USAID
FROM THE AMERICAN PEOPLE

BASICS

HEALTH SYSTEM TRANSITION AND THE TRANSITION GAP IN LIBERIA

A REPORT TO THE OFFICE OF FOREIGN DISASTER ASSISTANCE

HEALTH SYSTEM TRANSITION AND THE TRANSITION GAP IN LIBERIA

A REPORT TO THE OFFICE OF FOREIGN DISASTER ASSISTANCE

July 2007

This publication was produced for review by the United States Agency for International Development. It was prepared by Megan Shepherd-Banigan, Stephen C. Joseph, Iain Aitken, Franklin Baer, Paul J. Crystal, Carrie Hessler-Radelet, and Diana Silimperi.

Recommended Citation
Shepherd-Banigan, Megan, Stephen C. Joseph, Iain Aitken, Franklin Baer, Paul Crystal, Carrie Hessler-Radelet, and Diana Silimperi. 2007. *Health System Transition and the Transition Gap in Liberia.* Arlington, VA, USA. Basic Support for Institutionalizing Child Survival (BASICS) for the United States Agency for International Development (USAID).

U.S. Agency for International Development
Bureau for Global Health
Office of Health, Infectious
Diseases and Nutrition
Ronald Reagan Building
1300 Pennsylvania Ave., NW
Washington, D.C. 20523
Tel: (202) 712-0000
Email: globalhealth@phnip.com
www.usaid.gov/our_work/global_health

BASICS
4245 N. Fairfax Dr., Suite 850
Arlington, VA 22203
Tel: (703) 312-6800
Fax: (703) 312-6900
Email: basics@basics.org
www.basics.org

This report was commissioned by the U.S. Government Office for Foreign Disaster Assistance (OFDA) in response to Contract Number GHA-I-00-04-00002 Order No. 05.

BASICS (Basic Support for Institutionalizing Child Survival) is a global project to assist developing countries in reducing infant and child mortality through the implementation of proven health interventions. BASICS is funded by the U.S. Agency for International Development (contract no. GHA-I-00-04-00002-00) and implemented by the Partnership for Child Health Care, Inc., comprised of the Academy for Educational Development, John Snow, Inc., and Management Sciences for Health. Subcontractors include the Manoff Group, Inc., the Program for Appropriate Technology in Health, and Save the Children Federation, Inc.

TABLE OF CONTENTS

ACKNOWLEDGEMENTS

We would like to thank the many people whose vision, time, and efforts ensured the success of this transition assessment.

To begin, we would like to thank the U.S. Government's Office for Foreign Disaster Assistance (OFDA), the USAID Africa Bureau, and the Bureau of Population and Refugee Migration (BPRM) for their deep commitment to the health of the Liberian people. Without their foresight and support, this project would never have happened.

The Ministry of Health and Social Welfare in Liberia also continually demonstrated their dedication to ensuring a smooth post-conflict transition process. They provided logistical and technical support during the planning phases of the project, and sent several representatives to accompany the assessment team and participate in all workshops.

Members of the county health teams—particularly the county health officers—were indispensable to these efforts, and we are grateful for their time and effort. NGO representatives from headquarters, Monrovia, and the field teams also assisted with logistical arrangements and ensured the completion of the Facility Impact Assessment Tool (FIAT) for the large majority of clinics.

Representatives of OFDA/Liberia also participated in the county-level workshops, and shared valuable perspective about Liberia and the state of the health system. The USAID Mission in Liberia provided the assessment team with sound vehicles and excellent drivers, and shared logistical and technical inputs.

The groundwork for the transition assessment was developed months before this mission by consultants from USAID/BASICS and the European Commission. These consultants developed a database that listed existing facilities and outlined contract end dates. This information was essential to understanding the potential gravity of the transition period and the need for a post-conflict transition assessment.

BASICS team members, Carrie Hessler-Radelet and Franklin Baer, also provided support in the design and facilitation of several of the workshops, as well as the creation of workshop materials. Finally, thank you to the BASICS headquarters staff, who provided us with continued support and encouragement throughout out the in-country assessment.

Stephen C. Joseph *Megan E. Shepherd-Banigan*

ACRONYMS

USAID	United States Agency for International Development
BPRM	Bureau of Population and Refugee Migration
BPHS	Basic Package of Health Services
CHC	Community Health Committee
CHO	County Health Officer
CHT	County Health Team
DFID	Department for International Development
EC	European Commission
ECHO	European Commission Humanitarian Aid
EU	European Union
FBO	Faith Based Organization
FIAT	Facility Impact Assessment Tool
FY	Fiscal Year
GIS	Global Information System
GPS	Global Positioning System
IDP	Internally Displaced Persons
IMC	International Medical Corps
IRC	International Rescue Committee
MOHSW	Ministry of Health and Social Welfare
(I)NGO	(International) Non Government Organization
OFDA	Office of Foreign Disaster Assistance
PA	Physician Assistant
PHC	Primary Health Care
PIP	Program Improvement Planning
ST	Scoring Tool
HR	Human Resources
TOR	Terms of Reference
UNMIL	United Nations Mission in Liberia
USG	United States Government
WVI	World Vision International

EXECUTIVE SUMMARY

The Transition from humanitarian assistance to development assistance

Conflict and immediate post-conflict periods are often marked by an abundance of donors and implementing partners providing humanitarian services, such as health care. However, once the immediate post-conflict period ends, perceived stability may lead to the withdrawal of relief donors. These groups are likely to re-direct limited resources to active conflict environments with the expectation that development-focused stakeholders will assume the responsibility for post-conflict support, including the establishment of a unified health system. The period between the withdrawal of humanitarian assistance stakeholders and the initiation of development donor funding is called the *transition period.*

The transition period has two aspects. The first is the *transition gap***,** which results from the withdrawal of emergency-focused NGOs and implementation partners due to decreased funding during post-conflict recovery. The second is the *health systems transition*, which describes the evolution from clinic-focused, emergency-funded services to a county-focused system that is supported by the national government and development-funded assistance.

Transition in Liberia

In 2003, Liberia emerged from a destructive, 14-year civil war that resulted in wholesale destruction of the country's infrastructure.

The Ministry of Health and Social Welfare (MOHSW) defined its vision for the future health system of Liberia in January 2007 through the National Health Policy and 5-year National Health Plan. The National Health Plan is based on four pillars: the Basic Package of Health Services (the minimum set of health interventions the MOHSW has determined necessary for all people), human resources, support systems, and infrastructure. Decentralizing support systems and enhancing responsibility for management and administration at the county-level is the basis of the support systems component. The current health system is a facility-centric system in which operations are managed by implementing partners and focused on the immediate service population with minimal direct involvement of the county health officials. The MOHSW envisions a shift from this facility-centered approach to a county-level system that is coordinated and supervised by the county health officials and structured around the implementation of the Basic Package of Health Services.

U.S. Government Humanitarian Assistance to Liberia

Since 2004, The U.S. Government Office for Foreign Disaster Assistance (OFDA) and the Bureau for Population and Refugee Migration (BPRM) have provided emergency health-related funding in Liberia to five non-governmental organizations (NGOs) for the purpose of maintaining health services in 61 rural health clinics. Additionally, USAID has been funding health facilities since 2003. As of October 2006, 77% of functioning health facilities were being funded by humanitarian assistance donors.

OFDA- and BPRM-supported clinics are located in the counties of Nimba, Grand Cape Mount, Bomi, Lofa, and Grand Gedeh. Current funding contracts for the NGOs that operate these facilities will end in or before December 2007. And, OFDA has indicated that funding will be reduced to no more than USD1.4 million in FY07, and will cease completely thereafter.

OFDA thus commissioned USAID/BASICS to 1) design and test an evidenced-based approach to inform funding decisions and support a smoother transition from humanitarian assistance to development funding in post-conflict Liberia; 2) make recommendations to OFDA and BPRM on the allocation of reduced FY07 funding to maximize public health impact, minimize loss of health

services, and support the implementation of the National Health Plan; and 3) develop a common process to be used in other post-conflict transition situations.

The Facility Assessment Impact Tool (FIAT)
USAID/BASICS developed the FIAT to examine the relative public health significance of each facility at the county level. It does not, however, assess the quality of services or of implementing partners. Design of the FIAT is based on evidenced-based public health significance standards for access and catchment areas (geographic and population factors), epidemiology (service delivery and demand), staffing patterns, infrastructure (equipment, supplies, and the physical facility structure) and operating budgets.

A scoring and ranking system was designed to allow for comparison between individual clinics, between clinics in various counties, and between implementing partners. Used together, the FIAT and the scoring and ranking system represent a semi-quantitative method to comparatively rank specific facilities.

Clinic scores are not reported in this document. The purpose of the scoring and ranking system is to provide information to OFDA and BPRM regarding the public health significance of the clinics they support to inform their decision-making process for FY07 funding allocations. The resulting rankings do not in any way reflect the quality of health care delivery or the implementing organizations. Nonetheless, distinct patterns were recognized at the county and organizational levels.

Transition Workshops and NGO Leadership Meetings
Qualitative information was collected primarily through two sets of transition workshops: a 1.5-day central-level workshop in Monrovia and 1-day county-level transition workshops in each of the 5 counties where OFDA- and BPRM-supported clinics are located. Supporting information was drawn from facility site visits conducted in at least one facility in 4 out of the 5 counties. These were not detailed facility 'inspection' visits, but instead provided insight into information collected through the FIAT. Additionally, a one-day UNMIL visit by air to Lofa County was valuable for context-setting, as well as specific health facility visits.

The assessment team also met individually with Monrovia-based NGO leadership, MOHSW staff, and potential donors to provide background material for assessment activities, and met again with the NGOs' country leadership following the workshops to report on results.

Transition Planning Data Collection and Workshop
BASICS conducted a second phase of the transition assessment to develop a framework for key elements of county-wide health planning, including BPHS implementation, and to reinforce county coordination mechanisms. The MOHSW led efforts to gather county-level data about facility infrastructure and service delivery. This was followed by a 3-day workshop to define initial county-specific planning frameworks and a facility accreditation system based on current delivery of the BPHS.

Lessons Learned
This transition assessment marks the first effort to undertake a process to guide the period from humanitarian assistance to development by identifying methods to minimize loss of care amid funding reductions. It is hoped that this process can be expanded to all counties in Liberia. It is also hoped that, with refinement and modification, the process will be useful in other countries undergoing similar transitions.

Future assessments should include all health system stakeholders (facilities, implementing partners, and funders) within each geographic area (county, district, etc.) to allow for a comprehensive view of the health system and assess public health impact. The inclusion of all actors would also promote greater support for the country health team and community health committees during the transition to a county-focused health system. This assessment was not structured as such because the purpose was to provide specific recommendations to OFDA and BPRM.

