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# Partnering for Transformational Change, Strengthening Liberia's Surgical Health System 2021-2023" Mercy Ships Norway

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End Review

Hera

Norad

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# Partnering for Transformational Change, Strengthening Liberia's Surgical Health System 2021-2023" Mercy Ships Norway

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# PARTNERING FOR TRANSFORMATIONAL CHANGE, STRENGTHENING LIBERIA'S SURGICAL HEALTH SYSTEM 2021-2023" MERCY SHIPS NORWAY

**End review**

**Final version – September 2023**


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September 2023

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# ABBREVIATIONS

| | |
|---|---|
| ASC | Africa Service Centre |
| BMET | Biomedical Technician |
| DHS | Demographic and Health Survey |
| ELWA | Eternal Love Winning Africa |
| ETA | Education, Training and Advocacy |
| GDP | Gross Domestic Product |
| GIZ | *Gesellschaft für Internationale Zusmmenarbeit* |
| HQ | Head Quarters |
| HTMU | Health care Technology Management Unit |
| IP | International Programs |
| ISC | International Support Center |
| KII | Key Informant Interview |
| LANA | Liberian Association of Nurse Anaesthetist |
| LFA | Logical Framework Approach |
| M&E | Monitoring & Evaluation |
| MELD | Monitoring, Evaluation, Learning and Development |
| MFA | Ministry of Foreign Affairs |
| MOH | Ministry of Health |
| MOA | Memorandum of Agreement |
| MSI | Mercy Ships International |
| MSNo | Mercy Ships Norway |
| MSSI | Medical and Surgical Skills Institute |
| NGO | Non-Governmental Organisation |
| OECD/DAC | Organisation for Economic Co-operation and Development/Development Assistance Committee |
| PiH | Partners in Health |
| SDG | Sustainable Development Goal |
| SEAH | Sexual Exploitation, Abuse and Harassment |
| ToC | Theory of Change |
| TOR | Terms of Reference |
| ToT | Training of Trainers |
| UHC | Universal Health Coverage |
| UK | United Kingdom |
| USA | United States of America |
| VID | VID Specialized University |
| WFSA | World Federation of Societies of Anaesthetists |
| WHO | World Health Organization |

# EXECUTIVE SUMMARY

## INTRODUCTION

This report describes the main findings of the end review of the project two-year *Partnering for Transformational Change: Strengthening Liberia's Surgical Health System* project in Liberia.

Liberia has a population 5,4 million, of which close to one million lives in the capital Monrovia. In 2019, health expenditure was 8% of Gross Domestic Product (GDP) vs 15% as per the Abuja commitment. The health system suffered considerably during the civil war (1989-1996) and the devastating Ebola outbreak in 2013/2014. The main challenges the country's health system faces currently are related to overall limited (national and donor) funding. The national capacity to implement the country's national health policies and strategic plans is insufficient. The Covid-19 pandemic further weakened the health system.

Mercy Ships, established in 1978, is a large international faith-based organisation that aims to improve the quality of life of people living with disease, disfigurement, and disability through provision of free surgical care in the poorest countries in the world. Motivated by its Norwegian affiliate Mercy Ships Norway (MSNo), in March 2021, Mercy Ships International Programs (IP) launched *A Programmatic Strategy to Achieve Lasting Change* describing the organisation's new direction that adds a more prominent role to capacity building.

The project under review aims *to make a significant, concentrated impact in Liberia by strategically focusing on strengthening the health system; specifically, by improving the availability, accessibility, and quality of its surgical system* in Liberia. It consists of three main components, implemented in different hospitals: training, the provision of anaesthesia equipment, and the provision of nursing kits for nurses and nursing drug reference books, and tool kits for Biomedical Technician (BMETs). The project, with a total budget of NOK 29 152 635, started in June 2021, and its end date has been extended to December 2023. The grant, managed by MSNo, has a monitoring plan including an overall Theory of Change (ToC), and a logical framework approach (LFA). Mercy Ships in country representation was ceased in July 2023 due to a strategic discussion of Mercy Ships leadership to suspend all activities in Liberia.

The aim of the review was to independently assess the programmatic performance of the project, with a focus on effectiveness, (cost) efficiency, and sustainability. The review used a mixed-method approach. Data required to answer the review questions were collected in June and August 2023 through document review, interviews with key informants (25) and a country visit (10 sites). Data obtained through different data sources and data collection methods allowed for rigorous triangulation.

## FINDINGS

Mercy Ships and Norway have a long history; various grants were provided to Mercy Ships via the Norwegian Embassy, the Norwegian Ministry of Foreign Affairs (MFA) and Norad. In 2018, Norad provided the first grant to MSNo for a project implemented in Guinea, Liberia, and Senegal. The application for the project under review was received in early 2021, and, after a considerable number of changes in the design upon request from Norad, the grant agreement was signed in September 2022. Three different Norad staff members have been responsible for management of this grant.

- **Review area 1: To what extent the programme achieved expected results?**

**To what extent have the programme outputs and outcomes been achieved or are likely to be achieved?**
According to the MSNo's implementation plan dated 3 March 2023, all activities foreseen are carried out, except for follow-up mentoring for the leadership training (output 2.1), and the Clean Cut activities (output

3.1). The leadership training is somewhat delayed, but scheduled to be finalised during the project extension. The Clean Cut activities however continue until mid 2024. Although indicators for some locations where the Clean Cut activities have been/are being implemented will be available, the final project outcome indicators to measure overall results of the will not be before the official projects end. Reported results of several LFA output indicators provide limited information on the actual achievements and results of the project (expected changes).

**What are the major factors influencing the achievement or non-achievement of the outcomes and outputs?** Several enabling factors supported the carrying out of the project activities. These are however mainly related to practicalities of the activities rather than the actual achievements.

- **Review area 2: To what extent the programme has been effectively implemented?**

**How effective has Mercy Ships been in its M&E approach, is a monitoring system in place that allows tracking, critical assessment and reporting of achievements?** The M&E approach put in place by Mercy Ships for monitoring the progress of the projects activities is only to a limited extent fit for purpose. It is overly complex and involves many different divisions and entities from within and outside the organisation, who share responsibilities. Norad however approved the monitoring plan and LFA.

**To what extent are the Norad funded activities aligned with the priorities from the government?** Norad funded activities are to some extent aligned with governments priorities but are actually more tailored to the capabilities and preferences of Mercy Ships. While training and mentoring related to surgical care, focus areas for Mercy Ships, are important for the government as first steps towards improvement of surgical care, more is needed to achieve actual change in this area. The country lacks a clear surgical care strategy or action plan, and Mercy Ships could have supported the government with more strategical reflection on how to embed surgical care in its national health development strategy and budgeting.

**How are the Norad funded activities coordinated with government and other partners/donors working on health systems strengthening?** Mercy Ships has not been an active partner in the health development space in Liberia. Coordination with partners was quite intensive in the project's start-up phase but decreased over time. Coordination with government actors focused on practicalities related to the actual implementation of activities rather than on strategic and sustainable objectives of health system strengthening.

**To what extent is Mercy Ships equipped (e.g., competence, experience) to implement a capacity development programme? How adequate are the approach and tools developed by Mercy Ships to implement this programme? What competences or tools are missing, if any?** Mercy Ships is not yet adequately equipped to efficiently and effectively manage a health system strengthening project as per the standards for government (bilateral) funding. The approach and tools used to implement the Norad funded activities were built primarily on experiences Mercy Ships main activity, providing free surgery and some activities *on shore* that have accompanied the *on ship* activities over the years.

**How efficient is the (internal) organisation of Mercy Ships in leading, providing technical backstopping and monitoring the capacity development programme in national institutions?** Mercy Ship's general model and the established structure to manage and implement the Norad grant is complex and only to a limited extent efficient for the project under review; many people and divisions from different (legal) entities are involved, adequate experience with and knowledge of public grant management is limited, and expertise with implementation of a capacity development programme of this scale is lacking. Mercy Ships ongoing transition to move to a more long-term development partner did not provide for a stable foundation and a conducive environment to implement a project in a relatively new technical area.

**To what extent are the main interventions of the program cost-efficient based on commonly applied benchmarks (e.g., the Global Fund)?** We aimed to carry out an analysis of training costs of the project under

review using benchmarks from other projects. This however proved difficult as no adequate datasets were available; both for the project as well as for the benchmarking. Instead, overall costs for the different training were calculated per person and then analysed, but actually no conclusions can be drawn.

**To what extent does the budget have a reasonable proportion of direct vs indirect cost, and is does reporting to Norad allow for adequate monitoring of budget execution**? Several versions of the project budget circulate, and while different budgets in the current set up were approved by Norad, questions kept coming up throughout the implementation of the project. Although these issues were clarified to some extent, the budget set up does not fully allow to ascertain and distinguish direct and indirect costs. The set up with MSNo as Norad's grantee but implementation of activities by both MSNo, MSI and external parties, including different ways in cost categorisation brought complexities in understanding the financial management of the grant. Expenses previously covered in specific budget categories, moved to other budget categories or were distributed across different categories during the project. The many requests and feedback regarding financial matters and the related communication back and forth took up considerable time for both parties.

**To what extent Mercy Ship has systems and procedures in place for working with/through third parties/implementing partners?** A protocol agreement between Mercy Ships and the Government of Liberia laid the basis for cooperation with the MOH and related entities (e.g., hospitals), the so-called beneficiary partners. For the implementation of the project under review, Mercy Ships collaborates with so-called operational partners with most of whom the organisation has a longstanding relationship. This relationship is formalised by means of a general Memorandum of Agreement (MOA). For the activities specific to Liberia, Mercy Ships developed amendments to these MOAs.

**Do the systems/procedures comply with the Norad grant agreement?** Systems and procedures in place for working with/through third parties and/or implementing (operational) partners mainly comply with the grant agreement's general conditions, but gaps are identified in compliance with the procurement rules and principles as per part 3 of the grant management agreement.

- **Review area 3: To what extent risks are identified and mitigated?**

**To what extent are appropriate systems in place for assessing risks?** Several risks are involved in working with the Government of Liberia. Potential risks are discussed on a regular basis but the sources of information to judge about these risks could be more comprehensive.

**What have been (unexpected) programmatical and managerial challenges and risks encountered during implementation?** The delay in procurement of services, and the decision not to bring the vessel to Liberia and the related suspension of new activities significantly affected the completion and possible continuation of the project. Both cases are a result of internal MSI procedures and strategies, with underlying causes regarding the Liberian context.

**To what extent Mercy Ships has adequate systems in place to ensure integration of considerations on cross-cutting issues (human rights, women's rights, gender equality, climate/environmental impact and corruption)?** Mercy Ships has policies in place for equal opportunity, harassment prevention and reporting, anti-terrorism, anti-corruption and a general code of conduct. No specific policies for gender equality and environment exist. It was not clear whether these policy documents are widely disseminated within the organisation and with its beneficiary and operational partners and applied during implementation of the project. Agreements available for review refer to anti-corruption and the right to audit.

- **Review area 4: If and to what extent the benefits of the programme can be sustained beyond Norad and Mercy Ships funding?**

**To what extent is Mercy Ships capable and willing to continue Norad funded activities when Norad phases out?** The decision to indefinitely halt activities in Liberia put the question regarding capacity and willingness

of Mercy Ships to continue activities in Liberia with own funding in a different perspective. MSNo had serious intentions to pursue activities at least for five years. MSI is financially a strong organisation.

**To what extent are the benefits of Mercy Ships funding programming likely to continue after donor funding ceases?** The changes achieved through the Norad funded activities may not be fully sustained, mainly because of the short duration of the project, which provided limited options for the accompaniment and mentoring required to achieve sustained change. Overall the (ongoing) mentoring component was rather limited.

**What are major factors which influence the achievement or non-achievement of sustainability of Norad/Mercy Ships funding and programming?** Generally, the environment in Liberia is only to a limited extent conducive to sustain changes achieved. The MOH has limited funding available to take over and contribute to (ongoing) activities, coordination of activities and available support does not happen in a systematic way increasing the risk of duplication or gaps, and staff rotation is overall high.

## CONCLUSIONS AND RECOMMENDATIONS

**Conclusions:** Both Mercy Ships and Norad made considerable efforts to bring the diverging views and approaches closer together to formulate a project that was acceptable to both and fell within Norads priorities, but challenges persist, and ambiguities were further aggravated by the multiple changes of Norad grant managers and the ongoing transition within MSI. Mercy Ships managed to raise awareness on the importance of surgical care and implemented most of the activities timely. Overall LFA milestones and targets set have been or will be achieved, but the short duration of the project does not allow to measure outcome and impact. Generally, despite satisfactory results in terms of carrying out the foreseen activities in the foreseen timeframe, several questions have arisen regarding the actual implementation of the project and even more so regarding its adequacy and effectiveness considering the overall definitions of health system and health system strengthening that traditional development partners adopt, and in particular also the compatibility with requirements for Norad funding.

Based on internal initiatives to transform Mercy Ships into a long-term health development partner, the project under review was designed to comply with Norads eligibility requirements, but in essence, with some exceptions, the approach opted was not much different from the Mercy Ships's *on-shore* activities in other countries.

Mercy Ships tends to maintain a traditional style of aid provision (charity), differing considerably from the usual philosophy of development as embraced by the majority of institutional donors including Norad. First small steps towards increased in-country presence are observed, which comes with other responsibilities towards the host countries and their population, and a practical realisation of these issues is not yet very visible. Most issues related to the actual grant management are observed in the legal and strategic relationship between MSI and MSNo.

Norad knew from the beginning that the project included only few activities with a potential for sustained strengthening of the Liberia health system, and its decision to fund the project for two years only comprised potential impact and sustainability on beforehand. Norad experienced difficulties to handle this grant. Despite all good intentions from both parties, mutual expectations were in hindsight different. The previous remote assessments limited the opportunities to conduct an informed dialogue in earlier stages.

**Recommendations for the remainder of the ongoing project:**

- **Mercy Ships** to update its risk register as the new situation (no in country presence and upcoming elections) is likely to bring additional risks

- **Mercy Ships** to clarify the remainder of the implementation of the Clean Cut activities (funding of activities after the projects end date, reporting of final results)
- **Mercy Ships** to carefully review and clarify the costs charged for training.

**Recommendations for future collaboration:**

Further to the conclusion of the review, at best we can give some guidance for further strategical reflection within both Mercy Ships and Norad.

- Both **Mercy Ships and Norad** to carefully reflect on the desirability of collaboration
- **Mercy Ships** leadership to ensure uniform guidance to implement the new strategy
- **Mercy Ships** leadership to make a clear assessment of whether it wants to invest in collaboration with Norad or other bilateral partners
- **Norad** to focus reflections on whether it wants to continue supporting projects of this nature (relatively short-term, implemented by an organisation with little technical knowledge in Norad's main focus areas, and limited experience in all areas of grant management of bilateral funding)
- **Norad** to revise its requirements for eligibility of funding, including the definition of what it considers health system strengthening
- **Norad** to analyse the risks associated with the application of changes and exceptions in grant management at its own level
- **Norad** to schedule a joint country visit with both representatives from Norad and the grantee in an early phase of the project

# 1. BACKGROUND

## 1.1. INTRODUCTION

Since 2015, Norway, through the Embassy, the Ministry of Foreign Affairs, and from 2018 onwards through Norad, supported several activities implemented by Mercy Ships. Currently, Norad funds the two-year *Partnering for Transformational Change: Strengthening Liberia's Surgical Health System* project in Liberia. Following a partner assessment in 2021 and an assessment of the proposal for the above-mentioned project in 2022, both conducted remotely, Norad requested hera to carry out an end review of the project. The review was performed under the long-term agreement with hera. This report describes the main findings of this review.

## 1.1 CONTEXT

Liberia, situated on the west African coast and consisting of 15 counties, has a population 5,4 million, of which close to one million lives in the capital Monrovia[1]. Despite the relatively high fertility rate (the total fertility rate is estimated at 4.2 children per women), the population's growth rate has been relatively low with around 2% in the past years, which is mainly caused by the high level of migration.[2][3] Liberia has a young population; it is estimated that 44% is younger than 15 years.[4]

The Human Development Report 2021/2022 from UNDP ranks Liberia on the 178th position out of 191 countries.[5] 84% of the country's households have access to an improved source of drinking water, 47% use improved toilet facilities, and 24% have access to electricity. There are however considerable variations between urban and rural areas (e.g., 39% of households in urban areas have access to electricity versus 4% only of those in rural areas). Education levels are generally low: among the population of 6 years and older, 41% of females and 30% of males have no formal education. Domestic violence is widespread with 60% of women between 15 and 49 years old experiencing physical violence, and 9% sexual violence. 55% of ever-married women experienced spousal violence and this proportion increased from 49% in 2007.[6]

In 2019, health expenditure was 8% of Gross Domestic Product (GDP), which is just over half of the proportion as per the Abuja commitment to spend at least 15% of national budget for the health sector. The health system suffered considerably during the civil war (1989-1996) and the devastating Ebola outbreak in 2013/2014. The main challenges the country's health system faces currently are related to overall limited (national and donor) funding. Liberia receives bilateral funding for health from several countries including Sweden, US, Germany, United Kingdom (UK), Ireland and France, and bilateral funding from amongst others the Global Fund, Gavi, and several UN agencies (e.g., UNFPA, UNICEF, WHO).

The national capacity to implement the country's national health policies and strategic plans is insufficient, and general health system issues including weak infrastructure and inequitable distribution of services, result in overall moderate health outcomes. The Covid-19 pandemic further weakened the health system. Restoration of services after the pandemic was generally low.[7]

The 2019-20 Liberia Demographic and Health Survey (2019-20 LDHS) shows childhood mortality rates were generally decreasing since 1986 but stagnated from 2007. The current under-five mortality rate is estimated

[1] https://worldpopulationreview.com/countries/liberia-population
[2] The 2019-20 Liberia Demographic and Health Survey (2019-20 LDHS)
[3] https://worldpopulationreview.com/countries/liberia-population
[4] https://www.afro.who.int/sites/default/files/2023-05/WHO%20Liberia%202022%20annual%20report.pdf
[5] https://hdr.undp.org/system/files/documents/global-report-document/hdr2021-22overviewenpdf.pdf
[6] The 2019-20 Liberia Demographic and Health Survey (2019-20 LDHS)
[7] https://www.afro.who.int/sites/default/files/2023-05/WHO%20Liberia%202022%20annual%20report.pdf

at 93 per 1,000 live births, and the infant mortality rate at 63. The maternal mortality ratio is estimated at 743 deaths per 100,000 live births. These statistics are among the worst in the region and at global level.

## 1.2 MERCY SHIPS

Mercy Ships, established in 1978 with the purchase of the vessel Anastasis, is a large international faith-based organisation that aims to improve the quality of life of people living with disease, disfigurement, and disability through provision of free surgical care in the poorest countries in the world. Mercy Ships' International Support Center (ISC) is based in east Texas, in the United States of America (USA), Up to recently, Mercy Ships focused almost uniquely on the work on and alongside hospital ships.
The organisation comprises of different (legal) entities: Head Quarters (HQ) in Texas (US) referred to as Mercy Ships International (MSI), an Africa Service Centre (ASC) to be established in Senegal, Mercy Ships (independent) affiliates in 16 different countries, two state-of-the-art hospital ships, and (temporary) representation in some of the countries where Mercy Ships carries out activities (e.g., Liberia, Sierra Leone). Most of the organisation's activities are funded with private donations.

Motivated by its Norwegian affiliate Mercy Ships Norway (MSNo), in March 2021, Mercy Ships International Programs (IP) launched *A Programmatic Strategy to Achieve Lasting Change* describing the organisation's new direction. While continuing to provide free medical services on the ships, a more prominent capacity building component is added to strengthen national surgical systems to meet future needs. This new component is based on the health system and related health system strengthening approach developed by the World Health Organization (WHO) and involves three main pillars, according to which MSI would be reorganised: Direct Medical Services, Medical Capacity Building and Health Systems Relationship Development. The strategy aims to implement the capacity building component through five-year country engagement plans. In January 2023, IP presented a revised strategy, now based on two pillars: Direct Medical Services and Education, Training and Advocacy (ETA). The revised strategy refers to the Dakar Declaration from May 2022, which confirms the intention of 12 heads of states from the region (western Africa) and Mercy Ships leadership to improve access to safer surgery. The five-year country engagement period is maintained.

During its long existence Mercy Ships built a large network with international organisations active in surgical care in low- and middle-income countries, i.e., World Federation of Societies of Anaesthetists (WFSA), the Ghana Medical and Surgical Skills Institute (MSSI), WHO, and Diamedica Ltd.

In this report we use the term Mercy Ships when we refer to the organisation as a whole. When we refer to a specific entity within the overall organisation, we use the name of that particular entity (e.g., MSNo, MSI).

## 1.3 THE PARTNERING FOR TRANSFORMATIONAL CHANGE: STRENGTHENING LIBERIA'S SURGICAL HEALTH SYSTEM PROJECT

The two-year *Partnering for Transformational Change: Strengthening Liberia's Surgical Health System* is a two-year project that aims *to make a significant, concentrated impact in Liberia by strategically focusing on strengthening the health system; specifically, by improving the availability, accessibility, and quality of its surgical system* in Liberia. It consists of three main components, implemented in different hospitals throughout the country: training of hospital leadership, health workers and biomedical technicians (BMET), the provision of anaesthesia equipment, and the provision of nursing kits for nurses[8] and nursing drug

[8] The nursing kits include items such as a stethoscope, blood pressure cuff, forceps, scissors, clock, non-contact infrared thermometer, penlight, and reference cards.

reference books, and tool kits for BMETs[9]. MSNo intended to implement a five-year project, aligned with the Mercy Ships five-year country engagement plans but Norad approved a two-year project only. The project started in June 2021, and its end date has, in mutual agreement, been extended with six months to December 2023.

The project has a total budget of NOK 29 152 635, more or less equally divided over the first 2 years (approximately NOK 10 and 11 million respectively), and approximately NOK 7 million for the 6 months extension, referred to as year 3.

MSNo manages the Norad grant but operates in close collaboration with a range of different Mercy Ships entities, particularly with relevant divisions of MSI (IP and its subdivisions, i.e., ETA, Program Design) and the Mercy Ship country director in Liberia. Mercy Ships in country representation was ceased in July 2023 due to a strategic discussion of Mercy Ships leadership to suspend all activities in Liberia after the project activities have been fully implemented.

The project has a monitoring plan including an overall Theory of Change (ToC), and a logical framework approach (LFA) (Annex 2)[10]. The ToC for the project developed by Mercy Ships is described in Table 1 below.

