Liberia Case Study: Aid Effectiveness during transition from relief to development funding

1. The context

1.1. Social & Political Environment
After fourteen years of fighting, the conflict in Liberia finally ended in 2003. A National Transitional Government of Liberia presided over the successful disarmament and demobilisation of combatants in 2004 and general elections the following year. President Ellen Johnson-Sirleaf was elected in November 2005 with 59% of the presidential vote, in elections that most Liberians considered fair, and has made significant progress restoring public confidence.\(^1\)

Despite numerous challenges, Liberia has reached important milestones for the relief of international debt, renegotiated major concession agreements, and developed a comprehensive, interim poverty reduction strategy. A three year poverty reduction strategy will be implemented from mid-2008, throughout which fees for basic social services such as primary education and healthcare will continue to be suspended.

Although reliable household information remains scare, estimates continue to indicate that over half the population of 3,200,000 live on less than $1 a day, with a majority of people living in Monrovia and unemployment hovering near 80%.\(^2\) Major challenges that lay ahead include maintaining peace and security after draw down of United Nations Mission in Liberia (UNMIL) peacekeeping forces, tackling rampant corruption, reducing the high level of unemployment, and continuing to reconstruct the country’s infrastructure.

1.2. Health Situation
The long conflict had a devastating effect on the health system in Liberia. Health facilities were looted, destroyed, and abandoned across the country. Health workers fled and the schools for developing new health workers crumbled during the war, leaving only one functioning medical school which graduated just 13 doctors in 2007. Three quarters of Liberia’s 380 functioning health facilities do so now only with the assistance of non-governmental (NGO) or faith based organizations (FBO).\(^3\)

The full human cost of the conflict as well as the persistent impact several years on is only now becoming clear. The 2007 National Demographic and Health Survey found that maternal mortality ratio has worsened from 578 to 994 deaths per 100,000 births since 1999, representing over one third of all deaths amongst women between ages 15-49 years.\(^4\) Malnutrition in children remains a major problem with 7% moderate acute malnutrition, of which almost 3% severe.\(^5\) A nutrition analysis in December 2007 found that nearly one in five deaths in children under five is attributable to malnutrition.\(^6\) However, the infant mortality rate reduced from 117 to 72 per 1000 and the under 5 mortality from 194 to 111 over the same period, possibly linked to improved immunization coverage.\(^7\)

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\(^1\) A 2007 Gallup Poll (published in the New Democrat, 7 March 2008, Monrovia) reported 68% of Liberians said the 2005 elections were fair and 74% of Liberians have confidence in the Government, both figures significantly above the West African sub-regional average;

\(^2\) A national census will take place from March 2008, with final results expected by 2010;

\(^3\) It seems difficult to determine the health service delivery coverage in Liberia. Several presentations state it to be 40% but nowhere is clarified where this is based on. This appears low, given other findings.

\(^4\) Ministry of Health & social Welfare’s (MoHSW) Rapid Assessment of the Health Situation in Liberia, 2006;

\(^5\) This rate reflects the maternal deaths during the 7-year period before the survey. However a 2007 reproductive health survey in Lofa county (see: UNFPA, USAID, JSI and CDC et al, “Women’s reproductive health in Liberia- The Lofa County Reproductive Health Survey January-February 2007”) concluded that of the recent deliveries almost 50% took place at home without a skilled medical person attending. Furthermore, over 75% of the women reported complications during recent pregnancies, whereby 20% of them did not seek medical help, highlighting again the potential scope of the problem.


\(^7\) MoHSW/AED/World Food Programme, Nutrition Policy Analysis using PROFILES: Investing in Nutrition to Reduce Poverty.

\(^8\) In 2005 WHO immunization monitoring had reported improvements with DPT-3 at 87% and measles at 94% as reported in the 2007 MoHSW National Health Policy on p.9-10
Despite these figures, the Government of Liberia, through its Ministry of Health & Social Welfare (MoHSW), has made important progress towards improving the situation. A comprehensive National Health Policy and Strategic Plan were developed in 2007, which prioritize provision of a Basic Package of Health Services, rebuilding infrastructure and investing in human resources for health. The principle challenge in the health sector will be implementation of the Policy & Plan in a context where an overwhelming majority of services are dependent upon support from NGOs and FBOs.

