The evolution of health service delivery in the Liberian health sector between 2003 and 2010
A policy analysis

Egbert Sondorp, Dept of Global Health & Development, LSHTM
Anne Coolen, Health Advisor, Royal Tropical Institute

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We would like to thank the many people we have been able to talk to regarding the developments in Liberia’s health system in the period 2003-2011. Their views are definitely taken on board, but it remains the sole responsibility of the authors how these views are incorporated in this study.

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<tr>
<td>BPHS</td>
<td>Basic Package of Health Services</td>
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<tr>
<td>CPA</td>
<td>Comprehensive Peace Agreement</td>
</tr>
<tr>
<td>DFID</td>
<td>Department for International Development / UK Aid</td>
</tr>
<tr>
<td>EC</td>
<td>European Commission</td>
</tr>
<tr>
<td>ECHO</td>
<td>EC Directorate-General for Humanitarian Aid &amp; Civil Protection</td>
</tr>
<tr>
<td>FBO</td>
<td>Faith Based Organisation</td>
</tr>
<tr>
<td>GFATM</td>
<td>Global Fund to fight AIDS, Tuberculosis and Malaria</td>
</tr>
<tr>
<td>INGO</td>
<td>International Non Governmental Organisation</td>
</tr>
<tr>
<td>JFK</td>
<td>John F. Kennedy Medical Center</td>
</tr>
<tr>
<td>JSI</td>
<td>John Snow Inc Research &amp; Training Institute (JSI)</td>
</tr>
<tr>
<td>KIT</td>
<td>Royal Tropical Institute (KIT), Amsterdam, Netherlands</td>
</tr>
<tr>
<td>M&amp;E</td>
<td>Monitoring and Evaluation</td>
</tr>
<tr>
<td>MOHSW</td>
<td>Ministry of Health &amp; Social Welfare</td>
</tr>
<tr>
<td>NLTG</td>
<td>National Transitional Government of Liberia</td>
</tr>
<tr>
<td>RBHS</td>
<td>Rebuilding Basic Health Services</td>
</tr>
<tr>
<td>PBC</td>
<td>Performance Based Contracting</td>
</tr>
<tr>
<td>OFDA</td>
<td>USAID’s Office of U.S. Foreign Disaster Assistance</td>
</tr>
<tr>
<td>RFTF</td>
<td>Result-Focused Transition Framework</td>
</tr>
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<td>UNMIL</td>
<td>United Nations Mission in Liberia</td>
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INTRODUCTION

Liberia’s National Health Policy and Plan 2007-2011 (MoHSW Liberia, 2007a) expressed as its vision: “a Liberia with improved health and social welfare status and equity in health; therefore becoming a model of post-conflict recovery in the health field”. The Policy and Plan then asserted that “enlightened leadership, sustained efforts, coherent prioritization, and generous external support are needed to materialize this attainable vision”.

This study aims to document the developments in Liberia’s health sector in the lead up to the formulation of the National Health Policy and Plan 2007-2011 and the period of its implementation. The focus will be on delivery of health services. This policy analysis of the post-conflict evolution of Liberia’s health services delivery is intended to contribute to a better understanding of the current state of affairs as well as present Liberia’s model for recovery in the health field, which may contain useful lessons for others.

STUDY CONTEXT

Years of civil war seriously eroded Liberia’s health system. Infrastructure dilapidated, many staff left their posts and often even the country, drug supplies dwindled and its governing institutions, including the Ministry of Health & Social Welfare (MOHSW) virtually stopped functioning.

The Comprehensive Peace Agreement (CPA) in 2003, followed by elections in 2005 and the installation of a new government in 2006 paved the way for recovery and reconstruction of the health sector. While during the war and the 2003-2005 transition period humanitarian agencies had become key actors in the health sector, as from 2006 the MOHSW increasingly took centre stage embarking on ambitious post-conflict health reforms. New policies were set and novel ways to finance and implement the policies were designed and set in motion.

In 2010, the MOHSW and the Royal Tropical Institute (KIT), Amsterdam, the Netherlands jointly initiated activities to prioritize and stimulate health system research, starting with the implementation of three interconnected studies regarding the evolution of the Liberian health sector between 2003 and 2011. Topics for these three studies are i) community participation ii) decentralization and iii) health service delivery. The three studies will be reported separately, followed by a synthesis report.

METHODOLOGY AND ANALYTICAL FRAMEWORK

The analysis in this paper is based on essentially four different sources. Documents, interviews during several visits to Liberia, participant observation during a range of consultancy missions, and a workshop with stakeholders from MoHSW, CHTs and NGOs in spring of 2011.

The focus of the report will be on policy choices, less on policy outcomes. The latter may be too early, since implementation is relatively recent, and that would require a different type of study. However, some observations regarding outcomes of early implementation can be mentioned.

A framework that was developed for another post-conflict context and proved to be useful will be adopted as analytical framework for this study (Percival & Sondorp, 2010). See figure 1.
A particular challenge for any post-conflict health reconstruction phase is to ensure that reforms are increasingly country-led, while in country capacity may still be relatively weak, and to ensure that often available, substantive external resources are appropriately channelled. There may be pressures on the health sector to not only improve the health of the population, but also to be instrumental in being part of the ‘peace dividend’ and of wider state and peace building objectives.

As the figure indicates, there are several factors that influence the health reform measures that will be proposed in a post-conflict setting. These factors include the wider in-country socio-economic and political context, a range of factors directly related to the health sector, and pressures from the international community. Implementation of the proposed reform measures will not only be influenced by the (quality of the) measures themselves, but also by other factors. These factors include the factors mentioned above as well as additional factors like government capacity and acceptance of the measure and implementation mode by the various stakeholders.

Prior to specifically looking at these various factors in the context of Liberia in consecutive chapters, the paper will start by describing Liberia’s health sector prior to the formulation of the National Health Policy & National Health Plan 2007-2011.

**SETTING THE STAGE**

Health planners in previous post-conflict health reconstruction efforts elsewhere occasionally fell into one of two traps. With massive destruction of the health infrastructure and health institutions during a prolonged conflict, it may seem that planning can start ‘from scratch’. This is rarely the case, and remnants of previous health systems are likely to play an ongoing role in any health reform and will influence implementation and outcome. The other trap is to just aim to rebuild the health services as they were before the conflict. A well known example comes from Uganda (Macrea, 2001). Uganda had relatively good health services before its prolonged internal conflict that ended in 1986. Efforts to rebuild the health services to its previous glory failed since circumstances were now very different. In particular the impoverishment of the country and its population as a result of the conflict meant that health services needed to be adapted to the changed needs and available resources.
So, post-conflict health reconstruction will have to take the past into account, but be ready for often extensive reforms to adapt to the new situation. Not only is there a need for extensive reforms, but the post-conflict period is also often seen as a window of opportunity to introduce novel solutions to the problems faced.

This chapter will therefore provide a brief look at Liberia’s health system before the conflict, assess what happened to the health sector during the conflict and in the immediate period thereafter, during the transitional period from 2003 to the end of 2005.

### A MINIMUM OF HISTORY

While in-depth sources about Liberia’s interesting history and the devastating 14 years civil war can be easily found elsewhere, the following table with some key dates and events will act as an aide memoire.

**1847** - Liberia established as independent state.

**1971** - Tubman, president since 1943 dies and is succeeded by William Tolbert Jr.

**1980** - Master Sergeant Samuel Doe stages military coup. Tolbert publicly executed.

**1989** - National Patriotic Front of Liberia led by Charles Taylor begins an uprising

**1997** - Presidential and legislative elections held. Charles Taylor wins a landslide and his National Patriotic Party wins a majority in the National Assembly.

**2002** January - More than 50,000 Liberians and Sierra Leonean refugees flee fighting. In February Taylor declares a state of emergency.

**2003** March - Rebels advance to within 10km of Monrovia.


**2003** September/October - US forces pull out. UN launches major peacekeeping mission, deploying 15,000 troops (UNMIL). National Transitional Government of Liberia in place.

**2005** September - Liberia signs an agreement under which the international community will supervise the state’s finances in an effort to counter corruption (GEMAP)

**2005** 23 November - Ellen Johnson-Sirleaf is proclaimed the winner of presidential elections, becoming the first woman to be elected as an African head of state.

### BEFORE AND DURING THE WAR

Before the conflict Liberia’s health care system was characterized by:

- Gross inequities between the rural and urban populations.
- A curative bias despite overwhelming need for preventive, promotive and rehabilitative services.
- A predominantly private ownership of health care facilities and private health care providers, accounting for over 60 percent of available health care. Private providers included churches, estates/mines and town-based private practitioners. As a consequence, Liberia did not have a strong tradition of health care management by government, unlike most African countries. It was only during the 1980s that the Government increased its involvement in health care provision.

Documentation on Liberia’s health sector prior to 1989 is not easily available. Liberia has a long tradition of provision of health care by Faith Based Organisations (FBO), including a range of up country mission hospitals. One of these is Phoebe Hospital in Bong County, established in 1921. This hospital was expanded in 1965, in a joint effort of missions and government, to become the up country referral hospital. Another major referral
hospital was established in Monrovia, in 1970, with funds from USAID, the John F. Kennedy Medical Center (JFK). As from 1974 the first four medical students graduated from JFK’s Dogliotti Medical School.

