

# UNIVERSAL, QUALITY, AND EQUAL ACCESS TO HEALTH CARE TO ALL LIBERIANS

## Situational Assessment of Liberia's Capacity for Performance-based Contracting of Non Governmental Organizations for the Delivery of the Basic Package of Health Services



May 2008



## Acknowledgements

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This situational assessment would not have been possible without the guidance and support of the Ministry of Health and Social Welfare. The Ministry of Health and Social Welfare made available to us the support services of its staff and provided us with numerous studies and documents which helped us to better understand the current health system in Liberia. Our appreciation goes to the following: Walter T. Gwenigale, MD., Minister, and Tornorlah Varpilah, Deputy Minister for Planning, Research and Development who led the team in the execution of this assessment and provided guidance and vision for this activity as well as all of the staff from the Ministry of Health and Social Welfare who so kindly took the time to meet with us and provide us with information and documentation on the Liberian health situation. Those members included Benedict Harris, Roland Kesselly, and Momolu Sirleaf. In addition we would like to express our gratitude to the many Non Governmental Organizations, Faith Based Organizations, and members of the International Donor community who generously and openly provided us with information on their work as well as their perspective on the potential for performance-based contracting in Liberia. Special appreciation goes to JSI staff Elizabeth Williams for all of her support in editing and coordinating this assessment and to Carrie Hessler-Radelet and Dekonti Sayeh of JSI and Winthrop Morgan for their editorial support. Primary authors of this report are Wendy B. Abramson and Ann Levin of JSI.

## Acronym List

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BPHS	Basic Package of Health Services
CHAL	Christian Health Association of Liberia
CHO	County Health Officer
CHT	County Health Team
CHW	Community Health Worker
CMO	Chief Medical Officer
DIFD	British Development Agency
EC	European Commission
ECHO	European Commission Humanitarian Aid
EU	European Union
ELWA	Eternal Love Winning Africa
FBO	Faith Based Organization
FPAL	Family Planning Association of Liberia
GOL	Government of Liberia
HMIS	Health Management Information System
(BP)HIS	(Basic Package) Health Information System
HISP	Health Information System Program
IDP	Internally Displaced Persons
IMC	International Medical Corps
IRC	International Rescue Committee
IUD	Inter Uterine Device
JSI	John Snow Inc.
LACE	Liberian Agency for Community Empowerment
LCM	Liberian Coordination Mechanism
MDM	Medicines du Monde
MERCI	Medical Emergency and Relief Cooperative International
MSF	Médecins Sans Frontières
(I)NGO	(International) Non Government Organization
OFDA	Office of Foreign Disaster Assistance
OIC	Officer in Charge
NEID	National Essential Indicator Dataset
NDS	National Drug Store
NGO	Non Governmental Organization
PMU	PMU Interlife
PPA	Performance-based Partnership Agreements
SC-UK	Save the Children – United Kingdom
TOR	Terms of Reference
USAID	United States Agency for International Development
BPRM	U.S. Bureau of Population, Refugees and Migration
USG	United States Government
UNFPA	United Nations Populations Fund
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Infant and Child Education Fund
UNMIL	United Nations Mission in Liberia
WHO	World Health Organization

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## Background

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When the fourteen year war, civil strife, and violence ended, health care service delivery was fragmented and uneven, and heavily dependent on donor-funded vertical programs and international NGOs. Since that time, and particularly since the democratic elections in 2005, Liberia has taken bold steps to transition from an emergency relief model of health service delivery to the development of a functioning, decentralized health system where counties are responsible for operational management of health services with support from the central Ministry of Health and Social Welfare and a diverse set of partners. The cornerstone of this decentralized primary care approach is the delivery of a Basic Package of Health Services (BPHS) to be provided at each level of facility in Liberia.

The BPHS includes six components:

- Maternal/newborn care (ANC, safe motherhood, EmOc, neonatal care)
- Child health (EPI, IMCI, nutrition, other)
- RH/Adolescent care (FP, STI, adolescent RH)
- Communicable disease control (HIV/AIDS, TB, Malaria, other)
- Mental health (PTSD, psychosocial, psychiatric)
- 6-emergency care (pre-hospital and referral systems)

The Ministry of Health and Social Welfare defined its vision for their national health system in January 2007 through the National Health Policy and a five-year National Health Plan (2007-2011). The plan defines a framework for shifting from emergency humanitarian relief to development and from vertical programs to an integrated health system.

At present, the health sector has decentralized authority to the County Health Teams (CHT) in Liberia's 15 counties. Guided by a clear vision of decentralizing many functions of government, the Ministry of Health and Social Welfare is striving to develop strategies, plans and capacity-building models that work towards the future sustainability of Liberia's health system.

A county-focused system has been put into place which decentralizes administrative and financial management to the county health teams and promotes the BPHS. The BPHS has been tailored to each level of the Liberian health system, and all facilities (both public and private) at the same level will implement the same package of services. The content of the BPHS is based on evidence of those interventions that have been proven to be most cost-effective at reducing morbidity and mortality. Effective delivery of the BPHS in every county will allow the Ministry

of Health and Social Welfare to extend overall coverage, strengthen Ministry of Health and Social Welfare management, improve the quality of service delivery, monitor performance and evaluate impact in a way that allows for direct comparisons between providers and programs.

At this point in time, to rapidly expand access to basic health services throughout the country, the Ministry of Health and Social Welfare will continue to rely on collaboration with the private/non-profit health providers that still deliver the majority of services to the Liberian people. The national health system will gain in transparency, efficiency and effectiveness if relationships with service delivery partners are formalized into mutually binding commitments - contracts.

## Introduction and Context

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Liberia is the first and only country, from what our research has shown, that has had the impetus to actually conduct a situational assessment of its capacity to carry out performance-based contracting prior to deciding whether to and how to contract NGOs. This demonstrates progressive, strong leadership and thoughtful planning. Most other countries that have carried out contracting with NGOs have only done so as part of international donor projects or through donor-driven mechanisms. Few national governments have directly designed, managed, monitored, evaluated and paid NGOs for services; mostly donors or their contractors such as the Asian Development Bank, the InterAmerican Development Bank, the World Bank, USAID, European Community, etc. have been the principal implementers of contracting.

This assessment is meant to be a general overview of Liberia's capacity to contract NGOs for the BPHS. Given that Liberia is currently in the process of starting over, of building its health care system from the bottom up, this assessment touches upon the key systems within the Liberian Health sector that are imperative for successful contracting of NGOs for the BPHS. These systems include finance and administration, human resources, supply chain management, regulation and quality assurance, and health information systems. Thusly, rather than assessing merely Liberia's readiness to contract NGOs for the BPHS this assessment has had to encompass a much wider scope of work. Most countries in the world have already established health systems in place which function to a large extent. On the other hand, in the case of Liberia - as a post-conflict transitional health system - these systems are being simultaneously developed as the country is working to develop a strategy for performance-based contracting of NGOs in order to increase access to the BPHS.

Over the last two years Liberia has conducted a number of assessments of key components of its health system including: community health workers, health information systems, human resources, financial management and accounting, NGO capacity, etc. all of which were consulted as part of this assessment. Prior to implementing contracting of NGOs the Ministry of Health and Social Welfare needs to consider specific in-depth analysis of key public health functions necessary for transparent and effective contracting of NGOs for services. These assessments may include but not be limited to: financial and accounting systems, human resource management, regulatory environment, and standardization/accreditation of NGOs/providers as recipients of GOL funding. These mini in-depth analyses should form part of the Ministry of Health and Social Welfare contracting implementation plan.

## Purpose

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The Ministry of Health and Social Welfare has contracted John Snow Inc. (JSI) directly to work with a team from the Ministry of Health and Social Welfare to conduct a situational assessment of Liberia's capacity to contract NGOs for the BPHS, develop a National Health Strategy/Policy on Contracting, and, based upon the Contracting Policy, design a contracting model or template for Liberia that will increase access to services included in a basic package of health services defined by the government.

This assessment serves to inform the development of the Ministry of Health and Social Welfare's strategy, contracting policy and implementation design. The Ministry of Health and Social Welfare will explore through this assessment the best ways to ensure a smooth transition from humanitarian relief to development and sustainable strengthening of the health care sector. This policy and the pilot model will be empirically-based upon research conducted in developing countries throughout the world including, but not limited to, those in post-conflict settings. Contracting of NGOs is exclusively Ministry of Health and Social Welfare driven and the international donor community has expressed its willingness to support and finance this effort; however, the impetus for contracting comes entirely from the Government of Liberia (GOL). This will aid in ensuring the sustainability politically of contracting in Liberia.

And lastly we wanted to mention that there are no specific policies on contracting of NGOs for service delivery or otherwise anywhere in the world. Rather contracting of NGOs has fallen under the purview of international donor projects or is done without the benefit of a specific policy. This assessment report intends to provide a general assessment of Liberia's situation vis a vis contracting of NGOs for the BPHS. We will develop a strong set of recommendations, options, and scenarios for the development of a contracting strategy and subsequent implementation plan as our second deliverable to this contract.

# Methodology

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## **1. Desk research**

Desk research was ongoing and focused on the roles of the public and non governmental sectors in the delivery of health services in Liberia and elsewhere in the world including other post-conflict transitional countries as well as countries seeking to increase access to care and improve quality of primary care service delivery. A listing of documents consulted is included in the Appendix 2. Country experiences, service delivery contracts, assessments of experiences in contracting out and in for primary health care services, and support and ancillary service contracts were looked at from a number of countries including: Afghanistan, Bangladesh, Cambodia, Cameroon, Colombia, Costa Rica, El Salvador, Guatemala, Haiti, Malawi, Rwanda, and South Sudan. This analysis also built upon the extensive body of research already conducted by JSI and others.