Table 1. The project's ToC

| |
|---|
| ***IF*** anaesthesia providers have better knowledge about safe anaesthesia provision for high-risk patients such as obstetric cases (output 1), ***AND IF*** they have functioning anaesthesia machines and ways to monitor the patient's vital signs (outputs 1 and 4), ***THEN*** surgery becomes safer for the patient. |
| ***IF*** hospitals are following best practice, ***AND IF*** this is encouraged by leadership through initiatives to hold teams accountable to quality of service (output 2), ***THEN*** surgical teams have an accountability structure to drive performance. |
| ***IF*** surgical teams and ward nurses are providing safe care, as determined by sterile facilities, improved surgical skills, adherence to the WHO Surgical Safety Checklist, ***AND IF*** patients are in less pain (output 3), |
| ***THEN*** the patient will recover more quickly from their surgery and face fewer complications, thereby making surgery safer. |

In the projects monitoring plan the impact statement is defined as *Improved maternal and neonatal health outcomes in Liberia.* For this statement, two impact indicators are formulated: *Improved maternal mortality rates and neonatal mortality rates*. The LFA reports against one outcome statement (*By 2023, targeted hospital facilities are providing safer and improved quality surgery to patients*), two outcome indicators (*Adherence to Surgical Safety Checklist at targeted facilities, and Surgical patient experience of care at targeted hospitals*), and four outputs with a total of seven output indicators. The LFA includes both quantitative and qualitative indicators. Table 2 below shows the activities[11] under the four outputs and the corresponding LFA indicators. The monitoring plan does not include the number of beneficiaries for the different activities (e.g., hospital, nurses, BMET).

[9] The tool kits for BMETs include an assortment of screwdrivers and pliers, soldering iron, de-solder pump, electronics snips, Allen key sets, oxygen analyser, and a multi-meter.

[10] Several versions of the monitoring plan and LFA exist; for this review we used the July 2022 versions.

[11] Mercy Ships refers to these as *projects*

Table 2. Project activities at outputs level

| Output | Statement | Activities | Indicators |
|---|---|---|---|
| **1** | Safer anaesthesia provision and resuscitation practices for neonatal and obstetric surgical patients | 1.1 Neonatal Resuscitation Training<br>1.2 SAFE (Safer Anaesthesia for Education) Obstetric Anaesthesia Training<br>1.3 Anaesthesia Provider Training and Equipment | 1.1 # obstetricians, nurses, and midwives with improved knowledge on how to help babies breathe (neonatal resuscitation – specifically: ventilation techniques, cardiac massage, and birth asphyxia)<br>1.2 # anaesthetists reporting improved confidence on safe administration of anaesthesia to obstetric patients<br>1.3 # functioning anaesthesia machines in targeted facilities |
| **2** | Surgical and management teams implement best practices to foster staff development and implement safe, quality surgery | 2.1 Leadership Training | 2.1 # targeted facilities with quality improvement monitoring processes (such as M&M reviews, staff appraisals, reporting SSIs and perioperative mortality) |
| **3** | Surgical and perioperative care providers have improved knowledge of safe care practices | 3.1 Lifebox Clean Cut™ Training<br>3.2 Safe Surgery Training Course<br>3.3 Surgical Nurse Training<br>3.4 Nurses' Kits and Nursing Drug Reference Books | 3.1 Surgical Capacity Assessment Score at targeted facilities<br>3.2 # nurses with improved knowledge in pain management of the critically ill patient |
| **4** | Biomedical Technicians have improved knowledge and skills in maintaining essential surgical and anaesthesia equipment | 4.1 Biomedical Technician Training and Mentoring | 4.1 # biomedical technicians trained, including in the maintenance and repair of Glostavent anaesthesia machines |

## 1.4 HEALTH SYSTEMS AND HEALTH SYSTEMS STRENGTHENING

Table 3 below provides definitions for health system, health systems strengthening, capacity building and capacity development; concepts that are often referred to in this report.

Table 3. Definitions of health system and health system strengthening

| Concept | Definition | Source |
|---|---|---|
| **Health system** | A health system consists of all organisations, people and actions whose primary intent is to promote, restore or maintain health. This includes efforts to influence determinants of health as well as more direct health-improving activities. A health system is therefore more than the pyramid of publicly owned facilities that deliver personal health services. It includes, for example, a mother caring for a sick child at home; private providers; behaviour change programmes; vector-control campaigns; health insurance organisations; occupational health and safety legislation. It includes inter-sectoral action by health staff, for example, encouraging the ministry of education to promote female education, a well-known determinant of better health. | WHO. Everybody business: strengthening health systems to improve health outcomes : WHO's framework for action. 2007 |
| | Set within the political and institutional framework of a country, a health system is "the ensemble of all public and private organisations, | https://www.who.int/docs/default-source/documents/15-165050.pdf |

| Concept | Definition | Source |
|---|---|---|
| | institutions, and resources mandated to improve, maintain or restore health." This definition, along with efforts to more concretely specify the "functions", "building blocks", or "control knobs" of a health system, focus on the characteristics or policy instruments of the system itself. | |
| **Health system strengthening** | Is defined as improving the six health system building blocks and managing their interactions in ways that achieve more equitable and sustained improvements across health services and health outcomes. It requires both technical and political knowledge and action. | WHO. Everybody business : strengthening health systems to improve health outcomes : WHO's framework for action. 2007 |
| | Involves "a significant, purposeful effort to improve performance." This goes beyond merely investing in inputs; it means reforming how the health system actually operates. | https://www.who.int/docs/default-source/documents/15-165050.pdf |
| **Capacity building** | Capacity-building is defined as the process of developing and strengthening the skills, instincts, abilities, processes and resources that organizations and communities need to survive, adapt, and thrive in a fast-changing world. An essential ingredient in capacity-building is transformation that is generated and sustained over time from within; transformation of this kind goes beyond performing tasks to changing mindsets and attitudes. | https://www.un.org/en/academic-impact/capacity-building |
| **Capacity development** | The processes whereby people, organisations and society as a whole unleash, strengthen, create, adapt and maintain capacity over time. (Many agencies, for example EuropeAid, GIZ, ADB, FAO, and others have decided to adopt this definition.)<br>Capacity development emphases the inherent existence of endogenous development processes in all countries and communities, and addresses the need to support and or facilitate processes that are already underway. | https://lencd.org/learning/the-core-concept/capacity-development, OECD |

## 2 PURPOSE, OBJECTIVES AND SCOPE OF THE REVIEW

The aim of the review was to independently assess the programmatic performance of the project, with a focus on effectiveness, (cost) efficiency, and sustainability. Furthermore, the review was expected to assess improvements in Mercy Ships policies on governance, gender equality, environment, human rights-based approach and its ability to work with and through partners.

The review built on results from previous assessments but focused on areas that were identified as weak in previous reviews, particularly capacity development of health personnel and institutions in Liberia.

## 3 METHODOLOGY

The review incorporated the following strategies:

- It was participatory and cooperative.
- It used a triangulated evaluation design by working with a variety of tools to collect qualitative and mixed data from different target groups and by exploring a large range of secondary data.
- It was culture-fair and trans-disciplinary.

We conducted a summative and formative evaluation, with an iterative evaluation design.

## 3.1 REVIEW QUESTIONS

The review areas and questions proposed in the Terms of Reference (TOR) have been slightly reorganised to ensure all areas and related questions are covered in a logical sequence and grouped where appropriate. The relevant Organisation for Economic Co-operation and Development (OECD)/Development Assistance Committee (DAC) criteria have been added as well. The review questions were approved by Norad on 10 June 2023.

Table 4. Main evaluation areas and questions

| Main review area | Review questions | OECD/DAC Criteria |
|---|---|---|
| **1. To what extent the programme achieved expected results?** | • To what extent have the programme outputs and outcomes been achieved or are likely to be achieved?<br>• What are the major factors influencing the achievement or non-achievement of the outcomes and outputs? | Effectiveness<br>Efficiency<br>(Impact) |
| **2. To what extent the programme has been effectively implement ed?** | M&E system: *<br>• How effective has Mercy Ships been in its M&E approach, is a monitoring system in place that allows tracking, critical assessment and reporting of achievements?<br>Coordination:<br>• To what extent are the Norad funded activities aligned with the priorities from the government?<br>• How are the Norad funded activities coordinated with government and other partners/donors working on health systems strengthening?<br>Competence:<br>• To what extent is Mercy Ships equipped (e.g., competence, experience) to implement a capacity development programme? How adequate are the approach and tools developed by Mercy Ships to implement this programme? What competences or tools are missing, if any?<br>• How efficient is the (internal) organisation of Mercy Ships in leading, providing technical backstopping and monitoring the capacity development programme in national institutions?<br>Financial management:<br>• To what extent does the budget have a reasonable proportion of direct vs indirect cost, and is does reporting to Norad allow for adequate monitoring of budget execution? *<br>• To what extent are the main interventions of the program cost-efficient based on commonly applied benchmarks (e.g., the Global Fund)?<br>Working with Mercy Ships' partners:<br>• To what extent Mercy Ship has systems and procedures in place for working with/through third parties/implementing partners?<br>• Do the systems/procedures comply with the Norad grant agreement? | Effectiveness |
| **3. To what extent risks are identified and mitigated?** | General risks:<br>• To what extent are appropriate systems in place for assessing risks?<br>• What have been (unexpected) programmatical and managerial challenges and risks encountered during implementation?<br>Risks related to cross-cutting issues:<br>• To what extent Mercy Ships has adequate systems in place to ensure integration of considerations on cross-cutting issues (human rights, women's rights, gender equality, climate/environmental impact and corruption)? | Efficiency |

| Main review area | Review questions | OECD/DAC Criteria |
|---|---|---|
| **4. If and to what extent the benefits of the programme can be sustained beyond Norad and Mercy Ships funding?** | None of the questions proposed in the TOR cover sustainability; we therefore suggest the questions below to address this evaluation area.<br>• To what extent is Mercy Ships capable and willing to continue Norad funded activities when Norad phases out?<br>• To what extent are the benefits of Mercy Ships funding programming likely to continue after donor funding ceases?<br>• What are major factors which influence the achievement or non-achievement of sustainability of Norad/Mercy Ships funding and programming? | Sustainability |

** In the TOR, the question on M&E is the last question in this review area. We however believe presenting our findings to this question at the beginning of this area will facilitate the understanding of our findings for the other questions in this review area since several sub-questions of this area also refer to monitoring.*

*** As discussed, and agreed with Norad/Vigdis Halvorsen on 13 July 2023, this question combines the two questions as in the TOR for this review.*

## 3.2 DATA SOURCES AND DATA COLLECTION METHODS

The review used a mixed-method approach that allowed for triangulation of data. Data required to answer the review questions were collected in June and August 2023 through document review, interviews with key informants and site visits. The review was executed through desk-based work and a one-week country visit in Monrovia, Liberia.

During the start-up of the review, a document library was assembled which was expanded throughout the review. Documents were obtained from Norad, Mercy Ships, operational partners, through further interaction with key stakeholders (e.g. through key informant interviews) and through internet searches. Documents include those related to Mercy Ships' strategy, procedures, annual plans and budgets, ToC, logical framework and indicators, project progress reports, audits etc. Relevant documents were coded and analysed using MAXQDA software[12].

Interviewees were purposively sampled to capture views and insights on the different areas of the review from a broad range of stakeholders (e.g., beneficiary partners, operational partners, development health partners). Interviews were conducted virtually with stakeholders based outside of Liberia, and physically with stakeholders based in Liberia during the country visit. All results of interviews are kept confidential. Apart from key informant interviews (KII) with the key staff of Mercy Ships, we conducted additional work sessions with Mercy Ships' staff responsible for programs design, finance, and M&E in particular. These work sessions allowed for an in-depth understanding of the particular aspects of project and financial management and M&E.

A country visit took place between 21 and 28 of June 2023. Ten sites were visited (e.g., Ministry of Health (MOH), hospitals). In one of the hospitals visited, we observed a user training for anaesthesia equipment conducted by one of Mercy Ships' suppliers. A total of 25 face to face interviews were held. Vigdis Halvorsen from Norad participated in the country visit as an observer.

Data obtained through different data sources and data collection methods allowed for rigorous triangulation.

[12] https://www.maxqda.com/

### 3.3 RISKS AND LIMITATIONS

To answer to review questions related to the overall management of the project (e.g., most questions of review area 2) we mainly depended on data from MSI and MSNo and virtual interviews with key staff from these entities. An important limitation therefore is that despite best efforts, this remote component may be limited by their accuracy and relevance. For crucial elements we requested MSI and MSNo to fact check prior finalisation of this report.

## 4 FINDINGS AND ASSESSMENT

This section provides answers to the review questions. Each sub-section describes the answers in the order of the questions as per Table 4 in section 3.1. Each answer starts with a short summary (in italic) which is then further elaborated upon. We start this section with an overview of Mercy Ships and Norway's joint history.

### 4.1 MERCY SHIPS AND NORWAY

To better understand the context in which this grant was negotiated and to put the current review and findings into perspective, we start this section with an overview of important moments in the recent joint history of Mercy Ships and Norad. We also provide some more background on the course of the project under review, including key events in the grant management process.

Previous Norwegian support to Mercy Ships (MSI and MSNo):

- From **2015 to 2016** MSI received funding from the **Norwegian Embassy** in **Madagascar**, and from the Norwegian Ministry of Foreign Affairs (MFA) for a two-year project in **Cameroon** (**2017-2018**).
- Norway's support during these years was directed by majority notes on the national budget (referred to as *Prop 1 S*) from the Norwegian Parliament, that at that time consisted of the Conservative party, the Christian Democratic Party, the Liberal Party, and the Progress Party of which some were part of the Norwegian government between 2013 and 2021. The Christian Democratic Party joined the government coalition in 2019 and held the position as Minister of International Development from 2019 to 2021. This Minister visited the vessel in Senegal and Liberia in 2019.
- From **2018 to 2021**, **Norad** supported the *Bringing health and hope – to people and countries project* that was implemented in **Guinea, Liberia, and Senegal**. Based on the concept note from MSNo for this project, sent to both MFA and Norad, Norad expressed concerns about alignment with Norway's priorities (e.g., national health system strengthening, Universal Health Coverage (UHC)), and sustainability. Both MSNo and Norad put considerable effort into improving the project proposal in line with Norad's requirements, and ultimately MFA confirmed its intention to allocate funds to MSNo through Norad. The agreement was signed in December 2018, but it took almost a year for MSNo to submit project documents at a satisfactory level to allow for approval by Norad. Both MSNo and Norad faced challenges with this grant; Mercy Ships with the implementation of the health system strengthening component, and Norad with management of the grant which was labor intensive and time consuming (e.g., due to numerous versions of documents and reports and extensive consultations). From 2020, the Covid-19 pandemic inhibited project implementation in country as well as adequate project review by Norad. The agreement ended in May 2021, but In July, Norad approved a no-cost extension for six months until 30 November 2021.
- Early **2021**, Norad commissioned a **partner assessment of MSNo** which led to the following main findings: MSNo mostly complied with administrative and financial management requirements, but delays were observed in the development and implementation of health system strengthening,

and weaknesses were identified in systems for data collection, monitoring and results reporting. Meanwhile Mercy Ships developed a new strategy combining the work *on-ship* with strengthening capacity at health institutions *on-shore*.

The application for the project under review, **Partnering for Transformational Change – Strengthening Liberia's Surgical Health System 2021-2023** for a total amount of 28 million NOK, was received in early 2021. It concerns an extension of the 2018-2021 agreement described above, but only for Liberia. It was submitted by MSNo. Norad's review and decision process took considerable time; not only due to an ongoing reorganization, tight budgets, and a general prioritization of the Covid-19 response, but also because of internal discussions. Eventually it was decided to provide the requested support, a decision that was primarily based on the revised Mercy Ships strategy (more focus on *on-shore* long(er) term support), the disruptive effects of the Covid-19 pandemic on the implementation of the project, and the impossibility, also due to the pandemic, to conduct an in-country review.

MSNo received a positive response on 25 May 2021 and was requested to revise several project documents focusing on capacity building and reflecting the key findings of the 2021 partner assessment. In June however MSNo started implementation of the project with its own funding, without, as per Norad's perception, formal approval from Norad. At that point in time, the project documents requested by Norad had not yet been summitted by MSNo. Based on email communication from Norad on the topic, MSNo interpreted that Norad agreed with the preliminary start of the project with Mercy Ships funding and reimbursement after grant signature. What was actually agreed between the two parties about an early start of the project (i.e. prior to grant signature) remains unclear from the information available to the reviewers. It is quite possible that related communication has been explained differently by both parties.

In the fourth quarter of 2021 several events took place: MSNo continued implementation of the previous grant during the project extension (until November 2021), followed up on the partner assessment, and revised application incorporating the recommendations provided by Norad. The project documents requested were received at the end of November 2021, but for a two-year period only. During the same period, resulting from a change of government in Norway, Norad was instructed to suspend any new agreements. MSNo was informed about the suspension, and about the possibility to sign the agreement early 2022.

In that period, MSNo was again requested to make additional changes to the application. At Mercy Ships' end unexpected events resulted in the project having to be adjusted too. It suspended activities at the ELWA hospital, one of its main partners. Ultimately, based on another extension of the deadline, MSNo submitted final project documents on 29 July 2022. An external assessment of the application was conducted in August, and Norad signed the decision document and the grant agreement on 26 September 2022. A first amendment was made mid-October following a change in the implementation plan and budget. The first disbursement was made on 19 October, 16 months after MSNo started implementation with its own funds, and one month after signature of the decision document and the grant agreement.

In the second quarter of 2022, Mercy Ships leadership decided to discontinue activities in Liberia after finalization of the ongoing ones, including those supported by Norad. Norad was (informally) informed on this decision during this present review (June 2023), more than a year after the decision.

Since the first application for the project under review, three different Norad staff members were responsible for grant management causing an uncomfortable situation and inconvenience at both levels. At Mercy Ships, confidence levels in Norad as donor slightly decreased while in this somewhat tense relationship both entities would benefit greatly from a smooth collaboration.

## 4.2 REVIEW AREA 1: TO WHAT EXTENT THE PROGRAMME ACHIEVED EXPECTED RESULTS?

**To what extent have the programme outputs and outcomes been achieved or are likely to be achieved?**

*According to the implementation plan dated 3 March 2023 provided by MSNo, all activities foreseen are carried out, except for follow-up mentoring for the leadership training (output 2.1), and the Clean Cut activities (output 3.1). The leadership training is somewhat delayed, and scheduled to be finalised at the end of September 2023 and thus during the project extension. The Clean Cut activities however continue until mid 2024.[13] Although indicators for some locations where the Clean Cut activities have been/are being implemented will be available, the final project outcome indicators to measure overall results of the Clean Cut activities will not be before the official projects end. While activities were to a very large extent carried out, reported results of several LFA output indicators provide limited information on the actual achievements and results of the project (expected changes).*

Before we describe the results of our more in-depth analysis of achievements of project outputs and outcomes below, we present a summary of the main results achieved until mid 2023 (see Table 5 below). Results listed focus on quantitative indicators: number of training participants, number of equipment and supplies (anesthesia equipment and nurse kits), number of hospitals and number of counties covered. Whenever possible, we complemented these quantitative data with qualitative data.

The results presented are reported in:

- Progress report 1 (Jun 22-May 23) and LFA
- Progress report 2 (Jun-Dec22)
- Mercy Ships Liberia Statistics Report 2022 Calendar Year
- Mercy Ships Liberia Statistics Report 2023 Calendar Year 30 Jun 2023.

Available results from the period January to May 2023 are those as reported in the Mercy Ships Liberia Statistics Report 2023, which is updated up to June 2023. A narrative providing additional information for that period was not yet available at the moment of the review. The Mercy Ships Liberia Statistics Report is not available for the first 6 months of the project (June to December 2021).[14] The LFA contains *milestones* for end of May 2022, and *targets* for May 2023. We use this same terminology in Table 5 below.

The table follows the LFA, starting with the expected results for the outcome, followed by results of the 4 outputs, as described in the narrative of the proposal and in the LFA what belongs to that proposal (dated July 2022).

Results of a detailed review of the M&E system, including the LFA, are presented in section 4.3.1 below.

[13] Norad will fund the activities up to the end of 2023, and Mercy Ships for the remaining period.

[14] General statistics for this period were incorporated in the first progress report submitted by MSNo.

