



IMA World Health

## REPOSITIONING PRIMARY HEALTH CARE IN SOUTH SUDAN:

*Transitioning From NGO-Managed to MOH-Directed Primary Health Care Service Delivery*



## INTRODUCTION

The health sector and development assistance changed dramatically in the Republic of South Sudan (ROSS) following its official independence in July 2011. Moving from a conflict to post-conflict environment created the concurrent challenge of addressing immediate pressing health needs while engineering the health system for longer-term sustainability. Primary health care (PHC) – which includes maternal and child health (MCH) – has been the country's first priority as it rebuilds.

In 2012, the Ministry of Health (MOH) launched a new PHC program that streamlined donor support and coordination. The government's increased prominence and capacity to successfully manage PHC service delivery has been a key characteristic of the program. Previously, non-governmental organizations (NGOs) led PHC provision during the conflict period in many areas. Transitioning from an NGO-managed approach to a government-managed PHC approach involved not only building the capacity of state and county health officials, but also changing the attitude, practices, and habits of NGOs.

IMA World Health (IMA), a U.S. faith-based non-profit organization, was one of the first NGOs contracted to work with the government in designing and implementing a new PHC approach in the pre-independent nation. IMA has worked in Jonglei and Upper Nile states since 2008 through the Multi-Donor Trust Fund (MDTF). That work laid the foundation for its current Rapid Results Health Project (RRHP), which started in 2013 and serves as part of the ROSS' new PHC program. This 2-year project continues to focus on Jonglei and Upper Nile states, which are simultaneously two of the most populous and most conflict-affected states in South Sudan.

This paper explores IMA's experiences in helping the government improve its decentralized health service delivery through RRHP. We offer several key lessons learned and recommendations that can help donors, the MOH, and NGO implementers increase the coverage, quality, and equity of PHC service delivery in South Sudan counties. Many factors have shaped IMA's success, but we believe our, and our donors', genuine commitment and investment in local capacity development has made the tangible difference. IMA's foundational policy of investing in its primary stakeholders - the government of South Sudan and its citizens – created the transformative results deemed impossible with any one intervention alone. Additional recommendations are discussed in the paper. Our discussion of challenges and best practices may also apply to other states and counties in South Sudan or in other Sub-Saharan African countries that possess weak, post-conflict health systems and large disparities in health indicators.

### ***IMA's RRHP Achievements (January 2013 to March 2015): A Snapshot***

- Half of all pregnant women attended all four ANC visits in one site
- More than two million children under age five received outpatient services
- More than 325,000 children have received a measles or DPT3 vaccination.
- IMA trained nearly 6,000 health care workers in MCH, IMCI, nutrition, and HIV/AIDS – leading causes of morbidity and mortality in ROSS

## HISTORY OF PRIMARY HEALTH CARE IN SOUTH SUDAN PRIOR TO THE COMPREHENSIVE PEACE AGREEMENT

South Sudan has had one of the longest struggles for independence in modern times. After nearly 30 years of fighting, the Khartoum government in the North and the indigenous leaders of the South signed a comprehensive peace agreement (CPA) in 2005. During the pre-independence era, faith-based and secular NGOs filled the health care service delivery void in Southern Sudan, struggling valiantly to meet



Figure 1: Sudan and South Sudan

overwhelming patient needs in the absence of government resources. It is estimated that NGOs supported nearly half of South Sudan's 800 health facilities.

Coordinating and overseeing a wide range of health services and partners proved challenging for the burgeoning government during the six-year period between the CPA and the formation of the new ROSS on July 9, 2011. Little coordination between NGO partners and the government or formal basic reporting channels existed, contributing to confusion, duplication of services, and service delivery gaps.

Prior to independence, South Sudan implemented what amounted to a two-tiered health care system: *NGO-managed facilities* and *MOH-managed facilities*. NGO facilities benefited from steadier supply chains and paid staff, reducing staff turnover and essential medicine stock outs.

