OBJECTIVES OF THIS SESSION

• **Share** progress on Liberia’s new CHW program and challenges in medium-term finance

• **Discuss** the approach and thinking on how to solve for these challenges that was used in Liberia

• **Gather input** from others facing similar challenges and discuss what works

This presentation was prepared by the Liberia Ministry of Health, Financing Alliance for Health, and Last Mile Health

- Roland Kessely, Director, Health Finance Unit, Liberia Ministry of Health
- Nan Chen, Deputy Director, Policy & Public Partnerships, Last Mile Health/Financing Alliance for Health
• Liberia’s Community Health Assistants

• Review of Health Fiscal Space
• Financing Alliance Project and Approach
• Recommendations
• Next Steps and Discussion
### THE PROBLEM: POOR NATIONAL HEALTH OUTCOMES

<table>
<thead>
<tr>
<th>National Indicators</th>
<th>Liberia</th>
<th>Ethiopia</th>
<th>USA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternal Mortality per 100,000 live births</td>
<td>1,072</td>
<td>420</td>
<td>28</td>
</tr>
<tr>
<td>Under-5s Mortality per 1,000 live births</td>
<td>94</td>
<td>64</td>
<td>7</td>
</tr>
<tr>
<td>Infant Mortality per 1,000 live births</td>
<td>55</td>
<td>43</td>
<td>6</td>
</tr>
<tr>
<td>Neonatal Mortality per 1,000 live births</td>
<td>25</td>
<td>29</td>
<td>4</td>
</tr>
<tr>
<td>Malnutrition Prevalence (% of children under 5)</td>
<td>15%</td>
<td>25.2%</td>
<td>0.5%</td>
</tr>
<tr>
<td>Life Expectancy at Birth (years)</td>
<td>61</td>
<td>64</td>
<td>79</td>
</tr>
</tbody>
</table>

Source: World Development Indicators, (2013)

- Even prior to the Ebola outbreak, Liberia had the 3rd worst maternal mortality rate in the world – but had been making some significant gains child health, falling to 24th worst in under-5 mortality rates globally in 2013.

- Post-Ebola, the country is now working to rebuild and recover against expected further drops in its national health outcomes.

**KEY FACTS**
- Population: 4,195,666
- Unemployment: 85%
- Health expenditure per capita: $46
- 1 health worker : 3,472 people
Nearly 1.2 million Liberians live outside the reach of any health facility (beyond 5km).
POST-EBOLA INVESTMENT PLAN FOR BUILDING A RESILIENT HEALTH SYSTEM (2015-2021)

ACCESS TO AND UTILIZATION OF SAFE & QUALITY HEALTH SERVICES

EMERGENCY RISK MANAGEMENT

APPROPRIATE ENABLING ENVIRONMENT

ESTABLISHING A RESILIENT HEALTH SYSTEM

Fit for purpose productive health workforce (including CHWs)

Re-engineered health infrastructure

Epidemic preparedness, surveillance and response

Medicines management capacity

Restored quality service delivery systems

Comprehensive information & research management

Sustained community engagement

Leadership & governance capacity

Efficient Health financing systems
FIT-FOR-PURPOSE HEALTH WORKFORCE: CHWS ARE KEY COMPONENT OF PRIMARY HEALTHCARE SYSTEM

Health Sector Investment Plan Costs (FY15/16-21/22, in millions)

- Total Rebuilding Resilient Health System Investment: $1,143,57
- Total Fit-for-Purpose Health Workforce Investment: $505,82
- NCHA Program Investment as a share of Fit-for-Purpose Health Workforce Investment: $80,95
- Total Fit-for-Purpose Health Workforce Investment: $424,87

- NCHA Program is largest component of the Health Workforce Investment
REVISED COMMUNITY HEALTH SERVICES POLICY

CHVs will serve communities <5km from health facility to conduct health promotion and referral

More than 5km from facility

CHAs serve communities >5km from health facility to provide primary health services and referral

