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# Liberia National Health System Capacity Assessment

## County Report: **MONTSERRAT**

September 26, 2023

*The authors' views expressed in this report do not necessarily reflect the views of the United States Agency for International Development or the United States Government.*

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# Montserrado County Profile

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Montserrado County is located in northwestern Liberia and hosts the country's capital city, Monrovia. The county was established in 1847 upon the foundation of Liberia and is considered the country's oldest, with Bensonville City as its capital. Montserrado County is bordered by Margibi to the east, Bomi to the west, Bong County to the north, and the Atlantic Ocean to the south. According to the 2008 national census report of the Liberia Institute of Statistics and Geo-Information Services, Montserrado is the most populous county in Liberia with 1,118,241 people.[1]

The county is subdivided into two statutory districts and further subdivided into six health districts for healthcare governance, supervision, and health system strengthening purposes.[2]

Farming is the primary economic activity for rural inhabitants, while the primary sources of income for residents of Greater Monrovia come from informal, small-scale trade, non-governmental organizations (NGOs), and government employment. Furthermore, the county hosts the largest markets in the entire country, which include Red Light, Duala, and Waterside.[3] Monrovia and Paynesville Cities host all the international NGOs, donor partners, United Nations agencies, and other regional and international organizations.

Montserrado is ranked 13th among the 15 counties in Liberia on the Human Development Index of the country, with a score of 0.420.[4] The county operates both public and private school systems. Public schools are expected to be free with minimal cost for registration, while private schools' students are expected to pay school fees. The county has the largest number of high schools in Liberia: 138 faith-based high schools, 24 public high schools, 8 community-owned high schools, and 197 private high schools.[5]

The county host the six top universities in Liberia. Montserrado County is densely populated, with large slum communities that include West Point. The county is further challenged by environmental degradation, coastal erosion, and a lack of public sanitation facilities, with a high prevalence of diseases such as tuberculosis.[6]

## Health Profile

Montserrado County has 40 percent of Liberia's health facilities.[1]

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The Montserrado health system is organized like the national health structure of Liberia. The County Health Team (CHT) oversees the clinical and administrative operations of the county health system and supervises the District Health Team (DHT) and Health Facility Development Committee (HFDC) at the community levels. The CHT is headed by a County Health Officer (CHO), who is advised by the County Health Board of Advisors. This structure is similar at each level of the Montserrado County health system, working in collaboration with local government and non-governmental stakeholders across all levels, and incorporate

[1] Liberia 2016 SARA and QOC Report Page 140, Annexes Table1: Health Facilities by County and Type.

them into its governance system for inclusive participation, and ownership of the health system across all levels.

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Among the health system levels, the DHT scored the highest at 83.2 percent (**functional**) in the leadership and governance domain. Facilities scored the lowest at 10.0 percent (**absent**) in the finance domain. The lower score in the finance domain was a result of a lack of a budget committee, as well as the confidentiality/limited sharing of account information. In fact, there was no documentation to verify the existence of an account. Additionally, assessors could not find copies of any bank reconciliations, and invoices/receipts were not well organized. There was no financial report to be verified, and there had been no audit visits in recent years and no procurement committee to document procurement activities.

Across all levels, public facilities scored the highest at 38.6 percent (**limited**) in the M&E domain. Private facilities scored the lowest at 3.9 percent (**absent**) in the leadership and governance domain, as a majority of Health Facility Development Committees (HFDCs) were functional in Montserrado County, especially for private facilities, so all the respondents answered "not applicable." Furthermore, all CHCs were not functional, and HFs had largely not carried out any supportive supervision.

Among all types of facilities in all levels, communities scored the highest at 60.0 percent (**foundational**) in the leadership and governance domain. Clinics scored the lowest at 5.5 percent (**absent**) in the finance domain. Across all districts in Montserrado County, Todee District had the highest mean score of 52.2 percent (**foundational**) in the leadership and governance domain. Central Monrovia District scored the lowest, with 0.0 percent (**absent**), in the leadership and governance domain.

DHTs did not have established and functional DHBs and an established Community Health Program, as in other settings, to help enhance the capacity of the leadership and governance domain.

