level of collaboration between both Departments; how the process is promoting service delivery; explain the linkage between health and social welfare; and the way forward for the Social Welfare Department. Staff at the county level were selected based on the fact that they are implementers and would be able to explain the benefits of decentralization with regards to service delivery and also the constraints, challenges and gaps in the service delivery. The chief, opinion leader, leaders of women, youth groups, and NGO supervisor being the direct beneficiaries were selected because they would be able to give their views as to the differences in a centralized system and that of a decentralized system in regards to service delivery; how effective is the process in meeting their demands; and identify gaps in its process.

3.5 Data Management and Analysis

The interviews were recorded with an audio recorder, duplicated and stored in an external storage device for safe keeping. The audio information was then transcribed into word document.

They were coded based on themes before analysis was done. Content analysis, a procedure for the categorization of verbal or behavioral data, for the purposes of classification, summarization and tabulation (Hancock, 1998) was employed in the analysis of the data that was collected from the field. Hancock contends that the content of data collected from the field can be analyzed on two levels: basic level which involves a descriptive account of the data and the higher level of analysis which is interpretative and concerns the ascription of meaning to the responses of the participants. This process usually involves coding and classifying in order to identify from the transcripts, the extracts of data that are informative and can be utilized to meet the objectives of the study. Steps involve in content analysis was followed by the researcher in this study.

According to Lacey et al, (2001), first and foremost, upon the transcription of the data, the researcher was enjoined by the content analysis procedure to become familiar with the transcriptions by reading and re-reading the data and making memos and summaries of interesting or relevant observations before the formal analysis began. The next step involved the researcher making a list of different types of information that were found based on the notes that were made in the first step. The researcher then proceeded to read through the list of data items and categories. Each item according to similarities in meaning. The next step involved the building of major and subthemes.

Major themes were built by linking categories that were alike and maintaining the original, smaller categories as minor themes. The researcher then perused the minor and major categories of data and compared and contrasted the various categories to fine tune the elements in the main and subthemes. The process was repeated for each transcript until all the transcripts were analyzed and themes developed for each. Upon completing the theming of each transcript, the researcher proceeded to combine the information on all the transcripts thereby obtaining one

document. Upon obtaining a single document, the next step was to integrate all identified themes and categorize them in order to avoid repetitions. Once the themes and subthemes were integrated, the researcher then proceeded to do the discussion of the information obtained in conjunction with the literature that was reviewed. The discussion was guided by the theoretical framework and the objectives of the study.

3.6 Ethical Consideration

Participants were duly informed of the purpose of the study so that they could make informed choices to participate or not to participate. By this, no participant was coerced to take part in the study thus, participation was voluntary. The privacy and confidentiality of research participants were protected and plagiarism was strictly avoided as all sources of information were duly acknowledged. Based on the issue of confidentiality, anonymity was considered as code names were given to participants in the discussion of the results in chapter four.

3.7 Challenges of the Study

The researcher encountered a number of challenges in the process of conducting this research. The major challenge of the study was the fact that the topic was politically sensitive and sampled participant felt reluctant to participate in for fear of political victimisation. However, with the strongest assurances of the researcher that the study was purely an academic exercise, the researcher got the participants to accept and to participate in the study. Other challenge was time factor as the researcher had to travel from Ghana to Liberia within the semester to gather data while lectures were on-going. This constrained the researcher and therefore she could not reach out to the people at the remotest parts of the country.

CHAPTER FOUR

Presentations of Findings and Discussion

4.0 Introduction

This chapter is devoted to the presentation of the findings as obtained from the field. It is divided into three sections: the first section gives an insight into the data analysis; the second section presents the findings of the study and the third section discusses the findings in line with the objectives, available literature in the field of decentralization, and the theoretical framework.

4.1 Key Findings

The findings from the data collected looked at eight thematic areas to which five officials of both Health and Social Welfare sector responded. Also, it considered the impact of decentralization to which six community members responded.

Reasons for Decentralization- out of five persons, two stated good governance as a reason. Effective service delivery was mentioned by all five participants including accessibility of services. Empowerment according to three participants is the reason for decentralization.

Challenges faced by Social Welfare- logistical support and inadequate staff was agreed as challenges by four respondents whilst funding as a challenge was agreed by all five respondents. Fragmentation of services was accepted as a challenge by two respondent and office facilities was stated by two respondent as a challenge faced by the Department of Social Welfare.

Access to health services as a challenge to the Department of Health was mentioned by two respondent and medication as a challenge was mentioned by two respondent.

Looking at the issues of funding and staffing, all respondents mentioned them as serious disparities between the two departments stating that the Health Department receives more money and hires more staff. Infrastructure according to four respondents was mentioned as a disparity because at the county levels, the facilities and structures were constructed by the Health Sector and filled with Health staff. Reasons given for such disparities are the prioritization of health activities, duplication of social services, and poor leadership on the part of the Department of Social Welfare in terms of mobilization and advocacy.

The data collected showed that some of the strategies used by the Health Department includes capacity building, improved service delivery, and restructured system of staff. Some areas that collaborations should take place between the both Departments according to respondents include but not limited to issues of mental health, HIV/AIDS, Rehabilitation services. But according to one respondent, the level of collaboration is poor while four others stated that it is gradually improving.

At the community level where decentralization is supposed to make impact, from the data out of six respondent only three had knowledge of what decentralization is. As one of the challenges with the Health Department is the issue of medication, it was confirmed by four of the respondent who had to purchase medication for themselves because health centers lacked drugs. The issue of accessibility of health and social services is seen also as a challenge because out of six respondent only one had access to these services.

4.2 Decentralization and Service Delivery

The first objective of the study looks at key issues relating to decentralization and how it can prompt service delivery in Liberia.

4.2.1 Reasons for Decentralization

One important purpose of this study was to engage the participants to ascertain the reasons underlying the decision by the Government of Liberia to decentralize its Ministries and agencies. From the findings of the study, it became evident that the need to ensure good governance, effective service delivery, accessibility of services and empowerment were the four main reasons the government of Liberia decided to chart the path of decentralisation. In a country which was bedevilled with a 14-year civil conflict, most of the structures for the delivery of medical and especially social services had broken down leading to the point where it had become obvious that a centralized governance system did not meet the needs of the people at the local level. Therefore from a two of the narratives below, there is a feel of some of the reasons behind the government's decision to decentralise:

“... there have been arguments that [government] services over the period of time have been very centralized, and because the services have been very centralized, the rural parts of the country were not really receiving the services adequately; they were not feeling the impact of service delivery in the rural parts of Liberia. So looking at the history of Liberia over the period of time, the Good Governance Commission that is charged with the responsibility of analyzing the governance system did a research and, in their own finding, they realized that we need to have a decentralized government, and that decentralizing the government is the best way to deliver goods and services” (SWO1, In-depth interview, MOHSW Central, April 19, 2014).

“Well, uhh, the government as a whole had been centralized for one hundred and forty some more years, and so as a background to this, in 2006 President Ellen Johnson Sirleaf ... promised to take her government closer to the people. As a manifestation of that, the Governance Commission and other policy-related agencies were instituted...” (DUO, In-depth interview, MOHSW Central, April 17, 2014)

The above quotes were captured from officials who worked within the Ministry of Health and Social Welfare. They are the ones responsible for the implementation of the decentralization program and therefore their exhibition of such good knowledge of the reason for the program means to a large extent, they would know what to do to ensure its implementation. The findings of the study as seen above indicate to a great extent, the country's continuous practice of the centralized system of governance had over the years proven not to be beneficial, especially to the people in the rural areas of the country. Moreover, when the civil war destroyed the social and state support systems at local levels of the country, services directly delivered from the central did not prove to have benefitted the people and therefore the decentralization of such vital service delivery institutions such as the Ministry of Health and Social Welfare became inevitable. As the French Corporation (2009) indicated, decentralization is characterised as being a part of democratic governance which is intended to give local authorities their own resources and responsibilities separate from those of central government. This by extension will enable the local authorities to reach out to and render the needed services to the people at that level. The central government making resources available at the local level and therefore enabling the local people to access the much needed services is a mark of good governance as indicated by Aspinall et al. (2003).

Aspinall et al (2003) posit that in some parts of the world, the process of decentralization was predominantly in response to either actual or potential regional conflicts. In the Liberian situation even though conflict played a significant part in the decision to decentralize, the role of conflict only goes as far as destroying the institutional set ups at the local levels and therefore impeding the smooth flow of services to that level from the central. The Liberian situation suites more with the views of Coulson (1995) and Menocal (2004) who both opined that decentralization was in

response to persistent demand from the local level for local democratic control and autonomy. Despite not seeking political autonomy, the findings of this study indicate that there were some forms of pressure from the local levels to have Health and Social Welfare services brought to their doorsteps and these pressures to a great extent led to the decentralization of the Ministry of Health and Social Welfare.

The issue of decentralization occurring because of effective service delivery also was captured from the findings of which Akpan (2007) corroborates that decentralization may result in better service delivery and the provision of social services such as education, health, water and sanitation may improve service delivery. According to the National Health and Social Welfare Decentralization Policy and Plan, (2012), the decentralization undertaken is to provide services that are equitable, accessible and sustainable for all people in Liberia. Falleti (2004) propounded that with decentralization occurring, empowerment is sure to follow as there will be improvement of local and state bureaucracies, trainings of local officials or the facilitation of learning through the practice of delivering new responsibilities. From the Liberian context it is ascertained that empowerment of staff for service delivery was one of the key reasons for the decentralization process.