1.3. Previous Research
The critical role of NGOs in Liberia was highlighted in a 2005 Liberia Interagency Health Report in which a ‘grim picture was painted of a population emerging from fourteen years of conflict in a situation which is not much better,’ as humanitarian funding was uncertain and neither development funds nor partners were ready to participate in the transition from relief to development. Amongst others things, it strongly recommended improving coordination, strategic planning, and delivery of an essential package of basic services at the primary care level. Subsequent to that 2005 Interagency Report, a Rapid Assessment of the Health Situation in Liberia was carried out in 2006 by the Ministry of Health and Social Welfare exploring management and level of resources available at health facilities, which lead to the development of the strategic health plan. A follow-up Interagency Health and Nutrition mission was carried out in December 2006. That report recognized the progress made in policy and planning but that also highlighted a pending transitional funding gap for health service provision and the need for donors to make increased and better coordinated commitments to funding health. This report sheds light on what has happened since with respect to the health sector in the transition of relief to development funding.

2. Trends in funding support to the health sector
2.1. The transitional funding gap has been avoided
To determine the status of health sector funding in the transition from relief to development, semi-structured interviews were held with a wide range of key stakeholders involved in the health. The aim of the interviews was to learn whether the funding gap for health service provision that was anticipated in 2006 actually occurred, thereby indicating the level of aid effectiveness experienced in Liberia during the transition. Major donor contributions to the health sector between 2005 and 2009 were also investigated to corroborate the findings of stakeholder interviews.

Table 1 presents the funding levels to the health sector between 2005 and 2009. In purely monetary terms, it is clear that health funding has not decreased during the transition from relief to development.

Table 1

12 The table above does not include all sources of funding. For purposes of presenting the health system funding over time, only major donor contributions and Liberian government funding is included. Known 2007/08 health funding includes at least $83 million USD from major and minor donors, international agencies, philanthropic organizations and NGO private funds, in addition to the estimated $20 million USD derived from individual health expenditure (MoHSW 2008 & WHO 2006). The 2006 USAID Health Funding level is estimated.
The stakeholder interviews confirmed that there has not been a reduction in health funding and revealed the importance of the Washington Partnership Forum held in early 2007. At a side-bar meeting to the Forum, the Minister of Health and Social Welfare, Dr. Walter T. Gwenigale, presented a compelling picture of what would happen if NGOs and FBOs, supporting 77% of the service delivery in Liberia, where to scale down due to reductions donor funding. The Minister explained that the Government of Liberia was not yet in a position to assume full stewardship of service provision in Liberia. This resulted in the extension of ECHO funding to its existing partners and increased contributions by Irish Aid and DFID to the health sector, as indicated in Table 1.

The advocacy undertaken by NGOs and the support provided by donors to assist the MoHSW to raise the alarm during the Forum are thought to have played an important role in avoiding the health funding gap, as was the decision by the Minister to request NGOs and donors to continue their support for at least another two years. The importance the international community assigns to Liberia, as evidenced by the commitments made at the Partners Forum, was highlighted by one donor interviewed:

“...internationally the government is well regarded with good reformist credentials. Important, not only to Liberia but to the wider post conflict scene in Africa, that they should succeed rather than revert back to conflict. This would have repercussions on wider Africa but also on the region as it was seen that e.g. there could also not be peace in Sierra Leone without peace in Liberia, as well as other neighbouring countries.”

With the continuation of funding, health service delivery has continued in largely the same manner as during 2005 and 2006; health facilities provided services with external support from FBO and NGOs. There were, however, interruptions to the grant agreements between some NGOs and their donors. One NGO mentioned a three-month delay in receiving funding during the period directly prior to the Washington meeting, when presumably donors were taking a ‘wait and see’ approach, after which funding came through relatively quickly. Several other NGOs mentioned experiencing substantial delays in receiving funding during previous years; funding USAID, Global Fund and CERF was mentioned as having been slow to materialize. However, no delays affected the actual delivery of health services, while activities such as training were sometimes temporarily suspended.

