Innovative Service Delivery Stocktake: DFID Case Study of Service Delivery in Fragile & Conflict Affected Situations using CSAE Framework

LIBERIA HEALTH SECTOR POOL FUND

1. Environment prior to the establishment of the Health Sector Pool Fund

a. Economic and Political Context

For almost two decades from 1985, Liberia suffered from sustained and brutal conflict, which had knock-on effects for the wider region. The roots of the conflict lay in divisions between the indigenous population and descendants of freed slaves from America, with successive leaders perpetuating patterns of ethnic dominance. Economic rents from timber, diamonds and maritime revenues also played a strong role in fuelling the conflict. As the conflict continued, the institutions of the State were eroded through corruption, mismanagement and disregard for the rule of law by successive regimes, leading to a progressive weakening of the bond between State and civil society. Local government institutions were undermined as power was increasingly centralised in Monrovia, and the state had a diminishing reach and legitimacy in Liberia's interior. Ultimately, government provision of basic services collapsed, as expenditure on basic service delivery was crowded out by war-related spending. In 2002, government health expenditure stood at just $2.7m, while education spending amounted to $2m[1].

By the time of the Comprehensive Peace Agreement (CPA) in 2003, it was estimated that over 250,000 Liberians had died, 300,000 were classified as refuges and over half a million were internally displaced. More than half of Liberian children of school-going age were out of school, while it was estimated that less than 10% of Liberians had access to any kind of health care[2]. Following the CPA, a National Transitional Government was established with a mandate to deliver basic services during the transition period, and plan for democratic elections in 2005. A democratically-elected government, headed by President Ellen Jonson-Sirleaf, duly took power in 2006. The new government was faced with enormous challenges. Due to years of economic mismanagement, Liberia was faced with a huge external debt burden and low levels of government revenue. At the same time, it was estimated that three quarters of the population was living on less than $1 per day, the literacy rate among the adult population was less than 40%, and the under five child mortality rate was 235/1000 live births[3].

b. Arrangements for health service delivery

Liberia's health services were severely disrupted by the conflict. Health workers fled to internally-displaced people's camps, to secure areas or to neighbouring countries, and medical supplies became unavailable. By the time of the signing of the CPA, it was estimated that 242 out of 293

[1] World Bank (2004) 'Country Re-engagement Note for Liberia'
[2] ibid
[3] Republic of Liberia (2007) 'National Health Policy'

public health facilities that had existed before the war had been looted or forced to close, so that health care was not available in large parts of the interior[4], and government service delivery had collapsed.

The end of the war brought about the gradual revitalisation of health services. However the 2006 Interim Poverty Reduction Strategy (iPRS) reported that just 41% of the population had access to health services, while out of the 360 health facilities estimated to be functioning by 2007, 80% were run by humanitarian or faith-based relief organisations[5]. This approach to service delivery best corresponds to Category 2 under the Stocktake Framework, *NGO/Charity Direct*, although it should not be assumed that the Government of Liberia was carrying out an active regulatory/licensing role.

Estimated health sector funding in 2006 amounted to $40m[6], of which approximately $10m was provided by Government, and the remainder by development agencies. WHO estimated that a further $10m was provided through out-of-pocket payments. Major development agencies included the US Government (through OFDA and USAID), the European Commission (through ECHO), the Global Fund for Aids, Tuberculosis and Malaria (GFATM), Irish Aid and UK DFID.

In terms of leading providers, 44 health centres were run by a faith-based organisation, Christian Health Association of Liberia (CHAL), while Merlin, an international NGO, supported four hospitals, 41 clinics, three youth drop-in centres and a resource centre at the Ministry of Health in Monrovia. Other active international NGOs and faith-based organisations included Africa Humanitarian Action, MERCI (Medical Emergency & Relief Co-operative International), Pentecostal Mission Unlimited, Catholic Relief Services and Save the Children. However, a number of NGOs, including several different sections of Medecins Sans Frontieres, started to withdraw their humanitarian services from Liberia in early 2007, and major funding agencies such as OFDA and ECHO signalled their intention to phase out funding, giving rise to the real risk of a delivery gap in the transition from humanitarian to development financing for the health sector.