## **2. In-country focus group discussions and interviews**

JSI team travelled to Liberia from May 6 -21, 2008 to work with a team from the Department of Planning, Research and Development at the Ministry of Health and Social Welfare to carry out discussions with key stakeholders. The team met with Senior Staff in the Ministry of Health and Social Welfare, members of International and Liberian NGO's, donor community, five of 16 County Health Officers and Team Members from Bomi, Bong, Sinoe, River Gee, Montserrado, and other key stakeholders. A list of stakeholders who either participated in focus group discussions or interviews is attached in Appendix 3. The team worked with the International Senior Lawyer's Project and the law firms Hogan and Hartson and Clifford Chance, who are providing the Ministry of Health and Social Welfare with technical assistance in the development of its Office of General Counsel.

## **3. Development of a Framework / Policy and a Plan/template for Ministry of Health and Social Welfare performance-based contracting**

Based upon the results of the situational analysis and the experience of JSI and others in this field, the team will assist the Ministry of Health and Social Welfare in developing a strategic framework and a plan for performance-based contracting with NGOs for the delivery of health services to increase access to the Basic Package of Health Services. The Contracting Plan will consider this situational analysis, current state of the practice and experiences in other countries with NGO contracting, the current situation in Liberia, future plans for decentralization of health service delivery, and the priorities of the Ministry of Health and Social Welfare as identified in the National Health Policy and Plan.

## **4. In-country validation**

Upon receipt of the final assessment, the Ministry of Health and Social Welfare will arrange a validation workshop to internally vet the results of the assessment with staff in the Central Ministry of Health and Social Welfare and CHT. External stakeholders such as NGOs and donors will also participate in these discussions in order to ensure wide participation in the formulation of Liberia's contracting strategy. Discussion will also ensue around what Liberia's contracting strategy might look like.

## **Contracting as a Useful Mechanism for Delivering Health Services: the Historical and Contemporary Context**

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There are a number of post-conflict states including Afghanistan, Cambodia, Democratic Republic of Congo, Rwanda and South Sudan that are employing performance-based contracting as a means to increase access to basic primary care services. In addition, countries such as Bangladesh, Guatemala and Haiti are utilizing contracting in order to target geographically and/or culturally difficult to reach populations.

The history of Afghanistan is one with strong donor support of a number of health reforms including a new public-private partnership model for service delivery. This new model was based on the split between purchaser and provider of services. A Basic Package of Health Services was designed and an attempt to cost it out conducted. Contracting of services was adopted on a large scale through Performance-based Partnership Agreements (PPAs). These agreements or PPAs between the MOH and NGOs would allow the MOH to capitalize upon existing NGO post-conflict capacity to deliver health care services while still maintaining control over the strategic direction of the health sector. The MOH chose to strengthen their stewardship role and focus primarily upon policy development and health sector regulation. The PPAs were financed by the World Bank, European Community and USAID. Although each donor adopted different implementation mechanisms, the MOH ensured that payment was tied to performance which was measured against predetermined indicators.

Afghanistan created a contract and management unit within the Ministry of Health and Social Welfare of Health to oversee the contracting process and universities were tasked with monitoring these contracts. Five years after contracting began, the majority of districts across Afghanistan are served by NGOs.

In Cambodia, two modalities for partnership with NGOs were implemented – contracting out an entire package of primary care services to a NGO and contracting in whereby a NGO managed health facilities staffed by Ministry of Health and Social Welfare of Health civil servants under government payroll. Both were successful in increasing access to care and improving efficiency, however the contracting out model whereby the NGOs hired staff, ensured supplies and equipment, and managed facilities had the greatest success.

# **Ministry of Health and Social Welfare Capacity to Contract and Constraints**

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The Ministry of Health and Social Welfare National Health Policy states that, “the county level shall be responsible for health service delivery, while the central level will focus on policies, resource mobilization and allocation, aggregate planning, standards setting and regulation.”

In order for the Ministry of Health and Social Welfare to effectively plan, manage, monitor and evaluate a program to contract out service delivery, it must have functioning regulatory and management systems in place at both the central and county levels. The following section describes current Ministry of Health and Social Welfare capacity in areas relevant to contracting.

## **II. Ministry of Health and Social Welfare Central Level**

### **A. Regulation, Oversight, Supervision**

An essential prerequisite for public sector contracting is the government’s ability to provide oversight and regulation of service delivery providers regardless of their origin (public, not for profit or commercial for profit). This oversight and regulation includes accreditation of facilities and providers, application and enforcement of national treatment standards, protocols, and norms.

At present, norms and standards are being developed at the central Ministry of Health and Social Welfare for various components of the BPHS. Treatment protocols which are currently available are those for malaria, HIV/AIDS, TB/Leprosy, and immunization. Those in process include: child health/IMCI, National Eye Care, Emergency Preparedness and Response, etc. For the most part, Ministry of Health and Social Welfare facilities and NGOs are applying WHO standards while the GOL develops its own protocols and norms. Given the significant challenges to human resource recruitment, training, mobilization and supervision, efforts to update health care professional standards and training curricula are priorities but are still not in place. Consequently, there is a great deal of variation in the quality and content of services delivered.

The Ministry of Health and Social Welfare central staff conducts supervisory visits to the CHT on a quarterly basis. An integrated supervisory tool was just developed and five teams of two people on each team conduct supervisory visits to the counties.

The referral system has not yet been standardized. There are no norms and protocols for two-way flow of information (such as referrals) from one level of the system to the next. A policy for referrals between facilities has yet to be developed.

### **B. The Legal Framework**

At this time the Government of Liberia (GOL) is presently conducting a thorough review of Liberia’s public procurement laws enacted in 2005 which dictate how government may spend its funds. The team consulted with both legal counsel from Clifford Chase who are advising the Ministry of Health and Social Welfare on their health law as well as the Senior Lawyers International Program in order to obtain their input and guidance on Liberia’s public

procurement law. Neither of these organizations at the time of the assessment were able to advise on whether there are any legal restrictions to contracting with NGOs for service delivery. Further guidance on the level of stringency of this law in terms of the Ministry of Health and Social Welfare's ability to contract NGOs for service delivery and examination of the Public Procurement Law once it is revised will need to be clarified in the future in consult with the Ministries of Justice and Foreign Affairs.

## **C. Financial Management and Administration**

### **1. Procurement and contract management**

The Ministry of Health and Social Welfare is presently interviewing for a new procurement director. The CHTs are depending on the central unit for most of their purchasing and it is important to find the best value for money.

Currently the Ministry of Health and Social Welfare manages two contracts: 1) security services and 2) printing of birth certificates. The first contract is under review and will be revised this year as it is due to terminate. This contract lacks specificity and requires more exact language. One issue to be resolved is a dispute over the boundaries of Ministry of Health and Social Welfare land and (eg: neighbors walk through Ministry of Health and Social Welfare property at night).

The second contract involves printing of birth certificates. The documents are free for children less than five years but a fee of L\$400 for those between five and 14 years of age and L\$800 for those 15 years and above. There is a problem with Ministry of Health and Social Welfare personnel inflating fees, not always obtaining receipts, etc. The Ministry of Health and Social Welfare and contractors reside in the same location. There is little control and oversight of this contract and it is difficult to determine where leakages exist in order to resolve the problems. More supervision and mechanisms to insure accountability need to be put into place.

### **2. Funding flows**

The process guiding the flow of funds is currently very laborious. Counties prepare their estimated needs for the fiscal year and send these requests to the Chief Medical Officer (CMO) in Monrovia. The CMO then compiles all of the requests and submits an allotment request to the Ministry of Health and Social Welfare of Finance (MOF). Although the fiscal year begins in July, usually the funds cannot be spent until September. Late submissions to the MOF can result in a delay in the flow of funds.

The Secretariat of Liberian Coordination Mechanism (LCM) was created to manage Global Fund activities and coordinate with the United Nations Development Programme (UNDP), the Principal Recipient (PR) of Liberia's Global Fund grants. The LCM is chaired by the Minister of the Ministry of Health and Social Welfare. This is supported by a technical coordinating committee that is chaired by WHO. This helps to ensure accountability and independence. After an assessment of the ability of the Ministry of Health and Social Welfare to manage Global Funds, a number of steps have been taken to improve management of funds and eventually strengthen the Ministry of Health and Social Welfare's capacity to become the Principal Recipient (PR) in the near future. A transition plan has been developed so that the Ministry of Health and Social Welfare will be able to take over the management of the funds.

Under the Global Fund, payments are made quarterly. The first disbursement is based on the work plan; subsequent disbursements are based on liquidation of funds. The LCM has

to report quarterly on progress made towards indicators. The Global Fund has hired Price Waterhouse Cooper to serve as the local fund agent (LFA) responsible for fiduciary oversight and monitoring sub-recipient performance.

UNDP plans to gradually turn over management of Global Fund activities to the Ministry of Health and Social Welfare. The MOHSW will become PR for Round Six (HIV) on June 1, 2009 and is scheduled to be so for Round Seven (malaria & HIV) in 2010. In preparation for that transition, with the help of donors, the Ministry of Health and Social Welfare is building its capacity to manage large grants, particularly in the areas of financial management, procurement and monitoring and evaluation. Before that is done, the Ministry of Health and Social Welfare will need to first develop a monitoring and evaluation plan and a procurement plan.