A written account from 1975 (Wheeler, 1975) provides the following description: “The government runs a hospital in each of the nine Liberian counties. In addition there are nine concession hospitals run for the benefit of the employees of mining and rubber concessions, and there are five mission hospitals. The country has a well-thought-out health care development plan which calls for a network of health posts manned by practical nurses in all strategic villages. Five such health posts would be supervised by a medical assistant in a “healthunit.” All the health units in a county would then be supervised by a physician.”

The report then continues: “Thus, the government is faced with the difficult task of maintaining a relatively expensive and uncoordinated system of crisis care medical facilities, assuming functions that the medical missions have traditionally served, putting more physicians in the country with the people, and developing a village-oriented health care delivery system in the midst of a world-wide recession”

In ensuing years there was increasing attention and support from the international community to develop primary health care facilities throughout the country. This came with the introduction of a typical ‘district health system’ or, for Liberia rather, County health system, with key elements like a basic hospital per county, a number of clinics and health centres and an integrating and supervisory role for a County Health Officer, with his or her team. This system remained in place throughout the conflict, be it often in very rudimentary form, and continues to be the key organising feature in the health sector up to today.

During the war, massive looting and destruction of health facilities took place. Prior to 1990, there were 30 hospitals, 130 health centres and 330 health posts and clinics. An assessment done in 1997 showed that 90 percent of the facilities were extensively damaged and vandalized. The war also caused enormous attrition of trained health staff of all cadres. As a stark example, the number of doctors reduced from a pre-war level of 237 to less than 20. And virtually all training opportunities of new health staff ceased to exist.

The 14 years of war, from 1989 to 2003, have in fact been a series of conflicts, affecting different parts of the country at different times, alternating with periods of relative calm, with or without the presence of peacekeepers. With the upsurge of the fighting in early 2003, in particular in and around Monrovia, many people fled from the country side to town. In response to the fighting and displacement of people, and where they managed to gain access, International Non Governmental Organizations (INGO) took on an increasing role in providing health services. Both through pre-existing health facilities and newly set up, ‘parallel’ facilities. The various stages of the conflict also meant that INGOs often changed operations resulting in highly intermittent support to many of the health clinics.

TRANSITION PERIOD 2003-2006

The Comprehensive Peace Agreement of August 2003 marked the beginning of a three year transition period. The CPA came with the establishment of the National Transitional Government of Liberia (NLTG) and the deployment of 15,000 UN troops - the United Nations Mission in Liberia (UNMIL) who managed to restore security and contributed to disarmament and demobilization of former combatants. The UNMIL also contained a civil affairs arm to jump-start civilian administration. A so-called Result-Focused Transition Framework (RFTF) was formulated by early 2004 to guide priorities and resource needs during the transition period. The transition period was foreseen to end with the election of a new parliament and formation of a new government by the end of 2005.
The RFTF grouped 13 priority sectors into 9 clusters. Basic Services was one of these clusters, which included the health sector. To cover humanitarian needs, the RFTF was complemented by a CAP (Consolidated Appeal Process), followed by an integrated RFTF Humanitarian Appeal for the year 2005. The RFTF has been successful during the transition period in securing peace, in disarmament and demobilization, in the return of many IDPs, and in organising broadly free and fair elections. Work in the other clusters was less successful. Part of the problem in implementing the RFTF were increasing concerns about transparency, integrity, accountability and fiscal management issues. By the end of 2005, this resulted in the signing of the GEMAP (Governance and Economic Management Assistance Programme), successful implementation of which would be a pre-condition for international donors for continuation of aid schemes and lifting of sanctions.

For the health sector, two key trends emerged during the transition period, and extending well into 2006. On the one hand, humanitarian health agencies managed to gradually reach more people, meeting immediate humanitarian needs and starting rehabilitation of quite a number of health facilities, in particular in areas of foreseen return of IDPs and refugees. On the other hand, the virtually complete absence of a coordinated effort to start addressing the short and medium term rehabilitation and reconstruction of the health sector became more and more visible. The Ministry of Health did not have the capacity at that stage to pay much attention to health sector policy and implementation strategy and the underlying problem of health financing. And none of other potential stakeholders, like UN agencies or major donors, did much to fill this policy void. This increasingly caused difficulties for current and potentially new health care providers, in terms of developing plans or formulating appropriate exit strategies.

By the end of 2005, and even more so during 2006 when the new government was installed, there was a real threat of substantial reduction of the available health care provision to Liberia’s impoverished and unhealthy population. Humanitarian donors felt their mandate came to an end by the end of the transition period and the establishment of a new, post-election government. The reduction of humanitarian funding would mean that quite a few NGOs would be forced to stop their support to health services, while no solution was in sight for possible new streams of funding either in the form of international development aid or from internal sources.

So, by the end of 2005, early 2006, after the 14 years of conflict, with its alternating periods of acute fighting and relative calm, and a three year transition period, the profound effect on all parts of the country were still very much visible. Some parts were particularly heavily affected by warfare and atrocities. All counties were affected by the general collapse of economic activities, government institutions and available services. Liberia had become one of the most under-developed countries in the world. The very low per capita GDP of $110 US, high infant mortality rate (134/1000), high under-five mortality rate (235/1000) and low life expectancy (48 years) are clearly indicative of the detrimental effects of conflict, poverty and lack of health services (Sondorp & Msuya, 2005).

During the war, massive looting and destruction of health facilities took place. Counties and facilities that did not receive external assistance hardly function; at best, there are some very minimal services still in place. Staff positions are usually filled, but mostly by people who do not have the qualifications for those posts, with, for instance, many nurse aides taking up senior positions. The war caused enormous attrition of trained health workers. And of staff that remain, the majority is not on the government payroll, being so-called ‘volunteers’. Those that are on the payroll receive irregular payment of extremely low salaries, if they receive anything at all.

Around 200 clinics are running by the end of 2005, supported by NGOs and other agencies. However, these clinics are unevenly spread, with a focus on areas that were worst hit by the war and home to many returnees, i.e. Lofa and Nimba, and around Monrovia. The south-east of the country is by then the most deprived of health services. There are only a few functioning hospitals in the country.
Government health expenditure was very low, possibly around $3 million US at best. Cost-sharing had been in place prior to and during the war, but the Fee-for-Service scheme had been suspended by the MoH as from June 2003, at least for the duration of the transition period because of the high levels of poverty in the population.

FINDINGS

The study looked at how the government re-established its institutional structures, including revitalizing its role in financing and regulation of the public health system. And it looked at how the various policies and plans, for the sector and sub-sectors, were developed, the role of other actors in the health sector, and the implementation modalities.

POLICY DEVELOPMENT

EARLY POLICY DEVELOPMENT 2006

In January 2006, the newly elected President, Ellen Johnson Sirleaf, is being inaugurated. In her cabinet she appoints Dr Walter Gwenigale as the new Minister of Health and Social Welfare. Dr Gwenigale brings in a number of new senior staff and together they start giving shape to the long awaited reconstruction of the health sector and provide the necessary leadership over the full period that this report covers.

The new Ministry found a heavily distorted health system, with skewedly distributed health services, serious lack of qualified health staff, extremely limited government health expenditure, scarcity of even basic information like the number of operational health facilities, and a lack of an overall vision and strategy.

The destruction and dilapidation of infrastructure during the war had given way, during the transitional period, to gradually expanding health services run by a variety of NGOs. While NGO activity during the last phase of the armed conflict, in 2003, had mostly been limited to Monrovia, after the CPA NGOs again moved out to other areas, as soon as this became possible. In part driven by the fact that most funding came from humanitarian donors, activities focused on areas that were worst hit by the war and home to many returnees, i.e. Lofa and Nimba counties, and around Monrovia. This led to a skewed distribution of health services, with the south-east of the country still heavily deprived of health services. Remaining health staff, if paid at all, received very low salaries. The collection of user fees had been suspended in 2003, a situation still in place today despite a quite hefty debate in 2005/2006 in which in particular NGOs vividly advocated against reintroduction. However, this only applied to the primary care level, while all major hospitals have forms of cost-sharing.