2. Assess the shortcomings associated with the environment for service delivery prior to the establishment of the Health Sector Pool Fund.

As already indicated, there were significant gaps in health service delivery coverage in Liberia, with almost 60% of the population estimated as having no access to health care in 2006. The shortcomings associated with the service delivery environment can be categorised as:

i. Fragmented health care delivery, dependent on over twenty different funding sources including donor-funded programmes and international NGOs whose financing tended to be unpredictable, combined with limited Government coordination capacity at central level.

[4] World Bank (2004) 'Country Re-engagement Note for Liberia'
[5] Ministry of Health & Social Welfare (2007), Health Sector Co-ordinating Committee, 'Project Memorandum on Funding Mechanisms'
[6] WHO (2008), 'Liberia case study: Aid effectiveness during transition from relief to development funding'

ii. Uneven distribution of health care services. Humanitarian relief agencies concentrated their interventions in the most war-affected areas and urban areas where refugees and IDPs were resettling. The distribution of trained health workers was imbalanced in favour of urban areas.
iii. Inadequate skills. Out of the estimated health workforce of 4,000 and 1,000 part-time staff, 36% were health aides and traditional midwives. Many workers held sub-standard qualifications.
iv. Unsustainable human resource financing. The Ministry of Health was considered unable to pay even a minimum wage, and had no clear picture of the overall number and profile of health workers in country. Many health care providers, including Community Health Workers, were being funded by emergency programmes which were starting to be withdrawn as the country stabilised.
v. Poor decentralised management of services. The lack of decentralised resources for County Health Teams (CHTs) and their lack of capacity hampered management of services at county level.
vi. Severely depleted infrastructure stock.

3. Establishment of the Health Sector Pool Fund

In 2007, the Government of Liberia launched its National Health Policy and an accompanying National Health Plan for the period 2007 -2011. The Policy & Plan identified four strategic areas essential to effective delivery of quality health services, namely:

i. Primary Health Care
ii. Decentralisation
iii. Community Empowerment
iv. Partnerships for Health

Delivery against these four strategic areas was in turn supported by four key operational components, as follows:

i. Basic Package of Health Services (BPHS) – the stated target was for the BPHS to be functional in 70% of existing health facilities by the end of 2008[7]
ii. Human Resources for Health – priority was given to ensuring a co-ordinated approach to human resource planning, increasing the number of trained health workers and enhancing health worker performance, productivity and retention through the provision of incentives amongst other things
iii. Infrastructure Development – priority was given to facilities delivering the BPHS, primarily clinics and health centres which comprised 94% of all facilities
iv. Planning & Management Support Systems

[7] This target was later transmuted to end 2010

Key features of the Policy & Plan were a commitment to decentralising responsibility for health service delivery to the county level, and overhauling the collaboration between the Liberian health authorities and private/non-profit health care providers through the use of mutually binding commitments/contracts. In terms of the BPHS, the Policy & Plan stipulated that for a health facility to be deemed fully functional, it must be able to offer the entire BPHS to the population it serves. In the event that no other sources of funding were available, public sector health funds would be allocated to health facilities for BPHS delivery.