The Ministry of Health and Social Welfare decided to create a Pool Fund joint financial mechanism after a working group (sub-committee) of the Health Sector Coordinating Committee evaluated various financing mechanisms. This fund essentially creates budget support to fund MOHSW priorities. The Pool Fund has a Steering Committee that meets to take decisions on and monitor allocations from the Pool Fund. The meetings of the Steering Committee are co-chaired by the Ministry and a designated Lead Donor identified by the donors and the Ministry acting together. It is managed by a Pool Fund Manager with financial disbursements being channeled through the Office of Financial Management (OFM) in the MOHSW, both funded through DFID and implemented by Price Waterhouse Cooper. The Pool Fund Manager is also fulfilling the Secretariat function for the Steering Committee. Some advantages to pool funding are that it can be used to 1. "to increase alignment with government policy and plans, while promoting ownership, coordination and reducing fragmentation; 2.) reduce the time and effort of the over-stretched Liberian government on managing multiple streams of support, reducing transaction costs and improving efficiency; and 3.) potentially be an effective, incremental step towards sector budgeting, especially if the Ministry of Health and Social Welfare plays an active role in targeting pool funds at priority needs." (Hughes 2007)

The Joint Financing Arrangement between the MOHSW and the first donor to join the pool fund, DFID, was signed in March 2008. The agreement stipulates the procedures for consultation and decision-making, disbursement mechanism, monitoring and reporting, review and evaluation, audit, financial management and exchange of information. For example, an independent company will be hired to conduct annual audits of funds disbursed under the Pool Fund mechanism. All future donors must sign the JFA when joining the pool fund.

DFID became the first donor to contribute to the Pool Fund with its deposit of \$8,000,000 in March of this year. Other donors have indicated that they are likely to begin contributing funding in 2009 and 2010: 1) IrishAid, has indicated interest in providing funding once the Pool Funds is operational and probably will make its first deposit in either 2008, otherwise in 2009. The initial commitment is likely to be \$3.5 million and could incrementally increase over time; and 2) A second donor, the European Commission, has also indicated interest in contributing to the Fund and is likely to contribute as much as 30-40 million Euros over a five-year period, beginning in 2009. The Fund managers have also held discussions with other potential donors such as the Swedish, Finnish and Norwegians and Swiss who may contribute at a later date.

### 3. The Office of Financial Management (OFM)

Due to lack of supervision during Liberia's 14- year war, the financial management systems of the Ministry of Health and Social Welfare that were in place disintegrated. A Global Fund assessment of financial management in July 2007 (PR Assessment) found that before PWC arrived, the Ministry of Health and Social Welfare had the following inadequacies in its financial management: 1. weak recording of transactions; 2. lack of the correct quality and quantity of accounting personnel; 3. lack of stringent accounting procedures and systems; 4. weak systems to transfer and track funds; 5. non-establishment of an internal audit unit; 6. non-preparation of financial statements; and 7. inadequate safeguarding of assets.

At the request of the MOHSW and in order to strengthen financial management practices, in 2007 DFID contracted Price Waterhouse Cooper (PWC) to set up an Office of Financial Management within the Ministry of Health and Social Welfare. PWC sees its role as improving the entire financial management system for the Ministry of Health and Social Welfare. The TOR of the PWC consultancy includes the following: budget management of DFID project funds; recruitment of personnel within the OFM (both international and national staff); oversight of financial management principles, procedures and policies within the OFM and Ministry of Health and Social Welfare, introduction of training and personnel performance appraisals; strategic planning; procurement of equipment; monitoring visits; and potential management of external funds provided to the health sector through donors and NGOs. Thus, it will be developing the rules and procedures and building the capacity of the personnel required for development of a more robust financial management system in the Ministry of Health and Social Welfare.

The agreement signed between the Ministry of Health and Social Welfare and the Donor Group for the Joint Financing Arrangement stipulates the procedures that will be followed for consultation and decision-making, disbursement mechanism, monitoring and reporting, review and evaluation, audit, financial management and exchange of information. For example, an independent company will be hired to conduct annual audits of funds disbursed under the Pool fund mechanism.

The vision of the Ministry of Health and Social Welfare of Health and Social Welfare for its human resource pool is to, "have a uniform workforce where employees are not cognizant of being contract or official government or NGO workers."

Although the work of the PWC is gradually improving the ability of the Ministry of Health and Social Welfare to manage financial transactions, the Global Fund assessment team concluded that the number of personnel were not sufficient to be able to manage Global Fund transactions and recommended that a Senior Accountant and Accounts Assistant be hired.

Currently in May 2008, the OFM has 11 accounting staff members, of whom two are responsible for the Global Fund. The Senior International Financial Controller for the OFM, an international position, has recently been hired, as well as the two additional Global Fund accountants. An accountant is presently being recruited for the World Bank as well. In addition, each major disease program (malaria, HIV, TB, and EPI) has dedicated account departments outside of the central Ministry of Health and Social Welfare with approximately 9 staff in total. The World Bank and Global Fund staff will be paid for out of its program/ or pooled funds.

The findings of this assessment of financial management suggest that a structure is being put into place with the capacity for financial management of pool and program funds. However, it is likely that additional accounting staff will be required to manage the

transactions for contracting of NGOs as in the case of the Global Fund. In addition, if the CHTs are to play a role in financial management of these funds, additional staff will need to be recruited to be able to manage the additional resources at the county level.

## D. Human Resources

Human resources are one of the key areas addressed in the National Health Plan. The plan articulates:

1. A coordinated approach to HR planning.
2. Enhanced health worker performance, productivity and retention.
3. Increased number of trained health care workers and their equitable distribution.
4. Gender equity in all aspects of employment.

At this time, the Ministry of Health and Social Welfare has draft Terms of Reference (TOR) for each professional category. The Ministry of Health and Social Welfare is working to standardize salaries and incentives based on training, experience, responsibility, and location; recruit graduates that received scholarships and contract them for service; change the status of volunteers (e.g.: former NGO employees receiving incentives from government) to contract employees; include administrative employees in training and BSP; recommend supervision to be quarterly; and attract doctors and other key health personnel working in other West African countries and abroad to work in Liberia. The text box below identifies the health worker gap in Liberia.

The total health workforce will need to increase by nearly 10,000 more health care workers in order to close human resource gap<sup>1</sup>.

There are a number of formidable constraints to creating a uniform and appropriately trained workforce, including: Ministry of Health and Social Welfare budget constraints; government efforts to reduce and rationalize the size of the civil service; differences in job titles, compensation, and status between NGO and contract workers and Ministry of Health and Social Welfare civil servants; lack of housing facilities and other services (schools, etc.) to attract health workers to remote areas; poor roads and limited transportation in the counties; and an inadequate banking system that can result in the use of money changers that charge exorbitant fees. In general, health workers prefer to work for government rather than NGOs because of perceived job security and retirement benefits. Salary scales are such that all professionals in a particular category are paid the same wage, with no increase or allowances made for seniority, good performance or years of service. It is common practice for incentives to be offered to health workers to encourage them to stay in the field. The Ministry of

Category	Unmet need (shortage)
Physicians	842
Nurses (includes all nurses)	4,223
Midwives (excludes traditional trained Midwives)	1,143
Physician Assistants/Medical assistants /	249
Pharmacists (excluding dispensers)	166
Lab technicians (includes lab assistants)	67
Other health workers (includes all health trained workers not classified elsewhere)	441
Management & support staff	1,167

<sup>1</sup> \*\*\*\*The target density is derived from the threshold density estimate (2.28 doctors, nurses & midwives per 1,000 population) and the skill mix data for the 36 shortage countries in sub-Saharan Africa. Source: WHO, Liberia Ministry of Health and Social Welfare of Health and Social Welfare.

Health and Social Welfare is making a concerted effort to rationalize its human resources and obtain accurate payroll lists. The Ministry of Health and Social Welfare is working with NGOs to ensure that health workers are not “double dipping” by receiving both government and NGO salaries.

## **E. Supply Chain and Logistics Management**

The majority of the information contained in this section comes from interviews with NDS senior management, interviews with CHT and Ministry of Health and Social Welfare central level and from the recent USAID | DELIVER Project Contraceptive Assessment report done last year. For more detail on the drug supply system see this report. The National Health Plan calls for the development of an integrated supply chain management system as well as an integrated Health Management Information System. Presently, the National Drug Service (NDS) is a semi-autonomous entity whose board of directors is chaired by the Ministry of Health and Social Welfare. There are many gaps in the logistics system, including transportation and distribution, warehousing, maintenance and repairs. The Ministry of Health and Social Welfare has requested USAID assistance for the implementation of a comprehensive logistics and supply chain management assessment.

### **1. Procurement:**

Drug forecasting is carried out by funders with little involvement from NDS. Reliable consumption data for drugs on which to base a forecast is unavailable. There is no sustained national essential drug financing or procurement. The GOL has only recently provided funding for “regular” essential drug procurement. NDS procure drugs through WHO prequalified suppliers like Mission Pharma and IDA. Otherwise, drugs are financed through a variety of mechanisms and funders including the Global Fund for AIDS, TB and Malaria (GFATM) who fund drugs for HIV/AIDS, other sexually transmitted infections (STIs), opportunistic infections (OIs), and malaria. Decisions on the quantities of drugs to procure by NDS are based on funding available and/or treatment targets combined with morbidity and epidemiological data, and historical consumption patterns. For contraceptives, procurement is undertaken directly by funders: USAID, UNFPA, and GFATM (through UNDP the PR in Liberia.)