### MOH RE-ALIGNS DONORS IN SUPPORT OF NEW NATIONAL PRIMARY HEALTH CARE PROGRAM

Recognizing the challenges created by the bifurcation of NGO and government services, the ROSS MOH launched a new national PHC program in 2012 that further streamlined service provision and responsibilities. Specifically, the MOH developed a "one donor per state" approach whereby donor assistance to any region or county would be mandated to support all health facilities in the geographic area (rather than private facilities exclusively). The initiative increased equity among South Sudan's health facilities. It also re-aligned NGO reporting and accountability to the South Sudanese government rather than exclusively to donors. The following two maps present the donor landscape, pre- and post-alignment. Under this new program, the MOH, working with donors, designated an NGO "Fund Manager" to lead health care service delivery support and capacity building in a distinct geographic region across each of the three major donors: World Bank, USAID, and DFID. The MOH and World Bank engaged IMA to lead PHC programming in Jonglei and Upper Nile States, two states that IMA had previously successfully provided health systems strengthening (HSS) support under the Multi-Donor Trust Fund (MDTF).

Each of the three NGO Fund Managers assumed responsibility for ensuring health service delivery and HSS support across South Sudan's 79 counties according to their geographic assignment. Their remit also included subcontracting to other NGOs for service delivery support and technical assistance, where necessary. Several principles guided implementation under the new MOH program: (1) All health facilities in a county were to be equally assisted; (2) health services were to be co-managed by the County Health Departments (CHDs); and (3) the assistance package and project indicators were to be identical across all 10 states.

### IMA'S DIFFERENTIATORS IN ITS FUND MANAGEMENT APPROACH

IMA's implementation approach under the new PHC program was grounded in its collective on-the-ground experience in-country as well as promising approaches used in other IMA programs. IMA offered several features under its World Bank-funded program that were not utilized in the other two donor-funded programs. These elements, described in further detail below, created both improved outcomes and identified challenges that should be noted for future implementation.

#### *Contracting Directly with the MOH for Improved Integration and Accountability*

IMA worked directly under the ROSS MOH to implement the program, hence IMA received funds directly from the MOH rather than via the World Bank. This contractual and management approach differed



## Pre- and Post-Independence South Sudan Health Donor and NGO Maps

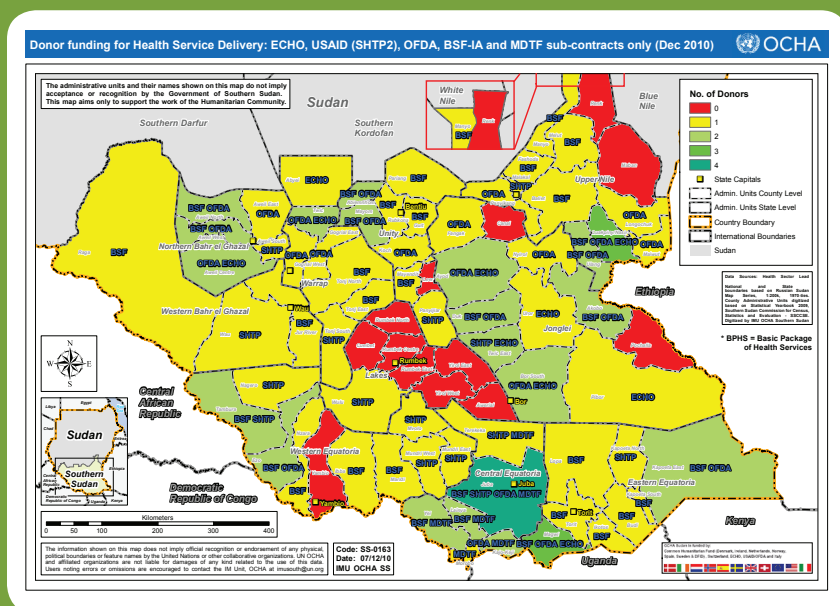


Figure 2: U.N. Office for the Coordination of Humanitarian Affairs (OCHA) December 2010 South Sudan Donor Map