Apart from a contribution from the Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM), the bulk of funding for the health sector in 2006 was still from humanitarian funding, primarily from humanitarian donors, namely ECHO and OFDA/USAID. ‘Reconstruction’ funds or regular development aid monies did not get into sight yet for the health sector, during that year.
Table 1: Implementing partners for Health Facility Assistance in Liberia, end 2006 (source: MoHSW)

<table>
<thead>
<tr>
<th>Implementing Partners for Health Facility Assistance</th>
<th>Type of Health Facility</th>
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<tr>
<td></td>
<td>Clinics</td>
<td>Health Center</td>
</tr>
<tr>
<td>Christian Health Assoc. of Liberia</td>
<td>32</td>
<td>10</td>
</tr>
<tr>
<td>Merlin</td>
<td>30</td>
<td>1</td>
</tr>
<tr>
<td>Africare</td>
<td>31</td>
<td></td>
</tr>
<tr>
<td>Medecins Sans Frontires (all)</td>
<td>19</td>
<td>2</td>
</tr>
<tr>
<td>World Vision Liberia</td>
<td>26</td>
<td></td>
</tr>
<tr>
<td>African Humanitarian Action</td>
<td>22</td>
<td>2</td>
</tr>
<tr>
<td>MFRCT</td>
<td>20</td>
<td>4</td>
</tr>
<tr>
<td>Save the Children UK</td>
<td>21</td>
<td>1</td>
</tr>
<tr>
<td>Int'l Medical Corps</td>
<td>20</td>
<td>1</td>
</tr>
<tr>
<td>Int'l Committee of Red Cross</td>
<td>10</td>
<td>3</td>
</tr>
<tr>
<td>Int'l Rescue Committee</td>
<td>9</td>
<td>2</td>
</tr>
<tr>
<td>Medecins du Monde</td>
<td>8</td>
<td>2</td>
</tr>
<tr>
<td>EQUIP</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>Northwest Medical Team</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>Other Partners ***</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td><strong>268</strong></td>
<td><strong>29</strong></td>
</tr>
</tbody>
</table>

***FFAL, LNRCS, WRC, MFCT and COCPA, Cag-Asanur, German Govt.

Therefore, by the end of 2006, the situation seemed pretty similar to the start of the year (Sondorp & Bornemisza, 2007). Health services were still predominantly run by NGOs (see table 1) and the funding gap became all the more imminent due to announced withdrawal of humanitarian funding. By November 2006, the Minister of Health, concerned about this situation, issued a letter encouraging the NGOs to stay until at least December 31, 2008, stating that their participation was key to giving the Ministry the time that it needed to build up its service provision capacity. And the letter urged the donors to continue their support to the NGOs.

Figure 1: NGO assisted and other health facilities in Liberia, 2006 and prospect 2008

This figure comes from an animated powerpoint slide, prepared by the MoHSW, and shows the predicted closure of health facilities between December 2006 and December 2008. The slide, in steps of 6 months,
showed the change of currently functioning health facilities (green/light coloured dots) to predicted closure (red/dark coloured dots) due to funding shortfalls.

The figure, and the underlying slide, do not only show the threat of a transitional funding gap, but also an important, less visible development during that first post-election year. It shows data collection by the MoHSW, really virtually from scratch. In this case, the figure could be drawn up thanks to information collected on number and sites of health facilities, the agency operating them and their funding prospects to keep running them. In that sense, the figure is symbolic for the changes within the MoHSW and Liberia’s health sector during that year 2006. It was the start of a planned process to set new policies and strategies, led by the MoHSW. The 14 year conflict had seriously eroded the health sector’s governing institutions and only poorly functioning MoHSW and County Health Teams were still in place, without the capacity to provide leadership to the sector. This had not changed during the 3 years following the CPA during the transitional period in which the policy void became all the more obvious. It was only with the establishment of a new government in 2006 that this policy void could start to be filled leading to a real transition in the health sector.

The MoHSW set out a number of steps that was to produce a new national policy and plan. Preparatory steps took place within the Ministry with inputs from partners, like the NGOs and other agencies concerned with health, and international consultants. Care was taken to build in moments for wider participation and consultation, in particular from national staff and other stakeholders in the health sector.

A first of such events was the “Liberia Health Sector Rapid Assessment Validation and Strategy Design Workshop” in early August 2006, with around 90 participants (MoHSW Liberia, 2006). The purpose of the workshop was to begin updating the draft National Health Policy as was formulated in 2000 and to create a policy orientation framework for a new National Health Plan that would coordinate partner actions to support the MoHSW’s vision, policymaking, next steps, and priority interventions.

A rapid assessment of Liberia’s health status, health infrastructure and human resources informed the workshop. Discussions took place around the following policy orientations: Community Empowerment, Partnerships, Decentralization, Financing and Sustainability, Integration and Coordination, Inter-Sectoral Collaboration, Strong Government Commitment, Assuring Equity and Quality, and Human Resources for Health. The workshop concluded by formulating a number of recommendations to update the National Health Policy and start preparing a new National Health Plan. These recommendations were:

1) Define a Basic Package of Health Services (BPHS) for each health system level— including community—and strengthen central level systems to implement the BPHS.
2) Develop an HR plan and complete a functional analysis and reorganization of Human Resources functions within the MoHSW to better train, deploy, and support the health workforce.
3) Create a core MoHSW Health Management Information Systems with interlinking databases for human resources, infrastructure, statistics and stakeholder coordination.
4) Reinforce the County Health Team’s capacity for planning and management of health service delivery and support systems management.
5) Develop a health infrastructure rebuilding, upgrading and maintenance plan based on micro-planning by County Health Teams in collaboration with all local stakeholders, and taking delivery of the BPHS into consideration.
6) Reinforce central level leadership capacity for planning and transparent management of all support components, including coordination of implementing partners, health financing, and standardization of services and incentives.

Key elements of what would happen in the years to come are becoming visible in these recommendations, in particular the orientations around a BPHS and the key role of the County Health Teams. Another element, which did not make it yet into a recommendation, but which was to play a role later on, was discussed during the workshop as the following quote shows:
“Contracting to NGOs and Faith-Based Organizations (FBOs) is an option for reaching certain populations efficiently, especially for services that the public sector is not able to deliver. It also taps into NGO/FBO commitment and creativity. Benefits and disadvantages of contracting were outlined with examples from Brazil, Afghanistan, and Guatemala. Successful contracting depends on clear governmental policies and having a BPHS with a Human Resources Plan. High-level coordination and monitoring and evaluation are essential to tracking performance.”

Following more technical work and regional and national policy conferences, by the end of the year a draft National Health Plan could be formulated and be subjected to discussion during a National Health Plan Conference in December 2006. The draft plan focused on the equitable provision of a basic package of health care. This BPHS would consist of primary care (basic curative and preventive care, child health and immunisation, maternal and newborn health) as well as basic secondary care (including emergency obstetric care). The provision of such a BPHS was seen as the most effective and cost-effective way of improving health outcomes. It was foreseen that the government would provide health services through the County Health Teams, although the option to (partly) contract-out service provision to NGOs was left open. The draft National Policy and Plan also described the need to address underlying health system components, including human resource capacity, institutional capacity building, infrastructure development, logistic and drug supply systems, and health financing.

So, by the end of 2006 a new National Health Policy and Plan (2007-2011) was about ready, following an extensive participatory and consultative process with stakeholders in the health sector, both at the national level and with the international community. However, there was still no outlook as to financing the implementation of the proposed policy and plan. And it was clear that at the short to medium term domestic resources would not suffice to finance even very basic health services. So, only a contribution from the international donor community would be an option. But at that stage there was still a remarkable lack of donor coordination vis-à-vis the health sector, both between donors, as well as between the emergency and development funding entities within certain donors. A World Bank mission (World Bank, 2006) at the time concluded that addressing the health needs of the population to foster social reconciliation and secure a social safety net for the poor and vulnerable populations during the transition would be a key priority and called for concerted donor action. This recommendation was put against the findings of (1) severe funding shortages and chaotic fragmentation in donor financing; (2) heavy reliance on direct out-of-pocket payments for many health services; and (3) fragmented payment systems and weak performance incentives.

2007 – LIBERIA PARTNERS FORUM

It was envisioned that a synopsis of the National Policy and the National Plan, along with requested financing, would be prepared for the Liberia Partners Conference on Feb 13-14th, 2007, hosted by the World Bank in Washington DC. This conference was seen to be key for the health sector in terms of obtaining pledges of support for the health sector from 2008 onwards. Surprisingly, basic social services were initially not on the agenda of the conference. However, as indicated by the President of Liberia, the transitional funding gap for health was identified as being one of Liberia’s seven major concerns. So, in the end, this resulted in the inclusion of a one hour session for health and education during the main Partners Conference, as well as a one-day health sector partner’s forum hosted by the World Bank and the Woodrow Wilson International Center for Scholars on Feb 16th 2007.

During the Liberia health partnership forum the following key challenges were emphasized: 1) building the capacity in human resources to effectively implement its National Health Policy and Plan within the interim and medium-term timeframes specified; 2) implementing the National Health Plan which is contingent upon
the Government’s ability to raise funding to cover the transition gap while investing significantly in the health infrastructure for longer-term sustainability; 3) putting in place the appropriate funding mechanisms to enable donor agencies to quickly mobilize resources to move the plan forward; 4) Liberia’s current status as a fragile state and the urgent need for resources and technical assistance, particularly for the health sector, to assure the level of progress for the country to be at a steady state of development (MoHSW Liberia, 2007b).