Despite the importance of implementing the Basic Package of Health Services for the county-focused system, this assessment focused mostly on the current delivery of services and NGOs' ability to shift from clinic-focused provision of care to a county health system. The package should be highlighted more significantly in future assessments.

Conclusions

If it is not managed and coordinated, a cessation of current humanitarian assistance funds has the potential to impede the transition process. The greatest consequences of involuntary NGO withdrawal include: a reduction of services with consequent increases in morbidity and mortality, especially among mothers and children; a loss of human capacity and institutional knowledge within the health care system; increased reliance on untrained, traditional practitioners and "black baggers" as a result of reduced access to legitimate services; and a loss of confidence in the government's ability to provide for its people and a potential for political upheaval.

Although some funding decrease during the transition period seem to be unavoidable, adverse effects could be offset by greater efficiency in managing facilities, including appropriate staffing levels and administrative cost sharing between the MOHSW and NGOs. Moreover, 'out of the box' innovations, such as mobile services and market clinics would improve health care quality and access at minimal costs.

It is also important to recognize the critical roles played by communities and NGOs in the transition process:

- As a means to ensure universal access, MOHSW policy prohibits user fees. Still, community members are eager to contribute to facilitating the provision of health services through contributions, lifestyle support to health care providers, and participation in income-generating activities on behalf of health facilities.

- Implementation of Liberia's National Health Policy and National Health Plan will require execution of a realistic implementation plan that involves the input of all stakeholders, capacity building for county-level MOHSW personnel to enable effective supervision and financial administration, strengthened partnerships along the continuum of care, and coordination among donors. NGOs are essential role players thanks to their ability to promote, demonstrate, advise, and assist in building capacity as part of implementing the Basic Package of Health Services.

Recommendations

When issuing continued clinic grants, OFDA and BPRM should include specific actions to be taken by implementing partners to improve efficiency, catalyze community in-kind support and ownership, collaborate with county health teams to implement the Basic Package of Health Services, and develop meaningful partnerships at all levels.

Recommendations for the MOHSW, NGOs and FBOs, and donors were also made that are aimed at ensuring a well-planned, coordinated transition of the Liberian health system through that capacitates counties to staff and run programs that achieve maximum reach.

I. BACKGROUND

A. Transition Period

Conflict and immediate post-conflict periods are often marked by an abundance of donors and implementing partners providing humanitarian services, such as health care. However, once the immediate post-conflict period ends, perceived stability may lead to the withdrawal of relief donors. These groups are likely to re-direct limited resources to active conflict environments with the expectation that development-focused stakeholders will assume the responsibility for post-conflict support, including the establishment of a unified health system. The period between the withdrawal of humanitarian assistance stakeholders and the initiation of development donor funding is called the *transition period.*

The transition period has two aspects. The first is the *transition gap***,** which results from the withdrawal of emergency-focused non-government organizations (NGOs) and implementation partners due to decreased funding during post-conflict recovery. The gap is not only characterized by a loss of financial support for service provision, but also a loss of the management, logistics, and other expertise that had been provided by NGO staff. A reduction in basic services, deterioration of key health indicators, and further weakening of an already fragile health structure are common risks during the transition gap.

The second aspect is the *health systems transition*, which describes the evolution from clinic-focused, emergency-funded services to a county-focused system that is supported by the national government and development-funded assistance. In the post-conflict period, basic health services are provided, but may not be coordinated within a greater health system. An essential aspect of conflict recovery is the creation of a unified health system which strives to improve public health and address acute medical needs. This can be conceptualized in several ways. For example, the Liberia Ministry of Health and Social Welfare (MOHSW) chose to operationalize health care at the county level. A county-focused system decentralizes management (including financial and administrative management) to the county level and encourages the standardized implementation of: a basic package of health services, geographically accessible service provision points, a coordinated logistics system, a consistent staffing structure, and harmonization of all stakeholders supporting the system.

Whereas intact social systems, such as health and education, are important indicators of stability to the general public, successfully addressing the transition gap and managing the health systems transition are essential to protecting against future conflict in fragile environments. And, functional social services may encourage the return of refugees and internally displaced persons (IDPs), thereby hastening the recovery of countries which have been destroyed by war.[1]

Liberia is currently considered to be at the transition gap stage on the post-conflict continuum. The gap and the health system transition create a moment of significant opportunity and extreme challenge for health care in Liberia.

B. Liberian Civil War

In 2003, Liberia emerged from a destructive 14-year civil war. This period was characterized by continual civil unrest and violence; destruction of infrastructure, such as roads, water tanks, and power plants; destruction of physical buildings, such as homes, schools, churches, and government buildings; and a lack of access to food, water, and medicines. Large population

[1] Personal correspondence, OFDA representative.

shifts took place to neighboring countries. Today, the visible vestiges of war still exist in the form of burned out cars and buildings, widespread poverty, a heavy presence of United Nations Mission in Liberia (UNMIL) and peacekeeping troops. Moreover, the entire country is reliant on generators for electricity.

C. The roles of USAID and USAID/BASICS in Post-Conflict Liberia

The U.S. Agency for International Development (USAID) has been heavily involved in Liberia during the post-conflict period, including through the agency's BASICS project. USAID has notably been funding health facilities throughout Liberia since 2003. In April 2005, the Agency co-hosted an NGO transition workshop to explore issues related to the shift from post-conflict to development assistance. In May 2006, the Liberian Ministry of Health and Social Welfare (MOHSW) and USAID conducted a Rapid Assessment of the Health Sector. The findings from this assessment formed the basis for the Liberia Health Sector Rapid Assessment Validation and Strategy Design Workshop (August 2-4, 2006) which was developed and facilitated by USAID/BASICS and resulted in a framework of the National Health Policy and Plan. USAID/BASICS continued to provide technical assistance to the MOHSW to complete these documents. The National Health Policy and 5-year National Health Plan were finalized in January 2007 and outlined the MOHSW plans for moving forward in the subsequent 5 years. USAID/BASICS was also heavily involved in preparations for the February 2007 Liberia Donor's Forum by providing logistical support and preparing MOHSW officials to present their 5-year plans.

In October 2006, BASICS and the European Commission (EC) collected and compiled information to define the potential NGO Transition Gap. The consultants presented this information through two memos: one directed to the Liberia MOHSW and the other to the U.S. Government. The memos noted that, in October 2006, 77% of functioning facilities were run by NGOs and FBOs, and funded primarily by humanitarian assistance donors. The data also highlighted that, by the end of 2008, the majority of humanitarian assistance contracts were due to end (prior to this, the MOHSW had no information regarding when implementing partner contracts would expire). Without additional funding, only 30% of the existing facilities would continue to function (i.e., those supported by FBOs and the MOHSW). The information collected through this exercise highlighted the need for continued NGO presence over the near-term and the importance of a coordinated handover between humanitarian assistance donors, the development community, and the MOHSW. Finally, this process emphasized the need to advocate for additional funding to support the existing health service delivery and to assess the most efficient use of reduced funds to maximize access to care.

D. The Roles of OFDA and BPRM in Post-conflict Liberia

Since 2004, The U.S. Government Office for Foreign Disaster Assistance (OFDA) and the Bureau for Population and Refugee Migration (BPRM) have provided emergency health-related funding in Liberia to five NGOs for the purpose of maintaining health services in 61 rural health clinics. These clinics are located in the counties of Nimba, Grand Cape Mount, Bomi, Lofa, and Grand Gedeh. See Appendix A for a map of each county in which the location of OFDA/BPRM-funded health facilities are designated.

Funding contracts for the 5 NGOs (IRC, IMC, Equip, World Vision, and Merlin) will end in or before December 2007. In addition, OFDA has indicated that FY07 funding will be reduced from previous years to no more than USD1.4 million and may cease completely thereafter. At the time of this writing, all NGO's were operating. However, the contract for IRC-supported clinics in Nimba ended in December 2006. IRC continued operating with funding from a private grant.

See Appendix B and C for a table of contract end-dates and a list of OFDA/BPRM-supported facilities.

E. The MOHSW Vision

The MOHSW defined its vision for the future health system of Liberia through the National Health Policy and 5-year National Health Plan. The National Health Plan is based on four pillars: the Basic Package of Health Services (BPHS—the minimum set of health interventions the MOHSW has determined necessary for all people), human resources, support systems, and infrastructure. Decentralizing support systems and enhancing responsibility for management and administration at the county-level is the basis of the support systems component. The current health system is a facility-centric system in which operations are managed by implementing partners and focused on the immediate service population with minimal direct involvement of the county health officials. The MOHSW envisions a shift from this facility-centered approach to a county-level system, which is coordinated and supervised by the county health officials and structured around the implementation of the BPHS. See Appendix D and E for National Health Policy and Plan.

F. The Transition Assessment

The objectives of the assignment were to 1) design and test an evidenced-based approach to inform funding decisions and support a smoother transition from humanitarian assistance to development funding in post-conflict Liberia; 2) make recommendations to OFDA and BPRM on the allocation of reduced FY07 funding to maximize public health impact, minimize loss of health services, and support the implementation of the National Health Plan; and 3) develop a common process to be used in other post-conflict transition situations.

This transition assessment provided the opportunity to work with central- and county-level MOHSW personnel, implementing partners, and community members to examine the provision of health services in Liberia and begin the development of plans to ensure a smooth transition from post-conflict to development assistance in the context of reduced funding.

In addition, the facility impact assessment tool, scoring and ranking system, and geographic mapping technology provided information about the public health significance of each facility funded by OFDA and BPRM, which will contribute, in part, to recommendations on the best use of funds to enhance public health.

The products of this mission include: 1) a detailed report highlighting the assessment of OFDA and BPRM activities on the ground; 2) a system for ranking facilities according public health importance in the context of the transition from emergency funding to development assistance and implementation of the National Health Plan; and 3) the development of a common process that can be used in other counties in Liberia and other post-conflict situations.

The detailed itinerary, contacts, specific activities, and findings of the assessment team can be found in the body and appendices of the report (See Appendix F and G for team itinerary and contact list). See Appendix H (bibliography) for additional sources of background information.

II. FACILITY IMPACT ASSESSMENT TOOL

A. Purpose

Terms of reference for the mission included the development of an assessment tool to ascertain and compare effectiveness and efficiency of individual OFDA- and BRPM-supported clinics, and form a basis for refining and developing a more generic instrument to be used in other post-conflict situations. The Facility Impact Assessment Tool (FIAT) examines public health significance of each facility at the county-level and was not designed to assess quality of service or implementing partners. This tool was designed as one factor to consider in the development of recommendations about funding allocation, and will be used in close conjunction with geographic and demographic information and qualitative information gathered from the field. A copy of the original and revised FIATs are included in Appendix I and J.

B. Methods

The FIAT was developed in consultation with other USAID/BASICS and MOHSW colleagues. It is based on evidenced-based public health significance standards. FIAT items assessed access and catchment areas (geographic and population factors), epidemiology (service delivery and demand), staffing patterns, infrastructure (equipment, supplies, and the physical facility structure) and operating budgets.