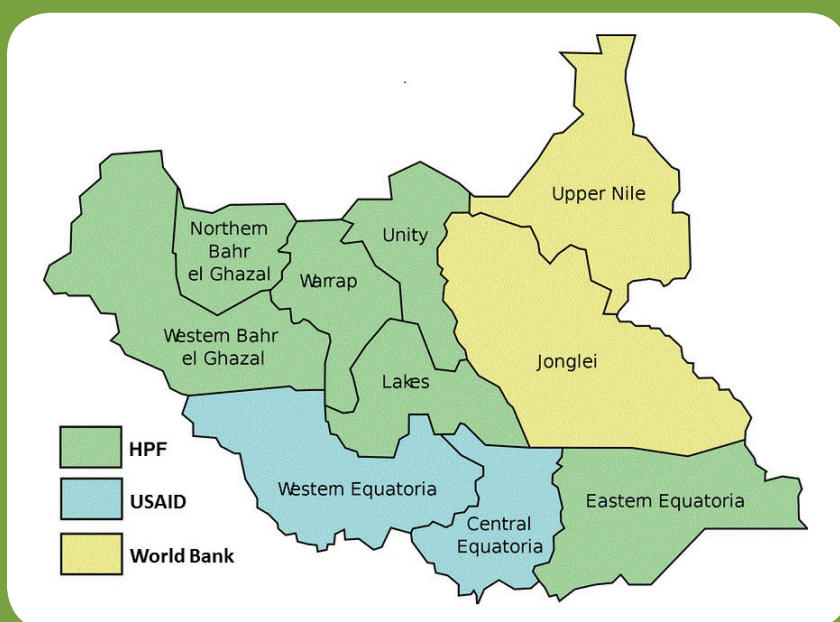


Figure 3: Re-alignment of donor agencies for PHC (January 2013)

from the other two Fund Managers, both which sub-contracted directly with the donors (USAID and DFID). The approach of contracting a managing NGO to the government ensured NGO accountability to the government rather than to an external donor. It offered a practical solution to the challenge prior to independence where many NGOs did not communicate directly with the MOH and reported only to their donors. However, the RRHP program was contracted through a series of short term contracts, including costed and no-cost extensions. This affected payment schedules as well as the ability of the project to plan longer-term interventions, which are necessary for achieving the long-term goals of health systems strengthening initiatives.

### *Harmonizing Salaries for Increased Parity*

The MOH's new PHC program sought to equalize assistance across all health care facilities, whether previously managed by NGOs or the MOH. This became particularly challenging as IMA rolled its program out, as there was a significant disparity between the salaries of NGO and government paid health care workers. To increase all health care worker wages to higher NGO pay scales would risk consuming nearly the entire program budget or at least diluting the impact of project interventions due to lack of funds for activities and commodities. It would also ultimately prove unsustainable for the new MOH to assume.

IMA, with approval from the State MOH (SMOH) in Upper Nile, developed and piloted a *harmonized salary scale* that effectively decreased the salaries of NGO-paid health care workers, while increasing the salaries of MOH-paid staff. This model, though challenging to implement due to the understandable resistance among NGO-paid health care workers, became a notable success, making it possible for public health facilities to retain their staff rather than losing them to NGO projects. Despite some predictions, the majority of health care workers accepted the change and remained in their posts, in part due to the fact that they would be moving to similarly compensated positions. All workers appreciated the harmonization and other support ensured they were paid regularly each month rather than waiting for months (at times) for payment. Six months into the program, the national MOH mandated the other two Fund Managers to follow suit in their implementation states and harmonize salary scales, making it a national standard.

### *Engaging Select Counties to Lead Implementation*

The MOH's program called for the appointment of an "NGO Fund Manager" within each county. The NGO Fund Manager would undertake the three foundational tasks of health systems strengthening (increase the capacity of county health departments), health service delivery (assist all health facilities), and health promotion (outreach, campaigns, etc.). In five counties, IMA contracted directly with CHDs to lead the foundational activities within the MOH's new PHC program. These counties were selected based upon their high capacity and geographic clustering. This strategy directly supported the second guiding principle in the MOH's reconfigured PHC program that called for co-management with CHDs.

IMA developed a targeted package of technical assistance to help the CHDs successfully manage their contracts. It provided specialized support that acknowledged and addressed the capacity constraints inherent in a new government ramping up PHC coverage and quality. IMA first either assigned or embedded technical advisors within each of these CHDs so that they could lead quality-assured activities in line with technical guidance and MOH strategies. The technical advisor helped the CHD establish and execute quarterly budgets and work plans for implementation of health services. IMA also provided human resource (HR) assistance to re-draft health care worker contracts so that all health care workers in a designated county were employed by the CHD itself, reducing the disparities seen previously with NGO-hired health care workers, and putting the CHD (rather than the NGO) in a position of management over health care workers.