Policy Highlights:
- CHA cadre recruited from communities
- CHA paid incentives
- CHA receive substantial pre-service and in-service training
- Service Package includes reproductive, maternal, neonatal, child, and adult health
- CHSS assigned to facilities to supervise

Less than 5km from facility

CHVs will serve communities <5km from health facility to conduct health promotion and referral
**LAUNCHING A NATIONAL CHW PROGRAM**

*National Community Health Assistant* Programs aims to deploy over 4,000 CHAs to serve the 1.2 million Liberians who live more than 5km from health facility.
• Liberia’s Community Health Assistants

• Review of Health Fiscal Space
  • Financing Alliance Project and Approach
  • Recommendations
  • Next Steps and Discussion
LIBERIA SPENDS MORE ON HEALTH COMPARED TO THE AVERAGE FOR LOW-INCOME COUNTRIES

Source: WB, WDI Database, October 2016
HEALTH EXPENDITURE HEAVILY EXTERNAL, BUT GOVERNMENT SHARE INCREASING

- High donor dependency for health service provision
- Donor support exceeded GOL support for health sector
- Households carry large burden

Liberia Total Health Expenditure

<table>
<thead>
<tr>
<th>Year</th>
<th>Public (MOF)</th>
<th>Private</th>
<th>Donor</th>
<th>Household OOP spending</th>
</tr>
</thead>
<tbody>
<tr>
<td>2007/08</td>
<td>35</td>
<td>47</td>
<td>3</td>
<td>35</td>
</tr>
<tr>
<td>2009/10</td>
<td>35</td>
<td>48</td>
<td>19</td>
<td>36</td>
</tr>
<tr>
<td>2011/12</td>
<td>4</td>
<td>79</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>2013/14</td>
<td>128</td>
<td>118</td>
<td>6</td>
<td>49</td>
</tr>
</tbody>
</table>

Source: HFU, Liberia NHA 07/08, NHA 09/10, NHA 11/12 and NHA 13/14
RESOURCES ALLOCATED INEFFECTIVELY AND OFF-BUDGET DONOR SUPPORT

Resources by County FY 15/16

- 43% of Donor Support OFF-Budget

USD ,000

Government
Donor/Partner
Per Capita Spending

Source: Resource Mapping Exercise, HFU, MOH, Oct. 2015
RESOURCES ALLOCATED INEFFECTIVELY AND OFF-BUDGET DONOR SUPPORT (CONT’D)

Resources by County FY 15/16

Source: Resource Mapping Exercise, HFU, MOH, Oct. 2015; Remoteness from DHS 2013
GOVERNMENT OF LIBERIA HEALTH FISCAL SPACE AND BUDGET TRENDS

Percent of Government Budget Spent on Health

Abuja Target 15%

… trajectory of health budget is on the right track to meeting Abuja target
GROWTH IS PROJECTED TO REBOUND, FROM 2016

Source: IMF, WEO, October 2016
GOVERNMENT OF LIBERIA HEALTH FISCAL SPACE AND BUDGET TRENDS (CONT’D)

Health Fiscal Space Estimates (millions)

Assuming:
• GOL share increase to 15% Abuja targets
• Slight decrease in external aid
• Increases in Liberia overall Govt budget

Source: Fairbanks, Alan. Fiscal Space Analysis for Health in Liberia. World Bank (Mar. 2016). Note that a more recent fiscal space analysis is pending from the Clinton Health Access Initiative
Estimated Program Costs are 80M over investment period, and 11M recurrently.

Largest cost drivers: training, supplies, salaries/incentives, commodities.

Source: LMH and FAH Analysis, *including commodities under low assumption, costs increase with higher assumptions*
MANY DONORS AND IMPLEMENTING PARTNERS ALIGNED TO LAUNCH THE PROGRAM

... but medium and long-term funding outlook still a challenge
• Liberia’s Community Health Assistants
• Review of Health Fiscal Space
• **Financing Alliance Project and Approach**
• Recommendations
• Next Steps and Discussion
PARTNERSHIP BETWEEN MINISTRY OF HEALTH, LAST MILE HEALTH, AND THE FINANCING ALLIANCE FOR HEALTH