Lead time is a major concern for NDS as well as a lack of quality assurance since not all drugs that come into the country come through the NDS. NDS does have a Monitoring and Evaluation unit that tries to ensure that quantities are reasonable based on consumption data. NDS attempts to monitor facilities every quarter depending upon travel conditions and availability of vehicles. NDS supplies the CHT with essential medicines through requisitions made from the facilities, to the CHT, to the Ministry of Health and Social Welfare CMOs office to NDS.

Additionally, NDS sells medicines to NGOs upon request and includes a 30% FOB mark up that covers NDS staff salaries and operating costs. Sometimes NGOs also procure medicines and supplies on their own as well. Each CHT has a Drug Delivery Focal Point (DDFP) who is paid a salary by UNDP and an incentive by NDS. The Ministry of Health and Social Welfare provides some funding through its budget (\$50,000 last year) to support NDS work. Funds from sales to NGOs and the central Ministry of Health and Social Welfare serve to create a type of revolving fund for NDS to function.

## **2. Transportation and Storage**

NDS transports drugs to the nine regional depots owned by the CHT and the CHT are responsible for transport from the depots to Service Delivery Points (SDP). NDS supplies the counties with fuel when they pick up their drugs at the depots. As often as possible, this fuel is covered with Global Fund money. Additionally, the GF has provided each county with a pick up truck for routine movement of commodities. In some circumstances, both NDS and the County Health Teams depend upon NGOs and UNMIL for transportation of medicines to the counties. The NDS has expressed openness to contracting out some of the supply chain functions as needed in the future.

## **F. Monitoring and Evaluation**

This section was developed based upon interviews with CHT and central Ministry of Health and Social Welfare as well as on information contained in an assessment report from 2007 on the Establishment and an Health Information System for post-conflict Liberia carried out by MERLIN and it's partner Health Information Systems Programme (HISP), an organization which has worked in close coordination with the WHO Health Metrics Network.

The Ministry of Health and Social Welfare is in the process of redesigning the HMIS with support from MERLIN and BASICS. The objectives of this work are to develop a standardized set of data collection tools; strengthen the capacity of Ministry of Health and Social Welfare staff to conduct surveillance as well as M&E, and facilitate utilization of the HMIS to capture and utilize data for Ministry of Health and Social Welfare central and county level planning. The components of the new HMIS will include a number of information systems and in particular a Basic Package Health Information System (BPHIS) which will focus on BPHS statistical and program reporting from health facilities and vertical programs, such as EPI, malaria, HIV/AIDS, etc. A template of Health Information Systems indicators -- the National Essential Indicator Data Set (NEID) has been developed, and the District Health Information System (DHIS) software has been introduced. It has been customized to Liberia and includes almost all of the service indicators developed during the County planning process.

Eventually training in the BPHIS and DHIS will take place at the clinic, county and central levels. For central Ministry of Health and Social Welfare staff, training of data managers and senior staff will take place in use of data for decision-making and planning as software manipulation through a Training of Trainers (TOT).

The central level receives epidemiological data on a weekly basis from the CHT as well as quarterly reports on service utilization and morbidity and mortality. The current system of data collection and analysis from the community to health facility, to NGO or/and CHT, and from the field to the central Ministry of Health and Social Welfare is weak and fragmented. However the Ministry of Health and Social Welfare is in the process of developing, with outside technical assistance, a consolidated HMIS. One of the first steps in this process is the development of a logical M&E framework to accompany the National Health Plan and BPHS, which would in turn feed into CHT planning. Indicators developed during the county planning process from this M&E framework at the national level should be consistently collected at the county level.

## **III. County Health Teams**

The Public Health Law Chapter 4 Article 4.2 states that "the Minister shall appoint as chief health officer in each county a licensed physician to practice medicine in Liberia. Such

officer shall be known as the County Health Officer.” The CHO is responsible for the administration in the county of all health and sanitation laws.

Additionally, the National Health Plan states that, “NGO/FBO partners will be involved in the reform through conventions or contracts. Resources will be distributed in favor of local communities, and with the objective of improving the capacity of health services to respond to local health care needs.” In other words, the County Health Teams are responsible for oversight of health services in the county.

The Superintendent of the county chairs the County Health and Social Welfare (CHSW) board. Intergovernmental agency county support team meetings are held periodically by the Superintendent’s office to ensure proper coordination between government sectors.

Following the objectives of decentralization, planning for the implementation of the National Health Plan has been directed by the County Health Teams in all 15 counties. These plans contain a list of key indicators to be achieved throughout the year. The planning and management process has received significant technical support from the Central Ministry of Health and Social Welfare, the Clinton Foundation, and BASICS. In order for the CHO to provide both leadership and operational management of health service delivery through contracts with NGOs, additional support and supervision will be needed.

A significant concern with respect to contracting is the deficit of trained managers and administrators at the county level, in addition to the documented shortage of clinical staff including physicians, nurses, laboratory technicians, pharmacists, janitors and maintenance workers. An additional concern is the ability of County Health Teams to monitor and supervise health facilities – constraints include a lack of clinical norms and standards; inadequate resources to properly monitor and supervise staff and facilities; the lack of a systemized monitoring and evaluation scheme for facility performance, and transportation difficulties, particularly during the rainy season. All of these issues are being addressed by the Ministry of Health and Social Welfare, but roll-out in the counties takes time.

## **A. Financial Management and Administration**

The County Health Teams do not presently have an accountant and have only one administrator that manages their funding. However, the CHTs’ ability to conduct financial management is currently being strengthened. The CHT are gradually being trained (four counties at a time) through a course on health systems management that includes a module on financial management. This course is given by Yale University in partnership with the Mother Patern College of Health Sciences and the William J. Clinton Foundation. In addition, PWC has hired an accounting company to carry out financial management training at the county level.

### **1. Funding flows**

The county manages a budget which is used primarily for recurrent costs, including all administrative supplies, medicines and medical supplies, and other administrative costs. Given that at present the counties do not have a systematic mechanism or format for recording financial transactions, and since reporting formats are not yet standardized between facilities or counties, it is still difficult to compile and manage financial information.

The County Health Teams<sup>2</sup> have been focusing on improving financial and administrative accountability and on creating and standardizing systems for financial accountability. The county teams generally have a finance officer and two administrators – one for the county team and one for the hospital. However, in some cases, not all the staff positions are filled.

Budget transfer from central level is used to cover recurrent costs including administrative support, minor repairs, fuel, computers, training, hospital food, electricity, etc. The county submits budget to the Ministry of Health and Social Welfare and then it goes to the MOF. A few hospitals also have their own line items such as Phebe and JFK Medical Center; their budgets are submitted to the Legislature. After passing through the Legislature, the amount allocated to the county often gets cut. Often the budget is greatly reduced through this process and the CHOs have to request additional funding from the Minister<sup>3</sup>.

## **B. Supply chain and logistics management**

At present there are no tools for forecasting or logistics management information systems although a request has been made to the USAID | DELIVER Project for assistance in designing an integrated supply chain management system.

### **1. Commodities**

Contraceptives are donated by UNFPA. Both the National Malaria Control Program and the TB and Leprosy programs are national vertical programs and supplies are provided to counties and facilities by each program. None of these products are requested by the county or facility level based on consumption or need, and the central level determines quantity and type. In the case of the vertical programs, particularly TB and Leprosy, the hospital will have a separate requisition for medicines. The program delivers medicines to the hospital which in turn distributes TB and Leprosy medicines to the clinics. The CHO receives reports on these transactions but is not always part of the transaction when stemming from vertical programs.

### **2. Forecasting and Procurement**

For essential drugs and supplies, the CHT decides drug quantities and types based upon requests from the facilities. Medicines are requisitioned by each of the health facilities through written requests to the CHT. The CHT compiles them and sends to NDS. The NDS sends supplies by truck to county depots. In the more difficult-to-access counties, especially during the rainy season, the NDS may need to send drug shipments to nearby ports in a container and the CHT then retrieves the container from the port. Some of the counties utilize the services of UNMIL for transport of drugs.

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<sup>2</sup> Bong County is an exception and administratively functions differently from the other counties. The county utilizes the Phebe county referral hospital's business and finance office. Funds are sent from the Ministry of Health and Social Welfare of Finance (MOF) to Bong County account. There is a separate account for the CHT and all funds are tracked separately. The County Health Team has a separate account. Ministry of Health and Social Welfare workers are selected, "contracted" and paid directly by the hospital. This is a practice that was started back in the 1970s.

<sup>3</sup> Bong county began a resource generation project to help offset this phenomena. The hospital has started an IV infusion plan; could sell as a source of revenue for the hospital. There is a fee for elective procedures; emergency surgery is in the basic service package and is not charged for.

Additionally, NGOs in many of the counties procure medicines through their own mechanisms and orders are not always coordinated with the CHTs. At times, NGOs supply the hospitals and other facilities with drugs in return for referral services for their clients. However, these donations from NGOs often do not include the drugs that the facilities need.