The completed forms are useful to highlight specific information (examples, geographic barriers to care, population in the catchment area, service utilization, etc.) and aid in 'pattern recognition.'

C. Limitations

a. The FIAT was developed for the purpose of this assessment and had not been tested prior to use in the field. It was reviewed by the CHOs, which allowed for its modification to better suit the Liberian context prior to most dissemination (Bomi and Grand Cape Mount Counties utilized the preliminary FIAT).

b. It is important to state that, at this stage, the FIAT should not be considered a scientific instrument and caution should be exercised in its use, especially when comparing one clinic (or one NGO) to another. It is not a clinical or administrative facility inspection report.

c. It does not include questions that would shed clear light on the extent and effectiveness of the communities involvement in and ownership of local health systems, particularly as encouraged by supporting NGOs or CHTs. As a result, the assessment of this factor is based on the reviewers' own observations, which could lead to significant bias. This should be rectified before further use of the FIAT so that community ownership can be assessed in a more scientific manner.

d. Internal inconsistencies might be present, and the tool should be reviewed and adaptations made for future use in the field.

III. SCORING AND RANKING SYSTEMS

A. Field Score

i. Methods

A scoring and ranking system was designed to allow for comparison between individual clinics, between clinics in various counties, and between implementing partners. This required a standardized method for clustering FIAT information according to major areas of interest, such as geographic and population factors, service utilization, and physical infrastructure. In Liberia, this process was undertaken in the field to provide a preliminary facility ranking.

Accordingly, a scoring tool (ST) was designed with assessment information from the clinic assessments. In this initial stage of development, both the specifics of the scoring measures themselves and the choices made on a simple 5-point scale should be interpreted with caution.

Used together, the FIATs and the ST can be a semi-quantitative method to comparatively rank specific facilities. With further and more rigorous development, these tools can become more generic instruments, useful in a wide variety of post-conflict settings.

The ST uses the public health prioritization criteria validated for the Liberian context by participants in the central and county transition workshops. These ratings provide a crude estimate of the public health significance of each facility, based on the use of prioritization criteria as proxy indicators.

The ST consists of 11 items, which correspond to prioritization criteria in: access, community ownership (which is unfortunately not possible to score directly because of current limitations in the FIAT), service utilization, epidemiology, infrastructure, and potential availability of other funding. The detailed ST items and the criteria for ranking them are attached in Appendix K.

For each item, a 5-point scale (-2 through +2) was used to assess the response, with positive values roughly representing ‘greater public health significance’ and negative values indicating ‘less public health significance.’ The cumulative value of the 11 items provided a single number between -22 and +22. To minimize reviewer variation, FIAT scoring was conducted by one assessment team member.

ii. Limitations

The scoring and ranking system is in the early stages of development and is somewhat crude, despite being based on evidenced-based public health significance criteria. Multiple factors, some of which may not be readily evident, can affect the outcome of scoring and comparison. However, there are several generalizations that appear from even a cursory review of the scores.

B. Data Analysis

Data collected from the FIATs was analyzed to examine specific relationships, such as clinic efficiency, accessibility, and operability, and to allow for a quantitative ranking of facilities according to their relative public health impact.

The clinics at the top of the ranked list are those that have the greatest relative[2] public health significance, based on the methodology explained below. Given the globally poor availability of health care services in Liberia, all clinics are necessary to the health system and provide important services for the maintenance of overall public health.

i. Methods

The clinic ranking is based on a summary score of items in the FIAT, ratios measuring clinic utilization and efficiency, and an accessibility component based on the distance to the nearest alternate functional facility. Items based on FIAT information include service demand and availability, access to safe water, facility infrastructure, available supplies and equipment, and socioeconomic status of the catchment population. Ratios included in the analysis provide an indication of facility efficiency and utilization through the measure of the service population to the number of facility staff, the monthly patient load to the number of staff, and the monthly patient load to the size of the service population.

Accessibility to health services was determined for each facility based on road distance to the nearest alternate functional facility. Because global positioning system (GPS) coordinates for the majority of facilities were unavailable, facility location is based on the GPS coordinates of the nearest “populated area” serviced by that facility. The majority of distances were verified by field staff from implementing organizations and county health officials. This information was used to determine facility placement on a county-level map. Using mapping software, road and overland distances to the nearest alternate facility were determined and facilities were grouped according to "no access" (greater than 10km road distance to thenearest alternate functioning facility), "some access" (between 5 and 10km by road), and "accessible" (less than 5 km via road). Facilities with populations that have “no access” to alternate health care services were allocated a higher score than those with better access to alternate clinics because an isolated facility potentially has greater public health significance for its service population.

Points were assigned to each item, allowing for weighting based on the relative importance of each item. Access to health care received the greatest weight (see Appendix L for details on items and scoring system). Any one facility could receive a total of 65 points. Points were determined based on information from the FIAT, mapping software, and information from the field.

ii. Limitations

The objectivity, quality, and completeness of information recorded on the FIATs vary between facilities since facilities self-reported. The scoring system is fairly crude in its current state and could use refinement. But, given that the data quality is also somewhat crude, any recommendations made based on the assessment tool should be considered only in conjunction with input from field personnel who are familiar with the characteristics and potential of the facilities.

[2] “Relative” is used to define this relationship because clinics are compared to one other rather than to a predetermined level of public health significance.

IV. FINDINGS

Clinic scores are not reported in this document. The purpose of the scoring and ranking system is to provide information to OFDA and BPRM regarding the public health significance of the clinics they support to inform their decision-making process for FY07 funding allocations. The resulting rankings do not in any way reflect the quality of health care delivery or the implementing organizations.

The assessment team received 100% of FIATs they sent out (61/61 OFDA and BRPM facilities). Hard copies of each FIAT form are available for review. A blank original and a blank revised FIAT is attached as Appendix I and J.

Because the assessment team was not successful in meeting with representatives from Equip, their leadership input was not received throughout the process and a verification of existing Equip facilities by NGO staff was not undertaken. A field representative from Equip did attend the county-level workshop.

Scores ranged from -8 to +14 (out of a possible range of -22 to +22), showing a wide variation overall, but indicating distinct patterns at the county and organizational level.

Facility scores ranged from 26 to 53 (out of a possible range of 0 to 65). Missing information did not allow for the scoring and ranking of the Duo Town Clinic (which is supported by Equip). Distinct patterns of facility efficiency, operability, accessibility, and utilization emerged at the county and organization levels, some similar to those resulting from the field ranking.

The facility locations are not completely accurate because they are not based on facility-specific global information system (GIS) information (except for facilities in Grand Gedeh, for which GIS points were provided by Merlin).

Some elements not recorded in the FIATs, such as community participation, are not assessed in this data analysis despite being included in the field scoring system and being considered as important to the overall assessment.

V. TRANSITION WORKSHOPS AND NGO LEADERSHIP MEETINGS

Qualitative information was gathered to provide insight into the state of Liberian health clinics and catchment populations serviced by OFDA and BPRM. This information was collected primarily through two sets of transition workshops; a 1.5-day central-level workshop in Monrovia and 1-day county-level transition workshops, in each of the 5 counties where OFDA- and BPRM-supported clinics are located. Supporting information was drawn from facility site visits conducted in at least one facility in 4 out of the 5 counties. These were not detailed facility 'inspection' visits, but instead provided insight into information collected through the FIAT (Facility Impact Assessment Tool). Additionally, a one-day UNMIL visit by air to Lofa County was valuable for context-setting, as well as specific health facility visits.

The Assessment team also met individually with Monrovia-based NGO leadership, MOHSW staff, and potential donors. These meetings provided background material for the specific activities detailed here. Once the workshops were completed, the assessment team hosted a wrap-up meeting in Monrovia for the country leadership from the 5 NGOs. See Appendixes F and G for Team Itinerary and Contact List.

A. Central Level Workshop

i. Objectives and Participants
Objectives of the Monrovia-based central-level workshop included: 1) arranging logistics for county-level workshops; 2) developing preliminary recommendations on the best use of decreased funds for the 61 OFDA and BPRM-supported clinics; 3) modifying the FIAT based on County Health Officer (CHO) input; 4) distributing the FIAT; 5) verifying facility locations to create accurate maps demarcating service provision in the 5 counties; and 6) beginning to develop CHO capacity to conceptualize a unified county health system (see Appendix M for Central Level Workshop agenda). Participants included the CHOs from Lofa, Bomi, Grand Cape Mount, Nimba and Grand Gedeh, as well as various staff from the central-level MOHSW.

ii. Outcomes
The CHOs provided excellent feedback on the FIAT, which was incorporated into the tool and disseminated to the clinics. Their comments addressed word choice, clarity of concepts, and additional content items.

Logistical arrangement tasks for the county-level workshops were defined and responsibilities for each task at the county-level were assigned. In addition, the CHOs provided valuable information about expected workshop, per diem and transportation costs, and proposed participants. Specifically, the CHOs recommended that, given the presence of NGO field staff, one member of the community health committee (CHC) from each district be included in the workshop as opposed to facility staff members.

The CHOs provided input on the importance of specific evidenced-based public health prioritization criteria. This is the basis of the FIAT field scoring system and recommendations about funding allocations. Criteria identified as most relevant for the Liberian context are: 1) access, 2) ownership, 3) epidemiology, 4) performance, and 5) infrastructure. However, CHOs did not provide concrete recommendations regarding the specific prioritization of decreased FY07 resources viewing this process to be analogous to facility closure. The CHOs were resistant to facility closure, stating that existing services were already unable to meet existing health needs and the the political implications of closure at the community level were great.

In addition, each CHO brought a hand-drawn map of their county indicating the location and name of the OFDA and BPRM funded facilities. This served to verify and update pre-existing

facility information and provided a sound basis for the creation of more accurate electronic county-level maps (see country and county-level maps in Appendix A). These exercises allowed for building capacity because they contributed to a shift in CHO understanding of the health system from the current facility-level, humanitarian assistance model to that of a county-focused system. They also provided an opportunity for the CHOs to understand more fully the MOHSW vision of a decentralized system and their role within that system.

iii. Limitations

The CHOs were reluctant to provide initial recommendations for the prioritization of funds because of the negative political implications and potential for reduced access to health care if these recommendations contributed to facility closures. The Grand Gedeh CHO was unavailable to attend the first day of the central level workshop and the county-level workshop.