At the operational level, IMA helped transport hard currency monthly to pay expenses, as there are no bank facilities in those counties, and supervised the payment of workers. IMA also ensured compliance on a variety of financial, donor, and tax issues, including timely payment of salaries, payment of employment taxes and pensions, adherence to national tax codes, vehicle management, and maintenance of VSAT and IT systems for reporting.

The CHD-led approach offered significant cost savings. Contracts to CHDs, generally, were 40-50 percent less expensive than contracts to NGOs. By eliminating high cost expatriate salaries, expensive R&R policies, maintenance of NGO camps and offices, savings typically approached 50 percent. Aside from being significantly cost-effective, the CHD-led County Implementation Model proved critical during the onset of conflict in December 2013, when most NGOs were evacuated. In their absence, the CHDs continued providing minimally interrupted services. This model, as in the example of harmonized salaries



**Photo 1:** IMA Country Director Dr. Bill Clemmer meets with the County Health Director (Malakal County) during supportive supervision of an IMA-supported rural health facility in March 2013.

above, became a model of PHC assistance. In 2015, as capacity has increased among some CHDs, the MOH asked IMA to replace expiring NGO contracts with a CHD-managed model rather than an NGO-led model.

#### *Instituting Performance-Based Contracts and Incentives for Improved Performance*

Performance-based financing aims to improve health system effectiveness and efficiency through linking allocation of financial resources to achievement of set performance targets. The RRHP performance-linked payment was modeled from the top: A fixed percentage of IMA's quarterly payments from World Bank were tied to performance against pre-determined indicators and targets. IMA in turn, included similar performance-based criteria in its contracts with the NGO lead agencies (and pilot CHDs serving as lead agencies) as well as for performance-based incentives for the recipient health facilities. Under this program, health facilities could earn up to 1,800 SSP (approximately \$600 USD) per month based on achieving certain quantitative PHC indicators, such as number of measles vaccinations or number of





**Photo 2:** *Embedded IMA Technical Advisors with the CHDs during monthly payroll in June 2013.*

curative consultations for children under age five. Performance-based funds for CHDs were awarded on a monthly basis as a block grant. IMA developed a performance-based contracting (PBC) manual for the RRHP to help guide implementation.

IMA ensured that all health facility workers could potentially benefit from PBC, developing a standard process that assured distribution to all workers in each facility according to their position. In this way, even a cleaner or a guard would benefit by their facility seeing more patients or vaccinating more children in any given month, creating an “esprit de corps” for the entire team and prompting health facilities to be open longer. Prior to RRHP, it was not uncommon for health facilities to only be open two to three hours per day. PBC also helped make health facilities be more physically appealing and welcoming to patients. In a nation where the salary of a nurse has no relation to number of patients seen or hours worked, performance-based incentives became a motivational factor and provided a highly appreciated monthly supplement to thousands of health care workers in IMA’s supported states.

Early analysis of the impact of performance-based incentives showed a clear relationship between incentives and health care worker performance as seen from the two examples below. Incentives paid for antenatal care (ANC)/ANC1 (left) provision were tied to higher uptake of services, as opposed to vaccination with DPT3 (right), where incentives played a minor role (DPT numbers were largely generated from campaigns that had no incentive based component).



### Ensuring Access to Essential Medicines

A fifth feature of the IMA-led program included essential drug procurement for target counties. This activity was not included in either the DFID or USAID funded programs. IMA made the intentional decision from the outset to budget for the purchase of drugs, recognizing that performance-based incentives for retention of health care workers had to be complemented by pharmaceutical availability for services to be provided.