The fact that Liberia was not successful for round 6 of malaria and TB proposals under GFATM did result in programmes coming to a halt. While the malaria program bridged activities withsupport from the President’s Malaria Initiative as well as other discrete funding arrangements, the TB program experienced major problems and had to scramble to find TB drugs for those already undergoing treatment. Fortunately a small German foundation was
willing to support provision of drugs, but the TB program was quite affected by the funding gap and continues to have inadequate resources.

The withdrawal of MSF Holland and France from Liberia in the beginning of 2007 resulted in the handover of primary health care clinics they were supporting to other NGOs. Most NGOs said this handover had been discussed months in advance. For some organizations it was no problem to assume support for these additional clinics, while another organization mentioned that this was just before the Washington Partners meeting when they were faced with insecurity on the continuation of funding for their own program. The subsequent funding provided by ECHO, DFID and Irish Aid, following the Washington meeting ensured the continued support to the clinics.

However, MSF’s withdrawal from several secondary health care facilities in 2005-2006 has been highlighted as causing gaps in referral service delivery. Two important hospitals providing referral services in Monrovia were handed over to the MoHSW. Redemption hospital was handed over to the MoHSW for ongoing management, while Mamba point hospital (an interim, 100-bed hospital established by MSF during the conflict) was incorporated into the existing national tertiary hospital, JFK. When interviewed, the MoHSW expressed that at that time they were unable to provide the required level of funding and drugs to ensure the service delivery would not be affected. It was reported by both the Ministry and NGO representatives that the situation has improved at Redemption hospital since MSF withdrew.

2.2 Has the transition been delayed?

It is plausible that the extension of support to the humanitarian agencies for a further two years has potentially just delayed the transition from relief to development. But discussions with the main donors revealed a general commitment to ensure no health service funding gap will occur:

- As it is essential under the European Development Fund (EDF) to have a reliable counterpart willing to participate in the oversight of the fund, the 9th round of the EDF did not provide funding to the Liberian health sector (the transitional government was not willing to discuss long-term health plans). In light of this and the persistent humanitarian need in many areas, the European Commission has extended its humanitarian funding in Liberia, at the same level and through ECHO until June 2009. The importance of ensuring a gap will not materialize as a result of the shift from ECHO to EDF funding was made clear during the interviews. Both the EC and the ECHO in-country representatives expressed the strong desire to ensure overlap between ECHO funded projects and the 10th EDF, which will come on stream in 2009 (potentially through pool fund, see section 3.2).

- DFID and Irish Aid have both continued and increased their funding to the NGOs supporting the health sector since 2005, but are planning a gradual shift from direct project aid to a more developmental approach. Both expressed intent to fund health through the pooled fund in order to increase MoHSW stewardship. DFID funding to NGOs is currently following an 18-month cycle that finishes at the end of 2008 and they are discussing new arrangements to provide long-term assurances of support. DFID said it is intending to change its approach from bi-lateral to tri-lateral with future agreements being made between MoHSW, DFID and the NGOs. Irish Aid will follow DFID’s approach.

- USAID also expressed its commitment to ensuring continuity between OFDA and USAID supported health services. In the second quarter of 2008, USAID will launch a Request For Applications (RFA) for continued support to at least the 71 clinics previously supported by OFDA, as well as to strengthening professional training for health workers.

- With support mainly from the USBPRM, UNHCR has been providing funding to three local NGOs to support about 60 clinics. UNHCR is winding up their activities at the end of 2008 and is unsure who will assume responsibility for the clinics they support. UNHCR felt that MoHSW does not have the current capacity to take on this responsibility, based on pilots of handovers done in Nimba last year, when medical staff were not put on government payroll and essential drugs and medical supplies were lacking several months after the handover. However, those BPRM/UNHCR facilities within counties where USAID will be supporting will be included in the upcoming RFA. In addition, funds are also being solicited through the current Critical Humanitarian Gaps Appeal, launched by the UN in March 2008.

to continue supporting the remaining BPRM supported facilities that are not in counties where USAID will be supporting.

- GFATM continued support since 2005 and has increased its contributions for 2008, significant funds have also been allocated for 2009 and beyond. The primary recipient and grant funds manager is UNDP but this responsibility will begin transferring over to the MoHSW in June 2009.