The Goal: Recommendations for how to move forward with Financing Liberia’s National Community Health Assistant Program
THE APPROACH: VIEWING FINANCING AS AN ITERATIVE PROCESS EMBEDDED IN POLITICAL AND OPERATIONAL CONTEXT

Note: Steps may happen in parallel or in a sequence different from that described above
THE METHODOLOGY OF PROJECT

Note: Steps may happen in parallel or in a sequence different from that described above
**OUTPUT: CASE FOR INVESTMENT IN THE SCALE-UP OF THE NCHA PROGRAM**

<table>
<thead>
<tr>
<th>Healthier population</th>
<th>Societal benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Reduction of child mortality of up to 12% nationwide (12,000 under 5 lives) from just a few CHA interventions</td>
<td>• <strong>Employment of 4,000 people</strong>; many of them could be some unemployed youth and/or women</td>
</tr>
<tr>
<td></td>
<td>• Key for <strong>health security and health system resilience</strong></td>
</tr>
<tr>
<td></td>
<td>• Potential reduction of cost for patients</td>
</tr>
<tr>
<td></td>
<td>• A “voice” for the community</td>
</tr>
</tbody>
</table>

**Economic returns and long-term ROI (return on investment)**

- **Returns from:**
  - Increased productivity through lives saved
  - Increased consumption through increased employment
  - “insurance” against disease outbreaks

<table>
<thead>
<tr>
<th>Year</th>
<th>Cost (in $m)</th>
<th>Return (in $m)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>6</td>
<td>15</td>
</tr>
<tr>
<td>2</td>
<td>10</td>
<td>15</td>
</tr>
<tr>
<td>3</td>
<td>15</td>
<td>48</td>
</tr>
<tr>
<td>4</td>
<td>13</td>
<td>50</td>
</tr>
<tr>
<td>5</td>
<td>14</td>
<td>54</td>
</tr>
<tr>
<td>6</td>
<td>11</td>
<td>53</td>
</tr>
<tr>
<td>7</td>
<td>11</td>
<td>54</td>
</tr>
</tbody>
</table>

Note: Actual returns from increased productivity occur at a later time; this only models a subset of interventions. If including all CHA interventions, higher ROI is expected
OUTPUT: ESTIMATED PROGRAM COSTS

Estimated Cost of CHA Program*

Year 1  |  Year 2  |  Year 3  |  Year 4  |  Year 5  |  Year 6  |  Year 7
---|---|---|---|---|---|---
6,01  | 10,34  | 14,72  | 13,41  | 14,10  | 11,09  | 11,36

Largest cost drivers: training, supplies, salaries/incentives, commodities

Source: LMH and FAH Analysis, *including commodities under low assumption, costs increase with higher assumptions
OUTPUT: ESTIMATED RESOURCE GAP ANALYSIS

Cost of CHA Scale-Up (in millions)

- **Secured**: Signed contracts, implementation agreements, and disbursements
- **Earmarked**: Initial commitments made, but disbursement and implementation timing unknown
- **Potential**: Funding that can be reasonably unlocked, based on existing
• Liberia’s Community Health Assistants
• Review of Health Fiscal Space
• Financing Alliance Project and Approach

**Recommendations**

• Next Steps and Discussion
THREE MAIN RECOMMENDATIONS FOR THE NCHA SCALE-UP FINANCING IN LIBERIA

Recommendations

1 Set a Vision for CHA financing: Develop a financing plan to coordinate all funding actors to a common vision of financing the NCHA Program over time that is aligned and complementary to the Ministry’s larger health budget and financing strategy.

2 Establish a structure to coordinate financing that includes
   • Identifying and empowering Ministry actors and supporters to lead resource mobilization efforts; and
   • Establishing effective coordination platforms and mechanisms to align donors and implementers.