Table 5. Summary of the main project achievements up to mid 2023

| Activity/intervention | Expected results as per proposal (29 July 2022) | Expected results as per LFA (July 2022) | Achievements up to mid 2023 |
|---|---|---|---|
| **Lifebox Clean Cut™ Training (course and equipment)** *Outcome 1/outcome indicator 1.1, Outcome 1/outcome indicator 1.2, Output 3/Output indicator 3.1* | 4 to 5 hospitals | 5 hospitals (for all indicator concerned)<br>Output indicators from Output 3 are related to 4 different training/activities | 2 hospitals<br>This information is not fully up to date: the Mercy Ships Liberia Statistics Reports do not include information on this activity and the latest progress report covers information up to December 2022 only. The next report is foreseen in October 2023, providing an update of Progress report 2 (Jun-Dec 2022). |
| **Neonatal Resuscitation Training** *Output 1/Output indicator 1.1* | 150 participants (100 in Monrovia, 50 in two interior locations)<br>6 courses, 570 hours in total<br>No information is provided on the number of hospitals | The LFA does not include intended numbers of participants and/or hospitals<br>Milestone 1 mentions 103 participants, but this is not related to the intended number of participants but to the scoring as per the baseline (*103 participants from 5 hospitals scored an average of 3.5 out of 10 on an Neonatal Resuscitation knowledge test*) | 165 participants from 10 public and non-profit hospitals in 5 counties<br>The LFA (progress report 1) reports an average result of 9.3 out of 10 on a neonatal resuscitation knowledge test as compared to 3.5 out of 10 at baseline. The test results are based on pre and post training tests, and do not consider the performance of the participants in their actual workplace.<br>Note: The narrative of the report states 11 hospitals in narrative, but lists 10 in the table that presents the numbers |
| **SAFE Obstetric Anaesthesia Training** *Output 1/output indicator 1.2* | 15-20 participants<br>No information is provided on the number of hospitals and/or counties | The LFA does not include intended number of participants, hospitals and/or counties<br>Milestone 1 mentions 77 participants, but this is not related to the intended number of participants but to the scoring as per the baseline (*77 participants completed the online safe obstetrics course prior to the skills day*) | 81 participants in 13 counties<br>The LFA (progress report 1) reports results of self-assessed confidence improvement of participants (99% scores 27 out of 30 elements). This however provides limited information on improved knowledge and capacity required to improve actual performance in the work place.<br>The total number of participants is higher than foreseen because, forced by the Covid-19 preventive measures in place at the time, the theoretical part of the course was done online, which allowed for a larger cohort. |
| **Anesthesia Provider Training and Equipment** *Output 1/Output indicator 1.3* | 12-16 Glostavent Helix Anaesthesia Systems and patient monitors<br>Numbers of participants for training, hospitals and counties are not provided<br>1 participant for mentoring | 16 anaesthesia machines | Equipment: 16 Glostavent anaesthesia machines<br>Training: 113 participants<br>Mentoring: 4 participants<br>The LFA dated July 2022 includes additional machines that were repaired during the project implementation period (7 machines in total)<br>The initial distribution plan was slightly changed; Mercy Ships, in collaboration with MOH opted to provide more hospitals with a machine, instead of providing second machines to the same hospitals. |
| **Leadership and governance training** | 30 participants per course, including from MOH, hospital staff, | 45 participants for leadership teaser training session (Milestone 1) | Varying number of participants for the different modules that make up the training course (between 16 and 20 on average). The fact that not all participants are present for all models (and maybe participants are not the |

| Activity/intervention | Expected results as per proposal (29 July 2022) | Expected results as per LFA (July 2022) | Achievements up to mid 2023 |
|---|---|---|---|
| *Output 2/Output indicator 2.1* | and medical training institutions<br>Numbers of hospitals and counties are not provided | 4 hospitals that report introducing at least 1 new quality improvement process (Target) | same throughout the training - this information should be known at Mercy Ships by means of the operational partner's reporting) can affect the impact of the activity. The training is set for the same participants for a certain period of time.<br>4 hospitals |
| **Safe Surgery Training course**<br>*Output 3* | 5 to 10 participants per hospital<br>Number of hospitals is not mentioned, but coverage of 15 counties is foreseen | No information is provided on the number of participants for this particular training<br>Output indicators from Output 3 are related to 4 different training/activities | 66 participants in 3 hospitals in 3 counties |
| **Nurses' Kits and Nursing Drug Reference Books**<br>*Output 3 (no specific indicator)* | 3,300 individual nurses' kits<br>70 nursing drug reference books | No information is provided | 3,000 individual nurses' kits<br>70 nursing drug reference books |
| **Surgical Nurse Training (MSSI)**<br>*Output 3/Output indicator 3.3* | No quantifiable information is provided in the proposal | No information provided on the number of participants for this particular training<br>Output indicators from Output 3 are related to 4 different training/activities<br>Milestone 1 mentions *28 participants complete the course, with an average score of 12+ out of 20 on knowledge tests about pain management and critical* care but this number does not seem related to the targeted number of participants<br>The baseline does not mention the number of participants, only a scoring (*Prior to the training course, nurses scored on average 9.5 out of 20 on knowledge tests about pain assessment and critical care*) | 107 participants from 7 hospitals in 2 counties<br>The LFA (progress report 1) reports a score of 13.2 out of 20 on knowledge tests about pain management and critical care as compared to the average score of 9.5 out of 20 at baseline. |
| **Biomedical Technician Training and Mentoring**<br>*Output 4/Output indicator 4.2* | 13 participants<br>Participants will receive their own toolbox | 18 participants | Training: 13 participants (as per the progress report) and 18 (as per LFA) from 7 counties (other counties were covered by activities MSI conducted with other funding)<br>Mentoring: 19 participants<br>The LFA reports that all 18 technicians who completed the course passed all modules, and the narrative added that the average score increased with as 34,5% compared to the pre-course skills test |

Information on activities carried out and their results is spread over different documents (LFA, implementation plan, progress reports), all with a different set-up and reference (e.g., the implementation plan refers to activity (project) numbers, the LFA to indicator numbers and these are not fully aligned), and all approved by Norad. None of these documents provide a full set of quantitative project data for activities foreseen and achieved (e.g., on the number of participants per training, the number of equipment). The following elements render a solid assessment as to whether results have been achieved and more important whether expected changes occur, virtually impossible: the project design with its strong focus on (short term and one off) training and provision of supplies (e.g., nurses kits, tool kits for BMET, anaesthesia equipment), a M&E system that is not fully set up for outcomes, and the short project duration. At most, we can indicate whether in big lines the activities have been implemented according to the proposal thus has training been conducted and was equipment delivered. See for more in-depth assessment of the M&E system section 4.3.1 of this report below). Section 4.5 provides more information on the main factors influencing achievement and non-achievement of sustainability of activities conducted by the project under review.

Intermediate results for the outcome indicators (*adherence to surgical safety checklist at targeted facilities and surgical patient satisfaction at targeted hospitals*) provide limited information on progress (e.g., agreement with Lifebox signed, research begun for the satisfaction survey), and final results will not become available before the project's end because the activities related to these outcomes (Clean Cut) will not be fully implemented before the project's end. The final project report will include activities as implemented up to December 2023. The contracting of Lifebox for its work in Liberia, MSIs operational partner for Clean Cut took longer than expected, which delayed the start of the activities. Some more delay incurred due to the suspension of activities in the ELWA hospital after the introductory course related to Clean Cut had started in this hospital. The ELWA hospital was replaced by another hospital. Due to the unexpected delays, coupled with unforeseen ceasing of Mercy Ships activities in Liberia, the activities pending implementation in the second half of 2023 will be implemented without Mercy Ships presence in Liberia. During this period, elections will be held in Liberia. These elements together pose a certain risk for the project, particularly for the Clean Cut activities that absorb a large portion of the total budget (almost 20%) and are responsible for the results of the only outcome of the project. See for more information on this and other risks and challenges section 4.4 of this report.

LFA targets refer to results per May 2023. Mercy Ships will report on these results in the next progress report to be submitted by October 2023. The Mercy Ships Liberia Statistics Report 2023 Calendar Year 30 Jun 2023 however already provides basic figures on activities conducted up to June 2023. Several LFA output indicators do not have a target because no activities were foreseen during the second project year; it concerns mostly indicators related to one-off training and equipment (output indicators 1.1, 1.2, 1.3, 3.2 and 4.1).

Results for the targets set for output indicator 2.1 (leadership training) and output indicator 3.1 (Clean Cut), are not yet known. Some changes were made in the selection of the hospitals for the leadership training due to internal challenges in one of the selected hospitals. Subsequently, in agreement with the MOH, two new hospitals were selected, which caused some delays in the implementation of this activity. Nevertheless, the training will be completed before the end of the project, and LFA targets are likely to be met (*selected hospitals report introducing at least 1 new quality improvement process*). According to interviewees however, actual results (changes in leadership) may be slightly less than expected because, due to the late start of the training in two out of the four hospitals involved, the mentoring period will be shorter than foreseen with subsequent less time for accompaniment of training participants and follow up on actions points identified.

For the indicators related to the Clean Cut activities (outcome indicators 1 and 2, and output indicator 3.1) it is expected that the targets will be only partially achieved; the Clean Cut activities will not be fully implemented before the project ends (December 2023). Mercy Ships will fund the part remaining in 2024 (up to June 2024).

The milestones and targets[15] for most LFA output indicators are providing limited information on the actual results and whether the expected change that is aimed for is observed. As such, for output indicator 3.2 for example *(# nurses with improved knowledge in pain management of the critically ill patient*) the milestone is defined as *'28 participants complete the course, with an average score of 12+ out of 20 on knowledge tests about pain management and critical care'*. The measurement is however based on pre- and post-test results, but with the post-test taking place directly after the training obtaining a high score is obviously expected. It would actually be more interesting to measure whether what was learned is effectively being put into practice and will lead to better care in the longer-term. The LFA indicates that additional qualitative information will be gathered from nursing supervisors' reports and case studies, but this information has so far not been reported on by Mercy Ships (in progress reports 1 and 2). For other indicators (e.g., output 1.2, *# anaesthetists reporting improved confidence on safe administration of anaesthesia to obstetric patients*), measurement is based on self-assessment only, and conducted immediately after the training. Interviewees indicated that pre- and post-testing are not informative, but these are required by Mercy Ships. A practical assessment also provides more insights in what the trainee learned and is capable to implement in its daily activities, particularly in the case of BMET.

Some activities carried out are spread over a relatively large number of hospitals, while others were conducted in just a few hospitals. A more holistic approach in a limited number of hospitals might have produced better results because it would have allowed more and deeper exploration of the different issues, and also because more people from the same hospital could have been trained which contributes to overall performance improvement.

Below we provide our main observations from the country visit, which adds further insights to the issues listed above that focus primarily on the LFA. Observations are grouped per main project component.

- **Nurse training (different training and courses, different output indicators)**: Overall, nurses we met were happy with training provided by Mercy Ships. The training on customer service (e.g., how to deal with patients and their families) was often referred to. The local realities incorporated in the training modules were appreciated, including by the trainers. Hospital management wished more nurses could have been trained; the available places did allow small numbers of participants per hospital for each training. Trainers/facilitators trained have the capacity, with some (financial) support, to provide further training in their own workplaces. Mercy Ships keeps records from those trained and shares these records with the MOH, but at that level no database is available to document training information (e.g., type of training, topics, level, who). The human resources information management database iHRIS is not updated for several years[16]. MOH is keen to incorporate training methods and materials used during training sessions organised by Mercy Ships in the curricula it will develop with support from the World Bank.
- **Anaesthesia equipment (Output indicator 1.3)**: The logbook of the anaesthesia equipment in one of the hospitals visited showed limited use (5 times since installation and training of the equipment in

[15] The LFA uses the term 'milestones' for results per May 2022, and 'targets' for results per May 2023.
[16] https://www.ihris.org/about

February 2023). This however seems an isolated case; well informed interviewees confirmed that most equipment already has many running hours. The limited confidence of nurse anaesthetists as well as the lack of necessary medication for pain management and other related health commodities in some hospitals may influence incidental (low) use of equipment. Mercy Ship does not provide any medicines and health commodities.

- **Leadership training (Output indicator 2.1)**: The two local trainers contracted by VID specialized university to, alongside with an international team, conduct the leadership training, are a strength. Training participants we met (in one hospital only) were enthusiastic about the training and these local consultants. Upon request of the MOH, two hospitals were added at a later stage and training only started end of 2022. For these hospitals, there will be limited time for mentoring and accompaniment which may compromise the training results.
- **Nurses kits (Output 3/no specific indicator)**: The distribution of the nurses kits put nurses throughout the country in the spotlight; they felt seen and that may boost their performance, at least temporary. Generally, the nurses met consider the content adequate, but reported issues with the batteries. However, very few kits were observed in the hospitals visited. Most nurses told they keep their kit at home for safety reasons (lack of lockers in the hospital), and use the tools from the hospital instead. Several tools of the kits shown during our visit seemed new or even unused; some were still in their original package. Mercy Ships informed that the MOH provided clear instructions to the nurses on their use at the workplace.
- **BMET (Output indicator 4.1)**: The level of knowledge and skills among BMET varies considerably, but some lack the basics. Training should probably have been more tailormade and be conducted in 2 phases: one on general technics and one specifically for biomedical equipment. Nevertheless, the training provided laid the foundation for MOH to conduct (basis) training, maintenance and repair. A well-equipped training centre is now up and running at the MOH Health care Technology Management Unit (HTMU). Equipment. Mercy Ships provided the anaesthesia equipment including a consumables and maintenance package covering, based on average use, a period of two years. A database to manage equipment available in the public health system does not exist making good maintenance and general management troublesome.

Overall, the project contributed to awareness raising on the relevance of surgical care and related unmet needs, including the importance of BMET.

**What are the major factors influencing the achievement or non-achievement of the outcomes and outputs?**

*Several enabling factors supported the carrying out of the project activities. These are however mainly related to practicalities of the activities rather than the actual achievements.*

Several **enabling factors** for the implementation of activities have been identified. Most of these focus on the practicalities related to this implementation, and less on actual results. The main ones include:

- Close collaboration with the Liberian Association of Nurse Anaesthetists (LANA). LANA maintains a basic but up-to-date database of all nurse anaesthetists which provided a good resource required for organising training.
- Covid-19 preventive measures including the travel restrictions, usually a barrier, stimulated innovations for alternative training methods; WFSA developed and implemented a hybrid SAFE obstetric anaesthesia course consisting of a theoretical part online, and (shortened) practical sessions at site, and that permitted the number of participants to almost double.
- The MOH departments involved (nursing midwifery department and HTMU) can only count on the support of a limited number of partners, which facilitated coordination and collaboration. Overall,

recipients (hospitals and health workers) were satisfied with the support received, and were willing to assist with implementation.

- The project mainly includes straightforward non-complex activities and for most of the implementation Mercy Ships could fully rely on its own (MSI) staff and volunteers, and on suppliers and operational partners with whom it has long-standing relationships.
- The Liberia country director and their team provided all necessary assistance (e.g., logistics, provision of materials required, coordination with the recipients).

The main barrier observed is related to Mercy Ships procedures at HQ level. Delays in procurement due to an update of MSI's legal document review process led to a late start of activities of Clean Cut in particular, contributed to the fact that these cannot be finalised before the end of the project (including the project's extension).

## 1. REVIEW AREA 2: TO WHAT EXTENT THE PROGRAMME HAS BEEN EFFECTIVELY IMPLEMENTED?

### 4.2.1 M&E

**How effective has Mercy Ships been in its M&E approach, is a monitoring system in place that allows tracking, critical assessment and reporting of achievements?**

*The M&E approach put in place by Mercy Ships for monitoring the progress of the projects activities is only to a limited extent fit for purpose. It is overly complex and involves many different divisions and entities from within and outside the organisation, who share responsibilities. The monitoring plan and LFA, part of the final proposal dated July 2022, have however been approved by Norad.*

Mercy Ships developed a monitoring plan and a LFA, and up to June 2023 submitted two progress reports. Furthermore, from 2022 onwards the Liberia country director developed monthly statistics reports listing the main activities conducted with number of participants for training, dates, hospitals and/or counties. These reports were submitted to MOH each month. MSNo developed an implementation plan listing the main activities per output, with start and (expected) end and completion rates.

The **monitoring plan** provides background on the selection of the project's impact and outcome indicators, and describes the different elements of the ToC, including output statements and output indicators that are linked to the project activities. It furthermore specifies which information will be provided in the narrative report[17] and which indicators are included in the LFA.

The **LFA** is presented in a logical framework format, and includes indicators, baseline data, milestones for end May 2022, targets for end May 2023 (the initial end date of the project) and means of verification. Furthermore, the LFA includes assumptions and evidence, as well as notes.

Until July 2023, the progress of the project is discussed in two reports: **Progress report** 1 covering the period June 2021 to May 2022 (the first project year), and an interim **Progress report** 2 covering the period June to December 2022 (the first half of the second project year). The latter was an extra report requested by Norad, considered as a risk reduction. Progress report 1 includes the LFA with results achieved during the first year, but, in line with agreements made on this 2nd (interim) progress report with Norad, an updated LFA was not provided along with progress report 2. Results for the entire second year of the project will be provided in an updated progress report covering the full year 2. The final report, due 6 months after the project end date (thus in June 2024) will cover the results form the entire project.

[17] It is assumed this refers to the progress report.

Analysis of the above-mentioned documents, yielded the following observations:

- The overall **impact statement** (*Improved maternal and neonatal health outcomes in Liberia*) is overly ambitious; this is unlikely to be realised within the scope of the project (short duration, limited activities). The **impact indicators** are not measurable by the project but require a population survey (e.g., the Demographic and Health Survey/DHS). Attribution to project results can therefore not be measured. According to the OECD, impact is defined as *the extent to which the intervention has generated or is expected to generate significant positive or negative, intended or unintended, higher-level effects*. Because of the emphasise on higher level effects, development health partners therefore often describe the expected impact of their projects *as contribute to XXX*. This is probably what Mercy Ships had in mind too.
- Some **output statements** provided in the monitoring plan are more focused on outcomes than outputs, such as for example output statement 1 (S*afer Anaesthesia provision and resuscitation practices for neonatal and obstetric surgical patients*). Under this statement, three output indicators are listed, of which two measure change (improvement) and thus actually are outcomes rather than output. This improvement however is measured based on self-assessment and self-scoring, conducted immediately after the training (see also section 4.2 and below).
- Due to the late start of the Clean Cut activities[18] (see for more information section 4.2), achievements for the two **outcome indicators** and for output indicator 3.1 will not be known before the end of the project. The year 1 milestones (results for end of May 2022) however were agreed by Norad.
- The monitoring plan includes several output and outcome indicators that are not part of the LFA. For these, the plan explains *reporting is for discussion within narrative report*. To some extent, results of these indicators are indeed included in the progress reports. It is assumed that the main source for these indicators are the narrative reports from the operational partners (see below).
- The LFA lists equipment donation records, quarterly monitoring, and maintenance records as sources of verification for **output indicator** 1.3 (*# functioning anaesthesia machines in targeted facilities*). Reportedly these data are usually collected by Mercy Ships staff during monitoring visits or by operational partners in their progress reports (see below), but the overall process and level of reporting for this output indicator remained somewhat unclear.
- The LFA monitors for a large part whether the activity has been conducted and to a more limited extent what the actual results of the activity have been. The indicators that measure change (usually improvement), i.e. output indicator 3.2 *(# nurses with improved knowledge in pain management of the critically ill patient*), mainly measure the scoring of the pre- and post-test. This however provides limited information on actual change in the performance of the trainees when back in their jobs. The Clean Cut activities provide date on actual change, and were particularly added to the project to cover that information gap. Unfortunately, due to the delays faced with implementation of these activities, only limited information on potential changes will become known during the project duration.
- Some indicators lack a clear definition, i.e. output indicator 2.1 *(# targeted facilities with quality improvement monitoring processes (such as M&M reviews, staff appraisals, reporting SSIs and perioperative mortality*). The improvement processes described in the progress report vary considerably among the hospitals involved, and for some activities described the stretch to quality improvement monitoring processes is rather long.
- Most of the baseline information originates from a baseline study conducted by Mercy Ships in November 2021, and from the CapaCare 2018 report which was referred to in the notes of the May 2021 workshop (see section 4.3.1 of this report). The baseline study focused on five hospitals only, and

[18] Clean Cut™ is an evidence-based quality improvement program aimed at improving compliance with six key perioperative processes and reducing surgical site infections. This program is implemented under Output 3.

provides limited quantitative information (e.g., which equipment exists and where it is installed). Mercy Ships project started more than 3 years after the CapaCare study and as no equipment management databases is in place, it is not unlikely that the baseline data were already outdated at the start of the project. It was however probably the most up-to-date information available when the LFA was developed, but it would have been fair to acknowledge this.

- As agreed with Norad, Mercy Ships reports progress on annual basis and the LFA follows that regularity[19]. However, Norad requested an additional interim progress report, covering the period June to December 2022. Generally, a two-year project however would benefit from a more regular progress tracking, a least for internal use at Mercy Ships. To our understanding, data to allow such tracking are collected. At the same time, several of the activities carried out are one-off courses and training and setting annual targets for these is therefore of limited use. The indicators rather serve as verification whether the activity has been conducted. General quantifiable information however (e.g., number of participants) has not been included in the LFA.
- While several of the indicators involve quantitative elements (e.g., change in knowledge test scores ) as well as qualitative information (feedback on the use of the learned skills and knowledge), this provides generally limited information on expected results i.e. actual improved performance. The M&E system is not well set up to measure this type of outcomes. From the few (internal) reports on activities conducted (e.g., training) reviewed we understood that Mercy Ships usually foresees follow up in-country activities to address course-related knowledge questions and provide additional training when needed, as well as country visits after to assess sustainability and impact two years after the activity. The duration of the project under review however did not allow for these activities and, as a consequence, limited information on outcomes is available.
- None of the project M&E related documents provides clear boundaries with regards to the numbers, e.g., number of hospitals targeted, number of nurses, nurse anaesthetists.

Mercy Ships followed the logical framework approach common in development projects, but operationalisation of the framework (data management and reporting) functions differs somewhat from most projects (e.g., data collection and management is a responsibility of the country office). Most of the data used for measurement of progress is made available by the suppliers and operational partners through reports on quantitative data for training[20], sent to the MSI Data Manager, and narrative reports sent directly to the contract holder at MSI (usually IP). Lifebox also reports directly to the MOH and MSI. Data received from suppliers and operational partners are co-managed and processed by IP and the MSI Data Manager before these are shared with the country director and MSNo. Verification of data and quality control is conducted to a certain limit: by direct observation by the country director or a MSI representative who accompany the activity in-country[21], and by general checks on reports received conducted by the Data Manager (e.g., are names of training participants filled out, are contact details are reasonable). Many entities are involved in tracking progress, but the country director and MSNo are limitedly implicated. Since the start of the project, several changes in the set-up and leadership of the division responsible for data management/M&E within MSI took place. MSNo requests the necessary data to feed the LFA and progress reports from the Director of the Monitoring, Evaluation, Learning and Development (MELD) division. In short, Mercy Ships developed a monitoring plan and LFA in line with Norad's guidelines but did not tailor its processes for tracking and reporting accordingly and efficiently.

[19] Norad requested an additional interim progress report for the period June to December 2022.
[20] For reporting on training Mercy Ships developed 2 templates (one for short- and one for long-term projects). These templates are not specific to the project under review.
[21] Usually, the MSI technical lead or a volunteer appointed for coordination of a certain activity.

The progress reports are overall quite rich providing background information and context, but not in a structured manner (the reports do not follow the sequence of the LFA indicators). Despite changes in presentation of the information made on request of Norad, it remains challenging to fully capture the links between the monitoring plan, the LFA and the progress reports. Information is presented in a somewhat scattered way. The second progress report covering the period June to December 2022 also presented activities conducted in 2023.

From interviews we understood that the activities conducted for the project under review are for 75% funded by Norad, and for 25% by other donors. As is reasonable, progress reports and LFA submitted to Norad include the full results of each of the activity but, only in a few occasions information is provided on this co-financing. In progress report 2 for example, it was mentioned that the Clean Cut activities in CB Dunbar hospital were conducted but with other than the Norad funds. For most results reported on activities conducted however, a clear and transparent explanation is not provided. In fact, Norad's funding contributed to only approximately 75% of the results reported but Norad seemed not be fully aware of this. In line with common practices at Norad, reports discussing results should be able to be read as standalone reports, and therefore should have explicitly referred to the proportion of funding from all donors involved.