Table 2 further demonstrates that a further shift from relief to development funding is anticipated during 2008/2009. It also reveals that overall increases in health sector funding show in Table 1 can be attributed to increases in development funding.

<table>
<thead>
<tr>
<th>Shift From Humanitarian to Development Funding</th>
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<tbody>
<tr>
<td>Millions USD</td>
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<tr>
<td>2007/8</td>
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<tr>
<td>$10</td>
</tr>
<tr>
<td>$20</td>
</tr>
<tr>
<td>$30</td>
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<td>$40</td>
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<tr>
<td>$60</td>
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<tr>
<td>$70</td>
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</tbody>
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It is important to note that from the 07/08 to 08/09 GoL fiscal years the amount of resources available for health service provision will not decrease, provided pool funds are used for health service provision. Contracting out to NGOs will be piloted in the coming months and may, if successful, be a means of continued provision of health services with NGO support, through the pooled fund. However, the Health Minister noted that this might only be a short-term solution while the question remains on the long-term sustainability of services when funds available are lower or unsure.

Many of the NGOs highlighted that at this stage it is unclear to them how exactly the transition from relief to development funding will affect them. Some NGOs mentioned that donors have requested them to provide an exit strategy in the upcoming year, whereas others noted that the MoHSW had expressed not being able to take on the support role provided by NGOs for another five years. What is lacking is a disseminated, operational plan on how support to the health services, including secondary health services, will be sustained so as to ensure appropriate levels of care in the long-term. This needs to be based on a sound health facility coverage strategy.\(^{15}\) The necessity for the latter, so as to ensure an equitable health service delivery, is also highlighted in the 2007 Basic Package of Health and Social Welfare Services plan\(^{16}\) and is recommended to be developed as soon as possible.

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\(^{14}\) Table 2 does include all known sources of health financing in Liberia, except estimated out of pocket payments.

\(^{15}\) It is difficult to determine current health service delivery coverage. Several presentations state it to be 40% but nowhere is clarified where this is based on. The recent United Nations “Critical Humanitarian Gaps in Liberia: 2008” names 41% and refers to the 2007 LDHS, but the LDHS preliminary report does not seem to contain information on health service delivery coverage. This same report finds the Antenatal Care coverage to be 79%, which gives the impression that 41% health service delivery coverage is rather low. Especially, given that 30% of the population is living in Monrovia whereas NGOs are supporting health services in each county.

The handover of the responsibility for supporting clinics (e.g. paying staff, supervision, supplying medicines) from NGO to MoHSW responsibility can consider a phased approach, e.g. handover of several clinics in each county or a subsequent handover of the different counties to the MoHSW. It should be supported by focused capacity building and institutional strengthening over the coming years. The contracting approach, if deemed successful, can support this process. Such a strategy will provide clarity to the role of all actors involved in the service delivery as well as those (intending to) providing technical assistance and capacity building. Moreover, it will allow the MoHSW to guide this handover process rather than depend on the withdrawal or transition from relief to development funding of individual donors.

The support of donors and NGOs to the development of such an overall handover strategy is vital. Special consideration should also be given to the role local NGOs and FBOs are to play in service delivery, especially as many of them will be active in Liberia long after international agencies have departed.

The withdrawal of actors contributing to secondary health services also needs to be taken into consideration. MSF delivers hospital services in Monrovia and Nimba and the different sections intend to depart during 2008-2009. In addition, the impact of the scaling down of UNMIL needs to be factored. While they are not a traditional health service provider, UNMIL has been providing some health services as well as logistic support (roads and infrastructure are still a problematic in many areas). A County Health Officer interviewed, described how the Pakistani medical contingent assists in the hospital, providing services such as dental care and X-rays as well as electricity 24 hours a day.

2.3 Resource allocation of health funding and per capita spending

While there has been a quadrupling of funding for vertical projects in Liberia, Table 3 below further demonstrates that the per capita spending on health services has not decreased during the transition.