B. County Workshops

The county-level workshops provided an opportunity to understand perspectives in the field about the health care system, including access issues, responsibility, and ownership. These activities also allowed for expanded county-level capacity development in areas of health systems transition and county-focused planning. A workshop session guide was created prior to the first county workshop. This session guide was modified after each workshop to incorporate new feedback and observations. See Appendix N and O for the final version of the county-level transition workshop agenda and session guide.

i. Objectives and participants

A one-day county-level transition workshop was conducted in Nimba, Grand Cape Mount, Bomi, Lofa, and Grand Gedeh counties. Objectives included 1) presenting the health system transition, the transition gap, and the transition planning process to stakeholders at the county level, 2) developing initial county-level recommendations to minimize loss of care despite decreasing resources, and 3) identifying transition strategies and plans which positively contribute to the shift from the current clinic care model to one based on decentralization and the implementation of the basic package of health services.

Participation in all counties, except Bomi, was high and included the CHO, the CHT, NGO field staff, and one member of the community health committee (CHC) from each district in the county. Staff from the local government and, in one instance, the superintendent (governor), participated as observers. Workshop facilitators included the USAID/BASICS assessment team and representatives from the central MOHSW.

ii. Activity Development

Each workshop started with an overview of the National Health Policy and Plan to frame the transition assessment in the context of the MOHSW's vision for the health system. A presentation that explored potential implications of the transition followed to allow the participants an opportunity to understand the current situation, the evolving financial circumstances, and the impending system change. A small group discussion ensued about the implications of reduced funding for each group of stakeholders in the health system, the community, NGO, and county health officials.

Presentation of county-level maps allowed most participants to understand for the first time the perspective of a county-level health system and how a shift to decentralization might entail a change in the importance of individual facilities. Through this exercise, the group explored facility location, proximity to alternate health facilities, populated areas, and county-level health needs.

Decision-making processes were explored through an exercise in which participants were divided into small groups and asked to rank the prioritization criteria discussed in the central-level workshop. A large group discussion followed in which participants explored access, humanitarian need, and efficiency within the health system. Finally, participants were asked to discuss whether efficiency or the needs of marginalized populations should be prioritized.

In several workshops, a central MOHSW representative moderated a discussion with community members to elucidate additional themes and considerations to be incorporated into future workshops, as well as final recommendations.

The final portion of each workshop was dedicated to transition planning and the identification of strategies to minimize loss of care. Stakeholder groups presented ideas about steps they had already taken and could take in the future to preserve health care access in spite of decreased funding and to prepare for the implementation of the National Health Plan, including the transition to a county-focused system.

C. Discussion Themes

i. Implications of decreased funding and the withdrawal of implementing partners
Participants expressed great concern regarding the potential impact of reduced funds on all levels of the health system. The greatest consequences included withdrawal of implementing partners, leading to a reduction in primary health care services, an absence of drugs and medical supplies, an increased burden on CHT, and consequent increases in morbidity and mortality. Absence of NGO-supported services might also result in the loss of existing health infrastructure and equipment, such as ambulances and health facilities. Decreased quality of and access to health care might further serve to reduce rates of demand for and utilization of health services. For example, the community health system depends heavily on local, untrained health practitioners, such as “black baggers.” As a result, increasing demand among rural populations for health services is a challenge and the reduction of services could have a negative impact on existing demand as rural communities must increasingly rely on alternative means of health care. Another serious implication cited was the loss of human resources. NGOs build capacity among communities, local providers, and county health officials. Withdrawal of NGO partners might decrease capacity building and, without NGO financial incentives, health providers might leave.

ii. Satisfaction with local and central leadership
Workshop participants stated that the government is responsible for providing health services to the people. A perception that the government is unable to fulfill this role was expressed as a great source of frustration by the participants and has implications for the government’s credibility. Further, participants indicated that a loss of confidence has the potential to incite upheaval at the local level. Frustration with several current government policies encouraged substantial discussion, particularly during the workshops in Nimba, Bomi, and Grand Cape Mount. For example, to enhance health care access and reduce potential for corruption at the county-level, the government has prohibited facility user fees. Many people in Liberia would be unable to pay even a modest fee for health services. However, a number of community members expressed that they should be allowed to implement user fees as a way to promote community ownership and garner funds for future use. The government policy, though grounded in reasoned theory, does not allow for a mechanism through which communities can contribute to their health services.

iii. Role of NGOs

NGOs administer 77% of the health facilities in Liberia and an even greater percentage in the counties that OFDA and BRPM support. NGOs supervise and conduct comprehensive training and capacity building of health care providers, manage logistics systems, and procure drugs and equipment. And, in Grand Gedeh, NGOs provide the county's only emergency transport system. Therefore, reducing the funds that support these activities has wider implications than a breakdown of health services, including the loss of logistics systems and important human capacity strengthening at the community and county level. NGOs also have great potential to utilize their expertise to ensure a smooth transition period in several ways: 1) ensure continued health service quality during the preliminary phases of the BPHS implementation; 2) focus current capacity building efforts to support shift to decentralization; and 3) initiate partnerships to support the CHTs and communities. NGO partners are uniquely positioned to ensure that the CHTs are equipped with the necessary skills to supervise and monitor facility providers, institute a uniform data management system, estimate drug needs, and manage procurement and logistics systems.

iv. Health care access

Health care access is a severe challenge throughout Liberia due to the high number of scattered populations and large areas not serviced by health facilities. Liberia is a relatively small country, however, in the majority of counties, distances between facilities, particularly those funded by OFDA and BPRM, are large. The lack of extensive road and public transportation systems impede access. During the rainy season roads become impassable and cut off large numbers of people from existing health services. For example, cars can become partly submerged in the mud on the main highway in Lofa. The majority of the people and health facilities in Lofa are located in the northern part of the county and impassable roads prohibit the transport of medical supplies and drugs from Monrovia during the rainy season. Therefore, geographical barriers and distances between clinics pose a challenge to the transfer of patient loads from one facility to another, should a facility close due to reduced funding.

v. Health care utilization

Over the past few years, utilization patterns in all counties have experienced changes. The return of Liberian refugees from neighboring counties and the closure of refugee camps in Liberia has increased the burden on the current health system. Also, there is an influx of citizens from neighboring countries (Sierra Leone, Guinea, and Côte d'Ivoire) who use Liberian health facilities. During the January 2007 assessment visit county health officials and NGO field personnel expressed concern that these numbers were likely to increase in the coming weeks in Lofa due to political instability in Guinea.

vi. Humanitarian need versus efficiency

When asked what criteria were most important for prioritizing resources, participants almost universally chose access (population and geographic factors) first. In an effort to further explore access and the public health context in Liberia, the participants were asked to assess health service priorities in rural and urban contexts. Participants in 4 out of the 5 counties voted to focus resources to meet the needs of marginalized populations in isolated rural areas because of their "absolute need" as opposed to the urban areas, where obstacles to access are less prevalent. Interestingly, this mirrors the Government of Liberia's policy to emphasize service delivery in rural areas.

vii. MOHSW staffing capacity

The issue of MOHSW staff salaries ignited considerable discussion among workshop participants. Despite that they are on the government payroll, many CHT members and service providers do not currently receive a salary. According to one CHT member in Grand Cape

Mount, a large percentage of MOHSW staff in the counties have not been paid since 1997. In the NGO supported clinics, staff should be on the MOHSW payroll, but the only "salary" that they receive are NGO incentives. Several participants reported the existence of "ghost workers" (i.e., persons who do not exist or have died and that receive an MOHSW salary). Several of the central MOHSW representatives cited that they had not been paid in over a year. In one case, the representative's position was paid, however the check went to the incumbent, who had died the previous year. This is an issue that has been recognized and is being addressed by the Government of Liberia. Nonetheless, the perception at the community level is that little is being done by the government to rectify this situation.

viii. Transition gap

There was differential understanding among the communities about the upcoming transition and ensuing changes that would occur. In Bomi and Grand Cape Mount, community participants expressed knowledge that NGOs would "leave one day" and had already prepared—with guidance from World Vision—an exit strategy in which they would assume ownership of facility services in the future. However, in Grand Gedeh, participants expressed resistance to the idea that the NGO might need to withdraw. This perhaps indicated a lack of communication between the NGO, CHT and CHCs regarding the transition, and the potential for funding decreases and a loss of NGO supported services.

D. Observations

i. Community-based health services are clearly an aspect of pride and value for the community. Members of the CHC demonstrated impressive creativity in their ability to provide concrete actions and steps that the community should take (and, in most cases, had already taken) to contribute to the health system if funding is reduced. The strength of these CHCs is a source of strength for the county-level health system.

ii. The county-level leadership—particularly the CHOs—was very impressive. The CHOs, while young, demonstrated intelligence, dedication to their communities, and great creativity.

iii. Logistical preparations for almost all of the workshops were completed before the assessment team arrived, including the identification of a venue, catering services, energy sources, and assessment team accommodations. This demonstrated solid communication among CHT members and a commitment to the goals of the workshop.

iv. Workshop attendees, including the observers, actively participated in all discussions and group activities. Discussions were frank and often allowed for vigorous debate, which provided excellent insight into existing issues. The community members also participated actively and showed great insight into health care challenges. In Lofa, several community members did not speak English, but were able to make solid contributions to group discussions through translators. In addition, community members in all workshops provided the greatest number of suggestions about potential community contributions to offset funding decreases (see below).

v. Community involvement is very important. Prior to the start of the mission, the central MOHSW requested the incorporation of a community component into the assessment. This commitment to the community was mirrored at every level; the CHT, NGOs, and CHC members went to great lengths to ensure full participation of CHC members in the workshops. In Grand Gedeh, the NGOs and CHT assumed the costs of transporting CHC members to and from the workshops. In other counties, community members paid initial transportation costs and were subsequently reimbursed.