The day of the health partnership forum was divided in two different parts that respectively primarily focused on Human Resources for Health and the health financing gap. Based on the rapid assessment done in June 2006, the following human resource gap could be presented:

Table 2: Human resource gap Liberia, June 2006

<table>
<thead>
<tr>
<th>Categories</th>
<th>Total</th>
<th>Required</th>
<th>Gap</th>
</tr>
</thead>
<tbody>
<tr>
<td>Certified Midwife</td>
<td>355</td>
<td>463</td>
<td>108</td>
</tr>
<tr>
<td>Pharmacists</td>
<td>29</td>
<td>98</td>
<td>69</td>
</tr>
<tr>
<td>Physician Assistants</td>
<td>273</td>
<td>370</td>
<td>97</td>
</tr>
<tr>
<td>Physicians/Doctors</td>
<td>168</td>
<td>219</td>
<td>51</td>
</tr>
<tr>
<td>Registered Nurse</td>
<td>453</td>
<td>438</td>
<td>-15</td>
</tr>
<tr>
<td>Registered Nurse/MW</td>
<td>18</td>
<td>122</td>
<td>104</td>
</tr>
</tbody>
</table>

Estimated budgets for the coming years could also be presented:

Table 3: Proposed National Health Plan budget

<table>
<thead>
<tr>
<th>AREA</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Human Resource for Health</td>
<td>15,300,000</td>
<td>19,149,000</td>
<td>19,608,000</td>
<td>20,079,000</td>
<td>74,136,000</td>
</tr>
<tr>
<td>Health Support System</td>
<td>6,800,000</td>
<td>6,963,000</td>
<td>7,130,000</td>
<td>10,952,000</td>
<td>31,845,000</td>
</tr>
<tr>
<td>Basic Package (FHC)</td>
<td>15,300,000</td>
<td>19,149,000</td>
<td>19,608,000</td>
<td>20,079,000</td>
<td>74,136,000</td>
</tr>
<tr>
<td>Infrastructure</td>
<td>1,700,000</td>
<td>1,741,000</td>
<td>8,913,000</td>
<td>12,778,000</td>
<td>25,132,000</td>
</tr>
<tr>
<td>Social Welfare</td>
<td>1,700,000</td>
<td>1,741,000</td>
<td>1,783,000</td>
<td>1,869,000</td>
<td>7,093,000</td>
</tr>
<tr>
<td>Subtotal</td>
<td>40,800,000</td>
<td>48,743,000</td>
<td>57,642,000</td>
<td>65,757,000</td>
<td>212,342,000</td>
</tr>
<tr>
<td>Transition Gap &amp; Health Plan</td>
<td>13,600,000</td>
<td>16,247,000</td>
<td>19,014,000</td>
<td>21,904,000</td>
<td>70,765,000</td>
</tr>
<tr>
<td>Implementation Costs</td>
<td>54,400,000</td>
<td>64,990,000</td>
<td>76,657,000</td>
<td>87,617,000</td>
<td>283,064,000</td>
</tr>
</tbody>
</table>

And it was foreseen that the budget could be covered by the following sources of finance:

Table 4: Financing of the National Health Plan (in US$ millions)

<table>
<thead>
<tr>
<th>Source of Funding</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>MOHSW + JFK (increasing to 15% of Nat.</td>
<td>10</td>
<td>18</td>
<td>28</td>
<td>33</td>
<td>89</td>
</tr>
<tr>
<td>External Support for National Programs</td>
<td>10</td>
<td>10</td>
<td>10</td>
<td>10</td>
<td>40</td>
</tr>
<tr>
<td>Other Humanitarian &amp; Development Funding</td>
<td>30</td>
<td>30</td>
<td>30</td>
<td>30</td>
<td>120</td>
</tr>
<tr>
<td>Other Funding (NGO, FBO, User Fees)</td>
<td>7</td>
<td>7</td>
<td>9</td>
<td>11</td>
<td>34</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>54</strong></td>
<td><strong>65</strong></td>
<td><strong>77</strong></td>
<td><strong>84</strong></td>
<td><strong>283</strong></td>
</tr>
</tbody>
</table>

The National Policy and Plan’s main theme is the provision of a BPHS. Priority interventions in the basic package will include: maternal and newborn, child health, adolescent health, disease prevention, control and management, mental health and social welfare. County-level contracting of NGOs and faith-based organizations is seen as the main mechanism to do this, however at the time it was not clear yet how
contracting could be implemented. This would partly depend on donor alignment to the proposed policy and plan, and decisions on funding modalities. Ideas were floated on setting up basket funding, similar to mechanisms in other sectors.

Finally a set of priority areas for partnerships were identified for each of the four key elements of the national plan:

- **Basic Package of Health Services**
  - Contracting for continued health service provision
  - Transitioning to county-wide contracts for service delivery
  - Training of existing personnel in BPHS
  - Procurement/Distribution of drugs and supplies

- **Human Resources**
  - Assessment of HR needs
  - Develop Human Resource Information Systems

- **Infrastructure Development**
  - Comprehensive infrastructure inventory
  - Rehabilitation of selected facilities

- **Support Systems**
  - Capacity building of County Health Teams
  - Health Management Info Systems
  - Drugs and Medical Supplies

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**NATIONAL HEALTH POLICY AND PLAN 2007-2011**

As described earlier, Liberia’s new Health Policy and Plan 2007-2011 had been developed during the year 2006, in an iterative, participatory way and was finalised early 2007. It turned into a rich document with quite detailed descriptions of a range of aspects (MoHSW Liberia, 2007a). This chapter aims to highlight some of the key elements, in particular those that help understanding the developments in the years to come.

Already the foreword of the National Policy, from Minister Gwenigale, highlights three key issues that are pervasive during the years of implementation. Firstly, there is the emphasis on the National Health Policy and Plan having been prepared with a theme of decentralization. This would include building the human capacity of the health sector at the community, district, and county levels as an essential component of the national health reform process and policy implementation. Secondly, there is the Basic Package of Health Services as the cornerstone of the new Liberian national health care delivery strategy. Though the delivery of the BPHS the MoHSW aims to ensure equity and quality. And thirdly, while acknowledging the need for support from donors and partners it is stressed that “we all share the goal of developing our internal capacities, so that with the passage of time Liberia will thrive with diminishing dependence on outside support”.

Very much in line with the central theme of decentralisation, and key to understanding future arrangements and challenges in contracting partners is the following paragraph from the Policy: “County health authorities will manage county health facilities. They will be responsible for financial management and personnel and will be fully accountable to local constituencies, as well as to overseeing public bodies. The Ministry will focus on health legislation and law enforcement; policy formulation, revision and enforcement; resource mobilization and allocation, national and long-term planning; broad health sector programming; monitoring and evaluation; and technical oversight of service delivery, regulation, major research and development initiatives”. 
Furthermore it is stated that the National Health Policy and Plan are designed around four strategic orientations of Primary Health Care, Decentralization, Community Empowerment and Partnerships for Health. The operational and integrated framework for implementing the National Health Policy and Plan is based on four key components:

- **Basic Package of Health Services:** Equitable access to an integrated “minimum package” of standardized prevention and treatment services. The BPHS will be adapted for each level of the health system – community, health clinic, health centre, county hospital, and tertiary hospital.

- **Human Resources:** The right number of health workers in the right place, at the right time, and with the right skills to deliver the BPHS. This will entail elements of improved human resource planning, training of new staff, and retention of good quality health workers, while taking equitable distribution and gender equity into account.

- **Infrastructure Development:** Reinforce and develop health infrastructure to increase geographic accessibility to the BPHS.

- **Support Systems:** The planning and management functions required to deliver the BPHS. These include Policy formulation & implementation; Planning & Budgeting; Human Resources Management; Health Management Info Systems; Drugs & Medical Supplies; Facility & Equipment Maintenance; Logistics & Communication; Supervision, Monitoring & Evaluation; and Stakeholder Coordination. Essential planning and management functions are to be incrementally and pragmatically decentralized to the county level.

These four components are to be supported through health financing and implemented in collaboration with a variety of partnerships for health.

### BASIC PACKAGE OF HEALTH SERVICES

Many countries use the term basic or essential or minimum packages of health services, usually with a notion of a set of cost-effective health services the population is entitled to. These minimum packages usually act as a priority focus within broader existing services. In the case for Liberia, however, as happened in some other post-conflict countries, where there were only scattered and fragmented health services left, the basic package of health services (BPHS) really acted as the cornerstone to rebuild a health care delivery system. Therefore, the BPHS is not just the description of a set of health interventions but a key element that is used to determine health care levels, staffing patterns and human resource development, drugs and equipment needs, standards and indicators, and health finance needs. In Liberia it also became used for the accreditation of health facilities. Hence some attention at this place for the principles and components of the BPHS in Liberia.

Once the National Policy and Plan 2007-2011 was endorsed, a process started to operationalise the various components of the National Plan. For the BPHS, this process led to a fully elaborated policy document, issued by June 2008 (MoHSW Liberia, 2008). The premise of the BPHS is that it identifies services that the MoHSW guarantees will be available to every Liberian citizen. With affordability in mind, this implies a thorough prioritisation process.