### **3. Distribution and Storage**

Most facilities have generators and the CHT budgets pay for fuel to run them. The MOH provides fuel vouchers for health workers in counties. The counties are given vouchers for fuel at specified gas stations. However, these gas stations are not present in every county and several counties must currently transport fuel from outside their counties. Some of the counties have an ambulance (provided by either NGOs or donors) for which the counties pay to maintain and operate. Some CHTs have motorcycles and trucks but have difficulty maintaining, repairing and fueling them. Most facilities have freezers and solar refrigerators which are placed at the community level in distant facilities in order to ensure maintenance of the cold chain for vaccines. There are some kerosene fridges. In places where fuel is limited, some facilities alternately turn on and then turn off generators in an attempt to ration fuel while still maintaining a minimal level of cold chain. Thermometers are sometimes not operational and the degree to which this strategy results in a compromised cold chain is uncertain though UNICEF is working to strengthen the cold chain.

All counties identified transportation as the most critical obstacle for stocking facilities. Many counties are dependent on NGOs and UNMIL for logistics support, particularly for transportation.

There does not appear to be a system to monitor and manage warehouse information but this consultancy did include a warehouse visit, so that could not be verified by the assessment team.

### **C. Human Resources**

There are currently 20 staff positions on the CHT organizational chart. The CHT is charged with oversight of the facilities in the county. The CHO provides leadership to the County Health Team and is tasked with three roles – operational manager of the CHT, hospital director, and chief medical officer of the county.

Some counties recruit, identify and hire their own staff under “contract.” A contract is signed between the staff person and the CHO. Then the staff person’s records are sent to the Central Ministry of Health and Social Welfare to the CMOs office that in turn approves the hire. The Ministry of Health and Social Welfare of Finance puts civil servants on payroll and salaries are paid directly by the MOF. The CHO cannot fire staff but can penalize them for poor performance by sending a letter to the central Ministry of Health and Social Welfare who has the power to suspend their services or transfer them. Other counties do not have “contracts” with staff; rather, implementing NGOs take charge of those staff through directly paying “incentives”. NGOs pay incentives to health workers with the exception of the 40 percent of facilities under the BPHS with designated facility support for salaries covered by Ministry of Health and Social Welfare Central<sup>4</sup>.

Across the country, health service delivery has been compromised by a loss of skilled workers during the war. Many of the health centers are not run by professionally trained

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<sup>4</sup> Bong county is the exception whereby the county pays salaries to workers directly.

administrators or health workers, but are managed by nurse's aides. Most staff persons have not had any refresher training in clinical norms and treatment guidelines<sup>5</sup>.

#### **D. Information systems, record keeping, supervision, and monitoring and evaluation**

The counties collect utilization data from the facilities or/and NGOs on a monthly basis and it flows from the CHT registrar to the central Ministry of Health and Social Welfare. It is unclear as to whether a process has been developed at the county level to analyze routine health information on service utilization with the CHT, providers and NGOs. The CHT aggregates data from the facilities and sends monthly reports to the Central Ministry of Health and Social Welfare (CMO). Overall there are issues with data reliability and analysis; reporting is not standardized or reliable across clinics. Data are input manually at all levels of care. Most facilities do not have computers or staff who know how to use computers; however, the CHT are all being provided with hardware and software along with training which should facilitate data processing.

There is little standardization of data or analysis at the county level except in the case of outbreaks. Weekly surveillance data for the eight notifiable diseases/syndromes also flows up from the facility level. County level surveillance officers collect the data and also investigate any outbreaks. The County Health Registrar and the County Health Surveillance Officer oversee analysis of epidemiological surveillance data. Some of the counties analyze the epidemiological surveillance statistics together with the NGOs on a monthly basis. There is no evidence that data are used for programming, planning, forecasting, or other decision-making. Some of the surveillance officers are paid by WHO although transportation is often a barrier to facility and community visits.

For the most part, joint supervision trips are conducted monthly between the CHT and NGOs utilizing a recently developed check list for integrated supervision developed by the Ministry of Health and Social Welfare Central level. There are not enough supervisors on the CHT to cover all of the facilities at the county level and supervision is sometimes carried out in parallel and other times done in conjunction with NGOs; supervision seems to be fairly sporadic and non systematic. This is due to a number of constraints including geographic access, transportation barriers and lack of human resources. In order for contracting with facilities to be possible, a uniform and standard reporting format must be developed and capacity to collect, review, validate and analyze reporting data built at the county level. Whatever system is ultimately designed for the monitoring of contracts by the counties will need to be one that is wholly compatible with any system that is built for Health Management Information Systems at the Central (and county) levels. This system should be built upon routine data collected through the health information system.

#### **E. Coordination**

In some counties there is significant coordination, joint planning, joint supervision between the CHT and the NGOs. In others there is very little coordination between CHT and NGOs. It appears that more often than not, NGOs do not share their plans with the CHT. A few of the CHTs hold monthly partner meetings with NGOs to discuss and analyze data and progress in the county; others hold meetings on a weekly basis. Many of the NGOs provide monthly reports (Ministry of Health and Social Welfare standard eight forms) and weekly

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<sup>5</sup> Bong county has a school for midwives and emergency training program and staff come from across the county to attend these trainings.

surveillance reports to the CHT. However, unfortunately some of the County Health Teams do not receive any information from some of the NGOs working in their counties. Not all of the counties have NGO presence in spite of the very difficult terrain and problems with access to care. Some of the CHTs have formal relationships with NGOs in the form of Memorandums of Understanding (MOU).

## **Non Governmental Organization Capacity**

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Significant efforts have been made by both the Ministry of Health and Social Welfare and the INGO/NGO community to increase communication and coordination. The team met with a number of INGOs as well as Liberian NGOs during the assessment (see appendix for list of those interviewed). In addition, several key assessments of NGO capacity were consulted; including those by BASICS, Africare, and JSI on Equip. Below are some of the general key findings.

### **A. Service Delivery**

Presently NGO services are provided throughout Liberia but as a result of the difficult circumstances of the war, when many of the INGOS first started service delivery, geographic distribution of facilities and services was somewhat haphazard. NGOs are willing to work with the Ministry of Health and Social Welfare and CHT to ensure proper geographic planning as well as appropriate service delivery of the BPHS. In addition, they would be willing to work towards meeting an accreditation standard once one is developed. The question of geographic coverage areas for NGOs was discussed and NGOs indicated that they would be willing to increase the catchment areas that they serve, if given proper support and funding.

In late April and early May 2008, a team of Ministry of Health and Social Welfare and IRC staff conducted a five-hospital assessment of improvements they had made towards the implementation of the BPHS. Baseline data were from November 2007 and end data were from April 2008. The hospitals included: Harper County Hospital (MERLIN), Redemption Hospital in Monrovia (MSF), JFK referral hospital in Montserrado (Ministry of Health and Social Welfare), Nimba county hospital (IRC), Voinjama hospital in Lofa county (IRC) and Kolajun hospital in Lofa county (IMC). The hospitals that showed the most improvements in terms of implementation of the BPHS were the Harper Hospital in Maryland county (receives support from MERLIN) and the Saniquelle Hospital in Nimba county (receives support from IRC). JFK the National Referral hospital (MOH managed) showed the least improvement according to the assessment.

### **B. Coordination with Ministry of Health and Social Welfare and CHT**

As mentioned above in the section on CHT capacity, there is significant variation among NGOS in the degree of communication and coordination with CHT. For the most part, the INGO community expressed a sincere desire that contracting with NGOS is done in a way that further empowers the CHT, and does not remove or detract from the efforts they have put into strengthening the Ministry of Health and Social Welfare at the local level. This was especially true among the larger INGO partners.

Throughout the war NGOs maintained independent systems of reporting and information sharing. Presently, coordination efforts take place formally through monthly meetings. The HCM meeting is held on the third Friday of every month, convened by WHO and chaired by the Ministry of Health and Social Welfare. The INGO meeting is held on the first Saturday of every month, hosted by Save the Children/UK and held at their offices.

### **C. Information systems, record keeping, supervision, and monitoring and evaluation**

As mentioned above, over the last six months, significant efforts have been made to strengthen the ability of the Central Ministry of Health and Social Welfare to support a more

coordinated and systematic approach. This initiative has been spearheaded by the Ministry of Health and Social Welfare together with MERLIN, through a sub-agreement to a South African group, HISP. They have supported the Ministry of Health and Social Welfare resource center and analysis and training in HMIS to install new software and train county health staff. MERLIN has held a number of meetings with the INGO community both individually and together with the CHTs to discuss data availability, data comparability, and to begin to standardize data collection and analysis.

Reporting streams appear to be fragmented. Nearly all NGOs (local and international) send reports to the Ministry of Health and Social Welfare (either central or county level), but reporting is not done systematically across NGOs or across counties. Most NGOs are obligated through a formal agreement to report directly to their headquarters and to the donors that fund their activities.

Currently there are gaps in reporting systems, utilization data and a lack of standardization among NGOs. For example, IRC sends periodic reports (monthly data reporting and weekly surveillance) to the county health teams in Lofa and in Nimba, utilizing the reporting forms that the Ministry of Health and Social Welfare requires. Now that the CHT will be implementing the new supervision tool, they may be able to improve upon the CHT data collection during routine supervisory visits.

## **D. Financial Management Systems**

This section provides an overview of the capacity of some of the NGOs that the team was able to meet to conduct internal controls including the ability to prepare regular, timely and reliable financial reports, systems to track funds; prepare financial statements; and maintains systems to record financial interaction.

### **1. Local NGOs**

The JSI assessment team visited two local NGOs – PMU and CHAL – to learn about their accounting and financial management systems.

PMU receives funding from three donors (EC, SIDA/PMU and UNICEF) and has clinics in Lofa and Montserrado Counties. The organization appears to have adequate accounting systems in place and its systems are computerized. In order to make disbursements, the clinics make requests for funding to the PMU accountant in Monrovia with supporting documentation. After the accountant approves these requests, these must be further approved by the Director. The NGO has a contract with a local auditor and is audited every quarter. Financial and program reports are sent to PMU donors on a quarterly basis.