E. Outcomes

i. Clear understanding of opportunities and challenges of the transition period
The workshops allowed for dissemination of information concerning the almost-certain funding decreases and the implementation of the National Health Plan to significant health actors at the county level. Through workshop discussions, participants demonstrated an understanding of the transition and acknowledged the need to enhance partnerships and further develop human capacity.

ii. Conceptualization of county-level health system
The workshops provided an opportunity for various stakeholders to come together and, for the first time, discuss the implications of the shift to a newly conceptualized county-level health system. This allowed stakeholder groups—particularly the CHTs—to examine how to capitalize on their combined expertise to operationalize this shift. It also allowed NGOs to view their contribution in the context of a county system as opposed to only at the facility level. Through these discussions, participants identified existing gaps and future steps to be taken by the NGO, CHT, CHC, and the MOHSW to minimize harm during the transition period, which includes both the gap in funding and the shift to a decentralized health system in the context of development funding (and not emergency relief). The discussion below will outline steps identified by the participants to address the potential gaps and challenges of this shift.

iii. Strategies and steps to move forward given reduced funding
Participants provided numerous recommendations that might serve to ensure a smooth transition in the context of reduced funding and implementation of the National Health Plan.

a. Capacity building
NGOs play a crucial role in building the capacity of the CHT, CHC, and community members. NGO efforts in this arena could continue to ensure that these actors have the skills needed to assume leadership and responsibility for the future county health system. In Grand Gedeh, Merlin trains the CHT to conduct facility supervision and monitoring and they have together developed a plan for the CHT to gradually assume supervision responsibilities for these clinics. Enhancing community knowledge about preventive health care and the best use of health services might contribute to the optimal use of scarce resources. For example, if community members are familiar with the danger signs of childhood illness, parents can connect a child to health services when appropriate.

b. Community sensitization
Additional awareness about the transition was needed in some counties, particularly in Grand Gedeh, where local NGO field staff expressed surprise about the potential for funding losses. Communities served by World Vision demonstrated the greatest understanding of the transition period and, incidentally, the greatest sense of ownership and desire to contribute to the health system. Awareness building is needed, particularly at the community level, and could set the stage for promoting enhanced local ownership of health facilities by communities. In addition, community sensitization would encourage the development of realistic options to continue health services.

c. Exit/transition strategies and plans
Strengthened partnerships between NGOs, CHTs, and communities would enhance the development of sustainable transition plans and exit strategies. The relationships between these actors differed among counties and NGOs. For example, some NGOs focused on community collaboration, but a strong relationship between the organization and CHT had not been developed. Other NGOs focused resources on training CHC and

CHT members, but had not effectively communicated to them future funding realities or started to plan for this eventuality. In some counties, the NGOs and CHTs had developed rudimentary exit strategies, but not comprehensive exit plans. World Vision, in particular, had developed a gradual transition plan in conjunction with the CHT and communities. Community members and CHT members in Bomi and Grand Cape Mount provided concrete transition strategies and seemed more aware that they would one day assume responsibility for their health facilities.

d. Enhance efficiency through the following mechanisms:

- Promoting NGO collaboration and cost sharing through strategies such as the sharing of housing, office compounds, and logistical systems for medical supplies and drugs.

- Modifying staffing patterns according to facility need. Several Facility Impact Assessment Tools revealed that, despite low patient use, some facilities were staffed daily by 7 health providers. Therefore, some participants suggested a reduction of staff in facilities that experience low patient loads. Other countries have staffed small rural clinics that service scattered populations with fewer staff who possess a greater range of skills, such as a village midwife. It is important to note that there was some resistance to this idea because it is in opposition to government policy. Some participants suggested that health providers might resist the adoption of other tasks than those for which they were trained.

- Implementing new modes of service delivery. Options include increased use of mobile services and market clinics. In Bomi, the vaccination team travels to market sites to promote vaccination services. Another option cited by NGO representatives included the reduction of existing services to a “bare bones” basic package of health services. This model would omit HIV/AIDS services, training programs, health awareness, and community education. Finally, a few respondents suggested enhancing access to health through the training of traditional practitioners, such as “black baggers,” CHWs, and herbalists. These providers have some knowledge of health and extensive reach in rural populations.

- Community-initiated Contributions. In every workshop, CHC members identified concrete contributions they might provide (if able) to offset funding constraints. These include the provision of housing and food goods for health care staff, and in-kind support such as labor and local materials. A small community called Sackie Town in Bomi County constructed their own clinic using local materials. Some communities collect small contributions in the form of a “development fee” to use as seed money if the NGO needs to withdraw support. Several participants cited examples of group funds or community insurance used to pay for emergency transport for pregnant women. Revolving drug funds were used in Liberia during the 1990s and many participants suggested their reinstatement. Participants in Grand Cape Mount also suggested that the community engage in collective income generating activities (e.g., cassava farming) to generate proceeds towards support of the community facility.

F. Limitations

i. Despite the lack of infrastructure in rural areas, conducting county workshops was relatively trouble-free. CHOs at each site had arranged for a generator beforehand, which facilitated the use of the computer and Power Point slides. In addition, road conditions were good and travels delays minimized.

ii. A full 2-day workshop agenda was not possible to complete in each county due to extensive travel demands. For example, several 10-12 hour drives were required to reach workshop destinations (see itinerary in Appendix F). Additional time might have allowed for the elaboration of more substantial county and organization-level transition plans. In addition, participants in the workshops in Lofa and Grand Gedeh expressed difficulty understanding the assessment team's "American English." Efforts to translate for those community members enhanced understanding of and communication with the assessment team. As translation requires time, an additional day might have allowed for more comprehensive translation.

iii. The county maps were an excellent tool to present the county-level system. However, despite repeated attempts, acquiring the GPS points of each clinic was not feasible. Therefore, the clinic locations were based on their proximity to "populated areas" and the GPS points of these areas were used as measures of clinic location. If a clinic was not located near a populated area, it did not appear on the map. In addition, the scale was misleading in that the circular representations of the facilities were large and facilities appeared closer on the map than they actually were. In many cases, this distracted the participants.

iv. Discussions about the allocation of decreased funding is a highly charged topic. The actors had a great stake in these decisions and proved very resistant to providing information which might lead to recommendations about the cessation of funding to any one clinic or community.

G. NGO Leadership Meeting

i. Purpose and Participants
The NGO leadership meeting provided an opportunity to share information and observations from the 5 county workshops and solicit official NGO input on enhancing efficiency and cost effectiveness in NGO operations, transition planning, exit strategies, and coordination and collaboration with other NGOs and the MOHSW (see Appendix P for the meeting agenda). Four out of the 5 NGOs were present, with Equip being the only absent organization.

ii. Discussion Themes

a. Numerous meetings whose agendas were based on technical issues prevented NGOs from fully coordinating with the MOHSW because time constraints inhibited their ability to participate in all these activities. However, the NGOs had submitted a joint position paper in which they collectively agreed to a sequential phase-out and handover of health services to the MOHSW.

b. The representatives provided several concrete suggestions on how to direct limited funds. These suggestions were similar to those made in the county-level workshops. One NGO representative suggested that, with less funding, they would choose to scale back to "bare bones" or "emergency mode" health service delivery. Reduction of staff, where appropriate, including the reduction of expatriate staff, would allow for greater use of limited funds. Finally, the deployment of mobile teams to rural areas with limited access to health services, coupled with a health education radio broadcast, might also enhance cost effectiveness and efficiency.

c. The Assessment team requested that each NGO submit a rough figure (in U.S. dollars) representing the amount needed to: 1) sustain a clinic at its current level of operations and to sustain a clinic operating in “emergency mode” (i.e. just the basic package of health services, omitting training, HIV/AIDS, mental health services, etc.). The figures submitted to run a clinic at the current level ranged from $3,000-$18,000 and the figures to run a clinic operating at “bare bones” ranged from $2,000-11,000.

VI. COUNTY TRANSITION PLANNING

In an effort to develop concrete county-level transition plans and respond to the MOHSW's request to expand the planning process, BASICS developed and implemented phase two of the Transition Assessment. This phase was designed to develop a framework for the key elements of county-wide health planning and conduct a workshop for CHTs and NGO representatives to develop collaborative county-level plans. A first workshop was organized June 18-20, 2007 for the five OFDA/BPRM-assisted counties (i.e., Bomi, Grand Cape Mount, Nimba, Lofa and Grand Gedeh).

Phase two objectives included:

1) Encourage county coordination mechanisms, especially between CHTs and NGOs;
2) Understand the BPHS and integrated implementation strategies;
3) Prepare a draft framework for developing a County Health Plan; and
4) Update the MOHSW health facility database.

A. Data Collection

In order to ensure the County Health Planning workshop is a data driven process, a five page data collection instrument was designed to collect information from CHTs concerning their health facilities, services, staffing and program implementation at facility, outreach and community levels (see Tables below). The data collection instrument was built on a County Health Team assessment form that was developed during the preparation of the National Health Plan. See Appendix Q for blank data collection form.

- Table 1: Health facility types, support, and workloads
- Table 2: Health Facility Services and Staffing
- Table 3: Implementation of public health programs in facilities and communities
- Table 4: Implementation of public health programs (supplement by MOHSW)
- Table 5: Community-based health programs

The MOHSW led the data collection process and organized several teams to visit all fifteen counties between June 4-12, 2007. Priority was given to the five USG supported counties participating in the June 2007 planning workshop. The data collection process was significant as it contributed to building the MOHSW's capacity to collect county-level data and engage in county health planning. The data was entered into Excel spreadsheets. This format permitted the creation of simple data tables with county-specific forms to use as handouts for group work during the workshop. A sample of selected data from Bomi county is shown below.

MOHSW database				Table 1											Table 2																		
Health Facilities by MHOSW database				Type	Owns	Dis	Statu	Othe	NGO	Pop	Outpatient Servivces					MD	PA	RN	BSc	LN	Nurs Aid	CM W	TT M	Lab Tech	Lab Aid	Disp	Env Tech	SW	Rec-order	Clea-ner	Secu rity	Vacci nator	24 hrs ?
	County	District Name	Health Facility Name	Pop	Type	Owns	Dis	Status	Other	NGO	Pop	<5	ANC	FP	Other																		
1	Bomi	Tubmanburg	Liberia Gov't Hosp	20065	Hosp	GOL		2	Y	UNFPA, S	20065	1769	786	317	3588	2	4	9	1	2	17	7			2	2	2	1	5	10	6		yes
2	Bomi	Tubmanburg	St. Lukes	13093	Clinic	Cath	2	2	Y	CHAL-CH	13093	1458	429	257	6717	1	2																no
3	Bomi	Tubmanburg	Befine	4700	Clinic	GOL	10	2	N	IMC	4700	1062	312	187	4866			2							1			1	1		1	no
4	Bomi	Tubmanburg	Sackie Town	4871	Clinic	GOL	22	0	N	IMC	4871	663	195	117	3042					1					1			1	1	1		no
5	Bomi	Klay	Gogehn	5065	Clinic	GOL	18	2	N	AHA	5065	1194	358	211	5475			1			1				1			1	1			no
6	Bomi	Klay	Zordee	4887	Clinic	GOL	33	2	N	WVL (UN	4887	1326	390	234	6084			2							1			1		1	1	no
7	Bomi	Klay	Gohnzipo/ORT	4665	Clinic	GOL	28	2	N	WVL (UN	4665	11260	372	222	5778			1		1					1			1		1	1	no
8	Bomi	Klay	Malema	5598	Clinic	GOL	33	2	N	WVL (UN	5598	1458	429	257	6693			1		1					1			1	1	1	1	no
9	Bomi	Klay	Guthrie	6620	HC/Clinic	FBO	30	2	N	Guthrie	6620	2322	684	410	10644		1	3			2	1			1	1			1	2	1	1	yes
10	Bomi	Klay	Gbah Jekeh	6309	Clinic	Private	29	1	Y	Bala Holm	6309	531	156	94	2433						1	1				1			1		1		no
11	Bomi	Klay	Gonjeh/ORT	4398	Clinic	GOL	32	2	N	WVL (UN	4398	1299	381	229	5964					1		1				1			1		1	1	no
12	Bomi	Klay	Sasstown	6885	Clinic	GOL	31	2	N	WVL (UN	6885	1659	489	293	7602			1			1	1			1	1			1		1	1	no
13	Bomi	Dewoin	Beh Town	5720	Clinic	GOL	33	2	N	AHA	5720	996	294	76	4578					1	1	1				1			1	1	1	1	no
14	Bomi	Dewoin	Vortor	5997	Clinic	GOL	45	0	N	IMC	5997	663	195	39	3042					1						1			1		1		no
15	Bomi	Dewoin	Dargwen Town (D	5299	Clinic	GOL	37	0	N	IMC	5299	1194	351	211	5475		1									1			1		1	1	no
16	Bomi	Dewoin	Jenneh #3/ORT	6209	Clinic	GOL	34	2	N	AHA	6209	1326	390	78	6084			1			1	1				1			1		1	1	no
17	Bomi	Dewoin	Bonjeh Town	5612	Clinic	GOL	38	1	N	IMC	5612	861	255	152	3954					1		1				1			1	1		1	no
18	Bomi	Suehn/Mecca	Suehn	8433	Clinic	GOL	92	2	N	SC-UK	8433	1989	585	351	9126			1	1		1	1				1			1	1	1	1	no
19	Bomi	Suehn/Mecca	Weawolo (change	4499	Clinic	GOL	95	2	N	IMC	4499	597	177	105	2736			1								1			1		1	1	no
20	Bomi	Suehn/Mecca	Fefeh Town	4899	Clinic	GOL	94	2	N	SC-UK	4899	1062	312	187	4866			1			1	1				1			1		1	1	no
21	Bomi	Suehn/Mecca	Mecca/ORT	5724	Clinic	GOL	130	2	N	SC-UK	5724	927	276	164	4260				1		1					1			1		1	1	no
				139548							139548					3	8	24	3	9	27	16	0	0	4	21	2	1	24	19	22	15	