Four criteria were used for inclusion of health activities in the BPHS:

- contribution to reducing the burden of morbidity and mortality
- availability of interventions that have been demonstrated to be safe and effective
The feasibility of implementing those interventions given Liberia’s current resources and constraints
potential for sustaining the activity in the medium- to long-term

The Basic Package of Health Services for Liberia consists of the following:

- **Maternal and Newborn Health**
  - Antenatal care
  - Labor and delivery care
  - Emergency obstetric care
  - Postpartum care
  - Newborn care
  - Family Planning

- **Child Health**
  - Expanded Program on Immunization
  - Integrated management of childhood illnesses
  - Infant and young child feeding

- **Reproductive and Adolescent Health**
  - Family planning
  - Sexually transmitted infections
  - Adolescent Health

- **Communicable Disease Control**
  - Control of STI/HIV/AIDS
  - Control of tuberculosis
  - Control of malaria
  - Control and management of other diseases with epidemic potential

- **Mental Health**
- **Emergency Care**

This list of interventions allowed for planning of service levels where interventions are to be offered, required levels of health worker skills, and needs for drugs and equipment. Mental health, although listed and seen as a high priority in this post-conflict environment, was not immediately integrated in the package awaiting further assessment. Some Non-Communicable diseases, like hypertension and diabetes, although seen as emerging priority, were not yet included.

**OTHER POLICIES**

The development of the National Policy and Plan 2007-2011 and its cornerstone, the Basic Package of Health Care, have been the two key influential documents that have been produced by the MoHSW in these early post-conflict, post election years. But in the years after a range of other subpolicies and strategies have been developed. These include National Policies for Mental Health, Sexual and Reproductive Health, Health Promotion, and a Health Management Information System policy. There are also National Strategies for Malaria Control as well as for Child Survival.
IMPLEMENTING THE BPHS

So, by 2007 the stage for Liberia’s health sector reconstruction had been set. Most important had been that the MoHSW had regained stewardship over the sector. In this way, new national policies could be set that would potentially benefit all Liberians addressing the major burden of disease through cost-effective interventions. In line with overall government policy a clear choice for decentralisation was made giving a key role to the County Health Teams. The MoHSW also recognised the role that local and international non-government organisation had played in the past years and could play in the coming years to bring in much needed capacity to run health services, in partnership with the government.

However, there were still major issues on how these policies could be implemented. For the time being, Liberia would remain dependent on foreign assistance to finance its health sector. And, while there was some willingness after the Liberia Partners Conference in Washington to provide funds, there was no good solution how these funds could be channelled. Major accountability issues in the recent past and still existing low capacity in government to deal with and account for external monies were a detriment and aid mechanisms like budget support or sector wide approaches were not yet on the agenda. In the end, donors opted for different approaches to support BPHS service delivery. While some donors continued with direct funding to NGOs, some other donors chose to set up a pool fund which gave the MoHSW a more direct say in fund allocation. The most ‘visible’ amount of money during the reported period, however, came in through a specially designed programme funded by USAID, the Rebuilding Basic Health Services (RBHS) programme.

The implementation of the BPHS may be best described by looking at four relatively novel approaches that came into place. Together these approaches ensured channelling of available resources, a sustained focus on the BPHS as the core policy element, instrumental use of the capacities NGOs could bring in, and setting up potential mechanisms for improved aid effectiveness. These four approaches, i.e. the Health Sector Pool Fund, accreditation, contracting NGOs, and performance based contracts will be described in the following paragraphs.

HEALTH SECTOR POOL FUND

The Health Sector Pool Fund, usually referred to as the ‘Pool Fund’, was established in March 2008. Its objectives were threefold (MoHSW & PWC, 2009):

- To help finance priority unfunded needs within the National Health Policy and Plan
- To increase the leadership of the Ministry of Health and Social Welfare (MOHSW) in the allocation of health sector resources
- To reduce the transaction costs associated with managing multiple different donor projects

The Pool Fund is a ‘co-managed’ fund under the oversight of a Pool Fund Steering Committee, chaired by the Minister of Health and Social Welfare. Sector-wide representation on the steering committee ensures close integration of pool fund support with resources from government as well as bi-lateral and multi-lateral partners. An internationally recognized financial management and accounting company is contracted to act as the fund manager. The MoHSW proposes all activities to be funded by the pool fund to the steering committee.

Along with the MoHSW, the accounting firm holds co-signature responsibility for fund disbursements and operates a secretariat within the ministry to support the steering committee. The ministry’s Office of Financial Management manages pool fund expenditures and financial transactions.
So far, the Pool Fund has attracted funds mainly from DFID and Irish Aid, with some smaller amounts from UNICEF and UNHCR, in total around 13.5 Million USD. Main allocation from the Pool Fund is towards the implementation of the BPHS till June 2011.

**ACCREDITATION**

The introduction and focus on the BPHS in Liberia’s health sector led to an interesting novelty by initiating an accreditation process for all operational health facilities throughout the country (Cleveland et al., 2011; MoHSW Liberia, 2009a). While more often used in other countries, accreditation is still rarely used in low income countries. Since the BPHS comes with standardisation and a set of requirements to be in place at the various health facility levels, this provides a good base to set up an accreditation system, as could be shown in Liberia. In the process, all health facilities are visited and existing services and management systems are being assessed. This will not only identify areas for improvement, but will also enable follow up through renewed visits. The use of standardised checklists, with a focus on items that can be easily observed during a site visit, allows for comparisons between health facilities and will highlight shortcomings in individual facilities as well as more systematic issues. The process, however, does not directly measure quality of care offered at a facility, but rather the necessary pre-conditions to provide quality care.

The accreditation process started by mid 2008 and identified 437 open health facilities, of which 349 were government-owned. In January 2009, all facilities were visited using a checklist with nine assessment categories: availability of BPHS health services being the most important category, the other eight looking at Human Resources and Facility Operations, Pharmacy, Dispensary and Storeroom, Drugs and Supplies, Laboratory/Diagnostics, Equipment, Communicable Disease & Infection Control, Medical Records and Guidelines and Infrastructure. Items are weighted and lead to an overall facility score. Facilities that received an overall accreditation score of 75% or higher were considered functional, and received a Bronze ½ Star. Facilities achieving 85% received a Silver 1 Star, while facilities meeting all of the required standards received Gold 2 Star certification.

As Cleveland et al indicate, the results had a number of effects. These included better understanding how performance of health facilities would be judged, improved benchmarking transparency, and healthy competition among implementing NGOs and CHTs to make improvements. In addition, staff at facilities often saw this initial accreditation process as a reengagement of the central MoHSW after all the years of conflict. And it allowed the MoHSW to "better manage NGO assistance, which has in turn increased NGO accountability and solidified the MOHSW’s leadership and authority in a previously fragmented health sector" (Cleveland et al., 2011).

The accreditation process in January 2009 showed that 123 facilities (36 %) of the 346 government facilities assessed met the standards for BPHS implementation, that is received a Bronze ½ Star or higher. This was just short of the target set for the end of 2009 of BPHS implementation in 40% of facilities. Efforts were immediately stepped up to make improvements. For instance, overall low scores for laboratories led to a major purchase of laboratory equipment. Since government had committed itself, in the framework of the Poverty Reduction Strategy, to reach 40% BPHS implementation by the end of 2009, a new accreditation round was scheduled for September 2009 (MoHSW Liberia, 2009b). Although not all government facilities were accessible due to the rainy season, the results showed that overall 47% of government facilities were now assessed as currently implementing the BPHS, so well beyond the target. A next target was set for the end of 2010 when 70% of facilities should be implementing the BPHS.
Two more full accreditation rounds were conducted in the following years, in January 2010 and January 2011 (MoHSW Liberia, 2010, 2011). The number of government facilities by then rose to 378 and 381 respectively. In addition, private facilities were assessed, 172 in 2010 and 155 in 2011. Overall results for these two rounds are given in the table.

### Table 1: Distribution of Average Scores by Facility Type and Accreditation Levels in 2011

<table>
<thead>
<tr>
<th>Facility Type</th>
<th>Clinic</th>
<th>Health Center</th>
<th>Hospital</th>
<th>Overall</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Two Stars (&gt;95%)</td>
<td>29</td>
<td>3</td>
<td>3</td>
<td>35</td>
<td>9.3%</td>
</tr>
<tr>
<td>One Star (&gt;85%)</td>
<td>172</td>
<td>14</td>
<td>10</td>
<td>196</td>
<td>52.1%</td>
</tr>
<tr>
<td>Half Star (&gt;75%)</td>
<td>71</td>
<td>9</td>
<td>6</td>
<td>86</td>
<td>22.9%</td>
</tr>
<tr>
<td>Less than 75%</td>
<td>53</td>
<td>5</td>
<td>0</td>
<td>59*</td>
<td>15.7%</td>
</tr>
</tbody>
</table>

*This number includes the Prison Facility

### Table 2: Distribution of Average Scores by Facility Type and Accreditation Levels in 2010

<table>
<thead>
<tr>
<th>Facility Type</th>
<th>Clinic</th>
<th>Health Center</th>
<th>Hospital</th>
<th>Overall</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Two Stars (&gt;95%)</td>
<td>14</td>
<td>1</td>
<td>3</td>
<td>18</td>
<td>4.8%</td>
</tr>
<tr>
<td>One Star (&gt;85%)</td>
<td>146</td>
<td>8</td>
<td>8</td>
<td>162</td>
<td>42.9%</td>
</tr>
<tr>
<td>Half Star (&gt;75%)</td>
<td>103</td>
<td>14</td>
<td>5</td>
<td>123</td>
<td>32.3%</td>
</tr>
<tr>
<td>Less than 75%</td>
<td>67</td>
<td>7</td>
<td>1</td>
<td>75</td>
<td>19.8%</td>
</tr>
</tbody>
</table>

Two trends are visible. Firstly, an overall rise in the number of facilities implementing BPHS as defined by the accreditation exercise (Half Star or more) reaching almost 80% by the end of 2010. This means that the target set in 2007 has been achieved. Secondly, within that group of facilities there is an upward trend towards One and Two Stars.