CHAL (Christian Health Association of Liberia) is a consortium of Christian organizations providing primary care service delivery. CHAL provides assistance to Christian organizations working in health through a revolving drug fund (currently not functional) and provision of storage space in Monrovia. In addition, the NGO has some of its own projects and receives funding from some USAID-funded projects (PACT, Medical Teams Int.), the Church of Sweden, UNDP, and Norwegian Gov/Norwegian Church Aid. It has a long history of working with donors and has financial management procedures in place. For example, one of its projects is a USAID-funded project administered by PACT, a New York based NGO. For this project, CHAL gives grants to local NGOs with HIV/AIDS projects. It has to follow all USAID rules for this project and submits programmatic and financial reports on a quarterly basis to PACT.

## **2. International NGOs**

IMC manages a hospital and 19 clinics in Lofa as well as 16 clinics in Bomi. In most cases, its funding is channeled through the IMC-US and IMC-UK offices. However, its office in Liberia projects funding requirements and receives money at regular intervals based on these. IMC-Liberia does receive funding directly from UNHCR because this agency has an office in the country.

Other international NGOs such as Africare, IRC and Merlin are assumed to have adequate financial management since these organizations receive funding from bilateral agencies and must follow their procedures for these grants/contracts.

### **E. Training and Capacity Building**

To date, most NGOs are providing training of some type, utilizing a variety of training curricula, some of which have been recognized by the Ministry of Health and Social Welfare and other partners. For the most part, these focus on specific skill sets, such as basic lifesaving skills, training for traditional midwives, etc. In addition, some NGOs such as IRC provide refresher training for Physician Assistants and Resident Nurses and MERLIN and Africare train midwives.

Africare has a strong training program in basic lifesaving skills supported by the American College of Nurse Midwives. This is targeted to health professionals including PAs, nurses, and certified midwives. In addition to professional training, the program has a module on home-based life saving for training of traditional midwives. In addition, Africare has worked through the Traditional Midwife network to distribute family planning products in the community. The Ministry of Health and Social Welfare plans to roll this training out nationwide and create similar training programs throughout the counties.

The sustainability of the in-service training that Africare currently provides for the Phebe Nursing School is unclear since it was funded under a five-year USAID project which ends September 2008. These specific training courses, such as that for TTM or Emergency Lifesaving skills, could presumably be scaled up and/or expanded through contracting.

### **F. Supply Chain Management**

#### **1. Transportation:**

Transportation is across the board one of the most critical issues in Liberia. Presently the NGOs and Ministry of Health and Social Welfare often depend on UNMIL to provide transportation. An example is MERLIN, which is virtually unable to function effectively in the south eastern region of Liberia without the support of UNMIL for transportation, mainly with helicopters and boats. Occasionally rubber boats can be contracted to help transport containers. It should be noted that several road improvement projects are underway but that it will take some time before these are finished. Small privately owned motorcycles, canoes and other vehicles could be contracted to provide transportation on a small scale. It might make sense to have a single entity overseeing small administratively difficult-to-manage transportation agreements.

## Formal Agreements

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A number of international and Liberian NGOs have considerable experience with formal agreements. These agreements encompass MOUs, cooperative agreements, and contracts. There is a wide margin in the degree to which these agreements include linkages between performance and compensation however.

A summary of some of the contracts and agreements NGOs currently hold can be found in Appendix 1. The table below provides a listing of a few examples of existing contracts between donors and NGOs as well as Ministry of Health and Social Welfare and the types of payment mechanisms contained in these agreements.

DONOR/NGO	PMU	IRC	CHAL
UNICEF	Upfront payment of 80%; 2 <sup>nd</sup> payment of 20%	3 installments for Sexual and Gender Based Violence Project: 1 <sup>st</sup> installment of 35% after two weeks of signing; 2 <sup>nd</sup> installment of 30% at the end of the third month; 3 <sup>rd</sup> installment of 35% at the end of the project period	
UNHCR		1 <sup>st</sup> payment within ten working days; further remittances are commensurate with the progress of the sub-Project and liquidity status (not more than 30% of last payment remains on hand)	
ECHO	Request funds on a monthly basis		
SIDA	Request funds on a monthly basis		
UNFPA	50% upfront; other payments are quarterly and/or based on liquidity status		
Irish Aid		Grant: payment of 277,234 Euro; Requires financial reports at six-month intervals	
PACT			Request funds on a monthly basis; note: provides upfront payments to sub-grantees as needed
Medical Teams Int.			Request funds on a monthly basis (\$50,000 ceiling request)
UNDP			Funding given quarterly with no upfront payment

The findings of this assessment indicate that for the most part, NGOs are open and receptive to the notion of contracting with the government for the provision of health services and the implementation of the basic package of health services. NGOs are especially interested in contributing to building Ministry of Health and Social Welfare capacity both at central and at county level and would like to be a part of any capacity-building efforts on the horizon. The majority of NGOs are involved in some sort of contracting already. However, it was clear that they have real concerns regarding the Ministry of Health and Social Welfare's capacity to support and manage contracts both at the central and county level. It is also apparent that NGOs have large differences in their capacity to serve as "contractors".

Two of the main concerns of NGOs centered around health work force issues or "incentives" and a consistent supply of commodities in the health sector in order to provide quality health care services. Additionally, NGOs expressed some reluctance towards contracting with the Ministry of Health and Social Welfare, given government's difficulty in ensuring timely disbursement of funds. The administrative disbursement process from the central to the county level is at times burdensome and there are bottlenecks in the process. This has important implications on how the Ministry of Health and Social Welfare will financially manage contracts.

The areas that NGOs could improve upon are similar to those identified as areas to strengthen in the Ministry of Health and Social Welfare in order to contract. Those areas include: HR management, supply chain management, transportation systems (e.g.: schedule weekly visits to facilities since visits are not conducted on schedule and done haphazardly at present) and HMIS. In addition there is a lack of standardized health systems in place, particularly for staffing. For instance, one of the NGOs has fielded a surgeon in one hospital that the NGO manages, however there is no surgeon in a neighboring hospital also managed by the same NGO. This should improve once the Ministry of Health and Social Welfare implements the staffing plan requirements it has articulated in its health workforce plan. In other words, as the Ministry of Health and Social Welfare develops standards then the NGOs should naturally follow suite especially if they are under Ministry of Health and Social Welfare contract. At present, the NGOs are being asked to standardize the incentive payments that they give to facility staff based on the government's new list of incentives and are facing some resistance from their 'employees.'<sup>6</sup>

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<sup>6</sup> Some hospital employees in Lofa quit their jobs rather than take reductions in salaries as the new incentive structure is being implemented.

## International Donor and Cooperating Agency Support: Present and Future

### I. Financial Sustainability - Ministry of Health and Social Welfare Contracting

The following is based upon the collection of various documents and tables from the Central Ministry of Health and Social Welfare, interviews with representatives of donor agencies, and focus group discussions. The table below summaries present and future international donor and cooperating agency support to the Republic of Liberia's health sector.

#### Donor Support to Health Sector (in US\$ millions)

Source	Totals for 2007/8	%	Totals for 2008/9	%
Ministry of Health and Social Welfare	\$15.38	16.9%	\$16.0	13.7%
<b>Donor</b>				
DIFD*	\$4.60		\$10.80	
Dutch Gov.	\$0.81		-	
ECHO	\$6.30		\$6.00	
European Commission – TA	\$0.60		\$0.89	
France	\$0.10		\$0.13	
GAVI	\$1.52		\$3.12	
Global Fund	\$4.95		\$16.26	
IrishAid	\$7.75		\$7.50	
JICA	\$1.20		\$2.20	
LERHIS Foundation	\$0.50		-	
Malaria No More	\$1.00		-	
McBaine	\$1.00		\$1.00	
US Support:				
OFDA	\$1.60		\$0.00	
PMI	\$2.00		\$8.50	
USAID	\$9.78		\$14.30	
ODC	\$0.50		\$0.00	
Swiss	\$2.40		\$2.20	
CERF	\$3.36		\$0.00	
Clinton Foundation	\$1.50		\$1.50	
WHO	\$5.60		\$7.15	
World Bank	\$2.50		\$3.00	
MSF				
Belgium	\$4.91		\$5.21	
Esp/CH	\$2.50		\$0.00	
Sub-Total	\$75.593	83.1%	\$100.676	86.3%
<b>Total</b>	<b>\$90.97</b>	<b>100%</b>	<b>\$116.676</b>	<b>100%</b>

\* Includes both support of the OFM and the Pool Fund

	2007	2008
Health Expenditure Per Capita	\$14	\$15

Source of Funding	USD\$	US\$ Per capita	% of Total expenditure
Government	15	5	14%
Out of Pocket	17	5	16%
External	76	24	70%
Total	108	34	100%

**The Economic Community (EC)** is supporting the running of facilities; policy making; assessment of infrastructure, and human resources; support will extend for another year. Beyond that, the EC has recently pledged an additional 40 million Euros to support the long term implementation of the health plan and further improve capacity of the Ministry of Health and Social Welfare. The EC has stated that they are willing to support contracting with funding if the Ministry of Health and Social Welfare has a clear strategy in place for what contracting mechanisms will be used and how contracting plans will be implemented

**United States Agency for International Development (USAID)** is currently supporting NGO service delivery NGOs including Africare, IMC, and Equip. The agency is in the process of bidding out a large five-year health care delivery project of approximately \$46 million in addition to the support they are already providing to the health sector. A USAID representative has stated he is in favor of contracting NGOs as a long-term strategy to increase access to care and that the Agency is willing to support Ministry of Health and Social Welfare efforts to this effect. USAID is interested in having a larger discussion with the Ministry of Health and Social Welfare and donor community around contracting.