B. Framework for county level transition planning

A framework/template for county health planning (including details for facility by facility level assessment and planning) was developed in collaboration with the MOHSW staff. It is based on the components of the National Health Plan and includes the following sections (with a few selected summary tables shown below):

1. Basic Information
2. Indicators and Targets (Process and Coverage/Utilization)
3. Scoring for Priority Attention to BPHS Components
4. Human Resource Planning
5. Health Facility Planning
6. Five Star Assessment of current BPHS capacity
7. Support Systems Planning
8. Summary of Key Transition Planning Actions

See full County level transition plan framework template in Appendix R. See county-specific transition plans in Appendix S. Selected Elements of the County Health Planning Framework:

i. Human Resource Planning

Staffing of Clinics Total Clinics = _____	**Proposed NH Plan**	**Current Total**	**Clinics with correct number of staff**		
			Current	**Planned June 08**	**Planned June 09**
Officer in Charge (PA, N/M or nurse)	1				
Physician Assistant					
Registered Nurse (or BSc)					
Certified Midwife	1				
Dispenser	1				
Nurse Aide (including Vaccinators)	1				
Environmental Tech.					
Social Worker					
Lab Technician					
Recorder/HIS	1				
Security/Cleaner	1				
Total	6				

ii. Health Facility Planning

Infrastructure Development Summary Table	**NH Plan**	**Proposed**	**Target June '08**	**Target June '09**
1) How many facilities exist: functional & nonfunc.; public & not-for-profit?				
2) How many facilities are needed to make PHC accessible?				
Clinics				
Health Centers				
Hospitals				
3) How many health facilities are presently functional?				
4) What are your facility rehabilitation & construction plans?				

iii. Five Star Assessment of current BPHS capacity

	Health Facility Name	Population	Type	Current BPHS	Infra	HR	Equip & Drugs	Support Systems	Total	Targets (1-5 star)	
										June '08	June '09
1											
2											
3											
4											
5											
	Totals										

Totals		
	*****	
	****	
	***	
	**	
	*	

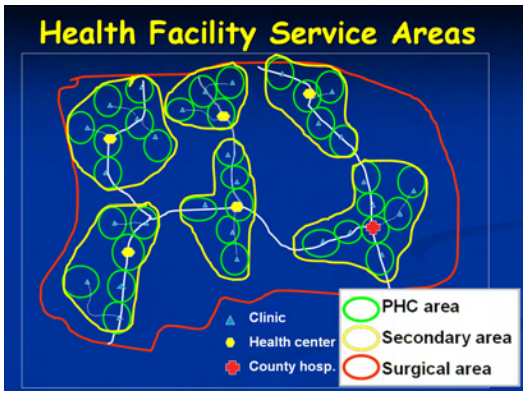
C. The Workshop Sessions:

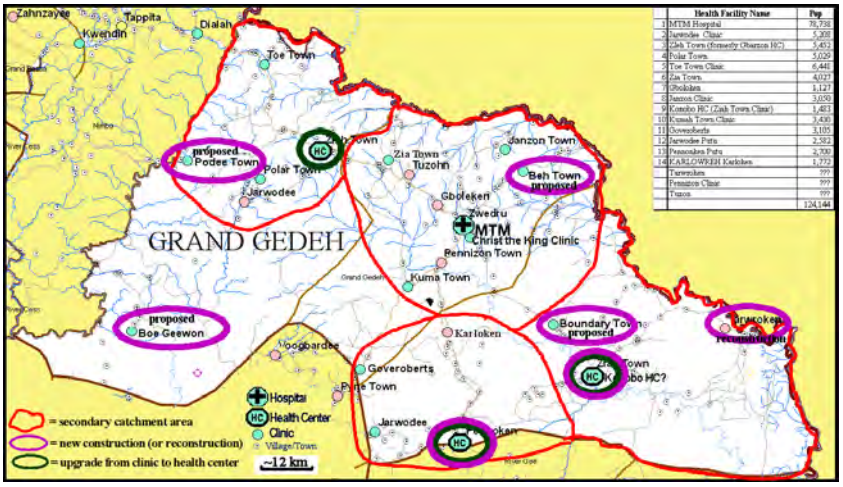
The workshop was conducted over a three day period and included the following sessions:
Session1 - Introduction
Session II - BPHS
Session III - Infrastructure Development
Session IV – HR Planning for the BPHS
Session V – BPHS Performance Improvement
Session VI - Support Systems
Session VII- Five Star Assessment of BPHS capacity
Session VIII - Next Steps for planning and implementation

Find the workshop session guide and agenda in Appendix T and U.

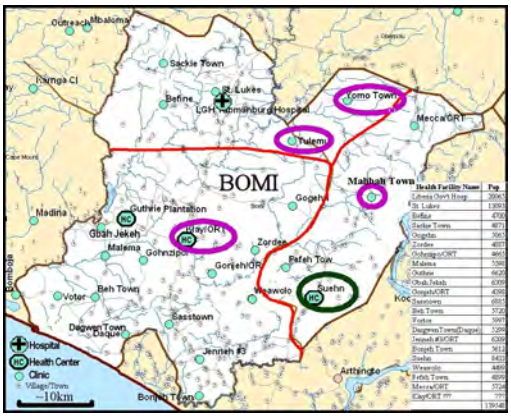
A summary of each session is provided below:
Session I - Introduction: S. Tonorlah Varpilah, the Deputy Minister for Planning, opened the workshop by explaining its objectives. He noted that the County Health Planning process should mirror the process and components of the National Health Plan. Frank Baer, BASICS Consultant, continued the session with an overview of the planning process "Planning and Management is as Easy as P I E".

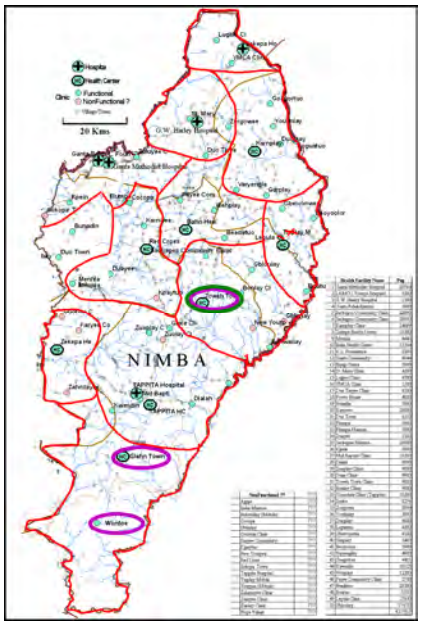
Session II - BPHS: Bernice Dahn, Chief Medical Officer, provided an overview of the BPHS and its components. She also explained that there are three types of health service "catchment" populations – primary, secondary and surgical. Iain Aitken, BASICS Consultant, expanded on the importance of planning service areas for the provision of the BPHS, i.e., noting that clinics, health centers, and hospitals each have a primary catchment area. The work in groups proposed new or reopened clinics for populations that lacked any access to health care, and secondary service areas for health centers and hospitals. This was one of the most important planning components of the workshop. The map below shows the results for Grand Gedeh.

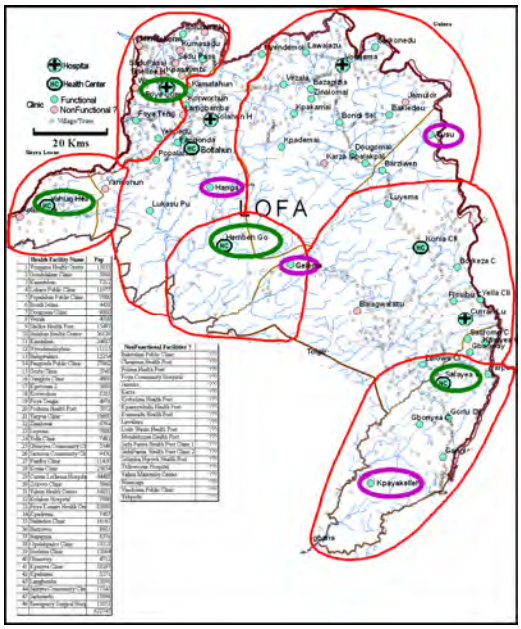




Notes: A purple circle indicates a proposed new facility to be constructed (or completely reconstructed). A green circle indicates a facility that has a “health center” infrastructure, but is currently functioning at the “clinic” level and needs to be upgraded. A green and purple circle indicates a facility that has a “clinic” infrastructure and functionality, and is to be upgraded (both in infrastructure and services) to function as a health center.







Session III - Infrastructure Development: This session updated infrastructure development projections based on the previous group discussions by answering the following questions:

1) How many facilities exist: functional & nonfunctional; public & not-for-profit?
2) How many facilities are needed to make Primary Health Care (PHC) accessible?
3) How many health facilities are presently functional?
4) What are your facility rehabilitation & construction plans?