Figure 4: Illustrative Performance-Based Contracting Indicators for RRHP

CATEGORY	TARGET
COUNTY HEALTH DEPARTMENT PBC INDICATORS	
HMIS	HMIS report sent to the SMoH with copy to IMA/NGO partner by the 21st of each month
IDSR	IDSR sent to MoH weekly
QSC Supervision of Health Facilities	Every facility receives a QSC supervision once a quarter and report is completed and submitted (one third of facilities should be planned each month)
Monthly CHD and VHC Meetings	Monthly meetings with minutes held: 1.CHD members to evaluate HMIS, IDSR and QSC data 2.Coordination meeting (with stakeholders) 3. VHC meeting.
Vaccination Coverage – DPT3	DPT vaccine is available and target coverage of DPT 3
PHCC INDICATORS	
HMIS	HMIS report filled out and delivered to CHD by the 14th of the month.
IDSR	IDSR sent to MoH weekly
Vaccination Coverage – DPT3	DPT vaccine is available and target coverage is attained (target will be fixed for each PHCC)
Hygiene and Waste Management	Facilities are clean, sharp waste is managed, and other waste is protected
Provision of ANC	Facilities Provide ANC

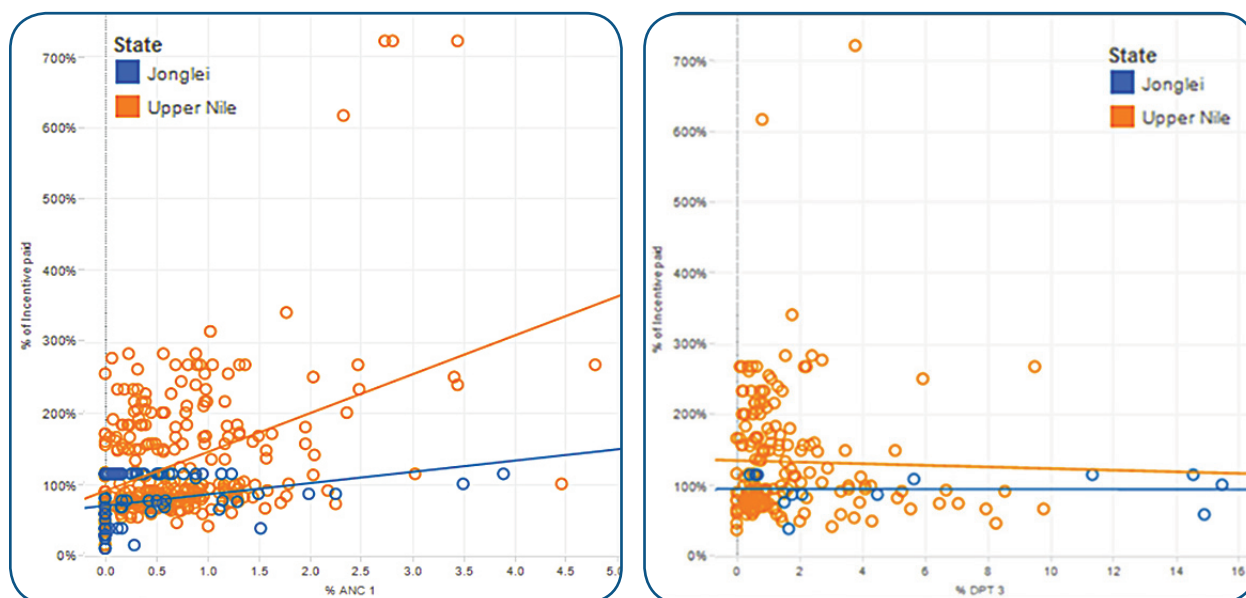


Figure 5: Incentive payment linked to ANC1 services (left) vs. non-incentive linked DPT3 services (right).

During the earlier MDTF years, the World Bank and MOH had purchased drug kits for the entire country and distributed them under a “push” system. Depending on the level of the facility (Primary Health Care Centre [PHCC], Primary Health Care Unit [PHCU], or County Hospital [CH]), as many as 50-80 cartons containing more than 100 types of drugs were given to facilities, whether or not they requested or needed them. While a push system is effective for various reasons (e.g., does not require training of health care workers to quantify monthly orders), it also can be wasteful. Health centers would receive dozens of cases of drugs that they would never use due to lack of demand. Conversely, facilities with a high number of pediatric patients would have frequent stock outs of medicine for children. Compiling of kits was also a labor-intensive process, typically conducted in China or India. The delivery time was lengthy as well, with the average time from the placement of a drug order to delivery to South Sudan taking up to one year.