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## Operations

The operations domain questions were developed to gauge the health system's capacity relative to a variety of key operational policies (e.g., waste management policy, information and communications technology or ICT policy, transport guidelines). [OBJ][OBJ] The operations domain includes the following subdomains: ICT, physical infrastructure, fixed assets, and stock. [OBJ]

In this domain, Montserrado County had an overall score of 26.1 percent (limited). The overall DHT score was 29.0 percent (limited), while facilities scored 25.9 percent (limited). In terms of ownership and types, private facilities scored 26.2 percent, while public facilities scored 25.5 percent. Hospitals scored 53.0 percent (foundational), health centers scored 30.3 percent (limited), and clinics scored 21.0 percent (absent).

DHTs scored the highest at 40.5 percent (limited) in one of the four subdomains (ICT) and the lowest 0.0 percent in two of the four subdomains (fixed assets and stocks). The lower scoring in the two subdomains was because of a lack of handheld radios, scanners, and printers in the facilities in the districts. Additionally, fixed asset lists were not available for verification. There was also no vehicle assigned, and there were no fleet management policies or procedures available, including the absence of stock cards.

Across all levels and types of facilities, hospitals scored highest at 71.4 percent (foundational) in the stocks subdomain, while clinics scored the lowest at 10.2 percent (absent) in the fixed assets subdomain. Among the seven districts in Montserrado, St. Paul River District scored the highest at 66.7 percent (foundational) in the stocks subdomain, while St. Paul River, Todee, and Careysburg Districts scored the lowest at 0.0 percent (absent) in the fixed assets subdomain. Central Monrovia also scored 0.0 percent (absent) in the stocks subdomain. Facilities in these districts scored low because of the absence of tablets/laptops for official use at facilities. These facilities also did not have daily waste disposal and weekly off-site medical waste disposal systems, and only trash cans were available for waste materials.

**Physical Infrastructure:** The overall county score was 34.7 percent (limited) for physical infrastructure. The CHT could not provide documentation to verify infrastructure reported as public. The team also reported two electricity sources for facilities, including the Liberia Electricity Cooperation supply in most HFs and fuel generators on standby.

**Fixed Assets:** The overall county score was 17.6 percent (absent) for fixed assets. There was no registry to verify fixed assets, such as vehicles (cars and motorcycles), printers, desks, hospital beds, and chairs. There was also no vehicle assigned or any fleet management policies or procedures available.

**Stock:** The overall county score on stock was 26.7 percent (limited). Stock with a short shelf life were placed at the front of the depot/storage. Challenges associated with insufficient storage space all contributed to the frequent reports of stock unavailability in facilities, especially public facilities in the county.

**ICT:** The overall county score on ICT was 23.9 percent (absent). The CHT reported having access to all MOH servers, but challenges with internet service stability underpinned the growth of the ICT subdomain, as most staff used personal internet to do work. Almost all of the county hospitals reported the use of available ICT equipment, such as desk phones, in all the wards for medical information only, as staff used personal phones, despite provisions for scratch cards for personal phones. At the facilities level, no ICT equipment was available for official use.

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**Finance:** The assessment of the finance domain focused on the CHT's application of the MOH Decentralization Policy and Financial Management Manual, which serve as guidance for policies on public financial management.

The overall county score for the finance domain was 11.4 percent (absent). The CHT scored 70.4 percent (foundational), facilities scored 10.0 percent (absent), and county hospitals scored 41.7 percent (limited). All other finance subdomains assessed across HF ownership and types showed absent capacities.

**Staffing:** The overall CHT score on staff was 9.3 percent (absent). The CHT reported having no CFO, Accountant, and Procurement Officer in the county. Staff taking over these roles were not knowledgeable about the MOH financial management policy and regulations.

**Internal Control:** The overall county score for internal control was 10.4 percent (absent). The CHT reported that there was no established budget committee, and the petty cash ceiling did not reflect MOH policy due to the capacity gap in the finance unit. The CHT internal audit unit was inactive, and there had been no MOH audit conducted over the past three years.

**Recordkeeping:** The CHT showed absent capacity in recordkeeping. Most financial records, such as receipts, invoices, and other documentation, were unavailable for the assessors to verify.

**Financial Reporting:** The overall county score for financial reporting was 11.6 percent (absent). The Facilities reported using QuickBooks for financial transactions; however, there was no documentation to verify them. Additionally, many private facilities and the CHT treated financial information as private and confidential, limiting assessors' access to relevant financial information.

**Budget:** The overall score for budget was 15.4 percent, placing the subdomain in the absent category**.** The CHT reported that there was no budget committee established. All other subdomains, including **procurement, supervision and monitoring, payment, audit, PBF, and accounting showed absent capacities.** For example, facilities reported that they had PBF training, and the CHT had PBF tools, but these were not implemented. The CHT also reported not having trained financial management staff at the moment.