The table below summarizes the results for all five counties. It is interesting to note that the number of facilities that participants said would be required to make PHC accessible has barely changed since the initial estimate made in October 2006 (i.e. 221 in October 2006 and 220 in June 2007). The number of proposed rehabilitation projects has increased from 58 to 107, but still seems reasonable. During the preparation of the National Health Plan CHOs were asked to estimate infrastructure development needs by responding to the following questions:

Infrastructure Development County Framework Planning Workshop (June 2007)	**Bomi**	**Grand Cape Mt**	**Grand Gedeh**	**Lofa**	**Nimba**	**Total**
2) How many facilities are needed to make PHC accessible?	25	38	22	68	67	220
Clinics	22	33	18	57	55	182
Health Centers	2	4	3	7	7	24
Hospitals	1	1	1	4	5	12
3) How many health facilities are presently functional?	21	33	15	48	50	167
4) What are your facility rehabilitation & construction plans?	9	12	29	3	47	107
Minor Rehabilitation of Clinics or Health Centers	0	1	15	10	8	34
Major Rehabilitation of Clinics	2	4	3		19	19
Re-Construct a clinic near same site	0	1	1	1	3	6
Construct a clinic in new health area	3	3	5	1	5	17
Major Rehabilitation (or new construction) of a Health Centers	1	0	0	5	7	13
Upgrade from Clinic to Health Center	1	2	3	2	2	10
Minor Rehabilitation of Hospital	1	1	1		2	2
Major Rehabilitation of Hospital	1	0	1	3	1	6

Session IV - Human resource (HR) planning for the BPHS: This session examined the BPHS with respect to human resource needs. The National Health Plan provides standards for the staffing of clinics and health centers. The county groups were asked to assess their current human resources situation in light of those standards and plan for the next two years focusing on needs for professional grade staff: certified midwives, physician assistants, and registered (or BSc) nurses. During the first step of this activity participants utilized a worksheet to assess met and unmet need for certified midwives and nurses / physician assistants (Pas) (treating these as interchangeable) by health facility. Using the results of the first worksheet, participants identified those facilities that had met the National Health Plan staffing standard. As a planning exercise, participants then selected those facilities to be brought to standard by June 2008 and by June 2009.

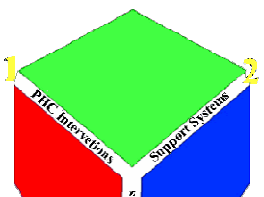
Staffing of Clinics NIMBA County Total Clinics = __53___	Proposed NH Plan	Current Total	Clinics with correct number of staff		
			Current	Planned June 08	Planned June 09
Officer in Charge (PA, N/M or	1	35	6	35	
Physician Assistant					
Registered Nurse (or BSc)					
Certified Midwife	1	9	6	20	15
Dispenser	1	41	41		
Nurse Aide (including	1	73	73		
Environmental Tech.					
Social Worker					
Lab Technician					
Recorder/HIS	1	41	41		
Security/Cleaner	1	66	66		
Total	6	265			

Session V – Prioritization for BPHS Performance Improvement Planning: This session focused on examining the content of priority BPHS programs and selecting programs for the BPHS. Facilitators also introduced the concept of Performance Improvement Planning (PIP) and designed timetables to implement this planning at the county level. The session initiated with a discussion about "Performance Improvement Planning for the BPHS at the County Level" which outlined the performance improvement planning process and reviewed data available on significant health issues in Liberia and the strategies to manage them. A worksheet was used to assess on a scale of 1-3 the number of deaths associated with the health issues, the impacts on family welfare, the current accessibility of the most important interventions, and the level of community concern.

	Many deaths? 1 - 3	Effect on family ? 1 - 3	Key service accessible? Community = 3 Clinic = 2 HC =	Community concern 1 – 3	Totals
Maternal Newborn	2	3	1	2	8
Child problems	3	2	2-3	2-3	9-11
High fertility	2	1	3	1	7
TB and HIV	1	2-3	2	2	7-8

The proposal for Program Improvement Planning (PIP) will be addressed individually for each BPHS component in the order cited above, beginning with three month intervals. At the start of each new cycle, the MOHSW technical leadership would facilitate a multi-county "Update Workshop" to review data about significant health concerns, evidence-based strategies, and experience implementing those strategies both internationally and in Liberia. The county specific groups would return to implement the performance improvement planning process at the county-level. The first of such workshops would also need to provide an introduction to PIP and a manual with worksheets for use by the county teams. The groups were asked to develop a draft timetable for implementing the PIP process.

Session VI - Support Systems: This session reviewed the nine support system components of the National Health Plan (see below) and their role in supporting the BPHS. During group work participants were asked to review each of the support system components in their county and then identify several areas and key actions for Support System strengthening. In retrospect it might have been more productive to focus their discussion on identifying priority support systems and joint actions to strengthen those during the transitioning period in collaboration with implementing partners.



Support Systems Components:

1) Planning & Budgeting
2) Health Management Information System
3) Supervision
4) Drugs & Medical Supplies
5) Logistics & Communication
6) Facility & Equipment Maintenance
7) Human Resources Management
8) Stakeholder Coordination
9) Policy Formulation & Implementation

Some specific examples of joint activities that were presented included:

- Planning: Need more joint planning of activities: CHT plus NGOs
- Supervision: Joint supervision, monitoring and evaluation of health facilities
- Stakeholder coordination: Monthly Coordination Meetings: CHT plus NGOs and Phase Out Planning of INGO assistance

Session VII - Five Star Assessment of BPHS capacity (and rollout planning): This session presented the concept of a Five Star Accreditation System for rolling out the BPHS. Each health facility (including catchment area) would receive a rating based on current BPHS delivery. If a facility provided the majority of BPH services it would be designed a "one star" facility. Additional stars (five in total) would be added as the facility achieved the MOHSW's standard in the categories of infrastructure, equipment/drugs, support systems, and human resources. The participants liked this approach. However, the facilitators found that more refinement and clearer definition of the criteria would be required make the designation of stars less subjective. For example, some counties, such as Nimba and Lofa, appeared more lenient in the dispensation of stars. Grand Cape Mount and Grand Gedeh counties officials, on the other hand, rated facilities in a manner consistent with facilitator expectations.

	Bomi	Grand Cape Mount	Grand Gedeh	Lofa	Nimba	Totals	%
*****	0	0	0	1	6	7	5%
****	1	0	1	8	11	21	14%
***	12	2	2	38	27	81	52%
**	1	10	8	0	6	25	16%
*	3	14	4	0	0	21	14%
Totals	17	26	15	47	50	155	

Session VIII - Next Steps for planning and implementation: This session emphasized the need to continue the county-wide planning process at the county-level in coordination with local authorities and communities. For example, the identification of sites for new construction of health clinics should be discussed with community leaders to initiate fund raising efforts, such as the preparation of grant proposals for submission to LACE, a project currently funding community-based initiatives. In his closing remarks, Mr. Varpilah charged the county groups to produce county health plans, based on the results of the workshop, within the next three months.

D. Observations

i. The Five County Planning Workshop went quite well, although the three day limit (Monday to Wednesday) was a challenge. CHTs were very enthusiastic and were represented by two or three participants from each county. The number of participating NGOs was a bit disappointing with only six organizations represented.

ii. The participants went much further with the concept of secondary (health center) service areas than BASICS expected. The updated information for the MOHSW database, transition planning for infrastructure development, and updated maps for the counties exceeded expectations.

iii. The opportunity for detailed discussions with the CHTs made it possible to compare and revise the MOHSW database. This process was fully completed for Bomi, Grand Cape Mount and Grand Geheh, and partially completed for Nimba and Lofa. A comparison of the assessment forms and MOHSW database from the remaining ten counties may provide some additional updates.

iv. It is of note that most of the participants had little or no training in public health beyond what they have learned on the job. Some aspects of the workshop were, therefore, more successful than others. The most successful were the exercises on primary and secondary service areas, planning for infrastructure rehabilitation, and assessing and planning human resource needs. These involved the application of straightforward principles and standards. Less obviously successful were the exercises on planning for performance improvement and support systems strengthening. These sessions dealt with general systems that need strengthening through processes with which the participants are still unfamiliar as opposed to the familiar specifics of the locations of clinics and distribution of health staff. Both performance improvement planning and support systems strengthening will need nation-wide support over the course of the next couple of years, at least. For that reason, it was important to touch on the importance of both and initiate analysis of these themes.

v. A county health plan file was prepared for each county. Only Bomi county was able to complete a full draft framework during the workshop. The number of health facilities in Nimba and Lofa counties made the process considerably more time-consuming for those counties. However, it was noted repeatedly during the workshop, that the objective was to understand the planning framework and to begin a planning process that would continue at the county level in collaboration with all stakeholders.

VII. LESSONS LEARNED

This transition assessment marks the first effort to undertake a process to guide the period from humanitarian assistance to development by identifying methods to minimize loss of care amid funding reductions. It is hoped that this process can be expanded to all counties in Liberia. It is also hoped that, with refinement and modification, the process will be useful in other countries undergoing similar transitions.

The first week in-country was spent in preliminary meetings and arranging on-the-ground logistics. A pre-assessment visit to coordinate with key actors, arrange county-level logistics, and distribute the FIAT would have allowed the assessment team additional time to focus on information gathering at the county level and would have provided a more realistic understanding of travel demands and time constraints.

Once facility-specific next steps have been determined, a series of follow-up efforts, both at the clinic and the organizational levels (NGO, CHT), should be anticipated and planned for the purpose of providing guidance to these actors in consolidating transition activities and beginning implementation.

Future assessments should include all health system stakeholders (facilities, implementing partners, and funders) within each geographic area (i.e. county, district, etc.) to allow for a comprehensive view of the health system and assess public health impact. The inclusion of all actors would also promote greater support for the CHT and CHCs during the transition to a county-focused health system. This assessment was not structured as such because the purpose was to provide specific recommendations to OFDA and BPRM.

Despite the importance of implementing the Basic Package of Health Services for the county-focused system, this assessment focused mostly on the current delivery of services and NGOs' ability to shift from clinic-focused provision of care to a county health system. The package should be highlighted more significantly in future assessments.

The transition assessment occurred in tandem with Liberia's Donor's Forum. This was useful in that preliminary conclusions from the assessment were used to inform discussions at the conference and supported advocacy to increase donor interest in Liberia's health sector. However, information about donor interest in Liberia was not known prior to the Donor's Forum, which hindered a realistic understanding of potential future funding sources. In addition, the Donor's Forum was a dynamic process that changed some of the on-the-ground realities during the assessment period. In small part, this changed the context within which the assessment was done, unbeknown to the team.

The original intent of the assessment included developing county and facility level transition plans during the county workshops, which would provide the foundation for moving towards a county health system. However, workshop participants were not ready to move to this stage of planning. As a result, USAID/BASICS designed a second workshop and sent another team out in mid-June 2007 to complete the county planning process. Future assessments should consider incorporating a second set of workshops to focus on developing concrete transition plans into initial assessment planning.

VIII. CONCLUSIONS AND SPECIAL ISSUES

Conclusions are based on observations and information gathered throughout the transition assessment process and provide context to better understand the recommendations and their potential implementation.