At the start of the new PHC program there was less than a 3-month drug supply in the pipeline in South Sudan. A new drug assistance program (EMF) funded by USAID and other donors was just getting underway and had not yet posted its first tender. IMA knew identifying and procuring essential medicines would be critical to success. During the first month of the PHC program IMA, in collaboration with the MOH, compiled a list of 15-20 most essential drugs for health facilities. The list was developed using criteria such as drugs needed for the most common illnesses, drugs most frequently out of stock, and drugs most essential for decreasing morbidity and mortality. Data was drawn from the Quantified Supervisor Checklist (QSC), the assessment tool used during health facility supervision.

Through a competitive procurement process, IMA placed multiple orders for bulk quantities of drugs during the first two years of the RRHP project. It teamed a pharmacist and assistants to compile more than 2,000 drug kits in labeled boxes, and distributed them to all 24 counties in the two project states. By the end of 2013, all health care facilities supported by IMA had sufficient quantities of life-saving drugs, while facilities in South Sudan’s other eight states were still experiencing stock-outs of even the most basic drugs. With permission from the MOH, IMA also distributed dozens of the locally assembled drugs kits to other health facilities that were outside of the two States supported by IMA to meet critical needs.



**Photo 3:** Unloading containers of World Bank-funded drugs (2013)

### ***Leveraging Additional Resources to Improve PHC in Target States***

While the World Bank-funded PHC program was generous in scope, IMA recognized that no single donor-funded program could meet the wide health needs of the population it served in a post-conflict state. IMA saw itself as the Fund Manager for the two states, not just the recipient of one grant. Thus, it actively pursued grants to fill gaps and increase the quality of health in Jonglei and Upper Nile. As it has in most of its other programs, IMA strategically leveraged other private and related grant funding to more fully provide essential health services for the population of 3.5 million people in Upper Nile and Jonglei. IMA used its role as Fund Manager to bring in more than \$10 million of related supplemental assistance during the first two years of the PHC program, a distinctive model for an NGO Fund Manager.

### ***Additional Successful Program Features***

IMA implemented three additional unique strategies as Fund Manager that improved its ability to achieve its targets. These models are currently being rolled out in Jonglei and Upper Nile States:

**Dry Season Health Campaigns:** South Sudan's rainy season creates often-impassable roads and prevents clients from uptaking health care. In recognition of the limited time available, IMA assisted CHDs to implement targeted, high volume Dry Season campaigns of health outreach to reach populations both internally displaced by conflict and in geographic settings, typically inaccessible during the 6-8 month rainy season.

### ***Strengthened Reporting through Improved Connectivity and Health Management Information***

**Systems:** IMA helped launch and roll out the DHIS2 reporting and information management systems in its supported counties. DHIS2 is an easily customizable and popular open source reporting platform.



**Bolstered by its extensive experience managing multiple grants in single geographical areas, IMA was awarded additional funding to fill essential gaps and complement the PHC project as follows:**

- *\$2.5 million grant from the **Global Fund** to distribute more than 1.3 million long-lasting insecticide-treated nets to vulnerable children and pregnant women in all 24 counties.*
- ***UNFPA** funding to conduct outreach in reproductive health in IDP settings. The project provides services through mobile clinics and outreach and through strengthening local capacity to implement the Minimum Initial Service Package for Reproductive Health, including GBV and STI/HIV services. To date, more than 1,500 women have attended two or more ANC visits, with 90 percent receiving HIV counseling and testing.*
- ***UNICEF** to scale-up expanded program for immunization (EPI) outreach and create community awareness and increased demand for vaccination services during 2014/15.*
- *A series of grants from **USAID/OFDA** totaling \$5.2 million to provide emergency medical services to IDPs, critical nutrition services for children with acute malnutrition in counties affected by the conflict that started in December 2013, and for emergency obstetric services. The project has helped establish nine mobile clinics and two outreach sites that treat more than 14,000 people in need monthly in two States. IMA also trained seven doctors in trauma care in Jonglei and a further 130 reproductive health personnel in lifesaving MCH.*
- *\$2 million **DFID** award to develop an emergency response to life-threatening outbreaks of Kala-Azar in IMA's two states and to re-establish and rejuvenate a dozen Kala-Azar diagnostic and treatment centers, which were closed or non-functional due to the conflict.*

Through RRHP in South Sudan, IMA chaired state-wide health coordination meetings and integrated the national reporting system into 295 health care facilities. This allowed health facilities to report their data up to the SMOH and then national MOH levels. The MOH praised IMA's role in helping it achieve a crucial milestone of all health facilities reporting into the national DHIS2 system by the end of Year 1, as well as all NGOs reporting to county authorities.