**DFID** is contributing between US\$20 – 23 million/yr to Liberia. In health, they have been providing humanitarian support to NGOs (SCUK, MERLIN, IRC). That funding is in a transition process and current commitments are set to end in Dec. 08. DIFD representative has stated that the agency is supportive of contracting. He says however, that if for whatever reason the GOL does not have the capacity to carry out direct contracting with NGO due to administrative, financial or other constraints, then DIFD would be willing to implement a tripartite model in which shared decision-making between the donor, NGO and Ministry of Health and Social Welfare takes place. Additionally the DIFD representative stated that he did not want to invest all of their funds in contracting rather he would like to see some of the support be channeled towards capacity building and other such activities.

**UNMIL** provides logistical support to the CHT as well as the NGOs. The UNMIL offices in the counties provide use of internet in the office. They also have been providing clinical services including physicians and nurses in the counties to complement services already being provided. Also play an important role in transporting commodities, supplies and equipment for NGOs free of charge on regularly scheduled flights. Role is particularly important during campaigns such as recent yellow fever campaign after an outbreak occurred.

**UNICEF, UNHCR, USBPRM** have a number of health related activities under way throughout Liberia. Among them includes a number of different types of contracts with NGOs for primary health care service delivery. UNICEF has a total of 24 separate contracts (previously 40) with PMU and MERCI, two Liberian NGOs to provide primary health services in seven counties. They had a problem with one NGO wanting to end service delivery before their contract was over. They note that they want to move from contracting out to supporting government in next few years (new program will end in 2012 and will assess it in 2010). BPRM funds NGOs to provide health delivery services in 47 facilities (FY06 funding) including: IRC, Merlin, World Vision, IMC, Equip. OFDA and BPRM work in Nimba, Lofa, Grand Gedeh, Grand Cape Mount, and Bomi Counties and have performance-based “grant” agreements.

**The World Health Organization (WHO)** has had ongoing support to Liberia and is now in the process of carrying out assessments on the delivery of health services and regulations as well as an assessment of the leadership and management capacity of the Ministry of Health and Social Welfare. This should help to inform the development of a capacity-

building plan for the Ministry of Health and Social Welfare and enable them to be effective purchasers of health services.

## **Conclusions**

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### **1. Ministry of Health and Social Welfare leadership is critical**

Discussions with leadership from the Ministry of Health and Social Welfare, County Health Teams and the NGO community indicate that it is crucial for the Ministry of Health and Social Welfare to be seen as a leader in the provision of health services to the people of Liberia. Delivery of health services in post conflict Liberia is important in order to authenticate and legitimize the government in the eyes of her people. Government provision of services will serve not only to increase access to care but also to strengthen political stability in Liberia. Therefore, Ministry of Health and Social Welfare will want to consider how to inform the public of its leadership role in the contracting process, and ensure that the public knows that the Ministry of Health and Social Welfare is ultimately responsible for service delivery through its financing, oversight, and regulation of the health sector, even if services are delivered by another party.

### **2. Status of the Liberian health care market**

The health care supplier market in Liberia is still immature, as there are still very few commercial or local NGO health care providers. Many local NGOs have limited capacity to write proposals for funding or financially manage accounts, grants and contracts, although there are a few that have experience in managing donor-funded grants. For the most part, the INGOs have had vast experience in preparing proposals, managing work plans and budgets, estimating their costs, implementing services and monitoring and reporting results. There are quite a few very strong INGOs who have shown leadership and management capability and who are well-positioned to assist in building Liberian NGO capacity through the contracting process. These NGOs can serve as resources to strengthen the capacity of other NGOs within Liberia quickly and efficiently without the need to go outside of the country for NGO capacity-building.

### **3. To prepare for contracting, Ministry of Health and Social Welfare management capacity can be strengthened through additional training and systems strengthening**

Although both the central and county level teams have come an enormous way in the past two years in terms of building essential management capacity, additional capacity is needed before the Ministry of Health and Social Welfare is fully prepared to procure, manage and evaluate performance-based contracts. The central Ministry of Health and Social Welfare and the CHTs have received training and are now in the process of carrying out assessments, developing strategies and plans, and implementing new procedures and tools. However, a new set of skills will be needed in order for the Ministry of Health and Social Welfare to carry out performance-based contracting. The Central Ministry of Health and Social Welfare will need to strengthen its legal, regulatory, strategic planning, procurement, supervision, monitoring and evaluation capacity. In order to effectively manage contracts. In addition, the CHTs will require additional support and ongoing management training in public health, strategic planning, operational planning, accounting and financial management, supervision, and monitoring and evaluation, to build upon the new skills they have acquired through BASICS training and other capacity building efforts. Most donors have expressed their support for this type of capacity-building and are planning to continue to fund these kinds of activities in the future.

**4. Central Ministry of Health and Social Welfare capacity for contracting will precede county capacity.**

Currently most CHTs have to travel to Monrovia to obtain funds since there are few banks outside of the capital. In addition, staff must either cash their checks in Monrovia or pay high fees to money changers. This environment does not facilitate financial and administrative management of contracts at the county level. It makes sense to first build capacity to contract within the central Ministry of Health and Social Welfare to strengthen administrative processes in the capital and then shift responsibility outward towards the counties as county capacity is strengthened. The management structure for contracting will require some additional personnel with specified skills: a contracting coordinator, monitoring and evaluation specialists, general counsel, procurement specialists, and accountants. The Ministry of Health and Social Welfare currently does not have legal expertise (other than intermittent pro bono legal counsel), and there are no currently available staff who have monitoring and evaluation or procurement expertise who would be available to implement a major new effort of this nature<sup>7</sup>. The Ministry of Health and Social Welfare has allocated resources for a local hire Legal Counsel, but at this point that position has not yet been filled.

**5. The Ministry of Health and Social Welfare is building capacity in regulation and oversight**

The capacity of the central Ministry of Health and Social Welfare and the CHTs to provide clinical quality assurance and oversight is currently limited, due to inadequate staffing and a lack of protocols, norms and standards for clinical care including case management and rational drug use. It has a plan for building its capacity to oversee health services, but this will take time. The Ministry of Health and Social Welfare is currently in the process of developing these tools. It also has an ambitious plan to renovate and expand health worker training institutions. In the meantime, many of the NGOS – Liberian and International -- have quite a lot of capacity building skills and experience in skills transfer. For example, AFRICARE and MERLIN have both trained midwives, while IRC has provided refresher trainings to Physician Assistants and Registered Nurses. FPAL has a training program in reproductive health, CHAL has a program to boost the skills of CHWs and midwives, and Equip has a training program for Community Health Workers.

**6. Standardized reporting formats and an integrated HMIS are needed**

The Ministry of Health and Social Welfare is in the process of standardizing its reporting forms and initiating the development of an integrated HMIS. In order to assure proper control and management of contractors they must report utilizing standardized forms that feed into an integrated HMIS managed by the central Ministry of Health and Social Welfare. That process has begun, but in the meantime, alternative systems can be created to facilitate oversight in the interim period. More detail on this topic will be provided in the draft strategic framework/guideline deliverable.

**Next Steps:**

The Ministry of Health and Social Welfare will need a strategic framework and guidelines under which NGO contracting will take place in order to develop an implementation plan. This framework and plan will be developed as the next step in this process. A detailed set of recommendations and options for future action and implementation will be presented in the next report.

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<sup>7</sup> It is currently recruiting a procurement specialist.



## **Appendix 1: Illustrative Examples of Contracting Experiences among NGOs in Liberia**

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IRC has signed MOUs with the Ministry of Health and Social Welfare at the CHT level as well as other INGOs, Liberian NGOs and donors, including the USG and Irish Aide. IRC and the International Medical Corps (IMC) have a signed MOU to work together towards improving patient's referral from Kolahun hospital to Voinjama hospital in Lofa County. The MOU is signed by both hospitals (each run by each of the NGOs, the IRC and IMC County field coordinators), and the Lofa CHO. IRC has another MOU directly with the Kolahun hospital whereby IRC commits to provide the following: supervision on use of essential drugs, medical materials and no-medical items; management; on the job mentoring and clinical and technical training; evaluation of quality of care provided to patients; provision of drugs and materials as well as medical equipment (in accordance with their budget); provision of medical services free of charge in line with Ministry of Health and Social Welfare national health protocols; salaries as defined by government protocol as well as incentives as prescribed by the Ministry of Health and Social Welfare as soon as the hospital staff become Ministry of Health and Social Welfare employees; and surveillance and reporting on a monthly basis to the CHT.

In addition, IRC's MOU with the United States Bureau of Population, Refugees and Migration (BPRM) stipulates that they will provide a number of services, among them disease prevention and primary health care curative services to target populations. This particular MOU with the USG has a number of performance indicators contained in it and is the only one which clearly outlines what is expected from the contractor. The objectives included in the MOU are concrete measurable performance targets.

MERLIN has an MOU with all five CHTs where it operates. The MOUs are signed as well by the Ministry of Health and Social Welfare (CMO's office). The MOU contains general maintenance and repairs by the NGO. MERLIN manages Liberian NGO ELWA in Greenville, Montserrado and Buchanan and supports the ELWA's logistics system. MERLIN also had a contract with Equip.