Beyond these overall scores, the full reports contain detailed information on achievements per assessment category, per county and per partner (supporting NGO) and identify facilities with a negative trend. These widely available results obviously provide a wealth of management information all stakeholders can act upon.

The accreditation was also incorporated into the performance based contracts that would be issued to NGOs, where it acts as one of the performance indicators.

### CONTRACTING NGOS

In recent years, contracting the private sector, mainly in the form of not for profit NGOs, to deliver health services on behalf of and under the guidance of the Government has gained popularity in a number of other post-conflict settings. The rationale is usually to take advantage of available capacity in NGOs while systems and capacity within government are clearly lacking without possibilities for a quick fix. The Government is then able to focus on its stewardship role, including policy setting and regulation, and to hold the NGOs to account.

Contracting may follow a number of different arrangements, including different fund holder arrangement and forms of performance-based contracting. At the same time, there is also more interest to use similar performance based contracting mechanisms between levels of government. The terminology to describe these different arrangements is sometimes confusing. In Liberia the following terms have been accepted. Options include contracting in, when one level of government contracts with another, contracting out, when a partner
is contracted with complete authority over all resources (human, material and financial) to provide health services, and management contracting, when a partner is contracted to provide management services alone over government resources.

Also in post-conflict Liberia it soon became clear that the government/MoHSW would lack systems and capacity to resume direct health provision to its citizens, while a range of NGOs with experience inside Liberia and capacity to run health services could be contracted to start working under a government umbrella.

As from 2009 a number of different contracting arrangements came into place. Most of them as performance based ‘management contracts’, some of them ‘management contracts’ through grant arrangement without a performance based element, and one pilot ‘contracting in’ arrangement with the CHT in Bomi County.

While the new national policy and plan for 2007-2011 was endorsed in early 2007, it took quite a while before new investments were being made available. The great majority of functional health facilities continued to be run by FBOs and NGOs. As of 2009, more than 70% of the government health facilities are operated on behalf of the MOHSW by FBOs or 1 of 15 international and local NGOs.

These were still financed through humanitarian funding, i.e. OFDA and ECHO, supplemented by private donations from agencies’ constituencies abroad. For instance, ECHO did not withdrew its money as planned in 2006, but much later using its ‘Linking Relief, Rehabilitation and Development’ mechanism. Only a few years later, commitments to ECHO supported health projects were taken over by EC development funds, still through direct contracts with implementing NGOs.

In the mean time a Pool Fund had been established so as to create a mechanism for a variety of donors to pledge monies. Initially, the Pool Fund could be used to strengthen MoHSW capacity but not yet for larger scale support to service delivery.

**RBHS**

It is only during 2008 that plans are being developed that would lead to the establishment of the Rebuilding Basic Health Services (RBHS) programme. This programme was developed by USAID, to last 5 year (2008-2013) for an estimated cost of 62 Million USD. After formulation, the first step was to find a partner to manage the programme. The tender was won by John Snow Inc Research & Training Institute (JSI), in collaboration with some other agencies like Jhpiego and Management Sciences for Health. The programme was designed to support the Ministry of Health in Liberia to implement its National Health Policy and Plan, specifically, the delivery of Basic Package of Health Services (BPHS). It would have three different components:

- Strengthening and extending service delivery through performance-based contracts to NGO partners.
- Strengthening Liberia’s health system in the areas of human resource management, infrastructure, policy development, and monitoring and evaluation.
- Preventing disease and promoting more healthful behaviours through behaviour change communication and community mobilization

The mainstay of the programme was to subcontract NGOs to be directly involved in the implementation of the BPHS in a number of specific target areas in the country. The other components contain a variety of activities, both in terms of support to and capacity building of the central MoHSW and activities at the community level. Reportedly the budget was formed from a range of programme budget lines within USAID, which hence had to be accommodated in the design of the programme.
By the end of 2008, JSI could start implementing the programme and set itself up in a building across the street from the MoHSW in Monrovia. It was then that preparations could start to issue a call for proposals for performance-based contracts with NGO partners, which consequently was distributed by March 2009.

Overall objective and sub-objectives for the call for proposals were formulated as:

**Objective:** Increased Access to Basic Health Care Services

**Sub-Objective 1:** Delivery of evidence-based BPHS services in a number of counties

**Sub-Objective 2:** Expansion of selected BPHS services to communities

**Sub-Objective 3:** Strengthening the capacity of County Health Teams to manage a decentralized health system

The call was for proposals to include a total of 106 selected government health facilities from six catchment areas, i.e. in the counties of Bong (16), Grand Cape Mount (15 facilities, but to add 2 from Bomi county), Lofa (21), Nimba (35), River Gee (16), and 1 in Montserrado. The choice of areas and clinics can be largely explained by pre-existing presence of INGOs supported by OFDA/USAID plus a commitment to the highly underserved and remote country of River Gee in the east. The contracts would be for two years, but with funding only ensured for the first year and continuation subject to availability of USAID funding and satisfactory performance of the contracted agency. As per MoHSW policy, the prospective contracting partners were encouraged to partner up with local NGOs, FBOs and Community Based Organizations in order to build local capacity and ensure long term sustainability.

Following evaluations of the bids and some further considerations, 6 contracts were issued to 5 NGOs, of which 5 performance-based contracts to 4 International NGOs and one grant contract to the local NGO Merci to deliver services in River Gee. The contracted INGOs by county are: Africare (Bong, 16 facilities), EQUIP (Nimba, 23 facilities), IRC (Lofa, 19 facilities), IRC (Nimba, 12 facilities), and MTI (Grand Cape Mount/Bomi/Montserrado, 25 facilities).

By mid June 2009 contracts had been issued and NGOs could assume activities, mostly building on their pre-existing activities in the areas, but expanding in ‘their’ area of contract and retracting from some clinics in areas now under other NGOs. And now with the contracted obligation to fully implement the BPHS. The contracted NGOs were monitored by RBHS, but RBHS was also able to provide extensive technical support to the health sector, MoHSW and NGOs alike, through in-house staff as well as flexible deployment of temporary experts, mostly from abroad. One of the key areas which was developed by RBHS in the first phase of its programme was the design of the mechanisms for performance based contracting (PBC), which will be dealt with in a later chapter.

**POOL FUND CONTRACTS**

The Pool Fund was established in 2009, mainly with funds from DFID and Irish Aid. The Pool Fund secretariat is based within the MoHSW. By the end of 2009, the Pool Fund contracted Bomi CHT to provide the BPHS in 20 health facilities, as a pilot on ‘contracting in’. By March 2010 the Pool Fund also contracted INGOs for support to the delivery of the BPHS. In total 4 NGOs were contracted to support 112 health facilities in 6 counties. These four NGOs are Africa Humanitarian Action (AHA) supporting facilities in Gbarpolu (17 facilities) and Rivercess (17), Pentecostal Mission Unlimited (PMU) in Lofa (17), Save the Children UK (SCUK) in Montserrado (7) and Merlin in Maryland (21) and Grand Gedeh (17). In addition IRC was contracted to run an additional hospital in Nimba. All INGOs partnered with a national NGO. These contracts were intended to be performance based, but during the first year the mechanisms were not in place to actually assess performance and no bonuses were paid. The figure below provides an overview of the supported counties and health facilities funded by RBHS and the Pool Fund as of early 2011.
At a given time the EC considered channelling funds through the Pool Fund as well, but due to internal administrative reasons this did not prove possible yet. But, following on from ECHO funding, the EC supports BPHS delivery, with funds being channelled through the National Authorization Office (Ministry of Planning). This programme runs along similar lines as the RBHS and Pool Fund schemes, but without a performance based component, in a number of counties, i.e. Sinoe and Grand Kru, mainly through the NGO Merlin. The same NGO is also operating BPHS activities with direct support from Irish aid.

So, by 2011, around 75% of all government health facilities were covered by one of the mentioned funding initiatives to step up BPHS implementation. Public facilities that are not contracted under any of these three schemes are still run directly by the government using a more traditional input model. The RBHS contracted NGOs would report directly to RBHS and performance achievements are being compared between agencies and discussed in regular joint meetings. The Pool Fund contractees report directly to the MoHSW, using pretty similar performance indicators as the RBHS. Also these results are compared between agencies in open meetings where feedback and common constraints and possible solutions are being discussed.

Quite a few of the initial contracts would come to an end by mid 2011, other by mid 2012. By mid 2011, there was still no formal confirmation of continued funding for all the work that had in fact just started, let alone some longer term outlook for more stable funding. However, the general expectation was that funders would renew their commitments. A first confirmation of this commitment as well as a step towards increased country leadership was a decision to bring the RBHS scheme within the MoHSW, to start in a year's time.