The health emergency is Liberia is far from over. Food, shelter, security, and basic health needs are not adequately supplied in quantity or quality. Viewing patients in the hospitals, health centers, clinics, and in the villages, as well as people along the roadsides, the acute and chronic toll of ill-health and poor nutrition caused by the war is evident. While many of the rural clinics, health centers, and hospitals in Liberia have been physically 'rehabilitated', the health infrastructure, facilities, and road systems are still substantially lacking.

Therefore, a cessation of current humanitarian assistance funds has the potential to impede the transition process if not managed and coordinated. The greatest consequences of involuntary NGO withdrawal include: 1) a reduction of services with consequent increases in morbidity and mortality, especially among mothers and children; 2) a loss of human capacity and institutional knowledge within the health care system; 3) increased reliance on untrained, traditional practitioners and "black baggers" as a result of reduced access to legitimate services; and 4) a loss of confidence in the government's ability to provide for its people and a potential for political upheaval.

It would take little additional strain to destabilize the Liberian health system. The current crisis in Guinea may result in an increased influx of refugees into Liberia, which would place undue strain on the health system. During the visit to Lofa County, NGO personnel were clearly preparing to manage increased patient loads. Conflict in this region has had past implications for neighboring countries and, for this reason, the maintenance of health services as a protective factor for stability is an important consideration.

Some decrease in funding—at least during the transition period between the end of humanitarian relief and the start of development funding—seems unavoidable. The MOHSW does not currently have the human and financial resources needed to offset these reductions and the consequent loss of NGO expertise. For example, the MOHSW does not have the means to pay all employees currently working in NGO-supported facilities, and there is a lack of management and financial administration capacity at the county level. Therefore, the support of international donors and implementing partners is crucial to maintaining sufficient health services. The MOHSW takes an active role encouraging donor collaboration through leading stakeholder partners to advocate for additional health funding to offset the transition gap.

Funding decrease might also be offset by a series of actions:

1. Greater efficiency by the MOHSW and NGOs in regards to agreed-upon staffing patterns, logistic systems, equipment, and sharing of administrative costs would reduce costs of service implementation. For example, information from the FIATs indicated that some facilities that only see 5 patients per day have a full-time staff of seven. Yet, government policy states that each facility must be fully staffed to be considered functional. If staffing patterns were adjusted to actual need, specific facilities could reduce spending on staff salaries, where appropriate. NGO logistic systems overlap and each organization maintains its own supply chain for drugs and equipment. Coordinating logistics would save time and financial resources. Finally, one NGO field representative suggested that NGOs share office and housing compounds to further reduce administrative costs.

2. ‘Out of the box’ innovations by NGOs and the MOHSW would increase access to care. This includes the use of mobile services or market clinics. Training existing traditional practitioners and private drug vendors is another method to improve health care quality and access at minimal costs. Finally, countries such as Indonesia utilize the village midwife model in remote communities. Health outposts are staffed by one trained midwife who can manage all routine health issues, including child health and labor and delivery.

Despite widespread poverty, it was clear that community members wished to contribute to health services as much as they were able. The MOHSW policy currently prohibits user fees. However, other community contributions (e.g., community insurance, cost sharing, and in-kind contributions) are fairly common. For example, many communities provide housing and food for health care providers. Raising funds through collective income-generating activities at the facility is another potential community contribution.

The MOHSW has produced a solid National Health Policy and National Health Plan, which provide a basis for health system transition. The smooth implementation of this vision will require several key steps. The execution of a realistic, detailed implementation plan that involves CHT, community, and NGO input is crucial to ensuring a timely transition. Increased capacity of central MOHSW personnel and the CHTs to manage and provide supervision and financial administration will also be necessary for a county-focused health system. Strengthened partnerships among the central MOHSW, CHTs, NGOs and communities (through the CHCs) will strengthen the health system and might also allow for the emergence of creative implementation strategies that can make efficient use of reduced funds. Decentralization needs to occur in tandem with strategies to ensure accountability and transparency at all levels. Finally, cohesive donor response and coordinated action will facilitate this process. If donors identify how to concentrate their funds (i.e., at a county or regional level, rural versus urban facilities, or primary versus secondary facilities) it will be easier to identify systematic gaps and improve systematic efficiency.

NGOs have great potential to contribute to the coordinated implementation of the National Health Plan and assist with the steps outlined above. NGOs form a critical ‘seed bed’ for pushing forward and demonstrating key elements of the National Health Plan over the next two years, particularly implementation of the Basic Package of Health Services. In addition, NGOs support the majority of health sector human resource capacity building initiatives, and work with communities, CHTs, and their own staff to ensure quality service provision and health prevention services. NGOs are responsible for the management, supervision, and accountability of their own facilities and can transfer these skills to county level health officials through a series of on-site, low cost training sessions and continuous mentoring. Finally, NGOs can further build capacity and encourage local ownership by contributing to the development and implementation of community transition plans, which outline concrete steps to be taken by the CHCs to transition from the current mode of health service delivery to a unified county-level health system.

The transition period can be navigated successfully with the resources and motivation of the Liberian people, a solid health plan, and international support. One young midwife related the story of a pregnant woman with labor complications who had to be rushed to the hospital. In the absence of a reliable emergency transportation system, her family brought her to the hospital in a wheelbarrow. Despite circumstances being less than ideal, the Liberian people will find a way to supersede current challenges.

IX. RECOMMENDATIONS

OFDA/BPRM

1. Continued clinic grants should include specific actions to be taken by implementing partners to improve efficiency, catalyze community in-kind support and ownership, collaborate with the CHT to implement the BPHS, and develop meaningful partnerships at all levels. Proposed benchmarks to measure actions can serve to monitor progress. Specific examples of measures to be considered include implementing flexible staffing and training patterns, streamlining logistic and equipment systems, sharing administrative costs, and using 'out of the box' innovations, like mobile services, village midwives, and controlled drug vending and community revolving funds.

MOHSW

1. Continue to advocate for additional health funding from donors to maintain a consistent level of services during the transition period.
2. Support capacity building for CHTs, and provide technical and administrative support to CHOs residing in counties where funding decreases will impact services during the transition period.
3. Where possible, develop creative solutions to assist NGOs and communities in sustaining services despite decreased funding.
4. Facilitate collaboration among donors, county health officials, and NGOs to work towards implementation of the National Health Plan through the (fairly immediate) development of concrete, feasible national and county-level plans which involve and incorporate the perspectives of the above-mentioned actors. The MOHSW should assume leadership of this process and rely on NGOs to provide guidance and CHTs to provide county-level coordination.
5. Over the next three months continue to support finalization and implementation of county-level transition plans, including the initiation of quarterly Update Workshops for county health officials.
6. Lead development of a coordinated, two-level transition strategy (national and county level) for implementing partners, based on input from NGOs, the MOHSW, CHT, and CHC, and meshed with anticipated development assistance.

NGOs and FBOs (Implementing Partners)

1. Identify and implement creative methods to enhance efficiency while maintaining quality services through innovative service delivery and shared resources, such as collective logistics systems.
2. Work with county-level health officials and communities to prepare for the shift to a county level system and standardized implementation of the BPHS. Steps might include the elaboration of transition plans that outline the role of CHTs, implementing partners, and communities; encouraging community ownership of health services through the identification of feasible community-initiated contributions; and building capacity of local health officials and volunteers to manage the health system at all levels (county and community). The identification and incorporation of innovative efficiencies is of particular importance at this juncture because these clinics can serve as seed beds for a sound and feasible health care delivery system with the support and guidance of implementing organizations.
3. Coordinate with stakeholders and partners at all levels to facilitate the shift to a county-focused system in which CHTs are responsible for the coordinated management of the health delivery system.

Donors (OFDA, BPRM, USAID, ECHO, EU, DFID, Irish Aid, Etc.)

1. Provide assistance to NGO-supported clinics with the greatest public health impact and that might experience decreased relief funding.
2. Increase funds to NGOs currently operating to support clinics that might experience decreased funding.
3. Formalize partnerships and coordinate with other donors to avoid gaps in health service delivery during the transition period. For example, donors can agree to shift to providing county-focused support, rather than clinic-focused support. USAID has assumed responsibility for the majority of clinics in Bomi and Grand Cape Mount Counties. This can lead to coordinated NGO operational structures and may translate into standardized service implementation at the clinic level.
4. Advocate within the donor community to raise awareness about the health situation in Liberia.

X. NEXT STEPS

1. Finalize the transition assessment report and transition toolkit to support further exploration of the transition process in Liberia and other post-conflict situations.

2. Conduct post-transition follow-up activities over the next three months at the county level to complete development of finalized county-level transition plans that determine concrete actions for delivery of the BPHS and support the transition to a county-focused system. Activities include: discuss draft county plan framework with members of CHT, NGO partners, and other stakeholders at the county level; conduct technical workshop to finalize county health plan; organize stakeholders' meeting to endorse plan; finalize plan; print, launch and distribute plan for each county.

3. Follow-on activities to ensure coordinated implementation and on-going monitoring of the county plan will also be necessary. Support the MOHSW to develop a framework for the quarterly Update Workshops including the development of a Program Improvement Planning (PIP) guide and corresponding worksheets. Finalize timetable for implementing PIP process.

4. Finalize the accreditation system through clear definition of facility criteria to ensure objective facility rating.

5. Provide general NGO-focused technical support to develop concrete activities and transitions plans that support implementation of BPHS and shift to county-focused system.

6. The transition process will be supported if the transition assessment is expanded to include all counties and implementing partners. The transition assessment can provide an opportunity to support coordinated development of transition plans and begin capacity building at local levels. Provide support to the MOHSW to expand assessment in a manner that ensures their integration into the process and builds their technical capacity in the area of health system planning and development.

7. Additional TA needs:

    a. Facilitate partnership building (NGOs, MOHSW, CHT) and donor coordination to begin effective implementation of the National Health Plan in OFDA- and BPRM-assisted facilities. Consultants who have experience and credentials to work credibly with senior MOHSW officials, have extensive 'on the ground' experience, and can work primarily in the field to forge the link between the MOHSW plan and actual implementation should be hired to provide long term technical assistance. Examples are public health consultants who are physicians, nurse practitioners, physician assistants, and nurse-midwives.

    c. Support NGOs and the MOHSW in the identification of strategies to transition and prepare the MOHSW for developing and managing systems for health care delivery that meet actual health needs, are cost effective, and can be implemented rapidly.

    d. Build financial administration, managerial, and planning capacity at the central and county levels.

    e. Assess living wages and develop a feasible pay scale for MOHSW and employees.

f. Assess existing and potential community contributions to health care system that will inevitably require some form of financial contributions by communities and/or patients, and necessitate the Government of Liberia to reconsider current prohibition of user fees.

g. Assess essential drug procurement and efficient logistics.