DHIS2 and other reporting systems were only part of successful monitoring though. South Sudan's poor connectivity means that most often phones and Internet are not available or are unreliable. As such, IMA installed new or supported currently VSAT (satellite communications systems) in all of its 24 counties. VSAT-provided Internet access has dramatically increased transmission of timely and accurate data that is now being used to monitor service delivery. IMA's installation of VSAT equipment improved reporting rates from a baseline of less than 50 percent to 90-100 percent. In addition, IMA included VSAT maintenance and timely and accurate report submission as part of its indicator package (with targets) for performance-based contracting, further reinforcing its importance.

**Hardship Incentive Programs for Doctors and Public Health Officials:** Extremely rural health facilities face huge challenges recruiting and retaining doctors, who are in short supply in ROSS. Achieving

improved health indicators and improving equity could not occur without improving health care worker staffing deployment. IMA designed a Hardship Incentive Program for doctors and health officials that provided monetary incentives to serve in counties, which were distant from regional capitals and frequently underserved. The program helped fill 75 percent of vacant positions in all of its counties.

## PROGRAM EVALUATION FINDINGS

The MOH contracted the London Associates in Tropical Health (LATH) to evaluate the three PHC Fund Manager programs in their respective ROSS states at the end of 2013. The IMA-supported states of Jonglei and Upper Nile were traditionally acknowledged by donors as the most challenging states to work in within South Sudan. Both states lie in the Sudd (swamp), meaning that access to the 24 counties is extremely challenging during the rainy season. In addition, even in the best of times, security is precarious in some parts of states. The cost of operating and providing care in these two states is double that of the other states.

Given these constraints, it is unsurprising that at the start of the program health services and indicators in Upper Nile and Jonglei States ranked as the worst in the nation. They ranked at number nine and number 10 respectively in late 2012 at baseline. Twelve months into the program, however, LATH's evaluation ranked the two IMA-led states as number one and three in the nation, with the best overall improvement for all critical health indicators.<sup>1</sup>

## CONCLUSIONS AND RECOMMENDATIONS

Through this innovative package of interventions, the two states witnessed an overall improvement in PHC performance. IMA and the World Bank's genuine commitment and investment in local capacity development no doubt made a tangible difference in South Sudan. IMA's foundational policy of investing in its primary stakeholders - the government of South Sudan and its citizens – created the transformative results impossible with any one intervention alone.

All program interventions—from performance-based incentives, to subcontracting CHDs, to local assembly of drug kits—responded to MOH-expressed needs. IMA embedded itself within the government and provided the tools, training, and resources they needed to be successful. The use of the QSC and monthly county-state meetings has reinforced this partnership and improved performance. Further, IMA constantly re-assessed (and continues to assess) and refine its strategies in this rapidly changing operating environment. It will continue to review and evaluate program progress formally and informally, and compare it to other geographic areas to make further improvements.

IMA's experiences to date offer several successful strategies and approaches that may be applicable for scale-up in other counties of South Sudan or in other post-conflict high morbidity/mortality environments in Sub-Saharan Africa. These are:

- ***Sustained long-term commitment by donors to building primary healthcare systems creates demonstrable results:*** Each leading donor (World Bank, DFID, and USAID) has made a long-term financial commitment to strengthening the PHC system in South Sudan. This unprecedented support, seen rarely in other countries, has ensured availability of primary health care services to the people of South Sudan. As the government capacity strengthens and the most immediate needs are met, this support should evolve and continue with a focus on longer-term goals and objectives. LATH evaluation findings support that the geographic ownership and coordination model improved nearly all-vertical health indicators as well as key HSS-related indicators.