3 Unlock additional financing by
   • Maximize and renew existing funding from donors already aligned to the NCHA Program;
   • Seek out high-feasibility domestic resources in the short-term to build toward larger domestic resource allocations in the long-term;
   Explore new sources of financing that set the groundwork for sustainable financing.
SET A VISION FOR CHA FINANCING

- Illustrative vision to serve as a starting point for conversation
- In a next step, government and partners to populate the vision for the financing

CHA Investment Finance Mix (in millions)

- Existing Donor
- Additional Donor Commitment
- New/Innovative Finance
- County Funds
- Incremental Government Contribution

1 Assumes all CHSS salaries, and CHA incentives from 2020 onwards
Establish Coordinating Structure

Identify and empower Ministry actors and supporters to lead resource mobilization efforts
• Clear roles and responsibilities assigned to ministry actors
• Clarify which department or departments hold responsibility
• Bring in partner support as needed

Establishing effective coordination platforms and mechanisms to align donors and implementers
• Issue invitations from individuals with convening power
• Include all key interests and stakeholders
• Provide framework and process necessary to build and document consensus
• Establish accountability mechanisms or commitment mechanisms
UNLOCK ADDITIONAL FINANCE (POTENTIAL SOURCES)

Options (in no particular order)

A  Domestic funding
   1 County/Community health budgets
   2 Overall health sector budget (including IDA allocations)
   3 Taxes (e.g. corporate health tax for health)
   4 Cross-ministry synergies (e.g. vehicles etc.)

B  “Existing” donor
   5 Global Fund (all three diseases and HSS if there is a separate component)
   6 Gavi (HSS component)
   7 World Bank/GFF (Ebola-recovery funds and other project support)
   8 USAID (implementer funding through PACS, FARA and other mechanisms)
   9 Pool fund donors
   10 Other Bi-laterals (e.g. JICA, DFID, EU, etc.)

C  Private sector
   11 Corporate support (e.g. CR forum, community fund contributions)
   12 Revenue-generation through CHAs

D  “New” sources
   13 Disease surveillance, preparedness and global health security funding/mechanisms
   14 Unemployment, education and economic growth programs (e.g. ADB)
   15 Philanthropic outcome funders (e.g. as part of impact bonds)
ANALYSIS: PRIORITIZED FUNDING SOURCES ASSESSED BY FEASIBILITY, FUNDING AMOUNT, AND SUSTAINABILITY

- **Feasibility**
  - Process complexity
  - Time
  - Political

- **Sustainability**
  - Low
  - High

- **Likely Amount of Funding**
  - Low
  - High

1. County budgets
2. Health sector budget
3. Health tax
4. Cross-ministry in-kind
5. Global Fund
6. GAVI
7. Worldbank/GFF
8. USAID
9. Pool Fund
10. Other Bi-laterals
11. Corporate support
12. Revenue-generating program
13. Disease surveillance
14. Unemployment/education funds
15. Development Impact Bond
ANALYSIS: PRIORITIZED FUNDING SOURCES – EXISTING DONORS

Feasibility
- Process complexity
- Time
- Political

Sustainability
- Low
- High

Likely Amount of Funding

“Maximize existing donors”

1. County budgets
2. Health sector budget
3. Health tax
4. Cross-ministry in-kind
5. Global Fund
6. GAVI
7. Worldbank/GFF
8. USAID
9. Pool Fund
10. Other Bi-laterals
11. Corporate support
12. Revenue-generating program
13. Disease surveillance
14. Unemployment/education funds
15. Development Impact Bond
ANALYSIS: PRIORITIZED FUNDING SOURCES - DOMESTIC RESOURCE MOBILIZATION

Likely Amount of Funding

Sustainability
• Low
• High

Feasibility
• Process complexity
• Time
• Political

“Early steps on domestic financing”

“Maximize existing donors”

1. County budgets
2. Health sector budget
3. Health tax
4. Cross-ministry in-kind
5. Global Fund
6. GAVI
7. Worldbank/GFF
8. USAID
9. Pool Fund
10. Other Bi-laterals
11. Corporate support
12. Revenue-generating program
13. Disease surveillance
14. Unemployment/education funds
15. Development Impact Bond
ANALYSIS: PRIORITIZED FUNDING SOURCES – NEW/INNOVATIVE SOURCES