PERFORMANCE BASED CONTRACTING (PBC)

Traditionally, most health care provision in the public sector uses input financing. Typically, a budget, often with specified budget lines, is made available from central government to a local government body or directly to a health facility, while staff is being paid along separate lines. Budget holders are then accountable for
correct spending of the agreed budget. More recently, there is much more focus on achieving results and to make payment to health care providers in part dependent on achieved results on a number of pre-set indicators. Interestingly enough, it has in particular been in a number of post-conflict countries where this novel approach has been introduced and tested, with some promising results. The underlying idea of payment according to achievement and thereby making health care managers and health workers responsible for performance, while providing them with the flexibility as to how to achieve those results, is similar to all performance based initiatives. However, there is scope for a lot of variation in its implementation depending on context specific circumstances and choices in design.

Given the situation in Liberia, where it had been decided to have a substantial part of health care provision covered by contracted agencies, it seemed to make sense to also introduce performance based contracts. From the start, it was suggested to have performance based elements in the contracts that were issued to the NGOs under the RBHS programme. Most Pool Fund contracts started about a year later, but were also intended to have performance based elements.

Essentially, the suggested, and for RBHS implemented, scheme was to agree on the total amount for each individual contract between fund holder and contracted agency, but to make final payment dependent on achieved results. Underperformance would then result in paying up to 5% less, while better performance would result in a bonus of up to 6%. Any loss would have to absorbed by the contracted agency, but the bonus could be used in different ways and would also benefit health facilities and, ultimately, individual health staff.

PBC requires a lot of attention to detail, in terms of the design of the scheme, a variety of tools needed to allow monitoring and evaluation, systems to validate reported outcomes, swift handling of reports and payment of next instalments, training of all involved, and good communication. A key element is obviously the choice of indicators against which results are being measured. Therefore, some more detail will be given here how this was done for RBHS and consequently also more or less adopted by the Pool Fund contracts.

Apart from the contract with Merci in River Gee, which was not performance based but otherwise monitored in a similar way, all RBHS contracts were ‘management contracts’. This means that the delivery of the BPHS was not fully ‘contracted out’, whereby the NGOs would have received complete authority over all resources (human, material and financial). The NGOs were given the dual task of both ensuring delivery of the BPHS in the government health facilities in their catchment area as well as strengthen the capacity of County Health Teams to manage a decentralized health system. To deliver the BPHS the NGOs were dependent on existing government health staff that they could not hire or fire and timely delivery of some crucial supplies, like drugs and bed nets by third parties. As described in detail by Vergeer et al, this influenced the choice of indicators to ensure that performance incentives would be linked to results that could sufficiently be influenced by the NGOs (Vergeer, Rogers, Brennan, & Sarcar, 2010).

For RBHS then, two sets of indicators were selected. One was a set of five ‘administrative indicators’. If one or more of these indicators would not be met, a penalty of 1% would be applied for each indicator not met, so up to a maximum of 5% of the totally agreed contract amount. The other was a set of ten ‘performance indicators’. Meeting any of these indicators would yield a bonus of 0.6%, so a potential maximum bonus of 6% of the totally agreed contract amount.

The administrative indicators were considered to be under the direct influence of the NGOs. They consisted of:

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1 The system to actually and accurately pay government health workers had long collapsed. So, although NGOs could not hire or fire staff, the contracts tasked them to regularly pay salaries and incentives to health workers in the health facilities.
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- Number of joint and total supervisory visits
- Percentage of timely, accurate and complete HIS reports submitted to the CHT
- Percentage of staff funded by NGOs paid on time
- Number of Community Health Development Committees meetings held per facility
- Submission of timely and complete quarterly report to RBHS

The performance indicators were formulated as:

- Percentage of priority facilities reaching one-star level in accreditation survey
- Percentage of facilities with no stock-out tracer drugs
- Percentage of patients receiving no more than 3 drugs
- Percentage of children under 1 year who received DPT3/pentavalent
- Percentage of children under 5 years with malaria who are treated with ACTs
- Percentage of pregnant women provided with 2nd dose of IPT for malaria
- Percentage of deliveries that are facility-based with skilled attendant
- Number of people tested for HIV and received their results
- Couple-years of contraceptive protection provided
- Percentage of gCHVs who received at least 1 supervision visit in last quarter
- Percentage of facilities achieving 70% average score on clinical standards assessment

Reporting of results was set to be quarterly and a prerequisite to receive the next quarterly instalment. Initially, bonuses were only calculated on an annual basis, but were later on paid quarterly to provide a more direct incentive. The way bonuses were used was left to the respective NGOs, in consultation with the CHT and health staff. In most cases the bonuses were distributed among all stakeholders, including the NGO, CHT, and the health facilities. Bonuses were both used for facility improvement and for staff bonuses. Individual staff within the facilities would receive a bonus on a pro-rata basis according to their salaries. This would typically accrue to an amount equal to half a month’s salary.

The figure has an example, well over a year after the start of the contract, of quarterly performance among the RBHS partners.

![RBHS partners' performance on PBC indicators, by NGO, Jan-Mar 2011](image-url)
Data obtained through the performance measurement will not only be used to determine bonuses, but have a variety of other uses. For instance, overall trends can be made visible, as in the example below for facility deliveries, but also specific bottlenecks by area or by NGO can be identified.

The set up of a system for performance based payments within the RBHS programme, including the establishment of indicators and a monitoring system, had to occur in a compressed time frame due to the pressure to get the call for proposals for BPHS delivery out and start implementation. The advantage of having a relatively small, dedicated team within the RBHS office ensured the timely set up of the system, including the necessary tweaks during implementation. This was not the case in the MoHSW where by nature such a focused approach is more difficult to organise and more time consuming. So, when the Pool Fund was ready to issue contracts to the NGOs, that were also assumed to be performance based, appropriate and sustainable institutional and implementation arrangements to really incorporate PBC concepts like the proposed bonus payments were not yet in place. In other countries, with less pressure to start implementation, for instance, a PBC operational manual would have been produced prior to implementation with the design, indicators, verification tools and M&E procedures and with clear lines of responsibility for validation of reports, feedback and timely payments. This was not yet the case for the Pool Fund contracts. So, while similar indicators were used to monitor progress, the bonus payments were not yet possible during the first year. Only by mid 2011, this would be addressed by drafting an operational manual and making the necessary institutional arrangements in the MoHSW to properly manage the scheme (MoHSW & WorldBank, 2011).
An interesting feature in the Pool Fund contracting is, of course, the use of a ‘contracting in’ modality with the Bomi CHT. Indicators, M&E, and, if they get paid, the bonus system would be identical for this contract with the CTH as the management contracts with the NGOs.

Despite the lack of bonus payment, implementing partners, including Bomi CHT have shown high commitments to increase service delivery and some have already increased coverage of key services such as institutional delivery since the relatively recent introduction of the contracts.

ANALYSIS

During the reported period, the health sector in Liberia made a remarkable recovery. In 2003, at the time of the CPA, the sector had virtually fully collapsed, with widespread destruction and dilapidation of health infrastructure, a decimated trained health work force, hardly any finance and a serious lack of governance. By the end of 2010, clear leadership by the government has been reinstated and there is good progress to reach the majority of citizens, all over the country, with a basic package of health services. Financial means have been obtained, largely through external assistance. A lot of the health infrastructure could be rehabilitated and, although wages may still be low, health staff is now at least receiving their salaries at regular intervals.

Most of these improvements are relatively recent, since only since mid 2009 substantial investments were available to implement the new government policy and plans, with at the core the systematic roll out of the BPHS. In other words, it has taken six years, since the peace accord to really start addressing the recovery of the health sector, 3 years during the transitional period where social services were hardly advanced, and still 3 years of preparation since the new government took office. During these six years, it has largely been the humanitarian agencies, through extended humanitarian funding, who managed to provide basic health services to at least part of the population, be it in a rather fragmented and non-standardized way. But the international community active in Liberia during the transitional years, 2003-2006, has not been able to stimulate preparatory steps that would have provided more impetus for the newly elected government to make the necessary policy decisions. Consolidated overviews of health facilities, health workers and funding could possibly have been produced earlier. And planning how to (financially) support the health sector could have been more advanced. In any case, the threatened ‘transitional funding gap’ as was feared by the end of 2006 did not materialize, thanks to a combination of identification of the pending gap and stop-gap measures by various stakeholders to prevent this from happening (Canavan, Vergeer, & Bornemisza, 2008).

The impact of the recent improvements in terms of reduced mortality and morbidity is likely, but has not really been measured yet. And, even if reduced mortality would be shown, it is always hard to attribute this solely to improved health services, since many other factors like improved nutrition and reduced poverty may play a role as well.

The last few years have seen an excellent start in improving the health sector, but there is still a lot to do. At the heart, and most intractable, is the enormous backlog in institutional capacity and human capital. It inevitable takes much longer before institutions and various systems are fully functional and before people are properly trained again. And, while the health sector can be a bit ahead of other sectors, overall developments in Liberia will also determine the speed whereby the health sector can improve.
Going back to the analytical framework as presented early on in the document may help to better understand some of the recent developments and challenges ahead.