With the understanding of the reasons for the decentralization of the Ministry of Health and Social Welfare and the Liberian Government in general, the next two subsections presents and discuss findings on the decentralization and service delivery with the Social Welfare and Health Departments of the Ministry.

4.2.2 Decentralization and Social Welfare Service Delivery in Liberia

The inception of the decentralization program in the Social Welfare Department surely came as a relief to the rural folks and other stakeholders in the social welfare services sector because of the potential the program had to deliver the much needed services at that level. This subsection captures finding from the field as to whether the Department has actually been decentralized and whether the people at the local level are benefiting from the decentralization process.

Findings from three of the respondents revealed that the decentralization of the Department of Social Welfare is only on paper, with the officers and staff of the Department found to be bedevilled with lots of challenges that obliterated the decentralization process. Among such challenges were lack of logistical support, and even office facilities which are prerequisites to establishing and providing services at the local level. It was realized from the findings that even at the county level there were no office spaces for Social Welfare staff. This sort of made their work difficult for them. Considering that the County Social Welfare officer has supervisory responsibility for district officers and they in turn, for Community welfare officers, one can only imagine the situation at the local level for social welfare service delivery if things are this way at the county level.

Another important challenge to service delivery in the Social Welfare sector despite introduction of the decentralization program was the lack of staff across the various levels of the structure of the Department of Social Welfare; National, County, District and Community levels. Staffing at the National level would not be a serious problem if the concept of decentralization was effective and the local structures strengthened with staff and needed logistics. It is at the local level that there is need for adequate and qualified staff who would be able to reach out to and render services to the people. However, right from the county level as expressed by the participant,

there were inadequate numbers of staff to man the activities of the department at the various levels of service delivery. Beside the inadequacy of staff in terms of numbers, there were also questions with the quality of staff. The findings of the study according to one of the respondent indicated that many of the staff of the Department of Social Welfare did not have the requisite training to competently handle Social Welfare problems at the local levels. The two issues of inadequate and inappropriately trained staff led to non-professionals like community leaders handling social issues that may warrant professional attention.

Another problem that still confronted the delivery of services at the Department of Social Welfare was the lack of funds to work with. Right from the Central to the local level, participants, both Social Welfare and Health officials alike attested to the fact that the Department of Social Welfare was bereft with the needed funds to work with. As a result of the shortfalls in funding from the government, the study found out that the Department more or less depended on a few Non-Governmental Organisations to run its services. One can only imagine for how long the Department will continue to depend on support from these NGOs.

Fragmentation of Social Welfare services was highlighted in the findings as one crucial challenge faced by the Department. A participant stated that because of this fragmentation, funds and technical supports that are believed to be benefitted by the Department are share with the other institutions like Ministry of Gender and Development, National Commission on Disability, Ministry of Planning and Economic Affairs and other institutions.

The narrative below affirm the findings above as discussed:

“...nothing, the funding is not there. Many times, that’s some of the challenges we have. This EPS Section, when they established it, we made our proposal – that time Sis. XX was here, the administrator, we gave it to her, they approved of it. Since they approved of it, it’s almost two years and

we've not implemented anything. All they always have to say is: "Social Welfare don't have budget yet". So if it comes, they will give it to us. Ma, [Madam; i.e., in reference to the researcher] it's not easy. ... We get on the field, we talk to the people, we counsel the people. At least we get on the field, if we've got at least the County Health Team to assist us, but they always tell us no money" (SWO2, In-depth interview, MOHSW Local, April 18, 2014).

From the findings of the study under this section, it is clear that the root of all the challenges of the Department of Social Welfare is the lack of funding which has tended to affect the provision of office space and the necessary logistics for the department. On the other hand with funds available, the department will be able to employ more staff and train the existing ones to make service delivery more formidable. However, without the needed funds as indicated by this study, nothing much can be achieved by the Department. It is a known fact that Liberia is a country that is now recovering from the ruins of 14 years of civil conflict (EPSS, 2011). The situation has plunged the country into serious resource constraints (EPSS, 2011). As Scott (2009) posited, where a country is under-resourced and defies the odds to decentralise, the local governments often have to operate in environment characterised by very severe resource constraints. The challenges that the Department of Social Welfare continues to face in delivering services to the people at the local level despite decentralization also go to affirm the position by the EPSS (2011) that resource constraints in many sectors of the country have prevented institutional transformations to address specific needs of vulnerable populations. The EPSS forecasted that the ability of communities to respond to problems depended largely on the availability of resources. This study has just indicated that the Liberian Social Welfare situation looks gloomy as there is no end in sight for resources to be made available unless government redirects focus towards the Department and makes the needed funds available despite the general budgetary constraints.

A closer look at the fragmentation findings corroborates with White Paper for Social Welfare (1997) concerning fragmentation which states that when social welfare services are spread out to other agencies, the result is fragmentation, duplication, inefficiency and ineffectiveness as it relates to meeting the needs of the vulnerable, as each agency, organization, etc. have their own procedures, styles of work, approaches and priorities.

The findings in regard of the role of NGOs in supporting the operations of Department of Social Welfare also confirms the position by Abramson (2012) that both national and international NGOs played crucial roles in supporting the activities of not only the Department of Social Welfare but the entire Ministry of Health and Social Welfare.

Juxtaposing the findings of this study in respect of funding to the sequential theory of decentralization as proposed by Falleti (2004), the study finds some contradictions with the proposition by Falleti in terms of fiscal decentralization. Whereas Falleti (2004) indicates that in the sequence of decentralization, the preference of central governments is to first ensure fiscal decentralization, this study finds that in the Liberian situation the government has failed to fiscally decentralize and funds are still generally distributed by the central. Hence with the failure of the central government to make funds available and the Department of Social Welfare having no capacity to generate funds of its own, service delivery to the people is bound to be insufficient.

4.2.3 Decentralisation and Health Service Delivery

Decentralization in the Health Sector from the findings of the study was quite advanced and on course as compared to the Social Welfare Sector. The findings indicate that the Health sector had a stronger infrastructural and logistical foundation compared to the Social Welfare sector. Unlike

the Social Welfare, office, staffing, logistics and funding of the Health Department was relatively better. The following statement by HO2 attest to the situation of decentralisation in the country as it stands:

“To some extent, decentralization has taken root at the Ministry of Health, because currently in, uhh, two of the counties, and I just learned that three counties right now – uhh, they’ve got their district health system that is established, fully functional; they’ve got all of the requisite health personnel that have to be part of the team. And then when you look at the community component, they’ve got general community health volunteers, they have the field agents – I mean it has taken roots, it has taken roots, it’s just that, you know, there are a couple of things that still need to be done, but yes”
(HO2, In-depth interview, MOHSW Central, April 18, 2014)

However, as seen from the statement by HO2, he is sure of only three out of fifteen counties having been well decentralized in their Health Sectors. This gives an indication that more of the counties still have a lot to be done. This affirms Jhpiego’s (nd) acknowledgment that there is still a long way to go in the decentralization of the Health Sector in Liberia despite the fact that all 15 counties of the country have begun operational management of health services. From the above quote therefore, one can only conclude that there have been general improvements in health service delivery in the country but not a holistic situation. Despite the general improvement in this sector it also faces fundamental challenges that ought not to be overlooked simply because the sector is doing better than the Social Welfare sector.

Access to health care facilities was identified as one of the challenges in the health sector. The problem of access came in terms of distant location of the health facilities to the people, the lack of vehicles to transport patients to and from health facilities and the fact that the ambulance service was not effective especially outside the major cities of the country.

Besides distance and transportation serving as barriers to health care access, another important barrier to access was the lack of medicines for patients even when they accessed health facilities. The study found out that patients were often made to buy medicines from private medicine providers such as pharmacies and dispensary shops which were relatively expensive. Considering that the majority of the Liberian people are living in the poverty bracket (EPSS 2011; Ruiz-Casares 2011), this has the potential to affect their ability to buy prescribed medicines and therefore get treated of their ailments.

The last but not the least challenge that confronted health care service provision was the unavailability of health service staff as a result of staff retention and turnovers created by low salary and lack of motivation. As a result, they seek greener pasture leaving a vacancy that should be filled by a staff that has to be trained with new funds. This Butali, Wesang'ula and Mamuli (2013) stated that staff turnover in organizations is caused by dissatisfaction with the conditions of work which may include insufficient career development opportunities, unpleasant and unaccommodated environments, and employers not living up to the expectations of the employees.

The availability of medication is particularly important as the people are poor and can hardly afford medical care. Therefore the ability of the Department of Health to focus on prevention rather than curative services will go a long way to improve the health of the rural folk and reduce the pressure on the limited health facilities.

The findings in respect of the difficulties with health service delivery in the face of decentralisation are echoed in the selected voice quotes below:

“Well, to be quite realistic, when it comes to health service delivery, it is not efficient, because at times, people will get sick, go to the hospital, you

will see! When your relative is sick like that you go to seek for the ambulance they will say, 'O my man, we are not here for that; we are busy on the other side'. All of that stuff. So it's not really effective, when it comes to health delivery" (CM2, April 18, 2014).

"...Sometimes when we go we get it, we buy some, because when you go, sometimes they give you paper; the person will be on [the hospital] bed, but they will give you the paper still; you go buy the medicine and bring it to the hospital. ..." (CM6, In-depth interview, Gorzon Community, April 18, 2014).