### 4.2.2 COORDINATION

**To what extent are the Norad funded activities aligned with the priorities from the government?**

*Norad funded activities are to some extent aligned with governments priorities but are actually more tailored to the capabilities and preferences of Mercy Ships. While training and mentoring related to surgical care - focus areas for Mercy Ships - are important for the government as first steps towards improvement of surgical care, more is needed to achieve actual change in this area. The country lacks a clear surgical care strategy or action plan, and Mercy Ships could have supported the government with more strategic reflection on how to embed surgical care in its national health development strategy.*

Based on input obtained from participants from the three-day workshop Liberia's surgical landscape conducted in May 2021, Mercy Ships proposed to the MOH the activities for which the organisation has the capacity and interest to implement, all in its main area of expertise namely surgeries and surgical care. The activities proposed by Mercy Ships emerged from a three-day workshop that was held in May 2021 with 25 representatives of key stakeholders to discuss Liberia's surgical space.[22] The report of a research project on the surgical system capacities in Liberia conducted by CapaCare in 2018 was a key reference during this workshop, as well as throughout the project implementation. The workshop was then followed by a baseline assessment conducted by Mercy Ships to understand the surgical and anaesthesia capacity, and the quality of surgical provision. To our knowledge, no national strategy or action plan for surgical care exists. If available, this however could have been a more solid foundation to base the project on and to select activities; it would ensure full alignment with government priorities and support to the implementation of government plans in that area.

The leadership training implemented is a result of the above-mentioned workshop, during which participants identified weak leadership, as well as lack of training on leadership, as a main challenge for improvement of surgical care.

The project as designed by Mercy Ships consists of somewhat fragmented activities in the field of surgical care for a wide range of beneficiaries (mainly hospitals and health workers) rather than a holistic approach to strengthening national capacity in surgical care provision in a sustainable manner. Some hospitals

[22] Including MOH, hospitals, WHO, MSF, PiH, CapaCare, UNFPA, Liberia Medical and Dental Association

benefitted from several training and activities implemented by the project under review, but in other hospitals only one or two activities took place, limiting their potential impact. The short duration of the project implies restrictions on the type of activities that can be carried out, but more efforts could have been undertaken to design a project with activities that have more potential to achieve sustained change (e.g., support the improvement and revitalisation of the human resources management information system iHRIS so that all training conducted can be registered and become and remain accessible for all relevant stakeholders). Despite suggestions from the baseline assessment to engage, in collaboration with Optimum Biomedical Ltd, in establishing a regional distribution hub for biomedical spare parts, challenges in this area described in the minutes of the workshop and confirmed by interviewees[23],Mercy Ships decided not to support supply chain management.

**How are the Norad funded activities coordinated with government and other partners/donors working on health systems strengthening?**

The answer to this question focuses on coordination with partners and donors working on health systems strengthening in Liberia. Coordination with partners directly involved in implementing the Norad funded activities is discussed in section 4.3.5 of this report.

*Mercy Ships has not been an active partner in the heath development space in Liberia. Coordination with partners was quite intensive in the project's start-up phase but decreased over time. Coordination with government actors focused on practicalities related to the actual implementation of activities rather than on strategic and sustainable objectives of health system strengthening.*

Mercy Ships' proposal puts a strong emphasis on both local and international partnerships and lists their importance for the success of the organisations' five-year country engagement approach. The baseline assessment further highlights this importance of coordination and collaboration with partners working on improvement of surgical care in Liberia, particularly with the German *Gesellschaft Für Internationale Zusmmenarbeit* (GIZ), Partners In Health (PIH), Lifebox and CapaCare. The Mercy Ships' baseline assessment team met with representatives of these organisations to obtain an understanding of the scope of their work (geographic and thematic) and to ensure the project would not overlap with existing activities but rather complement. During the start-up phase of the project regular (informal) consultations took place with these organisations, but interviewees informed that the level of (structural) consultation decreased during the project. The mitigation measure described in the risk register is implemented to a certain extent only (*Work closely with the MOH and other key partners to ensure a balanced partnership throughout the lifetime of the project. All partners will need to make contributions to the project to avoid dependence on one actor (Mercy Ships)*).

LANA provided indispensable input for Mercy Ships throughout the project, mainly to connect with nurse anaesthetists and other health workers qualifying for training and with hospitals eligible for the donation of anaesthesia equipment. Collaboration with LANA has not been formalised.

Despite the recommendation by the baseline assessment team to participate in relevant government and partner working groups in Liberia (e.g., oxygen supply working group and BMET technical working group) Mercy Ship never joined these groups. That stated, the actual existence and functionality of these working groups remained unclear. Stakeholders interviewed eventually confirmed that the MOH failed to set up/ensure continuation of these groups. They however also recognised that partners could have performed better in terms of coordination and collaboration.

[23] Optimum Biomedical Ltd confirmed that after thorough investigation, this project turned out to be not viable, mainly because of stipulations imposed by the Ghanaian government and (dysfunctional) distribution agreements already in place.

On a higher level, the health partner working group, chaired by WHO, meets monthly to discuss overall health related issues. Considering MSIs aim *to bring hope and healing to providers and health systems*[24], it would have been an option for Mercy Ships to take part in these working groups and meetings to remain updated on developments in the Liberian health sector and opportunities for contribution of Mercy Ships. Several other coordination bodies involving the MOH and relevant development partners exist at central and county level, yet for most of these bodies, the functionality and efficiency are limited. In general, interviewees believe coordination mechanisms at county levels are more efficient than those at central level.

For the overall collaboration of Mercy Ships and the Government of Liberia a General protocol agreement exists (see for more information section 4.3.5 of this report). A technical committee, chaired by the Minister, was set up in 2019 to coordinate the arrival of the ship and related activities on both ship and shore; the committee however did not reconvene after the Covid-19 pandemic, as it had become clear the ship would not land in Liberia. In the absence of a formal coordination platform, interaction with the (different entities within) MOH was primarily based on an as needed basis, and focused on operational issues.

In-country coordination on practicalities related to the actual conduct of activities (e.g., dates and locations of activities) has been adequate. Mercy Ships country director[25] maintains close contact with the different departments within the MOH (mainly HTMU and the nursing midwifery department) as well as directly with the hospitals involved. For the selection of participants for the different trainings as well as of hospitals for the donations, Mercy Ships strongly relied on the MOH. For the training, Mercy Ships provided the relevant information on each of the trainings, and the number of available places, based on which the relevant department of the MOH or the hospitals directly selected the participants. The selection for hospitals to receive equipment is a long process which involves the country director and the MOH in country; the ultimate decision for the selection of hospitals for the donation of the anaesthesia equipment was made by the Equipment Donation Review Team of MSI. A so-called Gift Donation Form is signed by both the receiving hospital and Mercy Ships (in this case by the country director). Mercy Ships recommended the anaesthesia equipment (Glostavent) from Diamedica Ltd due to its design for use in low resource settings, and the MOH accepted this recommendation.

### 4.2.3 COMPETENCE

**To what extent is Mercy Ships equipped (e.g., competence, experience) to implement a capacity development programme? How adequate are the approach and tools developed by Mercy Ships to implement this programme? What competences or tools are missing, if any?**

*Mercy Ships is not yet adequately equipped to efficiently and effectively manage a health system strengthening project as per the standards for government (bilateral) funding. The approach and tools used to implement the Norad funded activities were built primarily on experiences Mercy Ships main activity, providing free surgery, rehabilitation, and aftercare for patients and the couple of activities on shore that have accompanied the activities on the ship over the years (e.g., mental health training, nutritional agriculture training). The key tools (e.g., LFA, budget) were approved by Norad.*

As reflected in the project documents reviewed, Mercy Ships considers the project under review a health system strengthening project, more specifically a project that aims to improve the national surgical system. Within that health sub-system only two elements are covered; health workers, and inputs (equipment and key tools for nurses and BMET). Other pillars of the surgical care system required to run the system (e.g., financing, policy making, data management) were not foreseen to be covered by the project. According an editorial by Joseph Kutzin and Susan P Sparkes in the Bull World Health Organ 2016;94:2, *health systems*

[24] Mercy Ships International Programs, Strategic Framework 2023-2025 (January 2023)
[25] She for more information on the role of the country director section 4.4.2.

*strengthening involves significant, purposeful effort to improve performance that goes beyond merely investing in inputs; it means reforming how the health system actually operates*.[26] Based on this definition, it may be aspirational to consider this a system strengthening project, even if this project only focuses on a few pillars of the health system (e.g., human resources) and to a sub system (surgical health). There were nevertheless reasons for Norad to approve this project.

Within the projects' boundaries Mercy Ships opted to concentrate on capacity building by training, including Training of Trainers (ToT), aiming at building skills of individuals to address specific problems (e.g., unsafe surgical care provision). The provided training included a (relatively small) component of mentoring. Capacity development however entails a broader range of activities that are required to empower individuals and institutions to conduct their roles and responsibilities adequately (e.g., policy development, institutional reforms, retention of capacity)[27]. This type of elements however is only addressed to a very limited extent.

With the organisational and managerial set-up opted for by Mercy Ships, the organisation's in-country capacity to conduct training and mentoring is limited. Training courses are managed by (international) MSI staff or volunteers and implemented by operational partners contracted by MSI. The latter are sometimes supported by MSI staff and volunteers. The temporary or short-term in-country presence of trainers and mentors is not an ideal approach to develop capacity. Two operational partners opted to contract local consultants to carry out (part of) the activities (leadership training and Clean Cut). This is a more (cost-)efficient approach.

Since 2020 a Mercy Ships country director has been based in Liberia. They initially primarily focussed on activities in preparation for the arrival of the ship. Hence, the country director profile is aligned with corresponding responsibilities, but is less appropriate to implement a system strengthening project efficiently and effectively. Their role focuses on supporting activities rather than managing the project and technical issues, and they have limited involvement in M&E and financial management.

Mercy Ships approach to collaboration with the main recipient (MOH) and its partners is not fully aligned with common practices. There are no regular coordination and steering meetings, and Mercy Ships is not involved in (technical) working groups and other coordination platforms. The country director has good working relations with the relevant entities within the Liberian MOH which facilitates coordination of activities. Interaction with higher level MOH leadership generally occurs on an irregular basis, yet to achieve and sustain changes realised at lower levels, full commitment from this level is required.

All contracts and coordination with suppliers and operational partners are managed by MSI. This includes reporting on implementation of the activities and results. The country director is only involved in practical issues related to implementation of activities but is not part of more technical and managerial aspects concerned. More information on working with partners is provided in section 4.3.5 of this report.

Existing tools for project management (e.g., M&E, budget monitoring and grant management) provide room for improvement. Mercy Ships basically used the same approaches and tools as the organisation applies for projects funded with private funds. The vast majority of Mercy Ships' funding comes from private donations. Maintaining its approaches and tools therefore makes sense from a (cost-)efficiency point of view; adapting systems that have been working adequately for many years in a big organisation is a considerable investment in terms of time and resources. At the same time, it should be recognised that conditions and approaches for private funding differ considerably from bilateral government funding, which is made available by tax

[26] https://www.who.int/docs/default-source/documents/15-165050.pdf

[27] https://www.diplomacy.edu/blog/what-difference-between-training-and-capacity-development/

payers. In the past, Mercy Ships received funding from the UK government, but currently Norad is the only bilateral donor. See for more information on financial management and M&E see sections 4.3.4 and 4.2.

The activities selected for this project are not well aligned with the project's objective (*Strengthening Liberia's Surgical Health System)* and with the impact statement as per the monitoring plan (*Improved maternal and neonatal health outcomes in Liberia*), or may indeed have been misleading. It is unlikely to expect these outcomes can be improved by conducting training on surgical care, and provision of basic supplies within a period of 2 years only. Arguably Mercy Ships, because of its limited experience and expertise in the broader field of health system(s) (strengthening), underestimated what it entails to manage a bilateral government funded project in this area, what it involves to adequately implement it, and what tools it requires, but it should also be noted that Norad decided to approve a two-year project only (instead of five-year as per MSNo intentions).

Mercy Ships has proven technical experience and capacity to manage the *on-ship* surgical services and related activities. Several trainings and courses are organised alongside *on-ship* activities, in close collaboration with MSI's longstanding partners (e.g., MSSI and WFSA). This valuable experience however is not fully sufficient to adequately design and implement a health system strengthening project. It does require an in-depth understanding of all elements of a health system in all its dynamics, relevant technical and managerial expertise and coordination skills, and insights in the health development spectrum, and all or at least most of this through country presence.

Overall, for adequate implementation of a health systems strengthening project in line with the set up and approach applied by development partners in health and according to Norad's priorities, Mercy Ships does not yet posssess the necessary technical capacity and experience.[28] Interviewees informed that few people in key positions within MSI have a background in development; in line with Mercy Ships' new strategy changes are being observed recently, particularly in the more operational positions and in-country.

Mercy Ships, motivated by Norad, invested considerably in developing and improving systems and tools required to manage the grant according to Norad's guidelines and requirements. As such, a monitoring plan and LFA were developed and then approved by Norad.

The IP strategy was launched in 2021, and fully revised in 2023, with subsequent revision of the MSI organisational structure, including recruitment of staff qualified and experienced in longer-term, external donor funded health projects with a focus health systems strengthening. This transition is still ongoing, and the continuous restructuring of MSI had its repercussions on the grant management (e.g., changes in the set-up of the support for M&E).

**How efficient is the (internal) organisation of Mercy Ships in leading, providing technical backstopping and monitoring the capacity development programme in national institutions?**

*Mercy Ship's general model and the established structure to manage and implement the Norad grant is complex and only to a limited extent efficient for the project under review; many people and divisions from different (legal) entities are involved, adequate experience with and knowledge of public grant management is limited, and expertise with implementation of a capacity development programme of this scale is lacking. The ongoing transition within Mercy Ships did not provide for a stable foundation and a conducive environment to implement a project in a relatively new technical area.*

[28] The partner assessment dated February 2021 states that Mercy Ships is *considered to have the managerial, administrative, and financial capacity to manage the project* and *that MSNo has three well qualified staff working with the capacity building project covering organisational/capacity development, managerial and financial aspects of the cooperation with MSO.* It should be noted that this partner assessment focused on the first Norad grant to MSNo implemented between December 2018 to 2021. The assessment was conducted before the proposal for the project under review was approved by Norad.

Overall management of this project consists of a complex system with several underlying factors influencing its efficiency and effectiveness (e.g., unclarity or diverging views on the strategic direction of the organisation). Because of Mercy Ships organisational structure, the project is likewise managed in a much different way than most development health projects. Many interviews were needed to obtain a clear picture of how Mercy Ships is structured, and which management model was adopted for the project under review.

Within the vast universe of Mercy Ships, the following (sub)departments and entities play a key role in implementing the Norad funded project: IP under HQ, MSNo and the Liberia country director[29]. Regular coordination meetings are held between these actors, and other entities are called upon on an as needed basis (e.g., contract department, procurement department).

Generally, the country director has limited information about the project. They are only indirectly involved in programmatic issues which does not allow for a full understanding of the approach and technical and programmatic issues, and overall challenges and potential limitations. Their decision-making power was overall restricted. This weakens Mercy Ships' position in strategic discussions and coordination with MOH and its partners.

Despite having a MELD division in MSI IP, at least in the new structure, activities required to adequate tracking of progress according to the approved monitoring plan and LFA are conducted by a large number of entities including but not limited to MELD. Similarly, responsibilities for management of the Norad approved budget are spread over different people and entities within and outside Mercy Ships (see section 4.3.4 below).

The exact roles and responsibilities and division of labour between MSI, MSNo and the country director related to implementation of the project under review remain to a large extent unclear, but while MSNo is the grant owner and therefore ultimately responsible for management of the Norad grant, most decisions seem to be made by MSIs IP. The country director has limited responsibilities. Interviewees believe that through its relationship with Norad, MSNo has a unique position among the affiliates. In practice however, MSNo, despite being the Norad grant holder, does not have considerably more responsibilities and decision-power than other affiliates.

Based on experiences from the project under review, Mercy Ships aims to expand its work field to development aid. Capacity building has been part of the organisation's work in the past, but on a different scale, with a different approach and with different funding, and most of the time in parallel with the *on-ship* activities. Inspired by the Norad grant, in March 2021, Mercy Ships IP launched the *Programmatic Strategy to Achieve Lasting Change* in which the direction of the Mercy Ships programs for the coming five to 10 years, including a ToC, is described. This strategy was revised in 2023 to emphasise the shift to more longer-term investments in surgical care, and is published under the name *Strategic Framework 2023-2025*. It exemplifies the tumultuous transition the organisation is currently in. Interviewees informed the ongoing shift from ship to shore has been challenging and has been marked by multiple leadership changes within a short period of time.

### 4.2.4 FINANCIAL MANAGEMENT

**To what extent does the budget have a reasonable proportion of direct vs indirect cost, and is does reporting to Norad allow for adequate monitoring of budget execution?**

*Several versions of the project budget circulate, and while different budgets in the current set up were approved by Norad, questions kept coming up as a reaction to the financial and narrative reports submitted*

[29] The country director reports to the Director Africa Service Centre. There is also a 'dotted line' between the country director and the Director of IP and between country director and MSNo.

*by Mercy Ships, mainly related to the different budget categories (mainly Other, Program Support and Admin Support) and which costs belong to which categories and why. Although these issues were clarified to some extent, the budget set up does not fully allow to ascertain and distinguish direct and indirect costs. The set up with MSNo as Norad's grantee but implementation of activities by both MSNo, MSI and external parties, including different ways in cost categorisation brought complexities in understanding the financial management of the grant. Expenses previously covered in specific budget categories, moved to other budget categories or were distributed across different categories during the project. Up to the final stages of this review, updated budgets were submitted to Norad. The many requests and feedback regarding financial matters and the related communication back and forth took up considerable time for both parties.*

As per the budgets used at MSI, the budget presented by MSNo includes seven budget categories: *Personnel, Travel, Supplies, Contractual, Other, Program support and Admin support*.

In the decision document[30] dated 31 August 2021 used for the grant agreement there was already mention of concerns with regards to the set-up of the provided budget. However, no proofs of communication with MSNo on this topic could be found, meaning that probably Norad did not explicitly make MSNo aware on these concerns. One of the important limitations was that it did not include the number of people to be trained and the number of trainings that would be conducted, which caused challenges to calculate the unit costs and assess cost-efficiency and cost-effectiveness at the time of developing the partner assessment. Undesirably, this situation persisted, and also the review team is therefore not in a position to fully assess cost-efficiency and cost-effectiveness.

Norad noted important deviations of actual costs in the budget categories, mainly with regards to Personnel costs in a reaction to the financial report covering the first year of implementation. All deviations beyond 10% or NOK 15.000 need a written explanation from Mercy Ships. As such, Mercy Ships provided clarifications about the deviations in the budget categories *Personnel*, *Travel*, *Other* and *Program Support*. An important deviation constituted the transfer of salary costs between the different budget categories (e.g. *Personnel*, *Contractual* and *Program Support*).

However, the financial reporting covering the second year of project implementation raised similar questions from Norad. The programmatic report was not organised in such a way that it could be easily compared with the approved budget, and it also appeared that the budget was adjusted to cover for an updated exchange rate. Furthermore, the budget category *Other* remained substantial, and even increased, but no detailed breakdown of what this budget category included was provided. Moreover, the budget category *Admin Support* represented 8.3%, while, according to Norad's requirements, it could not exceed 7%.

Since many exchanges occurred on the budget and the financial reports during the course of the project, the review team had access to a considerable number of documents with financial information. In addition, two meetings were held with both MSNo and MSI to improve understanding about the budget, the financial reporting and the financial management in general. However, and due to some of the reasons described above, the review team was not fully able to re-constitute how finances have been managed and reported. It should also be acknowledged that most of the updated budgets provided by MSNo were ultimately approved by Norad.[31] Several staff rotations in portfolio management at Norad furthermore led to the loss of institutional memory with additional challenges for both Norad and MSNo related to the financial management of the project under review.

The review team relied its analysis on the budget for the disbursement request sent to Norad in June 2023, which was reportedly the latest approved budget available.

[30] The decision document is an internal Norad document that summarizes Norad's assessment. It is used for decision making on grants.

[31] The budgets not approved by Norad were considered by MSNo as working documents.

Figure 1. MSNo financial report, May 2023

**Financial Report per May 2023 and Budget**

| | Year 1 Actual | Year 2 Budget | Year 2 Actual | Year 3 Budget | Project Totals |
|---|---|---|---|---|---|
| | NOK | NOK | NOK | NOK | NOK |
| **Budget category TOTALS** | | | | | |
| Personnel | 1 748 526 | 1 682 869 | 1 904 243 | 378 944 | 4 031 713 |
| Travel | 649 213 | 1 036 231 | 527 735 | 244 908 | 1 488 424 |
| Supplies | 3 312 157 | 6 892 562 | 3 272 778 | 2 314 330 | 8 948 134 |
| Contractual | 1 638 760 | 1 770 871 | 415 929 | 453 887 | 2 519 724 |
| Other | 726 159 | 4 773 856 | 3 478 434 | 2 423 904 | 6 641 129 |
| Program support | 1 417 047 | 1 746 096 | 867 719 | 870 195 | 3 170 126 |
| Admin Support | 1 081 943 | 1 279 489 | 565 879 | 702 699 | 2 353 385 |
| **TOTAL** | **10 573 804** | **19 181 974** | **11 032 717** | **7 388 867** | **29 152 635** |

Although the questions around the different budget categories remained, the overall amounts in the different budgets that the review team analysed remained to a large extent the same. Some observations can however be made:

- Considerable difference in foreseen budget for Year 2 between the budget that was submitted as part of the baseline data and the latest budget for Year 2 (NOK 12 727 802 instead of NOK 19 181 974).
- A slight difference in the audit report Year 1 produced by Deloitte for the budget of Year 2 (NOK 19 238 155 instead of NOK 19 181 974).
- The budget for Year 2 includes costs for training that according to the most recent version of the LFA and the two progress reports took place only in Year 1 of the project (e.g., Neonatal Resuscitation training, SAFE Obstetric Anaesthesia training)

All financial documents reviewed contained a breakdown of cost categories per implemented activity and follow the same structure with the seven budget categories. As such, there is a breakdown of the budget for the following activities and interventions:

- Neonatal Resuscitation Training (1.1)
- SAFE Obstetric Anaesthesia Training (1.2)
- Anaesthesia Provider training and equipment (1.3)
- Leadership and governance training (2.1)
- Lifebox Clean Cut™ (3.1)
- Safe Surgery Training (3.2)
- Surgical Nurse Training (MSSI) (3.3)
- Nurses' Kits and Nursing Drug Books (3.4)
- Biomedical Technician Training and Mentoring (4.1)
- Project management & long term strategic development (5.1)
- Baseline(s) (5.2)

- Endline Assessment (5.3)
- Indirect administration costs MSNO (7 %) (5.4)

Some financial documents, however, also contained a more detailed breakdown of costs as per Figure 2 below.