The essential reform measures that have been taken during this period are the choice to provide a BPHS to all Liberians to be managed by county health authorities, who will be accountable to local constituencies. In this decision the health context plays a clear role, with a high burden of disease in all of the population that can be addressed by relatively simple, effective interventions at the primary care level. And the choice for decentralization and the role of the county health teams is given by higher political choices to increase accountability of government and inclusion of previously less well represented parts of the population.

This choice precluded an alternative solution, whereby health service delivery could have been fully contracted out, for instance county by county, to third parties, i.e. NGOs, as was done in some other post-conflict countries. Instead, the NGOs were contracted through management contracts with a dual purpose to contribute to the delivery of the BPHS and strengthen the capacity of the CHTs. As will be argued below for PBC, this dual role causes a number of ambivalences both with the CHT and the NGOs towards each other.

The extreme poverty, in part as a result of the conflict, and the very limited resources accessible to government also clearly play a role in the relation with the international community. While Liberia is clearly dependent on foreign aid, at this stage, to even provide very basic health care to its citizens, the conditions that external aid poses are clearly visible in the way the proposed reform measures are being implemented. The backdrop is a lack of trust by the international community, fuelled by events during the conflict and still pervasive during the transitional period, to let the government handle monies. This lies at the heart of the set up of specific arrangements to channel the money. And different donors chose different approaches, due to their own specific institutional demands and arrangements. So, USAID opted to set up a programme, close to but essentially separate from government. The Pool Fund is intended to provide a mechanism which gives the government more leadership but with a number of checks and balances in actual disbursements. And the EC provided funds directly to NGO BPHS operations that were as such in line with government policy, but without much involvement of the MoHSW and, for instance, not imbedded in a joint M&E system.

The existence of various way of external funding has also an impact on the continued fragmentation of service delivery within counties. Donors like USAID and EC continued to fund areas where they had previously supported health activities through their humanitarian funding arms, while the Pool Fund then targeted its funding to underserved areas. The various schemes did reduce the pre-existing fragmentation at county level,
where there was often a multitude of players. But in quite a few counties there are still various funding schemes in place involving various NGOs, with the obvious problems of coordination, duplication and strain on the CHTs. This is most obviously the case in Montserrado County, the smallest but most populous county in Liberia, which includes the capital Monrovia.

Finally, external pressures can be seen in the implementation of the performance based nature of the BPHS contracts, which internationally has now become ‘fashionable’. It could be argued that in the initial phase of the BPHS implementation, the sheer fact that there is a contract with a range of indicators and increased attention to what is actually happening at field level, including through improved M&E systems, may be sufficient to achieve much better results. This was, for instance, obvious in the case of the Pool Fund contracts that were de facto not performance based in the first year, but nevertheless showed good initial results.

So, more time could have been allowed to properly prepare for the introduction of PBC. In particular the role of the CHTs should have received more attention. That role is currently not well-defined, nor understood. Although the role of the CHT is critical because of their support of direct service delivery and as overseers of the PBC scheme, nowhere is their role documented, nor specified in any contract. The strong emphasis on PBC might come with an unwanted centralization, since only the central level (RBHS and in future the MoHSW) has the capacity to perform the necessary M&E and make payment decisions.

Another side effect of the strong emphasis on PBC proved to be that NGOs pay particular attention to fulfilment of the performance indicators and less to their CHT capacity strengthening role.
CONCLUSIONS

Liberia, prior to its National Health Policy and Plan 2007-2011 had as its vision: “a Liberia with improved health and social welfare status and equity in health; therefore becoming a model of post-conflict recovery in the health field”. The end of this planning period allows taking stock of the achievements of the policy and plan. Much has been achieved and the initial recovery of the health system during this period will form the heart of the next planning phase, 2011-2021. During that period, the work on the BPHS/EPHS as cornerstone of the health system will continue to evolve, while challenges that have been identified will need to be addressed.

The initial post-conflict period, 2003-2006, did not bode well for the health sector. While more health services became available, primarily through humanitarian agencies, fragmentation and mal-distribution of these services only increased. And by the end of this period hardly any sector planning had emerged nor were preliminary steps toward planning taken like producing a simple overview of health facilities. At that stage there was even a concrete threat of substantial reduction in services due to dwindling funding sources. Neither the government/MoHSW nor the major donors or other parts of the international community, like the UN and NGOs have been able to fill the obvious policy void during this period, which was potentially a threat to the still fledgling peace process.

It was only after the elections in 2006 and the establishment of a new government in early 2007 that stewardship over the health sector could be regained by a MoHSW with new leadership. Within months the MoHSW managed to carve out a new health policy amalgamating a targeted health intervention approach addressing the major health needs with the national policy desire for decentralisation and the use of available international resources and technical capacities of the NGOs. The nascent policy was fuelled by a range of assessments, but in particular also by wide consultation and participation of national staff and other stakeholders. The emphasis on consultation in the policy process in Liberia was different from other post-conflict countries, where the pressure to re-instate health and other services as part of the peace dividend while contributing to stability took preference over time-consuming consultations.

Similar to some other post-conflict countries, in particular Afghanistan, Liberia chose to make a BPHS the cornerstone of its health policy. This proved to provide focus, energy and a vehicle to obtain funding to kick-start basic health service delivery. It allowed for standardisation, decreased fragmentation and improved equity in a post-conflict situation, while optimal use could be made of a range of different stakeholders, in particular NGOs and FBOs that have the capacity to manage health services.

Liberia did not choose to contract out the basic health services, as some other post-conflict countries have been doing. Instead, initial policy clearly indicated that the government would aim to provide health services through its County Health Teams. Because it was realised that the government would not have the capacity to directly provide the services, mechanisms were developed to have NGOs implement government policy and provide health services on behalf of government through management contracts. It took considerable time between setting the policy, by end 2006 / early 2007, and actual implementation through contracts, among others due to difficulties to find acceptable ways, between donors and government, to start channelling external funds. But once contracts to provide the BPHS were issued, a rapid increase in BPHS coverage could be noted.

While in Bomi County, the County Health Team took on a contract, under a ‘contracting-in’ approach, to deliver health services in its county, the role of the other CHTs is less clear. They not only mostly lack the resources and capacity to deliver health services, but also the capacity to oversee and coordinate the various providers in their county. This also leads to ambiguity in the relation between CHTs and NGOs. The NGOs deliver a substantial portion of the health services through government health facilities and are also assumed to build
capacity with the CHTs. Formally, the NGOs do so, on behalf of the CHTs, but they are not really accountable to the CHTs, but rather to more central bodies, like MoHSW and donors.

Also the introduction of performance bonuses under the PBC contracts shows an ambiguity between CHTs and NGOs. Performance based financing assumes a split of financing between the fund holder, the regulator and the provider. In Liberia’s initial PBC contracts, it is the NGO who receives the bonus from the fund holder if results are good, to be distributed among stakeholders in the county. In some counties, the CHTs would also receive a share of the bonus, which essentially blurs the lines between regulator and provider.

It is clear that the role of the CHTs, in relation to both MoHSW and third party providers will need to be clarified and capacitated in the coming years. Also in other post-conflict countries where the central Ministry of Health steps back from direct health provision and takes up the role of regulating the health system, it proves to be a challenge to get the role and capacities of the sub-national health authorities optimised.

The introduction of a performance based element in the contracts with the various providers was new to Liberia and was rather hastily imposed without much preparation. Within the more confined space of a tightly controlled programme like RBHS, resources and capacities could be made available to make the system work and develop the various indicators, verification mechanisms, bonus payments etc. This was more difficult under the Pool Fund mechanism, where resources and capacities to support and develop PBC were largely absent. Both programmes showed rapid increase in services provided. Rather than to the PBC element, this was more likely due to resources becoming available, regular payment of salaries, clear directions on the kind of services to be delivered, i.e. the BPHS, set up of M&E systems, and interest at higher management levels in results achieved. It seems that under similar conditions, the introduction of performance based elements could be phased in allowing for better preparation.

The MoHSW leadership role in setting up a new health policy and plan has been remarkable and paved the way for involvement of a range of partners to keep contributing to the reconstruction of Liberia’s health system. For the time being, and as a result of the war, Liberia is dependent on external resources to finance its health care system. International donors showed willingness to provide such funds and align with MoHSW’s policy. But it took considerable time for them to actually find the mechanisms, fitting their institutional arrangements and concerns, to channel the funds. A more harmonised approach, in a relatively small country like Liberia, would have been of benefit. For instance, the various mechanisms led to continued fragmentation in a number of counties where several players operate under different funding mechanisms posing additional difficulty to oversight and coordination.

Liberia definitely developed its own model for post conflict recovery in the health sector. Clear leadership from the MoHSW, an emphasis on consultation and partnerships, a clear move towards decentralisation, and sustained use of a basic health package that covers the population’s major health needs provided a good mix to make good initial progress in recovery. There is still a long road ahead to fill the capacity gaps in human resources and the institutions that govern the health sector. Community involvement will need to further evolve and financial dependency on external sources will need to be diminished over time. But during this early post-conflict period, from 2007-2011, many building blocks have been created that form the foundation for the health system for many years to come. It is therefore important to understand what happened during this period which in turn will help understand future developments.
REFERENCES