The findings above are an endorsement of the position by Jhpiego (nd) that key among the challenges faced by the Liberian health Sector were weak logistics, transportation and communications systems, as well as insufficient access to care and poor referral networks, particularly in remote rural areas. Also Devas (2005) warned that decentralisation without good road networks, and other vital social amenities hinders local level development; in this case, health service delivery as has been seen in the findings that have been presented.

The issue of staffing in particular is in sharp contrast to the EPHS (2011) as the package required that there will be trained community health volunteers who would go from home to home attending to community health issues and educating the people on primary health concerns. Further, the findings under this section affirm the challenges that were anticipated by the National Health Policy and Plan (2007) when it indicated that the main challenges to health care included the availability of funds at county level to support the continuous delivery of basic services; the availability of essential medicines and other critical health commodities; provision and rehabilitation of health facilities in under-served areas; upgrading the skills of health workers and redeploying them to areas where they are most needed; among others.

4.3 Departments of Health and Social Welfare, and the Decentralisation Process

This section of the study is dedicated to presenting and discussing the decentralization process in the two Departments of Health and Social Welfare. The study found out that while the Department of Health was responding quite rapidly to the decentralization process, the Department of Social Welfare was rather lagging behind. As a result, the first subsection under this section presents evidence to the effect that there were disparities between the two autonomous Departments of the Ministry. The subsequent subsection under this section presents the reasons for the Health Sector picking up quickly in the decentralization process but the Social Welfare Sector continues to lag behind.

4.3.1 Disparities in the decentralisation of the Health and Social Welfare Sectors

The Health and Social Welfare Departments of the Ministry of Health and Social Welfare are two units which are supposed to be seen as autonomous and equal in status. It is expected that once the Ministry of Health and Social Welfare was earmarked as one of the pioneers for the decentralization program in Liberia, steps taken to decentralize the Ministry would have been simultaneous in both Departments. However, findings from the field show that there is a wide disparity in terms of the equipment of both departments from the county through to the community levels. In almost all instances, the Health Sector was seen to have benefitted immensely from major government efforts to the neglect of the social welfare sector. Findings revealed three major areas of disparity between the two Departments of Health and Social Welfare. Allocation of funds, development of infrastructure and staffing were the three areas of disparity.

Concerning the allocation of funds, the findings indicated that funding was mostly allocated to the Department of Health and that the Department of Social Welfare was hardly considered in

the Ministry's budget. With regards to staffing, the story was the same as participants decried that the Health Sector was more equipped with staff compared to the social welfare sector. Study confirmed that there were staff of the Department of Health from the National even to the community level whereas there were very few Social Welfare staff assigned at the county level, not to talk of the district and the community levels which are yet to be assigned staff. The situation with Social Welfare in terms of staffing tends to defeat the core purpose of decentralisation which is to bring governance and service delivery to the doorsteps of the people. So that if the government embarks on a decentralization process without deploying the staff who would be responsible for delivering such services, then there can be no decentralization. The findings in regard to staffing in the two Departments also indicated that the staff of the Department of Health were more motivated than those of the Department of Social Welfare. One of the Social Welfare staff engaged in the study indicated that while the staff of the Department of Health for instance received per diem for attending meetings on behalf of their Department, those of the Department of Social Welfare did not receive such benefits because of complains of budgetary constraints on the Department.

The issue of staffing was not just limited to inadequate numbers but also to the quality of staff. It was realized that whereas the Health had standards for training and therefore employing staff, the concerns for social welfare staff at the lower levels were rather lowly educated and sometime their capacities are built by health institution. There were also issues with poor quality staff in the Department of Social Welfare, compared to the Department of Health. This stemmed from the fact that whereas there are well established institutions for training personnel of the Health Sector, including community health volunteers, the same cannot be said of the staff of the Department of Social Welfare.

Infrastructural provision was another area of disparity identified by the study. Infrastructural provision at the local level is very important in any decentralization process. However, even though one cannot say the situation of infrastructure in the Health Sector was best, and that of the Social Welfare Sector was worst.

Below are selected views of participants to the effect that there were disparities in the decentralisation process between the Department of Health and that of Social Welfare:

“I will just say, just as the Health Sector is allotted money, Social Welfare should also be allotted money. But this is not something we have not said, but they are saying the money that Social Welfare Department has at National level, is very, very small to distribute to the counties. That’s their explanation they always give. What is allotted to Social Welfare, if they should divide it among the 15 counties, it is very, very small. So what we are doing so that our social workers will not sit [idle] is that money sent for health purposes, we try to get them into it, ...So at least, when the funding comes into the pool fund, there is something inside for Social Welfare, since Social Welfare Department does not have the money, we created some avenue through the pool fund, so that, at least, they can have something to do, instead of just sitting down” (HO2, In-depth interview, MOHSW Local, April 18, 2014).

“Ahh! The Health Services [department] is more decentralized if you want to say it. Looking at the two departments, Health Services is more decentralized, and that, meaning that they have more personnel in the county. They have personnel at the level of the district; they have personnel at the level of the community; they have personnel at the level of the county. So at all levels of the Ministry, the Health Services department has functions to perform. ...You will find a nurse, you will find a physician assistant at almost every clinic. But in most of the districts, you will not find a social welfare person, except, in recent times there are few scattered about”. (SWO1, In-depth interview, MOHSW Central, April 19, 2014)

From the findings of the study under this subsection, it is evident that there are vast disparities between the situations of decentralisation in the departments of Health and Social Welfare. The

findings give some credence to the view by the European Commission (2007) that decentralization has the potential to lead to a clash between different sources of power and legitimacies, which could potentially lead to the scramble by local level outfits to find their places and fits. Even though in the case of the two Departments, there is no apparent scramble for power, there could be an inherent struggles for scarce resources between the two Departments. This is because, in the face of scarcity of resources, and as will be seen in the next subsection of this study, the Health Sector has an upper hand in the Ministry and so where funds allocated to the Ministry are insufficient, the more powerful Health Department may tend to serve its interest as a matter of priority.

Furthermore, Aspinall *et al.*, (2003) and Devas (2005) warn that decentralization can actually serve as a catalyst to conflict and to reducing social cohesion. Devas reiterates that decentralization can heighten the differences between regions and create the situation where resources tend to be channelled towards one area of the decentralized area to the neglect of others. This, Devas indicates can worsen the already bad situation of marginalised populations. Even though the situation of decentralization in the Ministry of Health and Social Welfare is not in the same line as political decentralization, the Departments of Health and Social Welfare represents certain interests in the country. Issues of health if not attended to may have direct effects on the government's political interest as compared to those of health as many people in the developing world as Liberia do not seem to prioritise social welfare issues. This could potentially explain the deep seated disparities in decentralization between the two departments of the ministry. Furthermore, because the health sector has long since been empowered, the management of the Health Sector should have acquired the power to pull resource allocations in the Ministry to the area of health, and to the neglect of the Department of Social Welfare.

4.3.2 Reasons for the Disparities between the Health and Social Welfare Sectors

Having confirmed that there are fundamental disparities in the decentralization and effectiveness of the two departments of health and social welfare, it is relevant that we try to ascertain the reasons behind such disparities.

The prioritisation of funding of the activities of the Department of Health to the neglect of the Department of Social Welfare in itself is a source of disparity in the Ministry. This priority comes not only from the government as seen from the lack of adequate budgetary allocation to the Social Welfare Sector but also in donations both in cash and capacity building given by international agencies to the Health Sector. Whereas Social Welfare Sector hardly receives donations from external sources, there are lots of donations from such sources to the Health Sector.

In addition to the lack of funding and capacity building that lead to the low performance of the Social Welfare Sector compared to the Health sector, there was also the issue of duplication of services that should have been traditionally the responsibility of the Department of Social Welfare and thus the funds that are allocated for such projects. The study revealed that several other government ministries and agencies such as the Ministry of Gender, the National Commission on Disability and the National Commission on Disability, Rehabilitation and Reintegration (NCDRR) perform similar roles to those of the Department of Social Welfare such that those other agencies tend to receive the attention that otherwise would have been given to the Department of Social Welfare.

Leadership was also seen as one of the factors that have undergirded the lagging of the Department of Social Welfare behind the Department of Health. There was a general indication

that the leadership of the Ministry has not done much to pull the two Departments along in the decentralization process and thus in their services delivery. Still on leadership, the findings also indicated that the Department of Social Welfare lags behind because the leadership of the Department have not been forthcoming in demanding the resources that are due the department. From the findings, it was apparent that if the leadership of the Department of Social Welfare were up and doing, they would have gained some support for the Department in spite of the inherent difficulties.

Another important factor that facilitated the creation of the disparities in the decentralization of the Health and Social Welfare Sectors and which led to a relatively effective Health Sector compared to the Social Welfare sector was the fact that health officials seemed to be leaders in all joint activities between the Departments. There was evidence to the effect that the county directors of Social Welfare were subject to the county directors of health across all counties. This seems to be a part of the organisational structure of the Ministry and may prove to be a serious part of the causes of the disparities. This is because by virtue of the health personnel heading both the Health and Social Welfare units it gives the Health Sector the undue advantage over the Social Welfare Sector in scarce resource distribution.