<table>
<thead>
<tr>
<th>Year</th>
<th>$US Dollars Spent Per Person</th>
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<tbody>
<tr>
<td>2005</td>
<td>3</td>
</tr>
<tr>
<td>2006</td>
<td>3</td>
</tr>
<tr>
<td>2007</td>
<td>9</td>
</tr>
<tr>
<td>2008</td>
<td>15</td>
</tr>
</tbody>
</table>

Change in Vertical vs. Overall Health Spending

With 65% of vertical project funding directed in 2008 at malaria control, it can be argued that additional health resources are being targeted at traditionally leading causes of morbidity and mortality in sub-Saharan Africa. During interviews, some stakeholders raised concern about

17 MSFB is committed to continue support to Island hospital (with 77% of the pediatric beds) in Monrovia until 2009. MSF Swiss intends to handover to the MoHSW a comprehensive health facility with 34 beds in Nimba in July 2008; while there are NGOs interested to provide additional support, funding has not yet been secured. MSF Spain provides MCH services from a (private) hospital in Monrovia where and may withdraw its support at the end of 2008.

18 The vertical project funding included is GFATM & PMI. Clearly delineated health system strengthening (HSS) makes up less than 10% of the vertical funding indicated; however, Liberia will submit for HSS under GFATM Round 8 for HIV.
23% of vertical funding being allocated to HIV whilst prevalence is generally low, according to the 2007 DHS, as well as with funds being spent more on treatment than prevention.

A critical factor to bear in mind when analyzing the per capita spending in Liberia is that, whilst it surpasses other West African countries, it does not include the full cost of reconstructing the health system; comparatively little of the overall health spending is on reconstruction of vital health infrastructure or on long-term human resources development. High reconstruction costs were conservatively estimated in the costing of the National Health Plan, leading to inconsistencies between estimated implementation costs and actual health spending. In Table 4 we see that the estimated total 2007/8 health expenditure in Liberia is twice what was projected and may exceed minimum Millennium Development Goal targets.

### Table 4

<table>
<thead>
<tr>
<th>Source of Funding</th>
<th>National Health Plan Estimate (US$ million)</th>
<th>Actual (US$ million)</th>
<th>Actual US$ per capita</th>
<th>% of total expenditure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Government</td>
<td>10</td>
<td>15</td>
<td>5</td>
<td>14%</td>
</tr>
<tr>
<td>Out of Pocket20</td>
<td>4</td>
<td>20</td>
<td>6</td>
<td>18%</td>
</tr>
<tr>
<td>All Donors &amp; Foundations</td>
<td>40</td>
<td>76</td>
<td>24</td>
<td>68%</td>
</tr>
<tr>
<td>Total</td>
<td>54</td>
<td>111</td>
<td>35</td>
<td>100%</td>
</tr>
</tbody>
</table>

However, the preliminary findings of the recent DHS21 reveal the health needs are still high. The fact that this cannot be reliably substantiated by other comprehensive mechanisms for monitoring health statistics highlights the importance of developing a Health Information Management System, allowing evidence based planning and management of the health system. Even the implementation of the Basic Package of Services designed for Liberia will not address all health needs as it prioritizes activities based on criteria such as the impact on morbidity and mortality as well as the likelihood of carrying out the services in light of available resources. As a consequence, the focus is mostly on primary health care and important (post-conflict) health activities, like mental health, have been made less of a priority for the time being.22

As mentioned, merely focusing on the gap in the service delivery (post conflict) may not be reflective of the needs in a post conflict country. Many of the health facilities and support services are below standard or non-operational. The Health Minister highlighted the need for staff with management experience and donor fund management experience. The demand for such capacity and the strengthening of institutions is likely to be even larger due to the policy to decentralize responsibilities to the counties in Liberia. A County Health Officer described the positive developments since the current government is in office, such as funds coming available and regular supplies of items like fuel and staff incentives. The need for further improvements was made as requests for funds to pay for other services such as vehicle maintenance have been experiencing significant delays at central level, consequently hampering referral and supervision activities and continuing the reliance on INGOs support.

3. Aid effectiveness in the health sector

3.1. Alignment and changing approaches to health funding


20 Although user fees are officially suspended, informal payments are widely charged. A WHO report, “Review of Health Financing Situation in Liberia,” 2006 estimates out of pocket and private sector annual health spending at close to $20 million USD.