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<sup>1</sup> ROSS MOH and LATH, South Sudan Health Facility Survey, Second Round, 2013.

[http://www.mohss.org/wp-content/uploads/2014/10/140324-MOH-presentation-2014-for-workshop\\_web.pdf](http://www.mohss.org/wp-content/uploads/2014/10/140324-MOH-presentation-2014-for-workshop_web.pdf)

- **Leveraging additional resources and coordinating across donors and partners creates seismic change:**

Fund Managers and other implementers assuming a geographically concentrated approach should leverage additional private and other donor funding opportunities to build on PHC system investments for improved health. As IMA demonstrated, identifying additional donors to support infrastructure, supplies, and training has resulted in more rapid achievements in MNCH in particular. Donors and implementers should further assist the MOH in helping capitalize and leverage these resource infusions in a coordinated fashion.

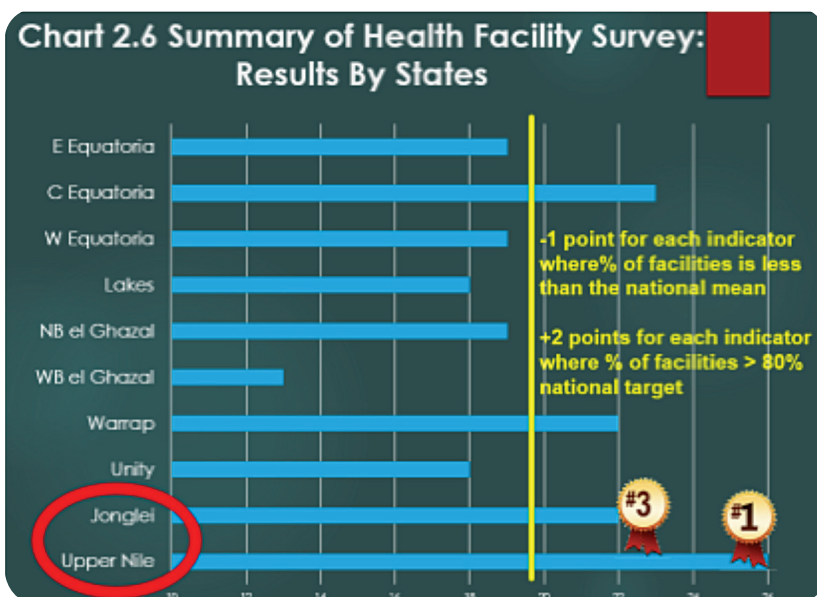


Figure 7: South Sudan Health Facility Survey Results: Second Round (2013)

- **Supporting well-positioned CHDs to manage PHC through sub-contracting offers a new platform for sustainability:** In areas where there is higher CHD capacity and a lack of qualified NGOs, donors may consider sub-contracting directly to CHDs to manage service delivery. Not only is this their actual mandate, but also it offers a capacity building opportunity that enables the CHDs to benefit from intensive technical assistance and embedded capacity building. IMA's CHD-led counties are showing strong improvements in record keeping, reporting, and logistics thanks to help from technical advisors.
- **Performance-based contracting and performance-based incentives improves staff performance and retention:** Initial findings from IMA's PBC pilots demonstrate a strong correlation between service delivery uptake and PBC, particularly for ANC. PBC can be used concurrently at multiple levels to reinforce a joint commitment to quality performance: At the donor-sub-recipient project level; at the County level; and at individual health facilities. By engaging all health facility staff in PBC incentives, IMA helped foster a culture of teamwork and joint success. Further, hardship post incentives helped recruit and retain doctors at remote posts and may be used selectively in other eligible areas of South Sudan.
- **Developing harmonized salary scales mitigates human resource migration from government:** Overcoming the stark differences in quality and equity among NGO and government facilities required a battery of strategies, chiefly among them a commitment to equity across all facilities. The MOH led this through the design and guiding principles of its new PHC program. IMA believes that harmonization of salaries of health care workers, though complex, was one key supporting asset that enabled its success. While this risked HR migration from NGO facilities, the overall harmonization process ultimately created a net positive gain for the SMOH in relation to recruitment and retention of employees. The government is scaling up this policy in recognition of its success in other states.







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