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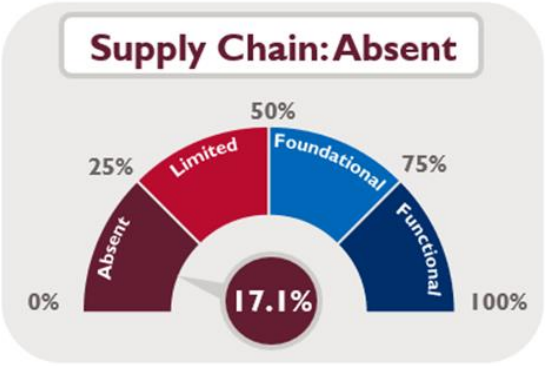
## Supply Chain




The supply chain domain questions were developed to gauge the health system's capacity relative to the MOH Supply Chain Master Plan and Standard Operating Procedures (SOPs). This domain includes the following subdomains: management, LMIS, requisitions and reporting, data analysis and use, storage and distribution, and stock availability.

**Supply Chain:** The overall county score for the supply chain domain was 17.1 percent (absent). The CHT scored 29.9 percent (limited), while health facilities scored 16.9 percent (limited). Public facilities scored 29.7 percent (limited), while private facilities scored 8.2 percent (absent). Hospitals scores were within the limited category, compared to health centers and clinics that had absent capacities. The CHT had a pharmacist in charge, but

the facilities in the districts did not have trained dispensers, leading some officers in charge (OICs) to double as dispensers.

**Supply Chain Management:** The overall score for supply chain management was 82.6 percent (functional)**.** A supply chain master plan existed; products with short shelf life were packed at the front of stock in all areas, and stock cards were available, up to date, and filed correctly.

**LMIS/eLMIS:** The CHT score was 26.3 percent (limited) for LMIS/eLMIS tool utilization. There were private HFs without the support of the CHT. Therefore, LMIS tools were not available for the assessors to verify. While consumption data were captured from the tally record, facilities did not have DDR and SSRR, and the MOH had not supplied them for some time. Thus, the staff were not submitting LMIS reports to the CHT. Furthermore, consumption records reviewed showed that a facility was not completed for government report because they were not reporting to the supply chain.

**Requisitioning and Reporting HF:** The overall score was 31.2 percent (limited) on requisitioning at all levels of the health system. The CHT scored 13.3 percent (absent), while facilities scored 31.5 percent (limited). Pharmacist records showed the unavailability of commodity stocks for the CHA program over the years. Facilities also reported not having a buffer stock of other essential drugs, and only prenatal products were supplied.

[…]**HR Management:** The overall score for this subdomain showed a limited capacity, with a score of 29.2 percent. The CHT scored 67.5 percent (foundational), while facilities had a limited capacity at 28.6 percent. The CHT reported that some staff job profiles/job descriptions were available and confirmed. The CHT had staff listings per cadre, location, and qualification. Work planning and performance review SOPs existed with a compensation and benefits system. The facilities noted playing a minimum role in HR management limited to recommending staff for re/assignments. Few staff at some facilities reported not receiving a copy of their job descriptions/terms of reference.

**Performance Management:** The overall performance management score was 14.8 percent (absent). The CHT scored 50 percent (limited), while facilities scored 14.3 percent (absent). The CHT had put a unique feedback mechanism channel used to follow up on the staff's monthly task. The CHT/MOH also implemented an annual training plan to improve health outcomes in the community. Facilities representation Worksite documentation did not adhere with occupational safety requirements. The absent score in this domain resulted from the fact that some facility staff members did not have a copy of their job description/terms of reference. Most HR performance decisions were mostly CHT/MOH decisions, and facilities played no role.

**In-Service Training Management and Planning**: This subdomain had a score of 5.9 percent (absent). The CHT had in-service training management and planning for all staff, especially clinicians, and a mentorship/coaching program for lower-level staff.

**Payroll Audit:** The overall score for this subdomain was 100.0 percent. The financial audit did not take place at the facilities, resulting in their absent scores.