Figure 2. Detailed breakdown of costs

| Detail | |
|---|---|
| Contract Labor | 60205 Contractual |
| Contract Services Expense | 60210 Contractual |
| Food Purchase Expense | 60330 Supplies |
| Insurance - Other | 60440 Other |
| Internet Access Expense | 60470 Other |
| Office Supplies Expense | 62020 Supplies |
| Supplies Expense | 68000 Supplies |
| Telephone - Cell Phones Expenses | 68055 Other |
| 62000 Meals & Entertainment Expense | 62000 Travel |
| 62005 Medical Supplies | 62005 Supplies |
| 62010 Miscellaneous | 62010 Other |
| 68000 Supplies Expense | 68000 Supplies |
| 68075 Travel - Other | 68075 Travel |
| Travel - Lodging | 68070 Travel |
| Travel - Transportation | 68080 Travel |
| Program Support | 69030 Program Support |
| Admin Support | 69040 Admin Support |

*Sources: Deloitte audit report Y1 and RAF 21 0055 Financial report for Y1 + Budget Y2 Mercy Ships Norway 2021-2022*

Especially the budget category *Other* raised several questions throughout the project implementation. MSNo and MSI provided clarifications, which have been accepted by Norad. Interviewees from MSNo and MSI highlighted that going forward there is an intention from Mercy Ships to break down this cost category in more detail to provide increased insight to grant providers. Looking at the project budget, the *Other* cost category is for example used when grants are being provided to other Non-Governmental Organisations (NGO) for implementation of activities (e.g., Lifebox). However, if under the same Norad-funded project activities are implemented by business operational partners, then these costs are accounted for as *Contractual* (e.g., Optimum Biomedical Ltd). Also, depending on the activity, there are different ways in which the costs are categorised. When a business operational partner is hired to conduct a training (e.g., Optimum Biomedical Ltd), this is thus considered *Contractual*. When equipment is needed to provide the training, this is considered *Supplies*. In order to get the equipment to the (training) location, the transport services are also considered as *Contractual* (or *Other*, depending on the project method, for instance if a driver is hired, vs. if a container is shipped) although the costs involved in organizing the procurement (e.g., the actual services of the procurement department to purchase the equipment and transport services) are considered *Program support*.

Another budget category that has raised issues is *Program Support*. MSNo and MSI interviewees stated that this budget category contains direct costs; it is a support that is shared across all MSI projects. Although salary costs would expected to be captured under *Personnel*, these are spread across different budget categories. Interviewees confirmed that the salary of the Liberia country director, for instance, is accounted for under *Programme Support*.[32]. Furthermore, the only activity that has *Personnel* costs included is the

[32] The review team received diverging information on the status of the Liberia country director. It was understood from the country director that they were voluntary, but MSI informed they were salaried staff.

leadership training, which covered the salary of the MSNo staff member who implemented this training in Year 1 and 2. However, as the employee left MSNo in Year 3, this cost was then moved to *Contractual* following the contracting of an external entity to implement the remainder of this training program. None of the MSO projects costs will be in *Personnel* in the new budget revision that will be submitted. As this is an MSO project, a portion of the MSNo employee has been seconded to MSO for the purposes of this project. According to MSI, legally, the employee must fall in the *Contractual* category instead of *Personnel*. According to MSI and MSNo the way of allocating salaries is based on the methodology used by USAID.

The *Project management & long term strategic development* and the *Indirect administration costs MSNo*(7 %)" also include *Personnel* costs, but it appears that some salary costs are also covered by *Admin Support*. *Admin Support* are costs that are considered as indirect costs, and cover for supporting finance, IT and human resources. MSNo, however, does not work with the budget category *Admin Support*, and therefore these costs are costs incurred by MSI. For MSNo, a separate cost category was created (*Indirect administration costs MSNO (7 %))* further to Norad's guidance. However, towards the end of this review, MSNo confirmed that this cost category would be dissolved in the new budget revision to be submitted to Norad, as per Norad's guidance to reduce indirect costs. According to MSI and MSNo this means that an increased portion of Norad funding will be allocated to the individual activities/projects. This may result in MSI and/or MSNo allocating other funds to cover for the admin costs.

Similarly, the review team could not fully ascertain what the difference is between the categories *Project management & long term strategic development* and the *Indirect administration costs MSNO (7 %).* Although each category independently remains under the 7% of the total budget, a straight-forward analytical exercise demonstrated that these two categories represent together 13% of the total budget.

Looking at the breakdown of budget categories for each of the separate activities, the proportion of the seven budget categories per activity differs considerably from one activity to another. As such, the *Admin Support* budget category for each project activity ranges from 1.3% (Surgical Nurse training) to 14% (Neonatal Resuscitation Training and Biomedical Technician Training and Mentoring) of the total costs of the activity. The *Program Support* budget ranges from 4.5% (Lifebox) to 60% (Neonatal Resuscitation Training) of the total costs of the activity.

Therefore, ascertaining the distinction between direct and indirect costs appeared challenging. An important complexity in re-constituting the financial aspects of the project lies in the fact that MSNo and MSI are different legal entities and that their way of accounting also differs. While MSNo is Norad's grantee, MSI budgeting and accounting mechanisms are also integrated into the budgets submitted to Norad.

With the many changes in the budget (particularly the redistribution between budget categories), including for actual budget of years 1 and 2, the question raised to what extent the amounts in the different budget lines are actual costs (for years 1 and 2) remains difficult to answer. It almost seems that the budgeting is a theoretical exercise to allow correct accounting between MSNo and MSNo, while ensuring results of this exercise remain within the existing requirements and margins of Norad's requirements.

MSNo outsourced the accounting to an external company and both MSNo and MSI contracted audit companies, but these are not the same. Reportedly, the accounting officer at MSNo merely carries out an internal control. The country director is not involved in management of the overall project budget; they are responsible for accountability for expenses incurred in-country only. In fact, MSNo is Norad's grantee and has outsourced the activities to a large extent to MSI but the budgeting and accounting appears directed by MSI (even seconding a portion of the salary of an MSNo employee). Although, according to MSI, the budgeting and accounting is in line with other NGO's and according to USAID methodology, compliance with Norad's requirements appears complex.

Although there were many exchanges between Norad and Mercy Ships on the budget and the financial reporting, it should also be acknowledged that Norad agreed with the additional information provided and approved the different versions of the budget and reimbursed accordingly.

**To what extent are the main interventions of the program cost-efficient based on commonly applied benchmarks (e.g., the Global Fund)?**

*We aimed to carry out an analysis of training costs of the project under review using benchmarks from other projects. This however proved difficult as no adequate datasets were available; both for the project as well as for the benchmarking. Instead, overall costs for the different training were calculated per person and then analysed, but actually no conclusions can be drawn.*

We intended to conduct a benchmarking analysis to estimate the cost-efficiency of the main interventions of the project (training) but while reviewing project data from Mercy Ships available for the review team we realised these data do not allow to reliably calculate costs per training, per day, and/or per participant, as highlighted above. Also, reliable comparable data could not be obtained (e.g., similar training, similar context, similar funding mechanisms). We however did an effort to calculate costs per training per participant, based on a number of assumptions in an attempt to analyse the cost-efficiency for training conducted with Norad funding. Results are presented in this section but should be interpreted with utmost caution.

Available project data did not allow to constitute a clear and comprehensive picture of actual training costs. We nevertheless attempted to summarise the costs involved in training for the project under review. The estimation of total training costs and costs per participant is based on the following data sources and assumptions:

- The number of trainees and the number of hours of training involved are obtained from Mercy Ships first progress report for 2021, and from the Mercy Ships Liberia Statistics Reports for 2022 and 2023. The latter contains information up to end of June 2023, but the number of trainees for trainings included in the analysis will not change anymore.
- Some training includes mentoring; this is not considered in the table below due to limited available data on mentoring.
- We based the estimation of the duration of the training (in hours?) on information provided in the MSNo progress reports.
- The training costs are obtained from the latest budget available (June 2023), and considered actual costs for year 1 and 2, and foreseen (approved) budget for year 3 (if applicable). We considered the full amount as specified in the budget per training but excluded the costs for supplies (the tool kit) for the BMET training and mentoring.
- We excluded the anaesthesia provider training as the costs for this training are included in the cost for equipment, and the documents available did not allow to distinguish which part of the costs relates to the actual equipment and which to the training.
- For similar reasons, the training involved in the Clean Cut activities are not considered; the budget does not allow to distinguish costs for the actual implementation of the activity and for training purposes.
- We also excluded the leadership training. An average of 20 participants per session per hospital are reported for the different modules that make up the training course, but we could not well estimate the duration of the training hours, as the training is still ongoing.

For comparison it would be more accurate to calculate the costs per participant per hour (or per day), but for some training, the number of hours of training per day were low (e.g., 3 hours), so calculating either a full day for a 3 hour training or a corresponding proportion of a day would not provide realistic figures.

Table 6 below shows the results of our analysis.

Table 6. Cost of selected training (per participants, in NOK)

| Type of training | Implementer | Total training cost | Total # participants | Cost per participant | Estimated duration of training (in # of hours) |
|---|---|---|---|---|---|
| **Neonatal Resuscitation Training** | MSI | 365 905 | 165 | 2 218 | 5,5 |
| **SAFE Obstetric Anaesthesia Training** | WFSA | 363 293 | 81 | 4 485 | 7 |
| **Safe Surgery Training** | MSI | 501 592 | 66 | 7 600 | 7 |
| **Surgical Nurse Training** | MSSI | 518 999 | 107 | 4 850 | 7 |
| **Biomedical Technician Training and Mentoring** | Optimum Biomedical Ltd., Diamedica UK Ltd | 3 472 776 | 18 | 192 932 | 242 |
| ***Total*** | | ***5 222 565*** | ***437*** | | |

Based on available data, firm conclusions on cost(-efficiency) cannot be drawn. As per the table above, comparison between costs of different training provided by the project is possible for three training: SAFE Obstetric Anaesthesia Training, and Surgical Nurse Training. These all have the same duration. The training conducted by MSI is higher than the two other trainings executed by operational partners. To our understanding, all these training worked, to the extent possible, with trainers and facilitators from the region and as such, it seems unlikely travel costs only makes the main difference.

MSI informed that for fundraising purposes, the organisation calculated an estimated costs of USD 6.000 (equivalent to NOK 62.280)[33] per day for the first three days of a training, and USD 4.500 for the consequent days (equivalent to NOK 46.710), which is based on information on training costs in the field of surgery in UK and USA. Firstly, the representativeness of these costs when conducting trainings in lower- and middle-income context raises questions. Furthermore, these costs are calculated per day, regardless of the number of participants in the training.

When, to allow for some sort of comparison of costs between the different training conducted, extrapolating the costs for the biomedical technician training to 7 hours, costs are within the same range as for the nurse training (NOK 5.576). This BMET was conducted by Optimum Biomedical Ltd and Diamedica UK Ltd, two highly specialised UK based organisations, and run over an eight-week period.

An important element to keep in mind when assessing cost-efficiency of project activities conducted is the fact that the costs as calculated for the grant are reportedly only 75% of the total cost; MSI pays the other 25% from other funds.

[33] We applied an exchange rate of 10,38 as used by MSNo in the version of the budget shared with Norad accompanying the request for disbursement in June 2023

More robust data, both quantitative as well as qualitative, and analysis are required to allow for evidence based unambiguous statements on cost(-efficiency) of the main activities implemented by the project under review.

### 4.2.5 WORKING WITH MERCY SHIPS' PARTNERS

**To what extent Mercy Ship has systems and procedures in place for working with/through third parties/implementing partners?**

*A protocol agreement between Mercy Ships and the Government of Liberia laid the basis for cooperation with the MOH and related entities (e.g., hospitals), the so-called beneficiary partners. For the implementation of the project under review, Mercy Ships collaborates with so-called operational partners with most of whom the organisation has a longstanding relationship. This relationship is formalised by means of a Memorandum of Agreement (MOA). The MOAs cover the different countries where Mercy Ships has been active. For the activities specific to Liberia, Mercy Ships developed amendments to these MOAs.*

Mercy Ships specifies two different partners: beneficiary partners and operational partners.[34] **Beneficiary partners** include entities and individuals within the MOH and NGO and/or institutions. All activities conducted for and with the MOH entities and/or individuals fall under the *General protocol agreement between Republic of Liberia and Mercy Ships* dated 25 September 2018, in which Mercy Ships and the Government of Liberia formalised their wish *to work tighter to pursue the Sustainable Development Goals (SDG) in the area of health by focusing on capacity building and training of local citizens* and *to be productive in healing of individuals and in the improvement of the country's health care delivery systems.* The agreement focuses primarily on the *on-ship* activities but also caters for other activities (e.g., services, mentoring, and courses), and furthermore supports visa application and other related legal issues. The protocol is valid for five years, and expires therefore on 26 September 2023, a few months before the end of the project (December 2023). It is not foreseen that Mercy Ships starts negotiations for an extension of the protocol agreement. No other agreements exist with beneficiary partners in Liberia.

There is no formal coordination or steering committee for the Norad funded project. As stated above, a technical committee was set up in 2019, chaired by the Minister of Health, to coordinate the arrival of the ship and related activities on-ship and shore, but the committee did not reconvene after the Covid-19 pandemic, also because it was decided that the ship would not come to Liberia. The country director provides so-called *Mercy Ships Statistics Reports*, monthly one page summary reports to MOH with a brief overview of activities realised up to the actual reporting month both with own funding as well as with Norad funding (e.g., main activity, name of the hospital where activity has been conducted, number of people involved, equipment concerned). There is no narrative report attached to this overview of activities.
Otherwise, Mercy Ships does not require any reporting from these beneficiaries (e.g., on use of equipment received, results of training). For the donation of the anaesthesia equipment however, Mercy Ships develops so-called donation receipt letters, that are signed by both the beneficiary (hospital) and Mercy Ships. The nurses who received a nursing kit were requested to sign for receipt of their kit.

With all **operational partners**, including suppliers, except for VID specialized university, involved in the project Mercy Ships already had an overarching MOA prior to the start of the Norad funded project. Amendments were added to these MOAs for the specific activities for the project under review, though with varying levels of details. All agreements available for review contain an anti-corruption clause as well as a clause on the right to audit, but no reference is made to any of the other relevant cross-cutting issues (e.g., human rights, gender equality) (see section 4.4 of this report below). For the selection of suppliers and

[34] Mostly called implementing partners.

operational partner for the project under review, no competitive selection process, as per the *Grant Agreement Part 3 Procurement*, was carried out, except for the selection of the partner to conduct the leadership training. More information on this selection and compliance with Norad requirements is provided below. Among the operational partners are no Liberian organisations but some contracted Liberian nationals to conduct (part) of the work.

The operational partners report to the MSI Data Management Director for output related data (e.g., number of people trained, hours mentored) and to the Senior Director of Program Design, Monitoring and Evaluation for more general regular updates or progress reports. For reporting on training standard templates exist. MSI however, does not necessarily have the relevant background and knowledge of Liberia, the project, and the grant requirements to judge on the content of these reports related to implementation of project activities. MSNo, who manages the grant with Norad, and the country director are not involved in the reporting process. VID and Lifebox are exceptions; VID (also) reports directly to MSNo, and Lifebox also reports to the MOH. The agreements do not provide any details on financial reporting.

Mercy Ships has strong systems in place for in-country support for operational partners who pay short or mid-term visits to Liberia to conduct training, install equipment. Partners interviewed unanimously valued this support.

### Do the systems/procedures comply with the Norad grant agreement?

*Systems and procedures in place for working with/through third parties and/or implementing (operational) partners mainly comply with the grant agreement's general conditions, but gaps are identified in compliance with the procurement rules and principles as per part 3 of the grant management agreement.*

The grant agreement's general conditions stipulate that transfer of all or part of the grant to cooperating partners has to be laid down in a written sub-grant agreement, and this sub grant agreement has to state that the partner concerned is required to comply with the grant agreement's conditions. The following main issues are identified:

- None of the agreements available for review, refer to Norads general conditions, and it could not be assessed whether operational partners comply with these conditions. Mercy Ships vendors are however required to submit a Declaration of Ethical Standards.
- Agreements between MSI and its operational partners include a clause on the right to audit, however this clause is not fully aligned with the audit requirements as stipulated in the general conditions. More precisely, MSI's agreement require relevant information to be kept available for audits during three years after the data of expiration or termination of the agreement, whereas the Norad grant agreement requires a five-year period.
- Although Mercy Ships has a Harassment Prevention and Reporting policy that includes sexual harassment, the MSI agreements do not include any clause regarding sexual exploitation, abuse and harassment (SEAH) as required by the Norad grant agreement general conditions (for grantees and cooperating partners).[35]

With regards to the procurement rules and principles applicable to the project under review, the following has been observed:

[35] The vendor declaration standards form, a document obliged for vendors to participate in tenders commisioned by Mercy Ships, states that '*Physical abuse or discipline, the threat of physical abuse, sexual or other harassment and verbal abuse or other forms of intimidation shall be prohibited*' but does not provide additional information and guidance.

- For implementation of project activities, Mercy Ships contracted operational partners with whom the organisation has worked for many years. Most of these operational partners are suppliers and organisations with whom the organisation has worked for many years, except for VID. To our knowledge, no open tender procedure was launched to contract, and amend existing MOA, with any of these longstanding partners. This seems a reasonable choice and consideration for the type of work and services in question. Norad's procurement rules and principles stipulate however that in such case, the grantee *shall justify and document in writing the choice of tenderers that are invited to submit an offer* (clause 5.3). We assume this also applies to existing agreements established prior to the project. Mercy Ships informed they have a procurement process in place to review Requests for Proposal and three-bid waivers. Internal MSI documents related to the selection of Lifebox were shared with the review team, but no information for (re-)contracting of other suppliers and/or operational partners became available for review. Also, no evidence was found that this information was shared with Norad for approval (in line with the requirements). Reasonably, Norad has known that these partners were contracted (the MSNo proposal lists these partners) but has apparently not followed this up further with Mercy Ship.
- For the selection of a partner to conduct the leadership training, a three-bid Request for Proposal process was implemented, led by MSNo, and MSI took part in the evaluation committee. The three companies requested to submit a proposal were selected based on an advertisement on the Mercy Ship website and in Liberian newspapers. All three bidders submitted strong proposals, but according to Mercy Ships documentation *the application from VID is the one which is easiest to evaluate because it follows the outline of the evaluation criteria from the ToR*. Overall VID presented the best offer, with higher scores than the other bidders on knowledge and experience from working on leadership development in Liberia and experience in academic leadership training and courses.
- Mercy Ships collaborated, to utmost satisfaction, with Lifebox in the past but a (new) MOA was required for the specific activities to be conducted in Liberia. MSI developed acceptable and reasonable justification for a single source contracting for its procurement department, but, to our knowledge, this justification was never shared with Norad.
-

## 4.3 REVIEW AREA 3: TO WHAT EXTENT RISKS ARE IDENTIFIED AND MITIGATED?

### 4.3.1 GENERAL RISKS

**To what extent are appropriate systems in place for assessing risks?**

*Several risks are involved in working with the Government of Liberia. Potential risks are discussed on a regularly basis but the sources of information to judge about these risks could be more comprehensive.*

The risk register developed by Mercy Ships as part of the project proposal and consequent update in 2022 October (as part of the first progress report) provide a clear overview of possible risks and mitigation measures. Risks identified cover a broad range of areas, and many are related to Covid-19 pandemic and preventive measures which was relevant at the time of proposal development. Other risks mainly cover practicalities and visible/tangible risks (e.g., training participants in remote areas cannot access the training courses, inequitable gender selection of training participants).

Risks are assessed during regular coordination meetings with relevant staff from MSI, MSNo and the country director, usually based on observations from the country director. They however have no full information on programmatic and technical matters (these are under responsibility of MSI) and are only to a certain extent interacting with the main development health partners in Liberia. Mercy Ships is not part of technical working groups or coordination platforms. The scattered management of the project within Mercy Ships is not advantageous for efficient identification and assessment of risks.

Follow up and mentoring activities conducted by MSI technical leads and operational partners provide occasions to identify risks. However, they miss an comprehensive overview of all project activities and may therefore be less aware of overall potential risks that can affect the project and/or reputation of Mercy Ships. Generally, risks related to equipment are fairly easy to identify (e.g., is the equipment functional, is the equipment in the correct location), but risks associated to the nursing kits for example (e.g., are the tools provided used for their intended purpose), or to changes and shifts in leadership positions at the MOH are less obvious.

Mercy Ships does not request any reporting from its beneficiary partners. Indeed, no direct payment is made to these partners, except for, if applicable, transport and accommodation costs for training participants, and all activities are implemented by Mercy Ships and its operational partners, and therefore reporting may not necessarily be required. It is however a missed opportunity not to create mutual accountability. Norads grants are funded by public money, and hence accountability is important.

Several government partners expressed there are (financial) risks involved in working with the Government of Liberia, including the US Embassy and the Global Fund who both made firm pronouncements on financial management of the MOH and perceived corruption within that Ministry.[36] Mercy Ships mitigates financial risks associated with their project by avoiding direct financial transfers to the government, and focusing on training (approximately 40% of the total project amount). This approach is risk averse, but it is disputable whether the support provided in these circumstances falls into fertile ground required to achieve the expected results, and is thus efficient use of available resources. The fact that many of the nurses we met during the country visit informed they keep the nurse kit they received from Mercy Ships at home, because of fear for theft in the hospital provides an example of suboptimal use of inputs provided. Mercy Ships is however aware of sustainability risks.

### What have been (unexpected) programmatical and managerial challenges and risks encountered during implementation?

*The delay in procurement of services, and the decision not to bring the vessel to Liberia and the related suspension of new activities significantly affected the completion and possible continuation of the project. Both cases are a result of internal MSI procedures and strategies, with underlying causes regarding the Liberian context.*

In the early phases of the project, Mercy Ships decided to suspend all ongoing and foreseen activities at the Eternal Love Winning Africa (ELWA) hospital in Monrovia due to a difference of opinion between Mercy Ships and the hospital management regarding the quality of patient care. The perceived risk was identified by Mercy Ships staff providing mentoring and direct medical services at the hospital. Prior to the suspension, health workers from this hospital participated in training on neonatal resuscitation and surgical care (Clean Cut), but no equipment and supplies were provided and Mercy Ships decided to cancel all other activities based on the recommendations from its staff that was embedded in the hospital for several months. This could suggest a difference in criteria applied by the MOH and values of Mercy Ships regarding selection of hospital to implement the project, although other issues related to the selection of hospitals/health workers were not observed. Mercy Ships mainly relied on the MOH for the selection of hospitals and health workers for training and related activities, but it had the final say in the selection of hospitals for the equipment.