Here is an excerpt of a participant that support the findings of the study as discussed:

“...uhh, the Health Service Department over the period of time has been able to decentralize because of their donor support – they have had a lot of donor support, and that donor support over the period of time has been not only in terms of funding but also in terms of capacity building. So the Health Services Department’s capacity has been built, and they have the funding. So over the period of time, they have been able to at least develop a lot of programs and develop a lot of services because of the level of capacity they have had over the period of time. So in terms of personnel, in terms of everything, they have had over the period of time, because a lot of the donors that usually come to the Ministry of Health and Social Welfare,

in many instances, are usually attached to health programs. ...” (SWO1, In-depth interview, MOHSW Central, April 19, 2014)

The findings of the study under this subsection reflect the budgetary allocation of the government of Liberia to both Departments of Health and Social Welfare. As sighted in the annual budgets of the Ministry of finance from the year 2009 to 2013, there have been gross differences in the amounts allocated to each of the Departments. In 2009, the department of Health received an amount of US\$11,260,891 while the Department of Social Welfare received US\$703,717, giving a difference of US\$10,557,174. In 2011, the Department of Health was again allocated an amount of US\$23,034,717 and the Department of Social Welfare received US\$ 682, 901. In this case, the gap between the allocations was not just wide, there was also a reduction in the amount that was allocated to the Department in the previous years. Considering that the cost of running the Department increases as time passes by and the government rather than increasing the already inadequate allocations chooses to reduce the amount only goes to confirm the position that the government does not prioritize Social Welfare activities. The trend in the allocation of funds was the same for the 2012 and 2013 fiscal years. In the 2012 fiscal year, the Department of Health was allocated US\$ 32, 281,119 while the Department of Social Welfare was allocated US\$948,690. Then in the 2013 fiscal year, the Ministry of Finance again allocated US\$ 48,351,281 and US\$ 936,819. Majority of the fund for Social Welfare Department are given to subsidize orphanages and old folk’s homes.

The trend is worrying for the Department of Social Welfare especially considering that the budgetary allocations to the Department over the years that have been consider is either reducing upon every marginal increase or with a minimal addition. Whiles the allocation to the

Department of Health has increased by about 329% that of the Department of Social Welfare has only increased by only 33%. This situation sums up the disparity in terms of funding of the two Departments by the central government. A whole Department being given a budget of less than US\$1,000,000 cannot efficiently operate at the central offices and its offices at the local levels, and this is what has been reflected in the findings of this study.

The findings of this study also affirm the fact as indicated by EPHS (2011), the EPSS (2011) and the National Health Policy and Plan (2007) that give evidence to the effect that in terms of human resources, the Health Sector has many staff ranging from medical doctors to community health volunteers and the Social Welfare Sector has staff with limited qualifications and is short in staff who are stationed at the county levels. The findings also corroborate existing literature that logistically, the Health Sector has many vehicles, while Social Welfare Sector has barely functional vehicles. A crosscheck by the research at the national level indicated that the Department of Social Welfare at the national level had only three vehicles which were old and always needed mechanical attention.

4.4 Collaboration, Coordination and Decentralization

This section of the study presents findings on the relationship and collaborations as well as the challenges to decentralization in the Ministry of Health and Social Welfare.

4.4.1 Relationship between Health and Social Welfare

This subsection is devoted to looking at how the two Departments of Health and Social Welfare have related with each other over the years that they have been put under the same Ministry. The study revealed that the activities of the two Departments were run at a parallel level without any much collaboration. It was surprising to note that the two Departments at the planning stage of

the decentralization process worked hand in hand to kick-start the process but this collaboration has been short-lived. The findings of the study however gave indication that the two Departments collaborated in certain areas of common interest such as mental health, HIV/AIDS, Care for the Elderly and Orphans.

The following quotes affirm the findings of the study as discussed above:

“Well, the issue of collaboration, as I said, is one area that needs serious, serious attention. There is collaboration, but you can’t see it; it’s not visible. We have gone to several meetings and these issues have been flagged, For example you have mental health the division responsible for that aspect of service to be working closely.... So there’s a need to improve whether good or not, there’s a need to mend that aspect of the service delivery” (DUO, In-depth interview, MOHSW Central, April 17, 2014).

“When it comes to service delivery, the level of collaboration is, uhh, specifically in some areas. Ahh, basically during the planning process, six, seven years ago the Planning Department of the ministry itself tried to make sure that Health and Social Welfare worked together. So at the level of the county, over the period of time –if you check on the county plan, you will see they put certain things for Social Welfare there. So in terms of planning, there’s some level of collaboration. And then the next collaboration between the Department of Social Welfare and the Health Services Department has been on the issue of this National Health and Social Welfare Policy and Plan. That policy and plan in its development, I think, there was a lot of collaboration. They were involved in the validation of that document, in the fixing of that document, although Health Services started earlier. Then even when it came to the Essential Package for Social Services (EPSS) the two departments worked alongside each other. So there has been some, to some extent, there has been some collaboration, when it comes to policy level between the Health Services and the Social Welfare Department...” (SWO1, In-depth interview, MOHSW Central, April 19, 2014).

This section based on two respondents, has provided evidence to the effect that there has really not been enough collaboration between the Departments of Health and Social Welfare and this might account for the inability of especially the Department of Social Welfare to decentralize as

much as the Health Department has. The performance of the Ministry of Health depends greatly on the collective performance of the two core Departments of the Ministry. It therefore would have been expected that the administrators of the Ministry would have done everything possible to see to an effective collaboration of the two Departments in their services delivery. The National Health and Social Welfare Decentralization Policy/Strategy (2011) indicated clearly that the essence of the provision for the appointment of a Director of Decentralization was to ensure an effective implementation of decentralization within the Ministry and not one Department of the Ministry. Therefore it will be important that the Director of Decentralisation in the Ministry works at building more stronger collaborations between the Departments of Health and Social Welfare to ensure a holistic decentralization rather than a one sided decentralization as is currently the case. Abramson (2012) posited that the County Health and Social Welfare Teams were expected to strategize and respond to the local Health and Social Welfare issues faced by their communities at the local level. It is Important that the welfare representatives on the team is increased and strengthened to enable them contribute to the effective decentralization process. Collaboration of services as espoused by Sandford and Milward (2007) has benefits and that it offers the promise of accessing more resources and sharing the risks associated with finding a solution to them. This also gave policymakers the argument that such partnerships increase efficiency and allow citizens to receive seamless services. Additionally, there are potential synergies that come from collaboration that can create opportunities for learning and organizational improvement (Sandford and Milward 2007). As the adage goes that, a single hand cannot fill a basket but rather two hands will do so much that it is necessary that they both work together to reach the desired goal. The importance of coordination and collaboration also gives strength to the meaning of health by the Constitution of World

Health Organization (2006) that health is not just the absence of diseases but it also seeks to address a person's mental, physical and social wellbeing.

4.4.2 Challenges to Decentralisation

Findings from the study so far has indicated that the decentralization of the Ministry of Health and Social Welfare has not met the expectation of the Liberian people as can be derived from the opinions of some of the participants. This section is devoted to the challenges that have confronted and therefore hindered the effective decentralization of the Ministry.

One of the most important challenges to the decentralization process was the fact that the Ministry was reluctant to relinquish power to the personnel at the county and local levels making certain essential services still tied up at the central. Relatedly, the study found out that there was a general inadequacy of funding especially for the Department of Social Welfare which affected the decentralization of the Ministry negatively.

Furthermore, the findings of the study showed that the Ministry generally did not have the capacity to fully decentralize. The lack of capacity by the Ministry reflected in such areas as low technical support, lack of infrastructure, poor staffing and poor education of the staff who are responsible for the implementation of the decentralization program especially within the Social Welfare Sector were the major challenges to the decentralization process.

There was also the case of poor management and the lack of adequate sensitization of the staff and the Liberian people on the decentralization program which some participants believed contributed as a challenge to the decentralization process. Other participants felt there has not been enough education and sensitization and this has obliterated the decentralization process. In

a similar light, the study found improper coordination of activities and poor communication parts of the barriers to the effective decentralization of the ministry

The following are a few of the quotes supporting the conclusions drawn by the researcher above:

“Well the challenges, uhh, they are countless. It should not just be seen as someone being in power or managing funds, because, you know, you know, most of the political issues can be surrounded around money; “money is power”, but seeing decentralization as a mechanism wherein they would be able to provide services to the population at large and to provide their own quotas. For example, for the past time I’ve worked here at the Ministry, CHOs, when you go there to ask them, they would say, uhh, ahhh, the Ministry does not want to relinquish power. But when you further look at it the other way, the Ministry is giving out some money. So if the regional support team is clearly functional, well-functioning, I will think that the Ministry’s role will only be to provide oversight, and the counties themselves will be able to manage the meagre funds they have,..” (HO2, In-depth interview, MOHSW Local, April 18, 2014).

“... one of the challenges, ... is the issue of capacity. Capacity at the level of the county is a serious challenge. You go to county like Grand Kru, for example or Gbarpolu, you see the issues of capacity. The environment alone has its own challenge. To take a medical doctor, nurses and social workers to assign them, when we don’t even have nurses quarters, we don’t have places to lodge them; we are not paying them well sufficient, the motivation is not at its peak is a challenge. So when it comes to the issue of attrition, staff turnover - one of the key challenges serious, even to retain; the retention process is another thing” (DUO, ‘In-depth interview, MOHSW Central, April 17, 2014)

As indicated by the sequential theory of decentralization, Falleti (2004) where national interests prevail at the beginning of the decentralization process, administrative decentralization will likely occur first, then fiscal decentralisation and then perhaps political decentralisation (Falleti, 2004). This may be the case in the decentralization of the Ministry of Health and Social Welfare as the Department of Health in particular has been administratively decentralized with facilities

in the counties and the districts but have not been fiscally decentralized to be able to effectively operate. With the matter of the Ministry holding on to power which is supposed to be de-concentrated to the local level, the study confirms Steiner's (2006) findings in Uganda that some ministries strongly resisted the decentralization process and were not willing to relinquish power to the local authorities.