In March 2008, the Government of Liberia, in collaboration with DFID, established the Health Sector Pool Fund in support of the National Health Policy & Plan. Using the Stocktake Framework's definitions of organisational arrangements for service delivery, the Pool Fund is best categorised under Category 4b: *Contracting Out* with the Government acting as purchaser using external funds. The Pool Fund's objectives are:

i. To help finance unfunded needs within the National Health Plan (2007 – 2011)
ii. To increase the leadership of the Ministry of Health in the allocation of health sector resources
iii. 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. The Steering Committee has five representatives from the Government of Liberia. In addition, all development agencies contributing to the Pool Fund are represented on the committee, alongside broader sector-wide representation from other major development agencies in the sector, NGOs and the private sector. All allocations from the Pool Fund are based on proposals initiated by the Ministry of Health in line with the results framework of the National Health Plan, for discussion and approval by the Steering Committee. Priorities for the use of Pool Fund allocations are based on the four key operational components of the National Health Plan.

An internationally recognised financial management and accounting firm is contracted to act as the Pool Fund Manager, with a two-fold role of management of the Pool Fund mechanism and management of fiduciary risk. The firm is a co-signatory to the designated Pool Fund accounts, alongside the Ministry of Health, and operates a secretariat within the Ministry to support the Pool Fund steering committee. The Ministry's Office of Financial Management manages Pool Fund expenditures and financial transactions under the oversight of the fund manager, while its procurement department is responsible for managing Pool Fund procurements using Government of Liberia procedures. For the first two years of the Pool Fund's existence, the fund management position was held by PriceWaterhouse Coopers, on contract to UK DFID, one of the fund's donors. After a retendering, it then switched to Ernest & Young, on contract to UNICEF, another Pool Fund donor, but paid for using Pool Funds.

On establishment, DFID was the sole contributor to the Pool Fund. However, by end June 2010, total cumulative development agency contributions to the Pool Fund amounted to $20.2m, distributed across four development agencies: DFID ($12.6m), Irish Aid ($5.7m), UNICEF ($1.5m) and

UNHCR ($0.4m). The fiduciary controls established through the Office of Financial Management, under the oversight of an externally-contracted Fund Manager, have played a significant role in attracting donor funding to a Government-led fund. Fund allocations are distributed across five outputs:

i. Pool Fund Management – cost of the Pool Fund manager and annual audits
ii. Expanded Access to the BPHS – contracting-out BPHS provision to NGOs and Faith-based organisations in up to 100 health facilities, and contracting-in BPHS provision to the Bomi County Health Team in 19 health facilities in Bomi County
iii. Human Resources – provision of midwifery training at Curran Hospital, provision of health worker incentives, development of a Human resources policy, and installation of a payroll system
iv. Infrastructure – construction of 10 primary health care clinics in under-served rural communities and reconstruction of the Dunbar Maternity Hospital (in conjuction with the McCall Bain Foundation)
v. Support Systems – establish a National Public Health Laboratory (in conjunction with funding from USAID and the GFATM), salary payments to key staff in the Ministry of Health's Monitoring & Evaluation (M&E) Unit, External Aid Unit and Office of Financial Management.

Output 2 (Expanded BPHS) accounted for the largest share of Pool Fund allocations as at end June 2010, amounting to 69%. In addition to the contracting-in arrangement for 19 facilities with Bomi County Health Team, seven contracts were in place with NGOs and Faith-based organisations to deliver services in one hundred government facilities (five hospitals, six health centres and eighty-nine clinics) up until the end of the time period of the National Plan (end June 2011), while a further four NGO contracts were already complete. Under the terms of the contracts, the NGOs were responsible for managing government facilities staffed by government health workers. It was the role of County Health Team staff within the relevant county to confirm who should be paid at the facility, using standard, centrally determined Ministry of Health staffing and salary scales, and the responsibility of the NGOs to effect payment. In this way, the contracts also included the incentive payments to health workers allocated under Output 3 of the Pool Fund.

Both the NGO contracts and the contract with Bomi County Health Team were performance-based, with payments linked to output and outcome indicators assess and paid on an annual basis. However, the maximum bonus or penalty was relatively small at plus or minus 5%. In the event of a bonus, the NGO had to make a proposal to the Ministry of Health as to how it would utilise the additional funds.