The strategic decision by Mercy Ships leadership not to bring the ship to Liberia and consequently discontinue activities after the end of this project generated some particular challenges and risks. Mercy

[36] https://lr.usembassy.gov/a-press-statement-by-u-s-ambassador-to-liberia-michael-a-mccarthy/, https://www.theglobalfund.org/en/oig/updates/2022-04-08-liberia-fraudulent-and-abusive-practices-in-global-fund-programs/, https://www.theglobalfund.org/media/8945/oig_gf-oig-19-019_report_en.pdf

Ships decided to close the country office at the end of June 2023, the initial end date of the project. After closure of the office, the leadership training and Clean Cut activities continue still until September 2023 and June 2024 respectively.

The late completion of the Clean Cut activities are caused by delays in contracting Lifebox, and with the decision to substitute the ELWA hospital after suspension of the collaboration and addition of a fifth hospital, with the consequence that these activities cannot be fully finalised during the (extended) project. Also, the results of these activities, the only two project outcome indicators, will not be reportable on during this project. More important, overall oversight can no longer be provided by Mercy Ships after June 2023 (the initial end date of the project). Implementation of both the leadership training and the Clean Cut activities is led by local consultants (contracted by Mercy Ships operational partners), which to a certain extent limits the need for in-country support by Mercy Ships Nonetheless, close oversight and guidance for such important activities remains essential.

On 10 October 2023, general elections will be held in Liberia, and while outcomes are unpredictable, some social unrest in the run-up, during and after the elections is not unlikely. The MOH as well as key hospital staff may have limited availability during that period because of participation in campaigning, which can result in further delays.

Norad raised concerns on gaps and limitations with regards to the consolidation of policies on governance, working with partners, gender equality, environment, and a rights-based approach[37]; this topic is further discussed in section 4.4.2 below. Another risk observed by Norad is related to the fragmentation of the project activities and limited integration and synergy between the different activities[38]. There is no documentation showing that these risks have been discussed with MSNo. Consequently, the project design has not been revised (see section 4.3.1 for more information).

### 4.3.2 RISKS RELATED TO CROSS-CUTTING ISSUES

**To what extent Mercy Ships has adequate systems in place to ensure integration of considerations on cross-cutting issues (human rights, women's rights, gender equality, climate/environmental impact and corruption)?**

*Mercy Ships has policies in place for equal opportunity, harassment prevention and reporting, anti-terrorism, anti-corruption and a general code of conduct. No specific policies for gender equality and environment exist. It was not clear from interviews and review of documents related to collaboration with beneficiary and operational partners whether these policy documents are widely disseminated within the organisation and with its beneficiary and operational partners, and applied during implementation of the project. Agreements available for review (MOA, amendments, general protocol agreement between the Government of Liberia and Mercy Ships) refer to anti-corruption and the right to audit.*

Table 7 below lists the main observations related to each of the cross-cutting issues.

Table 7. Main observations related to each of the cross-cutting issues

| Cross-cutting issue | Observations |
|---|---|
| **Human rights** | With its focus on improving the lives of people with disabilities through providing live-changing surgeries, human rights are at the centre of the on-ship activities. For the Norad funded activities this focus on disabilities is however less prominent. A specific policy on human rights does not exist. |

[37] hera. Partner assessment Mercy Ships. Final report, February 2021
[38] Norad. RAF 21/0055 Decision document - Mercy Ships 2021-2023

| Cross-cutting issue | Observations |
|---|---|
| **Women's rights** | The project claims to focus on women's and children's' rights, confirmed by the project's impact indicators (improved maternal and neonatal health outcomes). Two activities focus on maternal and child health (neonatal resuscitation and SAFE obstetric anaesthesia training), others are more general but provide benefits for women too. |
| **Gender equality** | Analysis of data on training participants show the majority of nurses trained are female, while the participants for the user training on anaesthesia equipment and for the technical training for biomedical technicians were male dominated. Male and female participation in the leadership is fairly equal.<br><br>Project results are gender aggerated.<br><br>A policy on equal opportunities exists. It confirms the organisation's commitment to non-discrimination based on race, colour, national original, age, sex, marital or veteran status, political opinions or affiliations, or disability or an otherwise qualitied individual. A gender policy does however not exist. |
| **Climate/environmental impact** | Most of the technical work involved in the implementation of the project activities is conducted by people based outside of Liberia who travel on an as needed basis to Liberia, usually for short-term visits. Both Mercy Ships as well as its operational partners aim to recruit people from the region to conduct these activities reducing overseas travels. According to the risks register, MSNo requires the purchase of CO2 compensation and/or biofuel for all flights booked.<br><br>Disposal of non- and/or malfunctioning equipment is not addressed by the project; it is the responsibility of the hospitals. The National Healthcare Technology Management Policy and Strategies 2022 – 2032 (dated May 2023), developed with support from GIZ, includes disposal of equipment.<br><br>An environment policy at Mercy Ship does however not exist. |
| **Corruption** | See also section 4.4.1 above.<br><br>Corruption is a known phenomenon in Liberia; in 2022, the Global Fund reported on systemic corruption within the MOH in Liberia. In a press statement from the US Embassy in Liberia from April 2023, the Ambassador poses serious questions to the (financial) management of the MOH.<br><br>Mercy Ships provides support in kind (equipment, training); it does not transfer funds to MOH and its entities. Transport costs and per diem, if applicable, is paid directly to the trainees based on a protocol by the Mercy Ships country office.<br><br>MOAs and amendments with suppliers and operational partners include an anti-corruption clause. |

## 4.4 REVIEW AREA 4: IF AND TO WHAT EXTENT THE BENEFITS OF THE PROGRAMME CAN BE SUSTAINED BEYOND NORAD AND MERCY SHIPS FUNDING?

### To what extent is Mercy Ships capable and willing to continue Norad funded activities when Norad phases out?

*The decision to indefinitely halt activities in Liberia put the question regarding capacity and willingness of Mercy Ships to continue activities in Liberia with own funding in a different perspective. MSNo had serious intentions to pursue activities at least for five years. MSI is financially a strong organisation.*

The decision from the high level MSI leadership to suspend all future activities in Liberia has been a somewhat unexpected yet impactful decision. It remains unclear whether and to what extent sustainability issues were considered in the decision-making process. From the start, MSNo's intention was to work in

Liberia for five years, with Norad or own funding, but Mercy Ships' decision abruptly ended this ambition.[39] The financial capacity does not appear to be a major issue; Norad's funding represents only a small portion of Mercy Ships budget.

Based on the ongoing transition of MSI to shift its focus to a development approach, we understand the organisation had the willingness and an increasing capacity to continue Norad funded activities in Liberia after Norad phases out. The revised strategy nevertheless is constructed on a five-year period in line with the logistics and activities related to the ships in-country presence, but interviewees confirmed this five-year period is rather an indication and will be assessed on a case-by-case basis.

While there is a perception within Mercy Ships that long(er) term presence in a country is not needed when trainers and facilitators are trained, examples of longer than 5-year country engagements exist (e.g., Guinea). Decisions on the duration of country engagement will be considered on a case-by-case basis. Development health partners claim capacity building as part of health system strengthening takes considerable time. As an example, PIH, who, according to their website aim to achieve systemic change in Liberia, confirmed a commitment for 25 years.

**To what extent are the benefits of Mercy Ships funding programming likely to continue after donor funding ceases?**

*The short duration of the project raises questions on the feasibility of achieving sustained changes. As one interviewee phrased it well; strengthening health systems requires a mind set and behavioural change, and therefore takes time. They said the intended changes start to happen about seven years after the start of the project. The changes achieved through the Norad funded activities may not be fully sustained, mainly because of the short duration of the project, which provided limited options for the accompaniment and mentoring required to achieve sustained change. Overall, the (ongoing) mentoring component was rather limited.*

More specifically, an analysis of the likelihood of continuation of benefits of the Norad funded activities reveals the following:

- Interviewees have varying views on the level of improvement of the skills of **BMET**. Their overall performance will mainly depend on whether they use the opportunities provided to them (e.g., tools, training, direct access to technicians from Diamedica Ltd). There is however consensus that, based on the training and tools provided, the repair of equipment will remain challenging.
- The **nurses kits** mainly provided a (short-term) boost for nurses, but it is unclear what the longer-term impact of this activity will be.
- Benefits from the **training of nurses** are likely to be relatively narrow due to the limited number of nurses trained. Training of trainers and facilitators in theory allow for future (refresher) training, but limited funding at MOH level inhibits conducting training at their level. Due to the lack of a functional human resources management database, it will soon be unknown who conducted which training and when, probably leading to duplication and gaps. The MOH has limited resources/capacities for supervision and mentoring outside of Monrovia, and trained nurses may therefore not be fully motivated to put in practice correctly what they learned.
- The **leadership training** laid a solid foundation to sustain changes achieved in the two hospitals where the full programme has been implemented, but this foundation is certainly more limited for the two hospitals that started the training at a later point. For these hospitals the total training programme will

[39] Instead, MSNo intends to submit a proposal for Sierra Leone, based on experiences and lessons learned from the project in Liberia.

be conducted, but the time for mentoring and accompaniment is restricted because of the projects end date.

- Obtaining the necessary spare parts and consumables for the **anaesthesia equipment**[40] may be challenging because of the limited funding available at the MOH, and the generally time-consuming procurement processes.
- Patient information collected for the Clean Cut are included into DHIS2, the country's health management information system.

**What are major factors which influence the achievement or non-achievement of sustainability of Norad/Mercy Ships funding and programming?**

*Generally, the **environment in Liberia is only to a limited extent conducive** to sustain changes achieved. The MOH has limited funding available to take over and contribute to (ongoing) activities, coordination of activities and available support does not happen in a systematic way increasing the risk of duplication or gaps, and staff rotation is overall high.*

More specifically, the following factors play an important role in the achievement of sustainability of the Norad funded activities:

- The lack of a software/database on equipment (e.g., location, type, functionality, maintenance) available in the public health system does not allow adequate management of the donated equipment (e.g., maintenance, timely procurement of required consumables).
- The project involved many different hospitals, which is commendable from a principle of leaving no one behind, but limited the potential impact, particularly because of the short duration and relatively low budget of the project.
- The project did not provide for supplies and consumables required before, during and after surgery; because of the lack of adequate pain management medication for example, the number of (non-emergency) surgeries may remain limited.
- The staff turnover at all levels and among all departments of the MOH and within hospitals is high, which may reduce the impact of training. The database for human resources management has not been functional for the past years, and thus relevant information on training of health workers and their workplace can therefore not be stored and accessed in a central location.
- Mercy Ships' abrupt departure and lack of exit plan did not allow for discussions with other development partners on possible continuation of (some of the) activities supported with Norad funding. In addition, initial plans were foreseen for five years, and therefore may not have included exit strategies during the first two years.
- The available budget of the MOH is mainly spent on salaries (over 80%) and procurement of medicines and other health commodities, leaving limited budget for other activities. While the number of development health partners supporting to the Liberian health system is limited, the MOH relies on partners support for most activities.
- A limited number of local institutions (universities, training institutions) was involved in the project and as such the capacity to continue training in surgical care at national level remains limited. From the pool of nurses from the various hospitals involved who participated in the training, some were trained as trainers/facilitators.

[40] A package of necessary sparce parts and consumables for an average duration of two years (actual use depends on the intensity of the use of the equipment).

# 5 CONCLUSIONS AND RECOMMENDATIONS

## 5.1 CONCLUSIONS

Right from the very beginning, the Mercy Ships project followed an unusual trajectory within Norad with regards to grant application and approval (e.g., long approval process with several changes in project design and related documents), and consequences of this deviation have had an impact on its grant management both for Mercy Ships and Norad to the present day. Both organisations made considerable efforts to bring the diverging views and approaches closer together to formulate a project that was acceptable to both and fell within Norads priorities of health system strengthening and sustainable programming. Challenges persist and ambiguities were further aggravated by the multiple changes of grant managers within Norad and the dynamics inherent to a transition in which MSI is in since a number of years. Mercy Ships started activities before the actual grant signature and first disbursement. Several versions of key project documents continue to circulate, which still causes room for misperception.

Mercy Ships managed to raise awareness on the importance of surgical care, including the role of BMET, an area that generally gets limited attention, and consequently not much funding, despite the enormous need in many countries. It implemented most of the activities timely, with the exception of two that started later than foreseen. Overall LFA milestones and targets set have been or will be achieved, yet by their definition LFA indicators provide limited information on the expected changes or outcomes. The short duration of the project does not allow to measure impact. Overall, despite satisfactory results in terms of carrying out the foreseen activities in the foreseen timeframe, several questions have arisen regarding the actual implementation of the project and even more so regarding its adequacy, effectiveness considering the overall definitions of health system and health system strengthening that traditional development partners adopt, and in particular also the compatibility with requirements for Norad funding:

- The project is formulated as a (surgical) health system strengthening project but covers mainly elements of capacity development with primary focuses on provision of inputs (training, equipment and supplies). This raises questions on lasting improvement of the actual system and its performance. Generally, with a focus on training and supplies during a five-year period, Mercy Ships system strengthening and sustainability approaches are only to a limited extent comparable with those commonly applied by (international) development health partners.
- Implementation proved efficient; almost all activities are conducted within the duration of the project (extension). However, implementation has been realised in a considerably isolated manner, with limited options for creation of synergies with other interventions and initiatives ongoing in the country. Local actors such as local training institutes or universities played a minimal role. All operational partners were international organisations with no or limited local representation.
- Mercy Ships uses a heavy and fragmented structure to manage a project of this relatively small grant and assigned MSNo, the grant owner, a minimal role as focal point for Norad with a limited responsibility in M&E and overall project budgeting, and without the necessary decision-making power.
- Mercy Ships grant management is not sufficiently aligned with Norad requirements. MSNo reported as per agreed timelines, but the report formatting and level of information for both the progress and financial reporting was, despite numerous exchanges between both parties, not up to Norad's expectations and standards.

In short, motivated by MSNo's wish to obtain funding from Norad and a group of change-minded actors within the larger organisation, a movement begun to transform Mercy Ships into a reliable long-term health

development partner. The project under review was then designed to comply with Norads eligibility requirements including a monitoring plan and LFA, but in essence, the approach opted was not much different from the Mercy Ships's *on-shore* activities in other countries. With the exception of the Clean Cut activities that focus on longer term accompaniment and actual implementation of learnings in hospitals supported, the project generally included the same type of training and equipment, the same operational partners were contracted, and the same monitoring and budget tools were applied, yet with slightly different reporting mechanisms. This raises some questions on the organisations' capacity and willingness to critically reflect on the appropriateness of its structure and activities. Maybe the biggest change involved the duration of the project, which was intended to be five years, but was approved by Norad for two years only initially.

In current debates on decolonisation of aid and the common operating models applied by multi- and bilateral partners, Mercy Ships tends to maintain a traditional style of aid provision. The organisation mainly operates as a charity organisation providing support to low- and middle income countries with funding from the Global North. The philosophy of development as embraced by the majority of institutional donors including Norad, however, differs considerably from the usual charity philosophy. First small steps towards increased in-country presence are observed, and there is an intention to get decision making closer to the supported countries with the establishment of the ASC. Increased country presence however comes with other responsibilities towards the host countries and their population including stakeholder engagement, local ownership, localisation, tackling power imbalances inherent in a funder/beneficiary relationship, and long(er) term commitments, and a practical realisation of these issues is not yet very visible.

Norad on the other side, knew from the beginning that the project it approved included only few activities that eventually allow for sustained strengthening of the Liberia health system. It is thus unfair to lay all the criticism on the limited contribution to this strengthening and other expected changes down on Mercy Ships only. Norad's decision to fund the project for two years only instead of for the requested five years comprised potential impact and sustainability on beforehand.

Furthermore, Norad experienced difficulties to handle this grant, which in many ways was different than its usual grants. Agreements made with Mercy Ships on the key documents (LFA, monitoring plan, budget) and subsequent approvals, did not work out as expected, yet the question remains to what extent that was due to Mercy Ships or the expectations (possibly against better judgement) of Norad. Despite all good intentions from both parties, mutual expectations were in hindsight different. If previous assessments commissioned by Norad could have foreseen a country visit (which due to preventive Covid-19 measures was not the case), several of the issues identified in the present review may have been clarified at an earlier stage. In any case, a more informed dialogue could have taken place with regards to the design of the project and implementation. Most issues related to the actual grant management are observed in the legal and strategic relationship between MSI and MSNo.

Based on the project design and the available (monitoring) data, no further firm conclusions can be made about the project's achievements and its contributions to the improvement of the (resilience of the) health system in Liberia.

## 5.2 RECOMMENDATIONS

For the remainder of the **ongoing project**, Mercy Ships should update its risk register as the new situation (no in country presence and upcoming elections) is likely to bring additional risks. It is furthermore recommended to clarify the remainder of the implementation of the Clean Cut activities; who will fund the work to be conducted after the projects end date and whether, when and how final results of these activities

will have to be reported to Norad. Mercy Ships furthermore should be encouraged to carefully review and clarify the costs charged for training.

Further to the conclusions of the review as described above, at best we can give some guidance for further strategical reflection within both Mercy Ships and Norad. Prior to considering further collaboration, both organisations are advised to carefully reflect on the desirability of such collaboration.

While **Mercy Ships** through its IP strategy confirmed the shift towards longer term (five to 10 years) development work, questions about the final direction of Mercy Ships' leadership remain. Uniform guidance is needed to implement the new strategy, and this should be provided Mercy Ship leadership. Currently, uncertainties about the final structure of organisation and the required management positions persist. The organisation is still in transition and given the size of the organisation and its many management layers, this process is likely to continue for an extended period of time. In case the organisation decides to head towards development aid, Mercy Ships leadership needs to make a clear assessment of whether it wants to invest in collaboration with Norad or other bilateral partners. Government/bilateral funding for long term development projects comes with specific requirements, and to be able to comply with these Mercy Ships should adapt to the current common development philosophy that includes investment in the necessary technical and grant management capacity. Working in this space will therefore require a solid capacity building approach that focuses on systems building and systems resilience, including an adaptation of M&E, budgeting, and general reporting in line with common standards applied in this sector. For small grants, as compared to Mercy Ships private funding, compliance with these requirements may involve more costs than benefits. At the same time, with the adequate system and capacity in place Mercy Ships could also apply for funding from other bilateral donors and possibly multilaterals, creating a range of new opportunities.

At **Norad**'s side, reflections should focus on whether it wants to continue supporting projects of this nature (relatively short-term, implemented by an organisation with little technical knowledge in Norads main focus areas, and limited experience in all areas of grant management of bilateral funding). Norad may have to revise its requirements for eligibility of funding, including the definition of what it considers health system strengthening. It furthermore should carefully analyse the risks associated with the application of changes and exceptions in grant management at its own level. For future grants with similar challenges, a joint country visit with both representatives from Norad and the grantee in an early phase of the project is recommended. This will contribute to increased mutual understanding with regards to technical approaches, including understanding about financial and programmatic reporting requirements, and limitations.

# 6 ANNEXES

## ANNEX 1. TERMS OF REFERENCE

**«Partnering for Transformational Change,**
**Strengthening Liberia's Surgical Health System 2021-2023"**
**Mercy Ships Norway**
**End Review**

### 1. Background

Mercy Ships is a Christian faith-based organization, operating the world's largest non-governmental hospital ship in sub-Saharan Africa. As a surgical non-governmental organization (NGO) working across eight surgical specialties, Mercy Ships programs focus on improving the quality of life for people living with disease, disfigurement, and disability. This is achieved by providing direct surgical services to reduce the burden of unmet surgical needs in the countries in which they operate; and strengthening the health system through targeted capacity building and learning to become more effective, efficient, and responsive -- ultimately improving surgical outcomes for patients. Since its establishment in 1978, Mercy Ships has provided over 95,000 lifesaving and life-changing surgeries, 445,000 dental procedures and trained more than 42,250 local healthcare professionals. Mercy Ships Norway (MSNO) is one of 15 national offices, responsible for recruiting personnel to implement projects and work voluntarily on board the ship, providing information for donors, securing project funding, and contributing through research and advocacy.

#### Funding history

Mercy Ships has received funding from the Norwegian government since 2015, first for a project in Madagascar, funded by the embassy, then Ministry of Foreign Affairs funded a one-year program on providing safe surgeries and capacity building in Cameroon. Since 2018, Mercy Ships has been funded by Norad.

The balance between service delivery and capacity building/system strengthening in Mercy Ships way of working, has been a recurrent topic for discussion between Norad and Mercy Ships.
Mercy Ships started as a humanitarian response contributing to reduce the back log of surgeries in LMIC through medical surgery on a hospital ship. The demand for building capacity of health personnel was later included in order to strengthen national capacity. MSNO has an ambition to move Mercy Ships from a vertical provider of patient surgeries and medical mentoring to a supporter of health system strengthening. In the new strategy within Education, Learning and Advocacy (ELA), health system strengthening is one of two organizational pillars; the other being Direct Medical Services (DMS).

In the program "Bringing Health and hope – to people and countries" (2018-2021 – total funds NOK 40, 870 million, Liberia, Senegal and Guinea) the purpose was defined as "taking the capacity building of local health personnel and health technicians together with quality improvement of buildings to a new level". With this, Mercy Ships added and strengthened a new dimension to the already well-established medical surgery programme. A system for capacity development, including training, mentoring and follow up of health personnel should be in place.

In the current agreement; Partnering for Transformational Change: Strengthening Liberia's Surgical Health System – (2021-2023, total funds of NOK 28 740 million) Mercy Ships continues to develop the capacity building components; (Proposal Document August 2021/ Revised July 29th 2022, page 4, Norad edits)

*"Whilst hospital ship deployment remains a key component of Mercy Ships programs, in 2021 Mercy Ships adopted a new programmatic strategy to achieve lasting change. MSNO has been advocating for Mercy Ships to adopt this strategy since 2018 and has expedited this process through their previous grant program with Norad. This new strategy seeks to align Mercy Ships' transformative work with the World Health*

*Organization (WHO) Health Systems Strengthening (HSS) framework, to encourage and support the strengthening of surgical care systems in the countries where we work. […] We align our activities to contribute to one or more of the six WHO HSS Building Blocks in each of the countries where we work: Service delivery; Health workforce; Health information; Medical products and technologies; Health financing; Leadership and governance."*

In contributing to these building blocks, MSI's model of engagement is based on three key pillars: the provision of direct medical services, predominantly through our hospital ship or key local partners; Medical Capacity Building (MCB) to improve the efficiencies and effectiveness of the health system to respond to the needs of its populations; and health systems relationship development to improve and enhance strategic relationships within the health system.