The finding with respect to the withholding of power goes contrary to the principles underlined in the decentralization policy document which indicates that the intention of the decentralization policy is to gradually allocate and transfer resources to the county (National Health Policy and Plan, 2008-2011). Crawford (2004) indicates that most local authorities rely heavily on the funds that are transferred to them from the central and in the case of both the Health and Social Welfare funds have been seen not to be forthcoming from the central government which is represented by the Ministry. For decentralization to be effective, there is need for the central to release funds to the periphery and on time for that matter.

With regard to the lack of capacity on the part of the Ministry to fully decentralize, the findings confirm the opinion expressed by the European Commission (2007) that decentralization may be too costly a process for most countries with smaller economies and has a potential of bringing about fiscal indiscipline. As seen in the first voice quote under this subsection, the participant hints of some monies being given out and yet raises questions as to how efficacious such monies are being used. This may just be an endorsement of the concern raised by the European Commission that the effect of smaller decentralized economies may have issues with fiscal discipline.

Further, according to Devas (2005), the economic development at the local level is dependent on the efficient and reliable service provision, and these in turn, are very much dependent on the right and adequate number of personnel as well as the availability of financial and logistical support. However, the findings of this study do not speak well for an effective decentralization of the Ministry of Health and Social Welfare.

4.5 Status and the Impact of the Decentralization Program

This section caps the chapter. It presents and discusses the findings of the study in respect of the state of decentralization of the Ministry of Health and Social Welfare and the impact of the implementation of the decentralization program on service delivery in the Ministry.

4.5.1 Areas Decentralized in the Ministry of Health and Social Welfare.

From the findings of the study, it is clear that there is still a lot to be done in the decentralization of the Ministry of Health and Social Welfare. However, there have been some marked areas that have been decentralized and merit mention. With the discussions in this chapter so far the study has given clear indications that administratively, the Health Department has largely been decentralised although the same case cannot be said of the Social Welfare Sector. From the findings of the study, the areas that have seen the most significant levels of decentralization in the Ministry have been planning and service delivery. However, the main area of decentralisation that is most relevant but which lags greatly behind was seen to be fiscal decentralization. It is in the opinion of the researcher that if the Department is fiscally decentralized and the Departments are able to generate and take major financial decisions at the local levels, most of the problems they face may reduce to the barest minimum.

Here are two of the quotes on the state of decentralization in the Ministry of Health and Social Welfare:

“The counties are now allowed to carry on their own planning. They carry on their own planning; they decide what their priorities are on a yearly basis or on an annual basis. So, that’s one. So those are the major areas. So in planning, in the area of planning, yes, we have decentralization; in the area of administrative structure, yes, you have decentralization. They perform their own functions. In fact, they have budgetary allotment that goes straight to the counties with the central ministry’s involvement” (SWO1, In-depth interview, MOHSW Central, April 19, 2014)

“Well, normally, you know the funding aspect is the government has the budgetary process, which is an annual event. It runs from June and then the following year’s July. So they send money to the Ministry of health broken down by department. So every department has its own support and then all those divisions, units and things, whether it is meagre, it’s given to those departments. The counties and hospitals are funded directly though under the health budget. JFK [John F. Kennedy Hospital] autonomously will have their own budget by the Health Budget. Jackson Doe Hospital, Phebe Hospital, all the other people will have their own budget. Ministry also gives subsidies to county hospitals, ELWA – all of that are under the Health budget” (DUO, In-depth interview, MOHSW Central, April 17, 2014).

The findings in this subsection indicate that the decentralization is still a fledgling in the Ministry of Health and Social Welfare and so much needs to be done. With the continuous arrogation of budgetary and funding responsibilities to itself by the Ministry, the counties and for that matter the local levels will continue to face the daunting task of effectively decentralizing and being effective in their services delivery. In effect, the situation of decentralization or better still the continuous centralization of the Ministry continues to limit the functions of the local officials and thus creating an environment wherein they have to continue to greatly depend on central government for both policy formation and implementation (Liberia National Policy on Decentralization and Local Governance, 2010)

4.5.2 Impact of Decentralization on Service Delivery in the Ministry of Health and Social Welfare

Considering that the preceding sections indicate fundamental challenges in both the Health and Social Welfare Sectors, and also the fact that vast disparities exist between the Departments, there is no need denying the fact that the decentralization program has come to stay of which Falleti (2004) stated that decentralization is a process which entails continuation rather than changing as a government changes. As has been seen in the foregoing subsection, there has been some level of decentralization in the Ministry of Health and Social Welfare albeit the many challenges. This portion of the study presents findings on the impact of the decentralization program on services delivery in the Ministry especially the local level. The findings showed that in some instances there were positive impacts of the program on services delivery and in other instances participants especially those at the local level opined that they did not feel the impact of the decentralization program.

On a positive note, the decentralization program has led to the formation of the County Health and Social Welfare Teams which have since been responsible for the implementation of the decentralisation program at the local level. Some of the implementations includes but not limited to making sure that people have access to health services, prevention of communicable diseases, and provision of birth certificate to every child. This to some extent has seen the activity of the Ministry at the local level. The findings of the study have also shown that there have been some establishments in terms of infrastructure and the provision of some logistics in the Health Sector. However, the findings of the study in terms of the actual impact of the services of the two Departments were generally not felt by the participants who were sampled at the local level.

For instance, in terms of the implementation of the programs of the Ministry, the Health and Social Welfare Teams are the key implementers from the county to the community levels because these represent the Ministry at the local level. For this matter, the effectiveness of the Health and Social Welfare Teams give indications of the effectiveness of the decentralization program. Mainly rural participants however indicated that they did not know of the County Health and Social Welfare Teams and this obviously means that they did not function in the communities of such participants. This cast doubts on the impact of the program on the lives of the local people.

Irrespective of such lapses as the foregoing, four officials who participated in the study indicated relative improvements in the delivery of services to the people of Liberia by the Health and Social Welfare Ministry, although the success was sharply skewed towards the Health sector of the Ministry.

Below are evidences stated by participants:

“Because nobody don’t come here. The town chief, sometimes we have meetings in our own community by ourselves. When the town chief [is] not able, then he sends it to the zone leader. When it goes to the zone leader, I know there can be some challenges especially when it comes to health and social welfare. But he can do something about it” (CM6, Gorzon Community, April 18, 2014).

Uhh, basically, there are improvements; there are improvements, and the basic improvement would be, especially when it comes to health, the fact that you have in all of the counties now; in lot of the districts you have health facilities, you have hospitals in all of the counties. At least, those basic services are there. Yes, indeed, one would say that to some extent the Health Services Department, the Health Services Department at least to some extent – at least the impact is felt in all of the counties (SWO1, In-depth interview, MOHSW Central, April, 2014)

From the findings on the impact of the decentralization program one can conclude that there have been some improvements in some areas of the services delivery of the ministry. To the extent that there have been an establishment of CHSWTs across the counties to oversee the implementation of the program is in the right direction and ought to be applauded. There has also been the expansion of health service delivery as implied by many of the participants. And despite the fact that the presence of the CHSWTs is yet to be felt by all the people at the local level, at least some of the people have started feeling their presence as can be seen in some of the voice quotes above. Finally, despite the disparities in decentralization between the two Departments of the Ministry of Health and Social Welfare, generally, there have been some marked improvements in especially health care service delivery that the program ought to be applauded for. The researcher concludes that the impact of the decentralization program may be gradual but will be felt greatly with time and the right commitments made by the government.

4.6. Conclusion

In conclusion, this chapter found relevant information on the objectives that it sought to achieve and the following are the conclusions on the findings:

Concerning decentralization and service delivery, the study established that there were four main reasons for the decision to decentralize and these were for the sake of good governance, effective service delivery, accessibility of services and empowerment at the local level. The findings also revealed that the decentralization of the Department of Social Welfare bereft with several challenges and also that though the Health Sector was more decentralized it also faced some challenges that affected effective service delivery. There were fundamental challenges in both Departments, including infrastructure, staffing, and logistics and funding.

In the area of the Health and Social Welfare Sectors and the decentralization process, the study affirmed that there were wide disparities in terms of the equipment of both Departments from the county through to the community levels. In all situations of disparity, the Health Sector was always more equipped compared to the Social Welfare Sector. The major reasons for the disparities were that the Health Sector was prioritised as more important compared to the Social Welfare Sector; funding and capacity building was geared more towards the Health Sector to the neglect of the Social Welfare Sector; and also that the Health personnel assumed leadership positions over the Social Welfare personnel and this potentially affected to some extent the allocation of resources to the departments.

With regard to issues around Collaboration, coordination and Decentralisation, the study concludes that there were no better collaborations between the two Departments and each Department ran its activities almost entirely detached from the other except in a few cases. The major challenges to decentralization included the reluctance to relinquish power to the personnel at the county and local levels, the generally lack of capacity of the Ministry to fully decentralize, and poor management and the lack of adequate sensitization of the staff and people of Liberia on the decentralization program.