Several of the donors and UN agencies expressed that, while recognizing that emergencies occur in Liberia, it is right to talk about a transition from relief to development, as the balance of attention has to shift away from emergencies to development objectives. The transition is not working perfectly as the government has such huge capacity challenges and institutions are not necessarily in place; however, the approach has changed to more engagement with government. The Liberia Reconstruction and Development Committee (LRDC) highlighted though that:

“Aid effectiveness is still a challenge as the international community has run Liberia as a government for so long, it is hard to take it back. There needs to be recognition that government provides leadership. The issue of capacity challenges is often mentioned but it is not always clear how this is built by the actors involved.”

Progress is being made, as an overall poverty reduction strategy will be implemented for Liberia from mid-2008, donors do support the national health plan, and NGOs write proposals based on the objectives of the plan and how they can contribute. And Policies developed by the Ministry are increasingly guiding the decision making process. One example being the Basic Package of Service, which has led to a more integrated approach to health services, countering the increase in disease focussed funding. Some resource tensions exist though, as all humanitarian service provision funding continues to be channelled to NGOs and the current focus is still largely on service delivery, whereas the MoHSW feels there is a need to also ensure that infrastructure development, systems and capacity building are prioritized as well.

The national health plan reflects these needs by focusing on human resource development, infrastructure destruction and strengthening of support systems. It was highlighted by donors, however, that the National Health Plan has areas that require further work with respect to realistic costing and realistic timeframes. This strengthening is seen as a precondition by most of the development donors, such as EC and DFID, before a sector wide approach could be initiated. It also requires discussions and a review of the relationship between the MOH and partners (incl. NGOs, private sector and FBOs) to ensure a coherent and coordinated implementation. Coordinated implementation is a challenge that requires a certain ability of the MoHSW to lead, an issue of debate amongst stakeholders. Several of those interviewed stated that while there is significant information sharing with the Ministry, real coordination is still lacking; conversely, INGOs continue to use parallel coordination mechanisms.

Continuous Technical Assistance to the MoHSW on health issues has been provided mainly by the Clinton Foundation. While specifically focusing on HIV, they have provided significant support to the MoHSW in other areas by filling gaps in capacity building identified by the Ministry, sometimes as a result of delays in assistance planned to be provided through other projects. This underscores the importance of experienced institutional strengthening advisers being mobilized to provide timely support to a post conflict country, and not only at central level, but also at county level given the intended decentralization.

The Government of Liberia and the MoHSW are in favor of budget support but realize that most of the donor partners are waiting until fiduciary concerns have been mitigated. The UN explained it had offered to establish a MDTF for social services, but the GoL declined, expecting that it would be too slow. Nevertheless, main development donors are interested to move away from a project approach with high transaction costs, and this has led to the development of a pool fund for the health sector. Most interested donors will initially have a two-track approach with continued direct funding to NGOs while making contributions to the pool fund. USAID is not in a position to take part in the pooled fund due to restrictions on co-mingling of US Government funds, it will instead contract to NGOs and external companies through competitive bidding processes. Both the EC & World Bank have indicated that future health funding will be channelled through the pool fund, explaining why in Table 5 there is an increased amount of funding ‘on budget’ as well as an increase in funding to ‘projects’.

Table 5
3.2. The health sector pool fund in Liberia

As Table 2 indicates, Section 2, over $100 million USD is projected be spent on health in 2007/8 from over twenty different sources. Such a large number of health financing actors presents an enormous coordination challenge for the MoHSW and risks high inefficiency. After engaging in a participatory exploration of potential aid mechanisms, the Government of Liberia decided to support the establishment a supervised basket or ‘pool fund’ in the health sector. A supervised pool fund has two principle purposes in the current context: 1.) to increase alignment with government policy and plans, reinforcing the stewardship role of the MoHSW; 2.) to reduce the time and effort the Liberian government must spend managing multiple streams of support, reducing transaction costs and improving efficiency. Pool fund ‘oversight’ addresses concerns about premature provision of general budgetary support and provide satisfactory fiduciary risk assurances to potential contributing donors.