Impact Statement: Improved maternal and neonatal health outcomes in Liberia.

Outcome Statement: By 2023, targeted hospital facilities are providing safer and improved quality surgery to patients.

Output 1: Safer anesthesia provision and resuscitation practices for neonatal and obstetric surgical patients.

Output 2: Surgical and management teams implement best practices to foster staff development and implement safe, quality surgery.

Output 3: Surgical and perioperative care providers have improved knowledge of safe care practices.

Output 4: Biomedical Technicians have improved knowledge and skills in maintaining essential surgical and anesthesia equipment.

The agreement was planned to end May 2023, but due to delays caused by covid and late funding, Norad recently approved a no-cost extension until end of December 2023.

Previous reviews and assessments

Two assessments have been conducted of MSNO the last two years, both by HERA/Stein Erik Kruse. Due to Covid and travel restrictions, both have been desk reviews.

Both assessments give valuable inputs and discussions on the questions around MSI/MSNOs ability to achieve results in capacity building, health system strengthening.

<u>Partner Assessment, February 2021</u>

MAIN FINDINGS (Partner Assessment page 1, edits by Norad):

- Mercy Ships has *delivered expected results in Guinea and Senegal in its regular programme* – surgeries, individual mentoring and medical training, provision of equipment and infrastructure, but the Norad funded capacity development project was not implemented […]
- […] There have been *significant improvements of the framework, but there are still limitations* in the monitoring and reporting of progress towards results. The annual country reports have data on activities and outputs, but not on progress in achieving outcomes. The M&E system is set up to assess outcomes […] but such results are not yet reported to Norad.

- Mercy Ships Operations and in Norway have relevant technical competence and working experience in implementing its regular programme – medical surgeries, patient care, and mentoring/training of medical personnel, but so far *less in the area of national health systems strengthening*[41].

- […] There are still certain *gaps and limitations in the formulation/consolidation of policies* on governance, gender equality, environment, human rights-based approach and working with partners.

- Mercy Ships has a solid financial base […]

- Mercy Ships has ethical policies and codes of conduct for human rights, equal opportunities (excluding LGBTI´s[42]), children, sexual harassment, and anti-terrorism. There is also an elaborate identification of risks and mechanisms in place for mitigating risks. Travel policies are in line with (even stricter than) Norad requirements while *Mercy Ships Operations salaries are on the high side.*

Mercy Ships grant proposal assessment from August 2022,
The assessment of the proposal recommended Norad to prepare a ToR for an end-review with a focus on an assessment of the relevance, design, compliance with Norad policies, implementation, results, and sustainability of the capacity development project including the potential for a new programme of support.

## 2. Purpose and scope of work for the end-review

The end-review will build on main findings from the previous reviews however, instead of a broad assessment it will focus mainly on the areas identified as weak in the previous reviews and especially on MSNOs ability to achieve results on strengthening the capacity of health personnel and institutions in Liberia. The main focus will be on programme level:

- To what extent the programme has been effectively implemented and achieved expected results in targeted countries (for patients/health personnel/health institutions)?
- The effectiveness and efficiency of the programme.
- If and to what extent the benefits of the programme can be sustained beyond Norad and Mercy Ships funding?

The end-review will have a limited yet targeted focus on partner assessment/organizational assessment with focus on MSNOs cost efficiency (travel, salaries, indirect costs, "other" costs) improvements in their policies on governance, gender equality, environment, human rights based approach and their ability to work with and through partners.

## 3. Assessment areas and questions

*Version 9 June 2023*

| MAIN REVIEW AREA | REVIEW QUESTIONS | OECD/DAC CRITERIA |
|---|---|---|
| **5. To what extent the programme achieved expected results?** | • To what extent have the programme outputs and outcomes been achieved or are likely to be achieved?<br>• What are the major factors influencing the achievement or non-achievement of the outcomes and outputs? | Effectiveness<br>Efficiency<br>(Impact) |
| **6. To what extent the programme** | Coordination: | Effectiveness |

[41] MSNOs commented they find this finding based on opinion vs conclusive evidence.
[42] MSNOs disagree with this finding. "MS does not exclude LGBTQIA+ rights; LGBTQIA+ rights were mentioned in the partner assessment due to a single instance, specifically cohabitation regulations on board one of MS vessels, in which case the regulation (not allowing cohabitation for same sex partners) was in place out of respect for and compliance with local norms and practices. Respecting local norms and practices is important for MS relationship and trust building with patients and local health care providers.

| MAIN REVIEW AREA | REVIEW QUESTIONS | OECD/DAC CRITERIA |
|---|---|---|
| **has been effectively implemented?** | • To what extent are the Norad funded activities aligned with the priorities from the government?<br>• How are the Norad funded activities coordinated with government and other partners/donors working on health systems strengthening?<br>Competence:<br>• To what extent is Mercy Ships equipped (e.g., competence, experience) to implement a capacity development programme? How adequate are the approach and tools developed by Mercy Ships to implement this programme? What competences or tools are missing, if any?<br>• How efficient is the (internal) organisation of Mercy Ships in leading, providing technical backstopping and monitoring the capacity development programme in national institutions?<br>Financial management:<br>• To what extent are actual salary and travel costs (e.g., on travel, per diem and other allowances) comparable with similar Norad grants?<br>• To what extent does the financial reporting from Mercy Ships to Norad allow for adequate monitoring of budget execution?<br>• To what extent are the main interventions of the program cost-efficient based on commonly applied benchmarks (e.g., the Global Fund)?<br>Working with Mercy Ships' partners:<br>• To what extent Mercy Ship has systems and procedures in place for working with/through third parties/implementing partners?<br>• Do the systems/procedures comply with the Norad grant agreement?<br>M&E system:<br>• How effective has Mercy Ships been in its M&E approach, is a monitoring system in place that allows tracking, critical assessment and reporting of achievements? | |
| **7. To what extent risks are identified and mitigated?** | General risks:<br>• To what extent are appropriate systems in place for assessing risks?<br>• What have been (unexpected) programmatical and managerial challenges and risks encountered during implementation?<br>Risks related to cross-cutting issues:<br>• To what extent Mercy Ships has adequate systems in place to ensure integration of considerations on cross-cutting issues (human rights, women's rights, gender equality, climate/environmental impact and corruption)? | Efficiency |
| **8. If and to what extent the benefits of the programme can be sustained beyond Norad and Mercy Ships funding?** | None of the questions proposed in the TOR cover sustainability; we therefore suggest the questions below to address this evaluation area.<br>• To what extent is Mercy Ships capable and willing to continue Norad funded activities when Norad phases out?<br>• To what extent are the benefits of Mercy Ships funding programming likely to continue after donor funding ceases? | Sustainability |

| MAIN REVIEW AREA | REVIEW QUESTIONS | OECD/DAC CRITERIA |
|---|---|---|
| | • What are major factors which influence the achievement or non-achievement of sustainability of Norad/Mercy Ships funding and programming? | |

## 4. Deliverable

The end-review should result in a report. The report should present conclusions backed by reference to findings. The representativeness of findings should also be commented.

Suggested template for the report:

- Purpose and scope of assessment
- Background
- Assessment criteria
- Methodology
- Findings and assessments
- Conclusions and recommendations
- Sources of information used

## 5. Methods and sources of information

The end-review should be carried out through a combination of (a) review of documents from the Mercy Ships and Norad, (b) interviews with key staff and board members in Mercy Ships Norway and Mercy Ships country office(s) and selected external stakeholders (e.g. WHO and UNFPA).
c) field visit to Liberia

## 6. Timeline and consultant

### The expected timeline:

Signing of contract 31 May 2023
Final ToR 12 June 2023

Initial interviews with MSNO, MSI, other key stakeholders as preparation for the field visit - June 2023

Collecting relevant documents - May/June 2023

Field visit – late/last week June 2023

Follow up interviews with key stakeholders as needed - August 2023

Hera - NCG / Final Report - August/September 2023

### Team/consultant – HERA/NCG

Lead consultant – Ingeborg Jille
Team members – Stein Erik Kruse, Leen Jille
Observing member – Vigdis Halvorsen, Norad

### Estimated time/budget:

20-25 workings days
Budget: 180 000 -225 000 + travel expenses

# ANNEX 2. LFA

| IMPACT | Impact Indicator 1 | Targets | Baseline | Milestone 1 (End May 2022) | Target (End May 2023) | Source (Means of Verification) | Assumptions and evidence | Notes |
|---|---|---|---|---|---|---|---|---|
| Improved maternal and neonatal health outcomes | Maternal mortality rates | **Planned** | N/A | N/A impact indicators will not be tracked as part of this grant as it will lie outside of the grant period. | N/A | National data | Liberia has one of the world's highest maternal and under 5 mortality rates. Research by Capacare (*Essential Surgery in Liberia, 2018* ) shows that cesarian sections are the most commonly performed surgical procedures in Liberia, yet it is still insufficient to meet the need. Availability of cesarian sections is highly inequitable across the counties. Montserrado county (home to the capital city, Monrovia) has a cesarian section rate of 7.7%, compared to the national average of 5.4%. Rural counties are seriously lagging behind, performing just 1.2% of Liberia's cesarian sections. This demonstrates poor surgical service provision as the need for cesarian sections is similar across the counties. Access to safe and timely cesarian sections are critical to lowering the maternal mortality rate in Liberia. The project below seeks to increase surgical capacity at targeted hospitals - in terms of introducing best practice such as safe instrument use, safe anesthesia administration, readiness of vital equipment and infrastructure for a sterile and safe surgical environment, best practice care in the post-operative environment, and so on. This in turn will improve hospitals | |
| | | **Achieved** | | | | | | |
| | **Impact Indicator 2** | **Targets** | **Baseline** | **Milestone 1 (End May 2022)** | **Target (End May 2023)** | **Source (Means of Verification)** | | |
| | Neonatal mortality rates | **Planned** | N/A | N/A impact indicators will not be tracked as part of this grant as it will lie outside of the grant period. | N/A | National data | | |
| | | **Achieved** | | | | | | |

| OUTCOME | Outcome Indicator 1 | Targets | Baseline | Milestone 1 (End May 2022) | Target (End May 2023) | Source (Means of Verification) | Assumptions and evidence | Notes |
|---|---|---|---|---|---|---|---|---|
| By 2023, targeted hospital facilities are providing safer and improved quality surgery to patients. | Adherence to Surgical Safety Checklist at targeted facilities.<br><br>(1. Skin preparation; 2. Appropriate use of surgical linen; 3. Surgical instrument reprocessing; 4. Instrument sterilization; 5. Appropriate timing of antibiotic prophylaxis; 6. Counting and reconciliation of gauze and instruments). | **Planned** | On average, hospitals have a 60% adherence rate to the WHO Surgical Safety Checklist. | Agreement with Lifebox signed to undertake Clean Cut project in 5 hospitals. Initial assessments started for 3 of the hospitals. | Targeted hospitals have 80% adherence to the WHO Surgical Safety Checklist. | Lifebox Clean Cut Project data; Interviews; Observations. | The assumption is that adherence to the 7 key perioperative processes directly improves surgical safety for patients. This has been evidenced in several research articles - demonstrating that consistent adherence to these 6 peri-operative procedures has a direct improvement in patient outcomes.<br><br>Research has shown that consistent adherence to the Surgical Safety Checklist reduces surgical site infections and peri-operative mortality. Please see the following published studies for evidence:<br>1. Lifebox research on adherence to Surgical Safety Checklist found risk of surgical site infections reduced by 46%: **https://pubmed.ncbi.nlm.nih.gov/34157086/**<br>2. The use of the Surgical Safety Checklist has been associated with a 36.6% relative reduction in mortality in Scotland. See: https://doi.org/10.1002/bjs.11151<br>3. Mercy Ships research into Surgical Safety Checklist training in Madagascar resulted in medium term change in practice, including increased counting of surgical instruments - vital to ensuring patient safety: **https://doi.org/10.1371/journal.pone.0191849**<br>4. Mercy Ships research into the scale up of the surgical safety checklist in Benin: **https://doi.org/10.1002/bjs.11034.** | The patient satisfaction surveys are new and will be introduced alongside the Lifebox Clean Cut project to add patient voices as a dimension to the increased surgical capacity. Therefore the baseline is currently 0 because the surveys have not yet been administered. Mercy Ships will insert a baseline figure after the Lifebox Clean Cut project has started implementation - as they will work with the local hospital to administer patient satisfaction surveys prior to any changes being introduced to the hospital facilities through the Clean Cut project, and will work with the targeted facilities to continue administering these through the life of the project. |
| | | **Achieved** | | Contract signed with Lifebox for surgical capacity improvement work to begin. | | | | |
| | **Outcome Indicator 2** | **Targets** | **Baseline** | **Milestone 1 (End May 2022)** | **Target (End May 2023)** | **Source (Means of Verification)** | | |
| | Surgical Patient satisfaction at targeted hospitals | **Planned** | 0<br>*(please see note in column I)* | Patient satisfaction survey developed for use with targeted hospitals | 5 hospitals scoring average patient satisfaction scores of 50% or above. | Survey of how patient feels care has been delivered. | | |
| | | **Achieved** | | Research has begun on the satisfaction survey, but has not yet been developed. This will be developed in August 2022 with local partners. | | | | |

| OUTPUT 1 | Output Indicator 1.1 | | Baseline | Milestone 1 (End May 2022) | Target (End May 2023) | Source (Means of Verification) | Assumptions and evidence | Notes |
|---|---|---|---|---|---|---|---|---|
| Safer anesthesia provision and resuscitation practices for neonatal and obstetric surgical patients. | # obstetricians, nurses, and midwives with improved knowledge on how to help babies breathe (neonatal resuscitation - specifically: ventilation techniques, cardiac massage, and birth asphyxia) | **Planned** | Prior to the course starting, 103 participants from 5 hospitals scored an average of 3.5 out of 10 on a Neonatal Resuscitation knowledge test. | **103** participants scoring 8/10 or above on the post-course Neonatal Resuscitation knowledge course. | As per milestone 1 as no further Neonatal Resuscitation training is planned for Y2. | Pre- and post- course test | The assumption is that increased knowledge on how to respond to a baby with breathing difficulties, will lead to more rapid assessments and confident responses, improving outcomes for babies.<br><br>The assumption is that increased knowledge on how to administer safe anesthesia for obstetric patients will result in safer childbirth for mother and baby.<br><br>The assumption is that having reliable anesthesia machines will support medical professionals to make timely decisions about surgical intervention for patients, particularly obstetric patients; and that the anesthesia provision will be safe and more reliable.<br><br>Together these assumptions lead to an overall assumption that ***IF*** anesthesia providers have the knowledge, skills and functioning equipment to deliver safe obstetric anesthesia, ***and IF*** skilled professionals know how to resuscitate a newborn baby in respiratory distress, ***THEN*** there will be safer surgery and positive outcomes for mother and child.<br><br>*hospitals to be decided in cooperation with MoH, based on need. | In addition to the Safe Obstetric Anesthesia training, Mercy Ships is also providing intensive mentoring for a period of 3 months to one anesthesiologist in JFK hospital. As there are just two anesthesiologists in Liberia, this mentoring is expected to improve their skills and knowledge, so that they can pass this on to nurse anesthetists that they regularly work with. This is not included in the logframe output indicator, but will be described in detail in the annual report to Norad.<br><br>* There were a total of 81 participants, however only 77 completed the course feedback and post-tests. |
| | | **Achieved** | | **165** participants, with an average result of 9.3 out of 10. | Achieved as per Y1. | | | |
| | **Output Indicator 1.2** | | **Baseline** | **Milestone 1 (End May 2022)** | **Target (End May 2023)** | **Source (Means of Verification)** | | |
| | # anesthetists reporting improved confidence on safe administration of anesthesia to obstetric patients. | **Planned** | 77 participants completed the online safe obstetrics course prior to the skills day. | **70 of 77*** participants (90%) reporting improved skills and clinical ability; self scoring at least 27 out of 30 in improved confidence to administer safe anesthesia to obstetric patients. | As per milestone 1 as no further Safe Obstetric Anesthesia training is planned for Y2. | Pre- and post- course test | | |
| | | **Achieved** | | Average self-assessed confidence improvements was 29 out of 30.<br>**76 of 77*** participants (99%) self-assessed improved confidence through scoring 27/30 or above. This is broken down as follows:<br>•52 (68%) self-assessed 30/30.<br>•12 (16%) self-assessed 29/30.<br>•4 (5%) self-assessed 28/30.<br>•8 (10%) self-assessed 27/30.<br>•1 (1%) self-assessed less than 26/30 | Achieved as per Y1. | | | |
| | **Output Indicator 1.3** | | **Baseline** | **Milestone 1 (End May 2022)** | **Target (End May 2023)** | **Source (Means of Verification)** | | |
| | # functioning anesthesia machines in targeted facilities. | **Planned** | 7 anesthesia machines in 4 hospitals, of which 86% are functioning. | Order submitted for 8 Glostavent anesthesia machines and patient monitors for use in 4 hospitals* | 23 anesthesia machines (and patient monitors) delivered and installed in 6 local hospitals*, of which 100% are functioning (*the 7 existing anesthesia machines plus 16 new anesthesia* | Equipment donation records, quarterly monitoring, maintenance records | | |
| | | **Achieved** | | Mercy Ships equipment donation review team and procurement team has approved the donation. The order will be submitted in Q4, after review and approval by MS risk and compliance and legal team. | | | | |
| **ACTIVITIES** | | | | | | | | |
| Project 1.1 Neonatal Resuscitation Training (**geographic coverage**: Montserrado, Margibi, Nimba, Bong, and Maryland counties)<br>Project 1.2 SAFE Obstetric Anesthesia Training (**geographic coverage**: Bomi, Bong, Gbarpolu, Grand Bassa, Grand Gedeh, Grand Kru, Lofa, Margibi, Maryland, Montserrado, Nimba, River Gee, and Sinoe counties)<br>Project 1.3 Anesthesia Provider Training and Equipment (including mentoring of an anesthetist at JFK hospital) (**geographic coverage**: Bong, Margibi, and Montserrado counties) | | | | | | | |

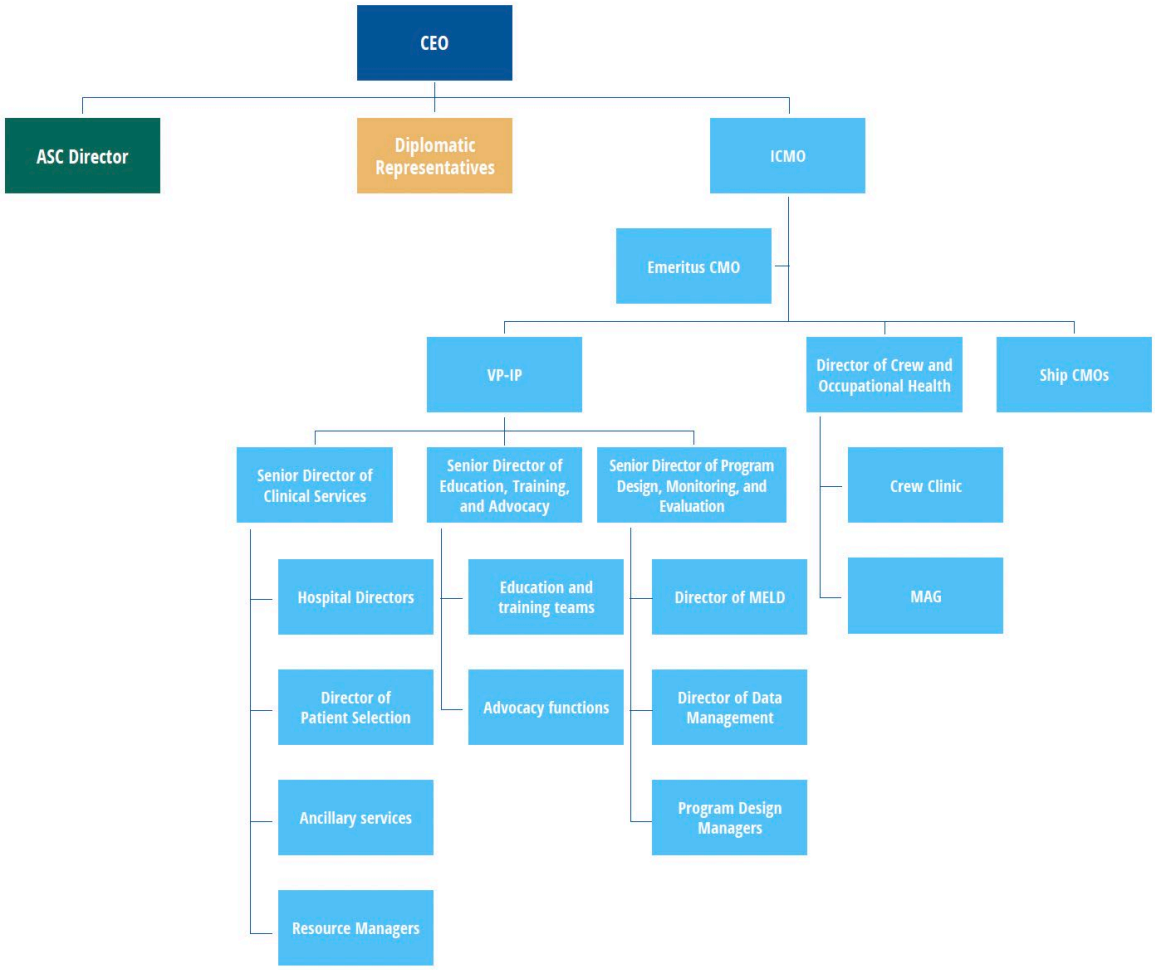
| OUTPUT 2 | Output Indicator 2.1 | | Baseline | Milestone 1 (End May 2022) | Target (End May 2023) | Source (Means of Verification) | Assumptions and evidence | Notes |
|---|---|---|---|---|---|---|---|---|
| Surgical and management teams in targeted hospitals implement best practices to foster staff development and to implement safe, quality surgery. | # targeted facilities with quality improvement monitoring processes *(such as M&M reviews, staff appraisals, reporting SSIs and perioperative mortality)* | **Planned** | 3 facilities reporting key deficiencies in quality processes, and a lack of articulation of milestones for quality improvement. | **45** people attend leadership taster training session and articulate key leadership needs. | JJ Dossen, Jackson F. Doe Memorial, Redemption and Emirates hospitals report introducing at least 1 new quality improvement process | Leadership training project documents, including individualized action plans from each hospital targeted. | The assumption is that ***IF*** hospital leadership teams know how to work together as a team, ***and IF*** they implement quality improvement processes (such as morbidity and mortality reviews, staff appraisals, starting to report on surgical site infections and peri-operative mortality) ***THEN*** the hospital will collectively learn what is working to ensure best practice by its professionals and offer a safer environment for surgical patients. | **Norad Reviewer: Please note** that the leadership course is deliberately tailored to the individual facility, and therefore the baseline will need to be completed at the beginning of the individual hospital trainings. At the Surgical System Needs workshop in May 2021, hospital leaders told Mercy Ships that they have never received training in how to manage and lead hospitals or teams and would greatly benefit from leadership training and mentoring. |
| | | **Achieved** | | 3-day taster sessions for leadership training and mentoring delivered at JJ Dossen Hospital and Jackson F. Doe Memorial Hospital, with **64** attendees. | | | | |
| **ACTIVITIES** | | | | | | | | |
| Project 2.1 Leadership Training (better resourcing and management of hospitals and surgical units) (**geographic coverage**: Nimba, Maryland and Montserrado counties) | | | | | | | | |