Feasibility
- Process complexity
- Time
- Political

Sustainability
- Low
- High

Likely Amount of Funding
- Low
- High

1. County budgets
2. Health sector budget
3. Health tax
4. Cross-ministry in-kind
5. Global Fund
6. GAVI
7. Worldbank/GFF
8. USAID
9. Pool Fund
10. Other Bi-laterals
11. Corporate support
12. Revenue-generating program
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14. Unemployment/education funds
15. Development Impact Bond

“Explore new sources”

“Maximize existing donors”

“Early steps on domestic financing”
• Liberia’s Community Health Assistants
• Review of Health Fiscal Space
• Approach
• Recommendations

• Next Steps and Discussion
Refine cost estimates as implementation continues and track the resource gaps and commitments in a coordinated fashion.

Identify formal forum for coordinating resource mobilization.

Convene stakeholders to develop a CHA Financing Roadmap that sets multi-year targets for donor commitments and provides a base for exploring government contribution in line with larger health financing strategy.

Develop targeted Investment Cases for the NCHA program, including exploring Innovative Finance mechanisms and program Cost-effectiveness.

Continue advocating for CHA inclusion as strategic priority in extensions of donor funding, including Global Fund and Gavi.
NC13  |  work through existing groups, maybe even up to HSCC. May not need to establish new TWG.
Nan Chen, 2017/03/21

NC14  |  or name a forum for CH, that includes people who are part the folks already
Nan Chen, 2017/03/21

NC15  |  Create TOR
Nan Chen, 2017/03/21

NC16  |  High opportunity within the concessions
Nan Chen, 2017/03/21
ONGOING HEALTH FINANCING SUPPORT TO NCHA PROGRAM FROM PARTNERS

- Ongoing assessment of commitments and resource needs
- Investment case drafting

- Work with MOH to plan for long-term investment for CHA system

Policy and Costing
- Updating costing as new information is received through implementation

Investment Case
- Prioritized sources of financing identified
- Assessing new and innovative sources of financing
- Work with MOH to advocate for CHA allocations

Resource Gap Analysis

Resource Mobilization

Financing Plan
DISCUSSION

1. How does this process compare with what’s been tried in your context?
2. What improvements would you recommend?
3. What additional assessments would you do?
4. What are the biggest challenges you see in your own countries?
5. How can we take steps toward increasing sustainability?

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THE APPROACH: VIEWING FINANCING AS AN
ITERATIVE PROCESS EMBEDDED IN POLITICAL
AND OPERATIONAL CONTEXT

Political Prioritization

Strategy, policies, costing
The case (incl. ROI)
Financial gap analysis
Identification sources of financing
Finance/investment plan

Operational Enablers

Note: Steps may happen in parallel or in a sequence different from that described above
## Assumptions

<table>
<thead>
<tr>
<th>Input</th>
<th>Assumption</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ratio</td>
<td>CHA to Population (1:350); CHSS to CHA (1:10); No Peer Supervisors</td>
<td>Revised Policy</td>
</tr>
<tr>
<td>Training</td>
<td>Each training is $200. CHAs are trained 4 times during first year of deployment. Afterwards there are yearly refresher trainings. Attrition rates at 5%. Training Failure rates are assumed to be 10%.</td>
<td>LMH Programs provided $150/training + $50 contingency.</td>
</tr>
<tr>
<td>Equipment</td>
<td>$407/CHA/Year</td>
<td>LMH Ops</td>
</tr>
<tr>
<td>Commodities</td>
<td>$115/CHA/month</td>
<td>LMH Ops</td>
</tr>
<tr>
<td>Vehicles</td>
<td>Land Cruiser is $50,000 + $700/month fuel and maintenance; Motorbike is $3,000 + $50/month fuel and maintenance</td>
<td>LMH Ops</td>
</tr>
<tr>
<td>Population</td>
<td></td>
<td>Liberia 2008 Census + LMH Analysis</td>
</tr>
<tr>
<td>Coverage</td>
<td>Starting from 0% to 100% in all 15 counties</td>
<td>Based on funding commitments by other implementing partners</td>
</tr>
</tbody>
</table>