The pool fund was established in March 2008. The United Kingdom’s DFID agreed to play the role of a ‘lead donor’ for the pool fund and made an initial contribution of $8 million USD. Other donors that have expressed interest in using the mechanism, provided it functions well, include Irish Aid, GAVI and the European Commission. In its capacity building role within the Ministry of Health’s Office of Financial Management (OFM) and through its existing contract with DFID, PricewaterhouseCoopers has been engaged to receive funds into a co-signatory accountseparate from the GoL funds and oversee their disbursement. The pool fund mechanism functions with a lead donor, contributing donors and a fund management function in the OFM, with the MoHSW proposing allocation priorities consistent with the National Health Plan for endorsement by a Pool Fund Steering Committee (a joint donor, MoHSW committee). This allows for a flexible use of the funds, based on information about needs as it becomes available, especially important during this time of transition and reiterated by many stakeholders. The OFM disburses funds and reports on their use.

This pool funding is a possible interim step on the path to budget support. The lifespan of the pool fund will therefore be influenced by progress made towards financial transparency and governmental accountability. GoL hope they will have made sufficient progress in strengthening their public financial management systems to qualify for direct budget support over the next two to three years. Failing this, it is possible that the MoHSW will have made sufficient progress in financial management strengthening to be a candidate for direct sectoral budget support by the end of the OFM project (mid 2009). Therefore the initial lifespan of this pool fund will be around three years.
**Aid predictability**

Table 6 highlights that there is little long-term insight into donor pledges. Of the major sources of health funding, currently only Global Fund and USAID funding levels are known beyond 2009. This results in challenges for longer term planning for the health sector. The Minister stresses the importance of this predictability as: “an investment of $34 p.p would require about $118 M a year, which constitutes 50% of the total government budget. Hence, outside help is needed for a long time to come.”

<table>
<thead>
<tr>
<th>Year</th>
<th>Liberia Health Funding Levels</th>
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<tbody>
<tr>
<td>2005</td>
<td>10</td>
</tr>
<tr>
<td>2006</td>
<td>20</td>
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<tr>
<td>2007</td>
<td>40</td>
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<td>2008</td>
<td>60</td>
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<tr>
<td>2009</td>
<td>80</td>
</tr>
<tr>
<td>2010</td>
<td>100</td>
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</table>

Major sources of health funding only, including GoL but excluding out of pocket payments;

It is important to note though that donor pledges do not necessarily provide predictability as, according to the LRDC, a UNDP study carried out in Liberia in 2006 showed that only 40% of what was pledged in 2004 was actually disbursed and spent. The LRDC is currently trying to gain insight into donor’s commitments over the coming three years and, while it has been difficult to get data, they would rate the cooperation of donors at 3 on a scale from 1 to 5. In preparation for the Accra High-Level Forum meeting, the LRDC is also involved in compiling the results of the Paris Declaration surveys to assess progress and identify obstacles and opportunities to improve aid effectiveness in the country.23Through a formula based on economic recovery indicators and based on a theory that States require external assistance until they can independently finance the basic service entitlements of its citizens, the Centre for Global Development have recently estimated that donors should not expect to disengage from Liberia until 2018.24

The United Nations is in the process of launching a Critical Humanitarian Gaps Appeal requesting $28M for Liberia. Rational for the report includes:

“...as is often the case in transitional situations, resource mobilisation for development is subject to delay, and adequate funding for the PRS and UNDAF will take time to come on line. In the meantime, resources are needed to ensure that the critical humanitarian gaps and needs of highly vulnerable communities during this important transitional period are addressed...Liberia has relied mainly on the support of international humanitarian organisations to provide basic social services, many of which have closed operations or are scaling back in light of reduced funding. The situation in Liberia is a reminder that the international community has yet to come to grips with the humanitarian-to-development gap.”25

This contrasts with Tables 1 & 2, Section 1, with respect to funding flows for health to Liberia and interviews conducted with stakeholders that largely indicate basic service provision continuity and that little or no health services interruptions as a result of funding. However, NGOs supported through the UN with funding from CERF and USBPRM are potentially at risk, if pool funding is not be allocated to ensure clinics they support remain open. The appeal indeed asks for $1.5M to maintain this support.