Table 1: Summary of Pool Fund Content

Commissioning	**Did the 'intervention' introduce a new method of *commissioning*?** Yes. In support of the policy established in the 2007 National Health Policy & Plan, it enabled direct contracting-out of BPHS delivery by the Government of Liberia to NGOs and Faith-based organisations. It also introduced a contracting-in approach, whereby the Ministry of Health established a contractual arrangement with an individual County Health team to deliver BPHS services in

	facilities at county-level.
Delivery	**Did the 'intervention' change the nature of *delivery*?** Yes. In support of the policy established in the 2007 National Health Policy & Plan, it introduced a performance-based element to direct Government contracts for BPHS delivery.
Financing	**Did the 'intervention' introduce *other* changes to the financial flows between donors, government and delivery organisations?** Yes. Contributing donors channelled their funds through the Ministry of Health, instead of contracting services with non-governmental organisations bilaterally.
Policy-setting and the Role of the State	**Did the 'intervention' seek to strengthen government capacity?** **Did the 'intervention' introduce a new mode of *planning and resource allocation*?** Yes. In pooling donor funds and enabling the Ministry of Health to propose allocations in line with the unfunded areas of the National Health Plan, the Pool Fund strengthened the Ministry's capacity to implement the National Plan and increased its influence over the allocation of resources in the health sector. It also enabled the Ministry to target BPHS delivery to under-served areas. The Pool Fund also aimed to strengthen the quality of health service provision by training midwives and improving the stock of health service infrastructure, and to strengthen the Ministry's core functions of human resource management, monitoring and evaluation and financial management.

4. Assess the efficacy of the 'intervention'.

The Pool Fund is aligned to the National Health Plan, which runs to end June 2011. Consequently, an external impact evaluation has not yet been conducted on its activities – it is to be expected that such evaluation will be conducted once the Pool Fund's current mandate expires. In the interim, two annual progress reports have been prepared by the Fund Manager[8], and an external audit has been carried out on the first year of the fund's activities[9].

The progress reports show that the Pool Fund has played an important role in supporting BPHS service delivery in government health facilities. By 2010, almost a third of all government health facilities were financed through the Pool Fund, and two-thirds of all Pool Funds had been allocated directly to supporting access to the BPHS. The Pool Fund has effectively introduced three innovations with respect to BPHS delivery, as follows:

i. It has enabled Government to enter into formal contractual arrangements with decentralised and non-governmental service providers for delivery of BPHS services in government health facilities, using government health workers.
ii. It has enabled Government to influence the allocation of donor funds to BPHS delivery
iii. It has enabled Government to introduce the concept of performance-based contracting to delivery of Government health services

[8] The first annual report covers activities up to end June 2009. The second annual report covers the period July 2009 – June 2010.
[9] Covering the period March 2008 – June 2009, to align with the Government of Liberia's financial year

Out of the 378 functioning government health facilities accredited for BPHS delivery in 2010, 100 were supported by Pool Fund contracts with NGOs, 95 were managed directly by Government without NGO support (including the 19 facilities managed by Bomi County Health Team through the contracting-in arrangement under the Pool Fund), 110 were supported by USAID, 30 by Irish Aid and the remainder by the EU. Pool Funds therefore enabled Government to more than double the number of government health facilities for which it had direct funding responsibility to almost 200, representing just over 50% of all government facilities. In this way, the Pool Fund has proved an important tool for increasing Government ownership of BPHS delivery and enhancing service provider accountability direct to Government.

There is also evidence to suggest that the Pool Fund has played a role in consolidating sources of BPHS funding and improving donor co-ordination[10]. As the number of donors channelling funding through the Pool Fund has increased, the number of different donors funding delivery of the BPHS through parallel mechanisms has reduced. Coordination improvements have materialised both in terms of reduced fragmentation of donor funding through the Pool Fund itself as well as by a reduced number of NGOs funded per county, resulting in less effort required by the County Health Teams (CHT) to manage and coordinate partners.