| OUTPUT 3 | Output Indicator 3.1 | | Baseline | Milestone 1 (End May 2022) | Target (End May 2023) | Source (Means of Verification) | Assumptions and evidence | Notes |
|---|---|---|---|---|---|---|---|---|
| Surgical and perioperative care providers in targeted facilities have improved knowledge of safe care practices. | Surgical Capacity Assessment Score at targeted facilities | **Planned** | Average Assessment Score prior to enrolment in the clean cut program is 22 out of 50. | As per baseline, as the capacity assessments are scheduled for Y2 of the grant. | CB Dunbar Hospital, Redemption Hospital, Jackson F. Doe Hospital and Liberian Government Hospital Bomi attaining a score of 40 or above (out of 50) | Lifebox Clean Cut™ project assessment data: Pre- and Post- project data collected by Lifebox in the four domains of the Surgical Capacity Assessment. | A ***Surgical Capacity Assessment*** is a score developed by the NGO Lifebox, which measures a hospital's capacity to perform safe surgery. The Surgical Capacity Assessment Score factors in four domains of surgical processes within the hospital:<br>1. Infrastructure (functionality, availability of equipment, sterilizing capacity, etc.).<br>2. Surgical guidelines & protocols the extent to which surgical teams are implementing best practice for safe surgery).<br>3. Training & Education (including standard operating procedures for safe surgery in place and being used).<br>4. Infection Prevention & Patient Safety Behaviors (measuring whether surgical teams are observing all 15 essential IPC and patient safety behaviors).<br>The Capacity Assessment is scored out of 50.<br><br>The assumption behind this indicator is that IF the infrastructure is conducive to safe surgery, AND IF staff follow all best practice including adherence to the WHO Surgical Safety Checklist, AND IF staff are properly trained and have standard operating procedures, AND IF they make every effort to prevent and control infection; THEN surgical site infections will reduce and surgery will be safer for patients. This is evidenced by Lifebox research in Ethiopia, the results of which can be found here: **https://pubmed.ncbi.nlm.nih.gov/34157086/.** As a summary of the results, Lifebox found that increased compliance with the 6 perioperative processes reduced the risk of perioperative infection by 46%. | |
| | | **Achieved** | | Agreement signed. | | | | |
| **WEIGHTING (%)** | **Output Indicator 3.2** | | **Baseline** | **Milestone 1 (End May 2022)** | **Target (End May 2023)** | **Source (Means of Verification)** | | |
| | # nurses with improved knowledge in pain management of the critically ill patient | **Planned** | Prior to the training course, nurses scored on average 9.5 out of 20 on knowledge tests about pain assessment and critical care. | **28** participants complete the course, with an average score of 12+ out of 20 on knowledge tests about pain management and critical care. | As per milestone 1 as no further nurse training courses are scheduled for Y2, however follow up will occur. | Pre- and post-course test results of the MSSi nursing training.<br>Qualitative information for the report will also be gathered from the following sources:<br>1. Nursing supervisors reporting active use of the nurse drug books.<br>2. Case studies of ways in which the books have enabled best practice. | | |
| | | **Achieved** | | **29** participants completed the course, with an average score of 13.2 out of 20 on knowledge tests about pain management and critical care. | As per 'Achieved Y1'. | | | |
| **ACTIVITIES** | | | | | | | | |
| Project 3.1 Lifebox Clean Cut™ Training (adherence to WHO Safe Surgery Checklist) (**geographic coverage**: Bong, Montserrado, and Bomi counties)<br>Project 3.2 Safe Surgery Training Course (**geographic coverage**: Nimba, Maryland and Montserrado counties)<br>Project 3.3 Surgical Nurse Training (MSSI) (**geographic coverage**: Montserrado and Margibi counties)<br>Project 3.4 Nurses' Kits and Nursing Drug Reference Books (**geographic coverage**: Bomi, Bong, Gbarpolu, Grand Bassa, Grand Gedeh, Lofa, Margibi, Maryland, Montserrado, Nimba, River Gee, Sinoe, and River Cess counties) | | | | | | | | |

| OUTPUT 4 | Output Indicator 4.1 | Targets | Baseline | Milestone 1 (End May 2022) | Target (End May 2023) | Source (Means of Verification) | Assumptions and evidence | Notes |
|---|---|---|---|---|---|---|---|---|
| Biomedical Technicians have improved knowledge and skills in maintaining essential surgical and anesthesia equipment. | # biomedical technicians trained, including in the maintenance and repair of Glostavent anesthesia machines | **Planned** | 0 | **18** | As per milestone 1 as no further Biomedical Technician training courses are planned for Y2. | Participant register; course facilitator report; Pre- and post- training scores | Biomedical technicians will be able to attend the 8-week course and will be available for follow up mentoring.<br><br>Biomedical Technicians have the tools and workspace to maintain anesthesia machines and patient monitors.<br><br>Biomedical Technicians can travel to hospital sites regularly for maintenance plans.<br><br>The assumption is that ***IF*** Biomedical technicians are trained in the maintenance and repair of the Glostavent anesthesia machines, ***and IF*** they have the tools to undertake the maintenance and repair, ***THEN*** there will be more functioning anesthesia machines available to support in output 3 activities (safe anesthesia) and safer, more reliable anesthesia for safer | *A total of **25** technicians completed the course, however only 13 were trained with support from this grant. The other 12 were trained with support from Mercy Ships Norge previous Norad grant.<br><br>All biomedical technicians in Liberia have been trained and are receiving ongoing mentoring through Mercy Ships project. |
| **WEIGHTING (%)** | | **Achieved** | | **13*** biomedical technicians completed the course, all of whom passed all modules. | As per 'achieved Y1'. | | | |
| **ACTIVITIES** | | | | | | | | |
| Project 4.1 Biomedical Technician Training and Mentoring (**geographic coverage**: Montesserado, Grand Cape Mount, Gbarpolu, Bomi, Sinoe, River Cess, and Margibi counties) | | | | | | | | |

## ANNEX 3. FUTURE STRUCTURE OF INTERNATIONAL PROGRAMS

According to the IP Strategy from January 2023, IP will be restructured as shown in the figure below.



## ANNEX 4. PROGRAMME COUNTRY VISIT

| Day | Date | Time | Activities |
|---|---|---|---|
| **Wednesday** | 21-Jun | 20:00 | Arrival |
| **Thursday** | 22-Jun | 09:00 | Mercy Ships, country director |
| | | 11:00 | James N. Davis Jr. Hospital |
| | | 14:00 | Healthcare Technology Management Unit |
| **Friday** | 23-Jun | 09:00 | CALM Leadership Associates (facilitators for Leadership Training) |
| | | 11:00 | St. Joseph Hospital |
| | | 12:00 | Ministry of Health, Human resources |
| | | 14:00 | GIZ |
| | | 15:30 | Optimum Biomedical |
| **Saturday** | 24-Jun | 10:00 | Diamedica |
| | | 12:00 | Mercy Ships, Biomedical Program Manager |
| | | 14:00 | Ministry of Health, Chief of Nursing Midwifery |
| **Sunday** | 25-Jun | 12:00 | LANA |
| | | 19:00 | CapaCare |
| **Monday** | 26-Jun | 10:00 | Redemption Hospital |
| | | 14:00 | Mercy Ships (country director) |
| **Tuesday** | 27-Jun | 11:00 | 14 Military Hospital (observation Glostavent User Training) |
| | | 16:00 | WHO |
| **Wednesday** | 28-Jun | 08:30 | Partners in Health |
| | | 11:00 | Lifebox Representative |
| | | 13:00 | Ministry of Health, Nursing division |
| | | 16:00 | Departure |

## ANNEX 5. PEOPLE INTERVIEWED

| Organisation | Name | Position | Type of meeting |
|---|---|---|---|
| **14 Military Hospital** | Several participants from anesthesia equipment training | | In country |
| **CALM Leadership Associates** | Dr Joshua Nador | Trainer | In country |
| **CALM Leadership Associates** | Dorine Cooper | Trainer | In country |
| **CapaCare** | Juul Bakker | Program Coordinator Liberia | In country |
| **Diamedica** | Jon Meek | Managing director | In country |
| **GIZ** | Daniel Lohmann | Project Director | In country |
| **GIZ** | Johanna Schulte | Technical Advisor | In country |
| **James N David J Hospital** | Garmai Beyan | Head nursing | In country |
| **James N David J Hospital** | Adela Suah Kyne | Registered nurse | In country |
| **James N David J Hospital** | Akoi Mulbah | Nurse anaesthetist | In country |
| **LANA** | Alieu Perry | Acting president | In country |
| **LANA / 14 Military Hospital** | Leon Snorton | Former president | In country |
| **Lifebox** | Dr Clarence Yaskey | Program Manager Liberia | In country |
| **Mercy Ships** | Emmanuel Essah | Biomedical program manager | In country |
| **Ministry of Health Liberia** | Wymah S Youyoubon | Director Healthcare Technology Management Unit | In country |
| **Ministry of Health Liberia** | Marvin Davis | Human resources | In country |
| **Ministry of Health Liberia** | Diana Sarteh | Chief of Nursing and Midwivery Division | In country |
| **Ministry of Health Liberia** | Dedeh Barr Kesselly | Nursing Division | In country |
| **MSI** | Tara Tobin | ETA | Virtual |
| **MSI** | Keith Brinkman | Country Director Liberia | In country |
| **MSI** | Michelle Bullington | International Programs | Virtual |
| **MSI** | Denny Alcorn | Director Data Managemnet | Virtual |
| **MSI** | Katie Woodard | Finance | Virtual |
| **MSNo** | Bethel Margareta Hamrin | Project coordinator | Virtual |
| **MSNo** | Curt Andreassen | Financial director | Virtual |
| **MSNo** | Samantha Page | Project coordinator | Virtual |
| **MSSI Ghana** | Kwame Agyire Tettey | Executive Director | Virtual |
| **Norad** | Vigdis Halvorsen | Department for Human Development<br>Section for Global Health | In country |
| **Norad** | Ingvar Olsen | Assistant director | Virtual |
| **Norad** | Nina Strom | Case manager Mercy Ships until 2021 | Virtual |
| **Norad** | Annette Wig | Casa manager for Mercy Ships until 2022 | Virtual |

| Organisation | Name | Position | Type of meeting |
|---|---|---|---|
| **Norad** | Paul Fife | Acting assistant director section for global health | Virtual |
| **Optimum Biomedical Ltd** | Hans Goldman | Technician trainer | In country |
| **Optimum Biomedical Ltd** | Sean Ryder | Managing Director | Virtual |
| **Partners in Health** | Ashley Damewood | Director of Policy & Partnerships | In country |
| **Redemption Hospital** | George T. Sarkor | Human resources | In country |
| **Redemption Hospital** | Several participants from leadership training | | In country |
| **St. Joseph Hospital** | Christine Tarr | Head nursing | In country |
| **VID specialized university** | Jorn Lemvik | Consultant (previous MSNo employee) | Virtual |
| **WFSA** | Joleen Moore | Vice chair | Virtual |
| **WHO Liberia** | Dr Musu Julie Duworko | Family Health and Population Advisor | In country |
| **WHO Liberia** | Charles Ocan | Health Systems Advisor | In country |

## ANNEX 6. DOCUMENTS AND WEBSITES CONSULTED

**Documents consulted:**


Addendum to the Memorandum of Agreement between Medical and Surgical Skills Institute and Mercy Ships 2022. October 2022.

Addendum to the Memorandum of Agreement between Mercy Ships and Lifebox Foundation for implementation of Lifebox Clean Cut program in Liberia 2022. July 2022

Addendum to the Memorandum of Agreement between Mercy Ships and Lifebox Foundation. November 2020

Addendum to the Memorandum of Agreement between Mercy Ships and Optimum Biomedical Ltd. 2022. July 2022

Addendum to the Memorandum of Agreement between Mercy Ships and Optimum Biomedical Ltd. July 2021

Amendment to Memorandum of Agreement between World Federation of Society of Anaesthesiologists and Mercy Ships. SAFE Obstetric Anaesthesia Online Courses. May 2022

Deloitte. Audit report MSNo. November 2022

Exhibit A between Diamedica and Mercy Ships. Glostavent Anaesthesia Machine Purchase and Training. December 2022

Exhibit A between Diamedica and Mercy Ships. Glostavent Anaesthesia Machine Purchase and Training. Order #2. April 2023

Exhibit A between Medical and Surgical Skills Institute and Mercy Ships. Nurse training. December 2021

Exhibit B between Medical and Surgical Skills Institute and Mercy Ships. Nurse training. May 2022

Exhibit B between Mercy Ships and Centre of Values-Based Leadership and innovation at VID. February 2023

Exhibit B between Mercy Ships and Optimum Biomedical Ltd. Biomedical Training Project. Liberia 2021. July 2021

Exhibit C between Medical and Surgical Skills Institute and Mercy Ships. Nurse training. October 2022

Exhibit D between Medical and Surgical Skills Institute and Mercy Ships. Primary Trauma Care. October 2022

General protocol agreement between Republic of Liberia and Mercy Ships. 25 September 2018

GIZ. Liberia Health Systems Strengthening and Epidemic Prevention. Project Fact Sheet. February 2022

hera. Assessment of Mercy Ships Grant Proposal 2022. Final report. August 2022

hera. Partner assessment Mercy Ships. Final report. February 2021

Liberia Institute of Statistics and Geo-Information Services (LISGIS), Ministry of Health [Liberia], and ICF. 2021. Liberia Demographic and Health Survey 2019-20. Monrovia, Liberia and Rockville, Maryland, USA: Liberia Institute of Statistics and Geo-Information Services (LISGIS), Ministry of Health, and ICF.

Lifebox. Grant to enhance safe surgery and deliver Clean Cut® in Liberia, interim report, May 2022 to December 2022

Master Purchase Agreement between Mercy Ships and Diamedica. December 2022

Memorandum of Agreement between Lifebox Foundation and Mercy Ships. November 2020

Memorandum of Agreement between Medical and Surgical Skills Institute and Mercy Ships. December 2021

Memorandum of Agreement between Optimum Biomedical Ltd and Mercy Ships. April 2021

Memorandum of Agreement between VID Specialized University and Mercy Ships. February 2023

Memorandum of Agreement between World Federation of Society of Anaesthesiologists and Mercy Ships. June 2019

Mercy Ships International Programs, Strategic Framework 2023-2025, January 2023

Mercy Ships International Programs. A Programmatic Strategy to Achieve Lasting Change. March 2021

Mercy Ships International Programs. Strategic Framework 2023-2025. January 2023

Mercy Ships International. HR Policy – Equal Opportunity. 2018

Mercy Ships International. IMT Policy – Mercy Ships Code of Conduct. 2019

Mercy Ships Liberia. Statistics Report 2022 Calendar Year. 31 December 2022

Mercy Ships Liberia. Statistics Report 2023 Calendar Year. 31 May 2023

Mercy Ships Norway. Partnering for Transformational Change: Strengthening Liberia's Surgical Health System, June 2021-May 2023

Mercy Ships. Annual Report 2022.

Mercy Ships. Anti-Terrorism Policy. October 2020

Mercy Ships. Analysis applications leadership development. No date

Mercy Ships. CS policy – Child Safety. May 2020

Mercy Ships. Donation receipt Letter F.J. Grant Memorial Hospital

Mercy Ships. FIN Instruction: Expenses For Entertainment & Out-Of-Town Travel. August 2019

Mercy Ships. FIN Policy: Travel Policy. July 2019

Mercy Ships. FIN Procedure: Expenses For Entertainment & Out-Of-Town Travel. July 2019

Mercy Ships. Final Project Report, Medical Capacity Building, SAFE Online/Hybrid Obstetric Anesthesia, Liberia. March 2023

Mercy Ships. Final Project Report, Safe Surgery, Liberia. March 2023

Mercy Ships. IMT Policy – Harassment Prevention And Reporting. April 2020

Mercy Ships. Job Description 0982-Country Director. March 2022

Mercy Ships. Leadership training. J J Dossen Memorial Hospital, Harper City– Week Five

Mercy Ships. Leadership training. J. J. Dossen - 4th training week - Focus: Delegation and following through

Mercy Ships. Leadership training. Overview program 2023

Mercy Ships. Leadership training. Proposed workshop Agenda Emirates Hospital– Focus: Leadership and organisation

Mercy Ships. Leadership training. Tool One – Facility Assessment

Mercy Shops. Lifebox Partnership in Liberia – Expansion of CleanCut® Program, Reasons for Lifebox Partnership in Liberia - 2022-2023. No date

Mercy Ships. Medical Capacity Building Cost Rate Calculation. No date

Mercy Ships. Monitoring Plan for "Partnering for Transformational Change: Strengthening Liberia's Surgical Health System" Funded by Norad (May 2021-May 2023). Revised version, July 2022

Mercy Ships. Philosophy of Service. Draft version. May 2019

Mercy Ships. Policy – Anti-Bribery and anti-corruption Compliance. August 2022

Mercy Ships. Procurement Process Documentation Form, Lifebox.

Mercy Ships. RAF021/0055 Progress report, June 1st, 2021 – May 31st, 2022

Mercy Ships. RAF021/0055 Progress report, June 1st, 2022 – December 31st, 2022

Mercy Ships. International Supply Operations Best Practices. March 2019

Mercy Ships and partners. Various course modules. Different dates

MSNo. Annual meeting minutes MSNo and Norad. February 2022

MSNo. Implementation plan. 3 March 2023

MSNo. Partnering for Transformational Change: Strengthening Liberia's Surgical Health System – June 2021-May 2023

MSNo. RAF 21/0055 Baseline - Budget. November 2021

MSNo. RAF 21/0055 Baseline – Activity Plan. November 2021

MSNo. RAF 21/0055 Baseline – Baseline Report. No date

MSNo. RAF 21/0055 Baseline – LFA. November 2021

MSNo. RAF 21/0055 Financial report per May 2023 NORAD.

MSNo. RAF 21/0055 Interim Progress Report. June 2022 to December 2022

MSNo. RAF 21/0055 Progress Report – Financial report. December 2022
MSNo. RAF 21/0055 Progress Report – LFA. No date
MSNo. RAF 21/0055 Progress Report – Risk register status. October 2022
MSNo. RAF 21/0055 Progress Report. June 2021 to May 2022
MSNo. RAF 21/0055 Proposal - Budget. June 2021-May 2023
MSNo. RAF 21/0055 Proposal – Activity Plan. November 2021
MSNo. RAF 21/0055 Proposal – Baseline Report. No date
MSNo. RAF 21/0055 Proposal – LFA. No date
MSNo. RAF 21/0055 Proposal – Monitoring Plan and ToC. July 2022
MSNo. RAF 21/0055 Proposal – Risk register. No date
MSNo. RAF 21/0055 Proposal – The Surgical Care System Needs in Liberia: Workshop minutes. May 2021
MSNo. RAF 21/0055 Request for No-Cost Extension
MSSI. Primary Trauma Care Course Montserrado County – LiberiaReport of Course Evaluation. June 2023.
Norad. Grant Agreement Part III: procurement in the context of projects financed by the Norwegian Agency for Development Cooperation
Norad. Overall assessment and follow-up of partner assessment of Mercy Ships. August 2021
Norad. RAF 21/0055 Application Decision Document Agreement – Grant Agreement Part 2 General Conditions applicable to grants from The Norwegian Agency for Development Cooperation. April 2022
Norad. RAF 21/0055 Application Decision Document Agreement – Grant Agreement Part 3 Procurement in the context of projects financed by the Norwegian Agency for Development Cooperation. October 2019.
Norad. RAF 21/0055 Decision Document. August 2022
Norad. RAF 21/0055. Approval of No-Cost Extension. April 2023
Norad. RAF 21/0055. Feedback on interim progress report MSNo. April 2023
Norad. Transfer of agreement - Mercy Ships 2021-2023. October 2022
Norad/MSNo. Communication Annette Wig and Bethel Hamrin; RAF 3066 RAF 18/0044 – Feedback on application for new agreement with Norad
Norad/MSNo. Communication Annette Wig and Justin Egdorf. Partner assessment response. July 2021
Norad/MSNo. Communication Christine Knudsen and Curt Andreassen. RAF-21/0055 Mercy Ships: Approved Progress Report and Financial Report for 2021-2022
Republic of Liberia. National Healthcare Technology Management Guidelines. No date
Republic of Liberia. National Healthcare Technology Management Policy and Strategies 2022-2023. No date
The 2019-20 Liberia Demographic and Health Survey (2019-20 LDHS)
UNDP. Human Development Report 2021/2022
WHO. Everybody business: strengthening health systems to improve health outcomes: WHO's framework for action. 2007
WHO Liberia. Rebuilding Liberia's health system - Annual Report 2022.
https://www.afro.who.int/sites/default/files/2023-05/WHO%20Liberia%202022%20annual%20report.pdf

**Websites consulted:**

https://hdr.undp.org/system/files/documents/global-report-document/hdr2021-22overviewenpdf.pdf
https://lencd.org/learning/the-core-concept/capacity-development
https://lr.usembassy.gov/a-press-statement-by-u-s-ambassador-to-liberia-michael-a-mccarthy/,
https://worldpopulationreview.com/countries/liberia-population
https://www.diplomacy.edu/blog/what-difference-between-training-and-capacity-development/

https://www.theglobalfund.org/en/oig/updates/2022-04-08-liberia-fraudulent-and-abusive-practices-in-global-fund-programs/
https://www.theglobalfund.org/media/8945/oig_gf-oig-19-019_report_en.pdf
https://www.un.org/en/academic-impact/capacity-building
https://www.who.int/docs/default-source/documents/15-165050.pdf