On the Areas of decentralization, the study concludes that administratively, the Health Department has largely been decentralized although the Social Welfare Sector lags behind in this area. There was however a clear indication that decentralization in the Ministry was generally visible in the areas of planning and some services delivery.

Generally, it is concluded that some improvements in some areas of the services delivery of the Ministry due to the introduction of the decentralization program even though much more needs to be done to fully harness the positive impact of the decentralization program.

CHAPTER FIVE

Summary, Conclusion and Recommendations

5.0. Introduction

This chapter concludes the study and encompasses the summary of the study, the conclusion drawn from the findings by the researcher and the recommendations that the researcher makes for the improvement in the effective decentralization of the Ministry of Health and Social Welfare.

5.1 Summary of findings

The study set out to investigate the decentralization and service delivery of the Ministry of Health and Social Welfare taking into consideration, the challenges that the two Departments face in their quest to deliver services to the people of Liberia and also to ascertain that there are disparities between the progress of the Department of Health and of Social Welfare in the decentralization process, and the reasons for such disparities. Also of concern to the study was and the impact of the decentralization program on the service delivery of the Ministry of Health and Social Welfare, and the challenges to the decentralization process.

The reasons for decentralization was the first item to be investigated by this study and the findings indicated that the needs for good governances, the taking services to the door steps of the people of Liberia, accessibility of services and empowerment were responsible for the decentralization of government ministries and agencies in the country.

Findings on the decentralization of the Department of Social Welfare revealed that the decentralization of the Department was only on paper, with the officers and staff of the

Department facing several challenges on the ground. The challenges faced by the Department of Social Welfare in their service delivery in the decentralization era include the lack of logistical support and office spaces even at the county levels; the lack of staff across the various levels of the structure of the Department of Social Welfare: National, County, District and Community levels.

With respect to the decentralization in the Department of Health, findings clearly showed that the phenomenon had taken root in a number of counties with offices, staff and health facilities scattered across the counties. However, such success were limited to a few counties and findings showed that there were some counties that lacked many of the essential facilities to enable them deliver quality services to the people. There were a number of challenges that were identified with the Health Sector as well. It was identified that health facilities were not accessible to a great number of Liberians because they are located distant from the people and there were no ready means of transportation to health facilities. The findings also revealed that medicines were not readily available and patients were made to purchase drugs from private vendors making it very expensive for them.

Despite the challenges with both sectors of the Ministry, the study found that the Department of Health enjoyed a lot more support than the Department of Social Welfare. Findings revealed that there were three major areas of disparity between the two departments. These areas included the allocation of funds, development of infrastructure, and staffing. In all of these areas, the Health Sector enjoyed the greater portion. With staffing in particular, the Health staff at all levels were seen as heads of joint teams. This situation is capable of influencing the other two as in the face of scarcity the health officials who are the leaders of the teams will always prioritize their needs to the neglect of the Social Welfare Department.

Considering the reasons for the disparities, the study found that the government has always prioritized health service as essential and on the contrary, trivialised social welfare services. Therefore every funding that comes to the Ministry, majority is directed to the Department of Health. The other reason identified for the disparity was the fact that there were a myriad of other agencies such as the ministry of Gender, the National Commission on Disability and the National Commission on Disability, Rehabilitation and Reintegration (NCDRR), Ministry of Planning and Economic Affairs which performed similar roles as those of the Department of Social Welfare and tended to receive the funds that ordinarily should go to the Department of Social Welfare. Finally there seemed to have been the view that the leadership of the Department of Social Welfare did not do enough to fight for what should be entitled to the Department. There were however a few areas that the Health and Social Welfare Departments collaborated such as on issues of mental health, HIV/AIDS, Care for the Elderly and Orphans.

The study also revealed several challenges to the decentralization process including the unwillingness of the Ministry to relinquish power and the lack of funding especially for the Department of Social Welfare. The findings also showed low capacity of the Ministry; low technical support, lack of infrastructure, poor staffing and poor education of the staff as major challenges to the decentralization process. Planning and some service delivery seemed to be the only areas that the Ministry had to some extent decentralized.

In terms of the impact of the decentralization program on service delivery of the Ministry of Health and Social Welfare as a whole, the general impression was that not much had been felt at the rural areas of the country. This is against the fact that they are the reasons for the decentralization. However, mainly officials who participated in this study were of the opinion that services have improved compared to previously.

5.2 Conclusion

The decentralization program for all intent and purpose is a very important means of taking service delivery to the door steps of the people at the local level. It also ensures good governance as to a large extent; it creates transparency in the delivery of services. This study has established that decentralization has actually been experimented in the Ministry of Health and Social Welfare and to some extent has affected the lives of the people positively to a minimum limit. However, there have been some imbalances in the process between the two Departments of Health and Social Welfare in such a way that the Health Sector has tended to benefit from all forms of support to the Ministry to the neglect of the Social Welfare Sector.

This study concludes that the entire Ministry cannot achieve its decentralization target if the Department of Social Welfare continues to be deprived of the needed support. Although it was discovered from the interviews that there is an on-going debate of merging the Department of Social welfare with the Ministry of Gender and Development, in the view of the research it will not make any difference if the necessary support will not be given as there will also be the merger of two entities just like the Health and Social Welfare.

5.3 Recommendations

If the government of Liberia is to decentralize the Ministry of Health and Social Welfare effectively, there is the need for the government to expand infrastructure at the county, district and community levels. This should include office spaces especially for the staff of Social Welfare Department.

There is need for the Government of Liberia to revisit funds allocation to the Department of Social Welfare is there should be improvement in development

It has been realized that the Department of Social Welfare is woefully staffed. It is therefore recommended that the leadership of the Department should conduct researches that will justify the need for funds and support

Leadership of the Department of Social Welfare should advocate with the legislature and the Liberian Government in general to commit resources for the recruitment, training and deployment of Social Welfare staff to the local level to make the services of the Department felt at that level in fulfilment of the principle of decentralization.

Furthermore, it is recommended that leadership of the Department of Social Welfare embark on a strategic advocacy and sensitization of key government official on the importance of Social Welfare to national productivity. This will enable the government to begin to prioritize social welfare and therefore make funds available for the activities of the Department.

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APPENDICES

Table 1:

Interview Guide

Part 1 Background Information

- a. Please tell me your name and present position in the Ministry of Health and Social Welfare
- b. Tell me about your roles and responsibilities within the Ministry
- c. How long have you worked with the Ministry?

Part 2 Decentralization and Service Delivery

- A. What informed the Liberian Government's decision to decentralize its ministries and agencies?
- B. In the cases of the departments of Health and Social Welfare, How has the process been successful in bringing about improvement in the areas of health and social welfare in the country especially at the local level?
- C. With the introduction of the decentralization process, what challenges do you still face as a department?
- D. Has the decentralization of the Ministry of Health and Social Welfare contributed in any way to the resourcefulness or other wise of the staff of the department at the local levels?
Please throw more light on this.
- E. How many Social Welfare/Health official are in a typical CHSWT at the local level?

- F. On the average, how many health worker and DSW workers is one expected to find at the county and district levels in Liberia?
- G. How do the departments of health and social welfare fund their operations?

Part 3 Reasons for Disparity between the Departments of Health and Social Welfare

- A. Kindly describe how services are delivered in the Department of Health/ Social Welfare
- B. There is an apparent disparity in the decentralization process between the Department of Health and that of Social Welfare. What might have accounted for this disparity in your view?
- C. What do you suggests makes it possible for the health department to have advanced in the decentralization process compared to the DSW?
- D. Do you think the slow pace of decentralization in the DSW has something to do with their internal operational mechanisms?
- E. Would you say the composition of the CHSWT is balanced in terms of representation of the health and Welfare officers? Explain why?

Part 4 Promotion of Wellbeing by Collaboration through Decentralization Process

- A. What is the level of collaboration between the Health and Social Welfare Departments in delivery of services to meet the wellbeing of the population?
- B. What do you think account for the low/high levels of collaboration?
- C. What do you think is there for the DSW to learn from the department of health in the decentralization process?
- D. What would be some of the areas of collaboration between your department and that of DSW in your quest to fully decentralize?

Community leaders

- A. In time of sickness, how do you get to the nearest health facility?
- B. Can you explain the kind of services that are provided?
- C. When there are social problems like child abuse, domestic violence, old age people, etc. how do you deal with them?
- D. Who are those that provide you with social welfare services in your community?
- E. How was service delivery in terms of health and social services some five years ago?
- F. Decentralization is expected to bring services closer to you. What do you think about the health and social welfare services?
- G. What are some social problems in the community that you think can be handled by social welfare and health?
- H. How easy is it to work along with the CHSWT?