Approximately $4M of the appeals $7M requested for health are for the UN to implement activities such as emergency response to epidemiological diseases, immunization campaigns, and distribution of reproductive health kits. These are important activities, but the importance of health system strengthening to ensure their sustainability has been highlighted during interviews. Less than $1.5 M is allocated to extend the health service delivery coverage, through the support of an additional 6 clinics in Rivercess county, the reopening of a health centre in rural Montserrado county, as well as addressing maternal health needs by increasing emergency obstetric care in three counties. Sustainability of all these activities still needs to be considered as any funding from the appeal will be for maximum 1 year. UN appeals for Liberia in 2007 were funded to only 62% and health received only 29% of what was requested in 2007 and only 13% in 2006. Several stakeholders expressed the risk of duplication due to the unpredictability of such funds, begging the question if this is the most reliable funding mechanism to be used for the health sector in a transition period.

### 3.3. Harmonization of aid

Speaking to stakeholders, it became evident that many times before people have come to visit asking questions; most of the time to do assessments, sometimes to carry out studies. The impact on the Ministry, with rather limited capacity, will also be significant. One person said:

“There are 1000 duplicating assessments, including yourself, e.g. EC capacity assessment, health assessment, USAID assessment of training institutions, someone who looked at what capacity was needed in clinics, a Harvard medical team looking at capacity. There is no info sharing going on, all ask the same questions.”

Donors did seem to recognize this. The effect of USAID’s competitive approach with an upcoming RFA has also led many, especially USAID funded organizations to come and in anticipation of funding that will become available.

While there may be duplicating assessments, donors have been able to coordinate to prevent duplication in implementation, examples include: the MoHSW financial management system strengthening which was initially intended to be done by USAID but taken on by DFID; or the importance that the EC attributed to developing a health information management system as soon as possible, but at the same time recognizing that this was something USAID was intending to carry out. However, the lengthy approval processes of donors can sometimes cause delays. USAID explained, for example, that it can take 1 year for plans to materialize due to lengthy approval mechanisms. There may be scope for discussion amongst donors to not only ensure duplication is prevented but also to coordinate which donor is best positioned to provide certain services in the shortest timeframe possible, so as to allow the starting of essential activities such as capacity building or urgently needed system strengthening as soon as possible.

The provision of a Technical Adviser to the Planning, Research & Development Department of the MoHSW, in support of international aid coordination and resource mobilization, was highlighted by several donors as having been very beneficial in providing insight into resources.

### 3.4. The effectiveness of aid

None of the stakeholders interviewed was aware of any evaluation undertaken of the effectiveness of aid in Liberia. LRDC has some intention to do this some time in the future, once donor tracking is further established. Most implementing agencies carry out project evaluations, often depending on donor requirements. Some donors expressed an interest in joint evaluations in the future.

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3.5. Recommendations for Liberia

- An operational plan, based on sound health facility coverage strategy, should be developed to accompany the National Health Plan in order to ensure continuity of health services, including secondary health services, during the transition. Consideration should be given to the role (local) NGOs and FBOs will play in the overall service delivery. The transition of responsibility for supporting clinics (e.g. paying staff, supervision, supplying medicines) from NGO to MoHSW should be included. A phased approach could be followed which would allow focused capacity building and institutional strengthening. The contracting approach, if deemed successful, could support this process. Such a plan will provide directional clarity to all actors involved in service delivery and allow the MoHSW to guide this transition process, rather than depend on funding flows and decisions from individual donors. The support and participation of donors and NGOs to the development of such an overall handover strategy is vital.

- A follow up to this study recommended to be carried out in 2009 to evaluate whether the transitional funding gap has been merely delayed or completely avoided. This will further allow the development of an evidence base on transitional issues.

Overall lessons learnt, based on Liberia case study:

- Consideration needs to be given whether it is beneficial to carry out appeals during times of transition from relief to development funding, given they are demanding to prepare but have a limited return and as such do not seem a reliable funding mechanism to be used for the health sector in a transition period.

- Enhanced coordination is recommended amongst donors to not only ensure gaps and duplication are prevented, but also to coordinate which donor is best positioned to provide certain support in the shortest timeframe possible, so as to allow the starting of essential activities such as capacity building or urgently needed system strengthening as soon as possible.

- The provision of a Technical Adviser in support of international aid coordination and resource mobilization was highlighted by several donors and the MoHSW as having been very beneficial.