However, both the annual audit and the second annual progress report admitted that the nascent state of development of the Ministry's Monitoring & Evaluation function meant that the Ministry's oversight of contract performance had been minimal. As a result, the performance-based approach to contracting introduced through the Pool Fund has not yet been used as a platform for evaluating service provider performance in order to ensure value for money and the quality of service delivery, nor has it led to an analysis of the efficacy of delivery approaches across different service providers.

Both the annual reports and the audit show that the Pool Fund has made less progress in the area of infrastructure delivery, due to a combination of low capacity to conduct major infrastructure procurements within the Ministry, and weaknesses in private sector capacity in Liberia's construction sector. Out of the 10 clinics planned for construction under the Pool Fund, none had been completed by end June 2010. Two were close to completion, seven were at various stages of construction, and one had not yet started.

In the area of human resources, the Pool Fund has enabled over 100 midwives to receive training. However, due to weaknesses in the Ministry's M&E unit and the nascent state of its health management information system, no information has been collected on how many health workers are receiving BPHS incentives, both through the Pool Fund and from other partners. This in turn means that evaluation of the efficacy of incentives as a means of retaining health workers has not yet been conducted.

Arguably one of the Pool Fund's greatest achievements, outside of the achievement of individual health objectives, has been its role in enabling the Government to directly influence the allocation of

[10] Hughes J, Glassman A, Gwenigale W (2011), 'Liberia Health Pool Fund, Transitioning from Emergency Support to Health System Development', Center for Global Development

development agency funds in order to meet unfunded priorities within its national health plan, thus strengthening both alignment of externally-financed interventions and national ownership. By fiscal year 2009/10, Pool Fund allocations represented an increment of approximately 75% on top of the Ministry of Health's funding through the Government of Liberia budget[11]. However, in this regard it should also be noted that a number of key health sector donors, including USAID and the EC, remain outside of the Pool Fund mechanism, although represented on the steering committee.

Table 2: Summary of Pool Fund Principal Conclusions

Cost & Quality	**Is there evidence of lower unit costs of service delivery and/or higher quality of service delivery? If so, do the results appear sustainable?** Not as yet, as the relevant analysis has not yet been undertaken.
Overcoming Bottlenecks	**Which of the shortcomings listed in Part II have been overcome?** i. Fragmented health care delivery – partially, as four donors are now pooling funds, and other sector representatives are involved in the oversight of the Pool Fund. A number of Pool Fund activities have been carried out in conjunction with other funding partners (USAID, GFATM), and use of Pool Funds to contract NGOs to deliver services in government health facilities has helped reduce the number of NGOs active per county. ii. Uneven distribution of health care services – the Pool Fund has enabled Government to double the number of health facilities for which it has direct funding responsibility, thus contributing to a better distribution of health care services in line with the National Plan. iii. Inadequate skills – the Pool Fund has contributed directly to midwifery training. iv. Unsustainable human resource financing – the Pool Fund has enabled payment of incentives to government health workers as a part of the BPHS package, but the results of this approach in terms of retention and motivation are not known. v. Poor decentralised management of services – the Pool Fund has enabled the innovative approach of the Ministry of Health contracting-in a County Health Teams for BPHS delivery at county level. vi. Severely depleted infrastructure stock – Pool Fund results in this area have been slow to materialise.
Capacity	**Has government capacity been strengthened, and are there plans for government to play an increased role in service delivery over time?** Government's policy setting role has been strengthened. However, it is clear that oversight capacity of the Ministry of Health in areas such as monitoring & evaluation still requires strengthening.
State-society relations	**Have there been broader impacts on state-society relations?** Not known
New bottlenecks	**Have new bottlenecks been revealed (limited capacity to contract, perverse incentives)?** Not known
Negative impacts	**Have there been negative impacts on the sector (donor cherry picking, provoking local conflict)?** No

[11] Ibid

References:

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