IMC has a MOU with the Ministry of Health and Social Welfare to provide capacity-building and surgery services for Lofa county referral hospital. They also work with 19 clinics in Lofa and have grants from OFDA, UNHCR, CSDA, and BPRM. The grants are channeled through their US and UK offices.

PMU and MERCI have contracts with UNICEF for basic primary health care. These are standard UNICEF contracts with no linkages between performance and compensation.

The Family Planning Association of Liberia (FPAL) has had contracts with other NGOs to train them in key areas including R/H, community health and mental health. The association works with health educators and CBDs for pills and condoms. It refers patients to clinics for Norplant and IUD and to JFK for sterilization.

PMU has contracts with ECHO and SIDA to support a health center. It also has a contract with UNICEF for 3 clinics. The ECHO contract pays for 25 percent of the staff salaries and medical supplies while SIDA pays for the other 75 percent of staff costs. These contracts do not link performance and payment. PMU also has a small grant with JSI to train traditional birth attendants.

EQUIP/LIBERIA has an established a record of implementing integrated health, education and development programs in remote rural parts of the country. The NGO trains and equips communities, social groups and other NGOs to plan and implement these community-based programs. EQUIP does not provide substantial service delivery as its focus is primarily on community outreach and environmental health.

EQUIP is challenged by limited management staff. There is a need for EQUIP to determine the costs of training and supervising the community-based health/water & sanitation/ environmental health program. Any group considering adopting the model would want to know the costs associated with establishing the program in a community and how much is required to maintain it effectively. Equip has been very good at diversifying its funding base and has a number of contracts with donors as well as with INGOs.

Christian Health Association of Liberia (CHAL) is a Christian based consortium of churches with 44 health facilities. They run independent multi-donor funded facilities as part of a network in the most difficult to reach areas of Liberia. They do employ user fees as a means to cost recovery. Drugs are purchased through the Internal Dispensing Agency (IDA) of the Netherlands. When stock outs occur CHAL will seek additional drugs from NDS. The CHAL clinics purchase drugs from the CHAL warehouse which is owned and managed by CHAL. There is a 10% mark up on drugs sold to the clinics. CHAL charges user fees by way of fee-for-service on consultations for cost recovery purposes. There are also fees for drugs but these are highly subsidized.

CHAL has carried out a number of capacity-building activities including workshops on psychosocial reconciliation and healing, water borne diseases, HIV/AIDS, RH, TBA, and PHC. All CHAL activities are focused on partnerships with the community and on community participation.

CHAL facilitates the organization of, "community health development councils" which are comprised of TBA, CHT that CHAL trains on Ministry of Health and Social Welfare guidelines. This training is funded by ECHO. TBAs are trained to identify and refer complicated pregnancies to health centers. The community provides their own transportation for labor and delivery using revolving fund created for birth and sickness called "susu". Delivery kits are provided to the TBA and all contents are from the community so that they can be easily replaced after use locally. The community builds "delivery homes;" two are functioning at this time – one in Montserrado and the other in River Cess. . CHW are also trained using IEC materials. A CHW TOT has been developed whereby literate CHT are trained; they in turn train household promoters in basic child survival skills. There are 520 trained household promoters. The promoters go house to house and explain to families how to care for children through the use of pictures. Promoters are provided with t-shirts or bags or feed rice for compensation for their services.

CHAL has VCT centers in Maryland, Grand Kru, Grand Bassa, River Gee, and Sinoe. CHAL refers HIV+ patients to the nearest hospital for treatment, but they do provide counseling and nutrition information. They send info on positive cases to the National AIDS program of the Ministry of Health and Social Welfare. Additionally, CHAL has supported the development and implementation of a mental health in-service curriculum.

This NGO has the ability to adapt to various requirements placed upon them by funders. The financial and accounting systems at CHAL are numerous depending upon the donor. For example PACT which is part of a USAID project required that CHAL have special reporting so they had their financial staff trained in Kenya on financial management.

CHAL does not provide service statistics to CHT. CHAL does meet with the CHT to report on notifiable epidemiological surveillance data when an outbreak occurs. They do not have standard reporting forms that the Ministry of Health and Social Welfare utilizes nor are there systematic ways of information sharing between them and the Ministry of Health and Social Welfare. They are not familiar with the BPHS but are open to receiving an orientation to the package and to forming partnerships to implement it. This may be difficult since the Ministry of Health and Social Welfare has stipulated that no user fees be charged for services and CHAL has implemented cost recovery scheme for its clinics.

The assessment team also met with one organization that does not fall into the categories of local health sector NGO or government FBO. However this local NGO potentially has quite a bit to contribute to strengthening service delivery in Liberia.

The Liberian Agency for Community Empowerment (LACE) has a particularly strong model of contracting out infrastructure development at the community level. It is receiving significant financial support from the World Bank, as well as the EC. LACE is a semi – autonomous parastatal organization that focuses mainly on the construction of buildings, local community NGO capacity-building for project management and community empowerment. LACE trains a team of 10 community members, five men and five women, in project procurement, implementation, monitoring and evaluation. Four people learn to procure, 4 to finance, 2 to manage and evaluate. This is done through a Training of Trainers modality whereby a local NGO is trained by LACE staff in project management through a public solicitation in the newspaper. After review of NGO capabilities LACE staff go the county and validate the information given by the local NGO. Then the NGO is “hired” by LACE, trained by LACE and then the NGO in turn trains the community. In other words the NGO is hired as “trainers”. See the LACE website at [www.lace.org.lr](http://www.lace.org.lr) for the LACE Operational Manual on the Contracting Process.

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## Appendix 3: List of Focus Group Participants and Persons Interviewed

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NAME	Organization	Position
<b>MoHSW</b>		
Walter T. Gweningale	MOHSW	Minister
Bernice Dahn	MOHSW	Chief Medical Officer
Vivian Cherue	MOHSW	Deputy Minister, Administration
S. Tornolah Varpilah	MOHSW	Deputy Minister Planning
Joseph W. Geebro	MOHSW	Deputy Minister, Social Welfare
Benedict Harris	MOHSW	Health Financing Coordinator
Roland Kessely	MOHSW	Health Financing Assistant
Momolu Sireleaf	MOHSW	Director, External AID Coordination UNIT
Roosevelt Tule	MOHSW	Health Planner
Jesse Duncan	MOHSW	Assistant Minister, Preventive Services
Julie Brown	MOHSW	Director, Human Resources
Jacob Hughes	MOHSW	OFM
Alex Nyarcy	MOHSW	SIFC, OFM
Arrabella Graeves	MOHSW	Technical Advisor
Bill Martin	MOHSW	Senior Advisor
David Logan	MOHSW	Coordinator, LCM
<b>COUNTY HEALTH OFFICERS</b>		
Dr. Massaquoi	CHO	Sinoe
Dr. Linda Birch	CHO	Bomi
Dr. Garfee Williams	CHO	Bong
Dr. Camara	CHO	Montserrado
Dr. Johnson Toe Chea	CHO	River Gee

<b>Other GOL</b>		
Mr. Gurley	NDS	Director
Mr. Johnson	NDS	Deputy Director
M. Varney Dukuly	MOF	Bureau of General Acct.
Amadu V. S. Kpahn	MOF	Macro-Fiscal Unit
<b>Donors</b>		
Desmond Curran	DFID	
Jean-Louis Alexandre	Delegation of the EC in Liberia	
James Durworko	USAID	Health Officer
Chris McDermott	USAID	Health, Population, and Nutrition Officer
<b>NGO Partners</b>		
Claudette Bailey	Africare	Chief of Party
Esther King Lincoln	Africare	
J. Mehmom Tekpa	Africare	Field Coordinator
Rose McCauley	BASICS	Chief of Party
Margaret Korpkor	BASICS	BPHS Coordinator
Ellen B. George William	Christian Health Alliance of Liberia (CHAL)	
Peter Ehrenkranz	Clinton Foundation	Medical Director
David Waines	Equipe	Director
Dr. George Odongi	Equipe	Medical Director
Precillia C. Guanue	FPAL	
Kota Kessely	FPAL	Deputy Director of Programs
	FPAL	Finance Manager
Dr. Shams-Ul-Alam	IMC	Country Director
	<b>IMC</b>	<b>Finance Manager</b>
Jennifer Geib	IRC	Deputy Director of Programs
Atillio Rivera-Vasquez	IRC	Medical Director
Caroline Bedos	MDM	Deputy Head of Mission
Kristin Banek	Mentor	
Tetee Brooks, M.D.	Merci	
Sonja Maria Van Osch	Merlin	Country Director
Dr. Asmatt	Merlin	Health Coordinator

Mitra Feldman	Merlin	Program Coordinator - Grand Bassa
Barbara Brilliant	Mother Patern College of Health Sciences	Dean
Dorbor Akoi	PMU Liberia	Executive Director
Clarence Massaquoi	PMU Liberia	Project Coordinator
	PMU Liberia	Finance Manager
Hari Bahskotz	Save the Children (SCUK)	Health Coordinator
Dr. John Agbor	Unicef	Health Leader
Ralph Midy	UNICEF	HIV/AIDS Coordinator
Eric Johnson	WHO	Senior Economist
Zakari Wambai	WHO	
Yasmin Fadlu-Deen	UNMIL	HCSO
Egbert Sonderp	London School of Hygiene and Tropical Medicine	
Ben Loevinsohn	World Bank	