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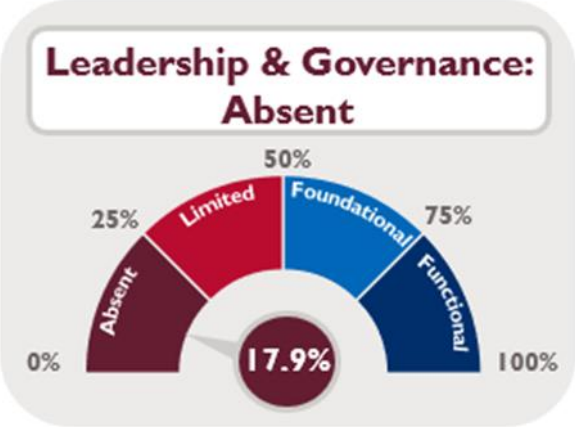
## Leadership and Governance

The leadership and governance domain questions were developed to gauge the health system's capacity relative to the Decentralized Governance and Management Operational Guidelines. This domain includes the following subdomains: leadership and governance, coordination, general, operations plan and implementation, community leadership, and emergency preparedness.




**Leadership and Governance:** The overall county score was 17.9 percent (absent). The DHTs scored 83.2 percent (functional). The CHT scored 64.4 percent (foundational), while facilities scored 10.1 percent (absent). In terms of ownership and types, public facilities scored 21.2 percent, while private facilities scored 3.9 percent.

[…]**Operations Plan and Implementation:** The overall score for the operations plan and implementation subdomain was 92.9 percent, placing it in the functional category. The assessors confirmed the availability of the CHT operational plan. The majority of DHTs received feedback after the CHT.

**Community Leadership:** The overall score for community leadership was 11.3 percent, placing it in the absent category. The were 334 facilities with less than half of HFDCs received feedback from the DHT or CHT.

**Emergency Preparedness:** The overall score for the emergency preparedness subdomain was 23.5 percent, placing it in the absent category. There were County and District Surveillance Officers assigned, but the lack of effective CHSS/CHA programs covering all facilities hindered the surveillance system in the county. There was also no well-structured feedback system to communities and active case identification in Montserrado.

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**Service Delivery:** The overall county score for service delivery was 24.8 percent, placing it in the absent category. DHTs scored 62.5 percent (foundational), while facilities scored 22.4 percent (absent). In terms of ownership and types, public facilities scored 33.3 percent (limited), while private facilities had an overall score of 15.7 percent (absent). Additionally, hospitals and health centers scored 44.5 percent and 30.9 percent, respectively, placing both in the limited category, while clinics scored 17.6 percent (absent).

**Management, Governance, and Policy Adherence:** The score for the management, governance, and policy adherence subdomain was 39.6 percent (limited). The CHT had assigned skilled clinicians to manage facilities. The National Service Delivery Guidelines were available and had been distributed to health facilities. Post-supervision meetings occurred regularly, and two to three patients received the correct treatment based on the treatment record reviewed by assessors. However, no JISS had been conducted at this facility in the past two years. There was some inconsistency in QMT meetings over the last year.

**Quality Assurance/Improvement:** The overall score for quality assurance/improvement was 15.9 percent (absent). The CHT had a QMT in place, but JISS was not conducted, with the paper-based JISS last conducted in 2020. There had been no post-supervision meetings for most of the facilities. Furthermore, the few facilities that had post-supervision meetings did not receive feedback.

**EPHS Implementation:** The EPHS implementation score was 3.2 percent (absent). The CHT reported assigning staff with the requisite clinical competencies in all facilities. However, assessors found that none of the services were offered as per the EPHS and per the level of facility PHC due to knowledge gaps and a lack of trained staff in core areas.

**Laboratory:** The laboratory subdomain score was 30.1 percent (limited). The county had a Diagnostics Officer and a Biomedical Engineer assigned. The Diagnostics Officer and Biomedical Engineer had the requisite qualification and competency, although laboratory equipment, such as rapid diagnostic tests (RDTs), was not available in most of the facilities. Additionally, no laboratory staff was seen in facilities during the assessment. Facilities had a laboratory, but the Nurse Aid was the one providing service. It was reported that there was no transportation of specimen, and only RDTs and HIV/Syphilis Duo Testing were available in facilities. The MOH was not providing facilities with malaria RDTs (mRDTs); only microscopic tests were done, and sometimes the facilities bought their own mRDTs.

**Community Health:** The community health subdomain score was 28.7 percent (limited). HFDCs were established at 334 health facilities but were not functional. There was no active CHA/CHSS program in the county with documentation.

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