Table 2**Demographic Profile of Participants**

NO	CODE NAME	POSITION	AGE	SEX
1.	SWO1	Social Welfare Technical Specialist	32	Male
2.	SWO2	Social Worker	37	Female
3.	HO1	Director of Community Services	42	Female
4.	HO2	Commuity Health Department Director	40	Male
5.	DUO	Decentralization Unit Officer	44	Male
6.	CM1	Opinion Leader	57	Male
7.	CM2	Youth Leader	23	Male
8.	CM3	Youth member	21	Female
9.	CM4	NGO Supervisor	39	Male
10.	CM5	Town Chief	62	Male
11.	CM6	Women Leader	41	Female

Table 3

CODING FRAME

Organizing Theme	Codes/Basic themes	Description and definition of code	Quote(s)
Reasons for decentralization	Good governance	Taking the government closer to the people from the central to the local levels, where they will have inputs in decisions regarding their wellbeing (I)	<p><i>“Well, uhh, the government as a whole had been centralized for one hundred and forty some more years, and so as a background to this, in 2006 President Ellen Johnson Sirleaf during her inaugural speech said - she promised to take her government closer to the people. As a manifestation of that, the Governance Commission and other policy-related agencies were instituted. So the Ministry of Health in 2007 started its own process of de-concentration as a first phase of decentralization, as a first five-year policy from 2007 to 2011. That expired in July of 2011. And then the 10-year policy and plan 2011-2021 was launched again by Madam President in July of 2011. And so henceforth, the Ministry of Health and Social Welfare is the lead institution or entity of government when it comes to decentralization, as evidenced by the Governance Commission and Internal Affairs (Ministry) always making references. Even among or between the three service-provision ministries, to be Agriculture, Education and Health, we are just the lead when</i></p>

			<i>it comes to that - very visible in the counties, even at the level of the communities”.(DUO, In-depth interview, MOHSW Central, April 17, 2014)</i>
Effective service delivery	Getting services as successfully and quickly as possible to those it is intended for which will imply some level of quality on the part of the organisation. (I)		<i>“In my view, the reason is that there have been arguments that the services over the period of time have been very centralized, and because the services have been very centralized, the rural parts of the country were not really receiving the services adequately; they were not having much impact on service delivery in the rural parts of Liberia. So looking at the history of Liberia over the period of time, the Good Governance Commission that is charged with the responsibility of analyzing the governance system did a research and, in their own finding, they realized that we need to have a decentralized government, and that decentralizing the government is the best way to deliver goods and services”.(SWO1, In-depth interview, MOHSW Central April 19, 2014)</i>
Accessibility of services	Services are available to the people at all times no matter their distance and is user-		<i>“For me, my own opinion, I think one of the things that informed the government in decentralization is the 10-year health plan and policy</i>

		friendly (I)	<p><i>– uhh, because it’s clearly spelled out that health services would be provided at all levels. And in other for health services to be provided at all levels, there are structures that have to be in place, that is, from the community upwards. You have the national, you have the county, you have the district, and downwards to the community. So I think that is one thing that has informed them; and the other thing that may have informed them in decentralization is trying to learn from neighboring countries, seeing how well they have structured their health services and they’ve provided care to their populations. Uhh” (HO1, 9months in present position, April 23, 2014)</i></p>
	Empowerment	Empowerment is the process of increasing the capacity of individuals or groups to make choices and to transform those choices into desired actions and outcomes (D)	<p><i>“Well, if you look at things and things are being centralized at the nation’s capital, it makes services to the rural part of the country inaccessible because it’s like every little you want to the various counties, you have to come to central Monrovia to have it done. So that was a serious challenge and in making services to reach the needy population at the given time. So for that reason it was prudent enough that decentralization can be put into place so that at the county level, people can be empowered to carry on similar activities that the</i></p>

			<i>central would do”.(HO2, In-depth interview, MOHSW Local, April 25, 2014)</i>
Challenges – Social welfare	Logistical support	Providing or supplying with money or necessities to carry out responsibilities and functions (I)	<i>“For logistic, sometimes it can be difficult because here sometimes you go on the field, you have to get scratch cards, at least, to be able to call your client, but no scratch cards. And the logistics area can give us problem, because if you don’t have like notepad – those things them, sometimes they can hardly even supply us easily. I stop”. (SWO2, In-depth interview, MOHSW Local, April 27, 2014)</i>
	Office facilities	Office spaces and infrastructures (I)	<i>“Number one, logistics. And to be frank with you, Patricia, we’re in the county we have no office space. My two years and a half, almost three years, since we’ve been here, we’ve been talking about office, we don’t have an office. If we have some cases, and most of cases like rape cases are confidential. You can’t be talking it among public. And for the CADP, we and he, we share the same office, but the sharing the same office, we don’t even get desk to sit on. When we sit, someone will say, EPI, I’m ready to do my work. Then on the other side, the TB: “O, I come to do my work”. So we’re just standing up.</i>

			<p><i>When people come, we use the conference room. That's where we can always go, and it's very, very much challenging for us, serious problem because the last time we had a case here and we were in the room; five minutes somebody would just come and open the door. And you know when the client is talking, and somebody comes in, at that time they will go off and keep silent because it's not everybody going to hear somebody's own of secret. But we've been approaching our CHO, and our CADP and the CADP was not here, but the CHO's own, he will just promise us: "You'al just wait; you'al just wait". But I've now made two years, almost three years. It never happens yet".SWO2, In-depth interview, MOHSW Local, April 27, 2014)</i></p>
	Adequate staff	Sufficient staff with the requisite knowledge assigned in every locality required that will make serves accessible.	<p><i>"We should have social workers in each of our clinics. Each of our clinics – social worker should be assigned in those clinics. But we've only got five in Buchanan. So can we say, it's a balance? No. If I say, there's a balance, then I'll be deceiving myself. There's no balance". (HO2, In-depth interview, MOHSW Local, April 25, 2014)</i></p>

	Fragmentation of services	Services mandated to an institution that are carried out by different institutions; disintegrated services (I)	<p><i>“Now for the Social Welfare side, not many donors have been providing that level of support. Now, and one of the reasons I see for the gap with the Social Welfare side is that over the period of time the Social Welfare side of the Ministry’s services usually have been duplicated by other agencies and other ministries. So once you have that duplication, what has happened over the period of time, most of the funding that should come for Social Welfare has been scraped; most of the technical support that Social Welfare should be receiving is all over the place. So that in itself reduced the level of support that Social Welfare should have had as a department. For example, you have the National Commission on Disability that has got support. Before that, you had the NCDRR (National Commission on Disability, Rehabilitation and Reintegration). Now that commission was set up. Now if that commission, if at the time, when they were setting up that commission, you had put it under Social Welfare and not as a commission, because of emergency, there was a lot of support it would had boost their support, because there was a lot of donor attention there. They would have provided the kind of technical support that Social Welfare needs to develop her</i></p>
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			<p><i>policies and standards. Then Social Welfare would have been on par. Then you have the Ministry of Gender. The Ministry of Gender has a mandate, but many times Ministry of Gender is performing certain functions that should be solely and wholly Social Welfare's functions. So what has happened over the period of time is the different technical support that should have been well focused towards Social Welfare is split all around. So everything becomes ad hoc". (SWO1, In-depth interview, MOHSW Central, April 19, 2014)</i></p>
	Funding	Money	<p><i>"Uhm. Nothing, Ma, because why I say nothing, the funding is not there. Many times, that's some of the challenges we have. This EPSS Section, when they brought it, we made our proposal – that time Sis. Joyce was here, the administrator, we gave it to her, they approved of it. Since they approved of it, almost going to two years and we've not implemented anything. All they always have to say is: Social Welfare don't have budget yet. So if is there, they will give it to us, but the money for them to look there and give to us, Ma, it's not easy". (SWO2, In-depth interview, MOHSW Local, April 25, 2014)</i></p>

Challenges- Health	Access to health services	Being able to reach and use health services on time because they are available and easy to reach	<i>“Serious emergency cases. You’re not thinking about Buchanan alone but the rural areas the roads bad, bad road network. These are some of the things that make it impossible too to enhance work of the health sector. But now we are seeing some sign of improvement on they are building more roads. Even clinics are being built in the rural areas. So I think there’s a bit improvement”. (CMI, Korduan Community, April 18, 2014)</i>
	Medication	Drugs that are prescribed for patients at the hospital	<i>“Sometimes when we go we get it, we buy some, because when you go, sometimes they give you paper; the person will be on bed, but they will give you the paper still; you go buy the medicine and bring it in the hospital”. (CM6, Gorzon Community, April 18, 2014)</i>
	Unavailability of staff	Staff that should be at work but are absent; staff that are unreachable	<i>“So there are couples of challenges still. Manpower – sometimes, you don’t have the right staff to work in the area; sometimes you may have the right staff but the issue of staff retention and turnover is about payment, salary, remuneration issues. Sometimes logistics – poor management of logistics. Every time you go there, they will cry, o,</i>

			<i>we want car, we want this, we want this, but there is no system to manage those assets, etc; and if we want to see decentralization as just leadership and governance but it goes beyond that. You have to touch every aspect of it”. (HO1, In-depth interview, MOHSW Central, April 17, 2014)</i>
Areas of Disparities	Funds	Resources provided, usually in form of money, or other values such as effort or time, for a project, a person, a business, or any other private or public institution (D)	<i>“...far far. The Heath Service budget is almost 60 close to 70 percent of all the money that comes to the Ministry, Health Service has that, I can tell you that for free. Even Planning has a very minute budget but Social Welfare is so huge an area when it comes to the scope of operation when it comes with very meagre budget, even vehicle is a problem at the central office”. (DUO, In-depth interview, MOHSW Central, April 17, 2014)</i>
	Infrastructure	the basic, underlying framework or features of a system or organization; the fundamental facilities and systems serving a country, city, or area (D)	<i>Obviously health is a part of health and social welfare. Even when it comes to the health, when you look, that’s why we have the health policy and social welfare policy but when you go to service delivery but the social welfare arm is not fully supported, to be very frank, so the issue of the capacity ,infrastructure is a challenge lot more to be done depending on the performance. So we see there’s an apparent disparity between the Health Sector and the Social</i>

			<i>Welfare Sector. The Health Service budget is far more than that of Social Welfare”. (DUO, In-depth interview, MOHSW Central, April 17, 2014)</i>
	Staffing	the process of acquiring, deploying, and retaining a workforce of sufficient quantity and quality to create positive impacts on the organization’s effectiveness	<i>“Ahh, two, the Health Services (department) is more decentralized if you want to say it. Looking at the two departments, Health Services is more decentralized, and that, meaning that they have more personnel in the county. They have personnel at the level of the district; they have personnel at the level of the community; they have personnel at the level of the county. So at all levels of the Ministry, the Health Services department has functions to perform”. (SWO1, In-depth interview, MOHSW Central, April 19, 2014)</i>
	Prioritization of health activities	Activities that are ranked highest and important as compared to other activities	<i>“Number two, uhh, the Health Service Department over the period of time has been able to, because of their donor support – they have had a lot of donor support, and that donor support over the period of time has been not only in terms of funding but also in terms of capacity building. So the Health Services Department’s capacity has been built, and they have the funding. So over the period of time, they have been able to at least develop</i>

			<p><i>a lot of programs and develop a lot of services because of the level of capacity they have had over the period of time. So in terms of personnel, in terms of everything, they have had over the period of time, because a lot of the donors that usually come to the Ministry of Health and Social Welfare, in many instances, are usually attached to health programs. For example, you have the Global Fund. You know the Global Fund focus on HIV and AIDs, malaria, tuberculosis, you know. And usually, the donors are interested in programs where they basically can have indicators. So the health services over the period of time have been able to have over the period of time to have all those different things in place. So over the period of time, a lot of the program, the donors have been focusing on health services”. (SWO1, In-depth interview, MOHSW Central, April 19, 2014)</i></p>
	<p>Duplication of social services</p>	<p>One or multiple kinds of services conducted by more than one organization</p>	<p><i>“... Some of Social Welfare functions have been performed by other people for example Ministry of Planning has this social protection program that is social welfare. The Ministry of Gender has social welfare functions they are performing which they shouldn't. other countries like South Africa, you see Social Welfare being pulled, supported</i></p>

			<i>and highlighted, but unlike here, we don't even have the support base, but when it comes to other things, we still need to put them in place". (DUO In-depth interview, MOHSW Central April 17, 2014)</i>
	Leadership	a process of social influence in which one person can enlist the aid and support of others in the accomplishment of a common task	<i>"...And then the Social Welfare Department over the period of time, like I said, has never had the human resources to provide the needed leadership. Leadership also is a key thing. So at the top, which we cannot squarely blame the department because the Ministry of Health was not planned to have Health and Social Welfare together, but the leadership over the time, most of them never had serious knowledge about social welfare function, were not exertive, were not on top of the issue. That has been a serious leadership gap. That to a greater extent affected Social Welfare". (SWO1 In-depth interview, MOHSW Central, April 19, 2014)</i>
	Capacity building	the empowerment which involves the ability, will and skills to initiate, plan, manage, undertake, organise, budget, monitor/supervise and evaluate project activities (D)	<i>"Capacity has been improved, example, the financial management have been training their financial staff in the counties, County Health Service Administrator, County accountants and hospital accountants. Some have gone to the Mother Patten School. We have also been sending people to countries like Japan and China. And also there are other trainings</i>

		<p><i>conducted for health facilities, officers in charge, environmental health technicians at some levels, different levels and there are series of interventions". (DUO, In-depth interview, MOHSW Central April 17, 2014)</i></p>
Strategies of Health	<p>Advocacy</p> <p>a political process by an individual or group which aims to influence public-policy and resource allocation decisions within political, economic, and social systems and institutions. Advocacy can include many activities that a person or organization undertakes including media campaigns, public speaking, commissioning and publishing research (D)</p>	<p><i>"Well, that's a difficult question, One, I think Social Welfare also needs to do a lot of work to bring the uhm go for some of the things that belong to them. Don't just sit back; you need to move; you need to do like the angel and Jacob. He placed demand and his name to be changed from Jacob to Israel. So move for it; go for the need; build some capacity; demand some reasons for capacity building and support and justify them beyond all doubts, make some constructive noise around, become part of some of the meetings and get their involvement". (DUO, In-depth interview, MOHSW Central April 17, 2014)</i></p>
	<p>Improved service delivery system</p> <p>Putting in place the facilities, personnel along with the needed resources to improve output (I)</p>	<p><i>"Uhh, basically, there are improvements; there are improvements, and the basic improvement would be, especially when it comes to health, the fact that you have in all of the counties now; in lot of the districts you health facilities, you have hospitals in all of the counties. At least, those basic services are there. Yes, indeed, one would say</i></p>

		<i>that to some extent the Health Services Department, the Health Services Department at least to some extent – at least the impact is felt in all of the counties”.(SWO1, In-depth interview, MOHSW Central, April 19, 2014)</i>
Restructured system of staff	Making sure the right people with the right qualifications are employed and placed in the position based on their qualification	<i>“Social Welfare can see the trend of decentralization occurring in the counties. When you go to the counties, you see the set-ups. The County Health and Social Welfare Teams are set-up. Even if it is not 100% they are making things happen at least 75-80%. They have the structure, everyone has their terms of reference, except for the District Health Officers that we are still trying to put together, but the rest of the people have their terms of reference on what they should do, they got their reporting channels and they’ve got their processes which is to deliver services and their feedback mechanisms, relevant supervisors and up to the central level. If that is done for Social Welfare it would be good...” (DUO, In-depth interview, MOHSW Central, April 17, 2014</i>
Mental Health, HIV/AIDS, Rehabilitation, etc.	Programs run by the Health Service Department (I)	<i>“Uhh, the, the – there are certain programs like the Mental Health Program – we have a collaboration. There’s a lot of collaboration in terms of the</i>

Areas of collaboration and coordination			<i>Mental Health with the Psychosocial Unit. There has been collaboration with rehabilitation. Collaboration is there. The next area of collaboration when it comes to the HIV and AIDS – they have what they call OAC (Orphans and Abandoned Children). Uhh, though that function should be squarely under Social Welfare, but there has been some collaboration between Social Welfare and Health Services when it comes to that, especially when it comes to the research”. (HO1, In-depth interview, MOHSW Central, April 17, 2014)</i>
Level of relationship/collaboration	Poor	Collaboration is not visible	<i>“Uhm. No good collaboration, no good collaboration. I don’t want to lie, because everything we need, Health got problem; when it comes to the Health, everything they do, they get their per diem; if they go to do supervision, they get their per diems. Everything they do is very good. But when it comes to the Social Welfare, it’s very ridiculous”. (SWO2, In-depth interview, MOHSW Local, April 18, 2014)</i>
	Gradually improving	Collaboration is being refined (I)	<i>“Uhh, if I am speaking from Ministry and my eight-month experience, I will say, generally things are gradually improving, but if I am speaking from other experiences – because I also</i>

			<p><i>worked as a social worker with NGOs, with the County Health Team as I earlier said, they - uhh, they are working, they are working, but there still needs to be - areas to be strengthened, especially the social welfare part of it," (HO1, In-depth interview, MOHSW Central, April 17, 2014)</i></p>
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TABLE 4

CODE FREQUENCY TABLE FOR OFFICIALS OF THE MINISTRY OF HEALTH AND SOCIAL WELFARE

Organizing theme	Basic Themes/codes	SWO1	SWO2	HO1	HO2	DUO	Total
Reasons for Decentralization	Good governance	✓				✓	2
	Effective service delivery	✓	✓	✓	✓	✓	5
	Accessibility of services	✓	✓	✓	✓	✓	5
	Empowerment	✓			✓	✓	3
Challenges – Social welfare	Logistical support	✓	✓		✓	✓	4
	Office facilities		✓		✓		2
	Adequate staff	✓	✓		✓	✓	4
	Fragmentation of services	✓				✓	2
	Funding	✓	✓	✓	✓	✓	5
Challenges-Health Challenges	Access to health services			✓	✓		2
	Medication		✓		✓		2
	Unavailability of staff			✓	✓	✓	3
Areas of Disparities	Funds	✓	✓	✓	✓	✓	5
	Infrastructure	✓	✓		✓	✓	4
	Staffing	✓	✓	✓	✓	✓	5
Reasons for Disparities	Prioritization of health activities	✓		✓	✓	✓	4

	Duplication of social services	✓				✓	2
	Leadership	✓			✓	✓	3
Strategies of Health	Capacity building	✓		✓	✓	✓	4
	Advocacy	✓				✓	2
	Improved service delivery system	✓	✓	✓	✓	✓	5
	Restructured system of staff	✓		✓		✓	3
Areas of collaboration and coordination	Mental Health, HIV/AIDS, Rehabilitation, etc	✓		✓		✓	3
Level of relationship/collaboration	Poor		✓				1
	Gradually improving	✓		✓	✓	✓	4

TABLE 5

CODE FREQUENCY TABLE FOR COMMUNITY MEMBERS

Organizing theme	Basic Themes/codes	CM1	CM2	CM3	CM4	CM5	CM6	TOTAL
Impact of Decentralization	Knowledge of CHSWT	✓	✓	✓				3
	Access to MOHSW Health services		✓					1
	Access to MOHSW Social Services (minimal level)		✓					1
	Purchase of medications	✓		✓		✓	✓	4