Republic of Liberia

Ministry of Health and Social Welfare

National Health and Social Welfare Policy and Plan 2011–2021

Foreword

It is my honor to present the 2011 National Health and Social Welfare Policy and accompanying ten-year National Health and Social Welfare Plan. This Policy and Plan represent our collective commitment to continue the journey we embarked upon just a few short years ago.

In 2006, we, the people of Liberia, under the very strong leadership of President Ellen Johnson-Sirleaf, started the process of transforming our country from a failed state into a more secured, prosperous and a healthier nation. To guide our efforts, we developed our Poverty Reduction Strategy with concrete actions to build peace and security, revitalize our economy, strengthen governance and rule of law and deliver basic services.

As its contribution to the Poverty Reduction Strategy, the Ministry of Health and Social Welfare carried out a participatory policy and planning process to develop a National Health and Social Welfare Policy and Plan. People and organizations from across government, civil society, the private sector and the general public selflessly contributed their efforts to the implementation of that policy and plan, and remarkable progress has been made.

We have reopened training institutions and expanded the workforce, invested in our health facilities and successfully rolled out the Basic Package of Health Services. As a result, access to basic services has increased, the prevalence of major killers like malaria and diarrhea has been reduced, and fewer children are needlessly dying than any time in decades. The Government of Liberia gratefully acknowledges the many contributions made by all those involved in this effort. But our work is just beginning!

We cannot be complacent with the progress we have made when too many people continue to struggle to improve their health and social welfare, suffer from treatable conditions, die from preventable diseases and remain severely vulnerable. The support systems underpinning our progress remain nascent and require sustained investment. New diseases threaten the population while familiar killers continue to plague our people and urban-rural inequities undermine long-term sustainability.

Recognizing that good health and social protection are key determinants of human development, and in the context of the national vision of Liberia becoming a middle income country by 2030 the Ministry of Health and Social Welfare in 2010, began the process of re-analyzing the health and social welfare situations in the country to determine the best ways to improve them today, tomorrow and beyond. This 2011 National Health and Social Welfare Policy and Plan are the products of this process.

Many individuals and organizations, from across the country and outside Liberia, have generously contributed to the development of this Policy and Plan, and we gratefully acknowledge all their contributions. With this document, we pledge ourselves to continuing our march towards our ultimate goal of a healthy Liberia with social protection for all our citizens.

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Minister
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Abbreviations

AFRR	Accreditation Final Results Report
AIDS	Acquired Immune Deficiency Syndrome
ANC	Ante-Natal Care
ARI	Acute Respiratory Infection
ART	Anti-Retroviral Therapy
BCC	Behaviour Change Communication
BEmONC	Basic Emergency Obstetric and Newborn Care
BLSS	Basic Life Saving Skills
BMI	Body-Mass Index
BPHS	Basic Package of Health Services
CA	County Administration
CBHI	Community-Based Health Insurance
CEmONC	Comprehensive Emergency Obstetric and Newborn Care
CHO	County Health Officer
CHSWO	County Health and Social Welfare Officer
CHSWT	County Health and Social Welfare Team
CHV	Community Health Volunteer
CLA	County Legislative Assembly
CM	Certified Midwife
CPR	Cardio Pulmonary Resuscitation
DHIS	District Health Information System
DHS	Demographic and Health Survey
DOTS	Directly Observed Treatment – Short Course
ECOWAS	Economic Community of West African States
EDL	Essential Drug List
EHO	Environmental Health Officer
EHRP	Emergency Human Resources Plan
EML	Essential Medicines List
EmOC	Emergency Obstetric Care
EmONC	Emergency Obstetric and Neonatal Care
EPHS	Essential Package of Health Services
EPSS	Essential Package of Social Services
EPI	Expanded Program on Immunization
FBO	Faith-Based Organization
FP	Family Planning
GAVI	Global Alliance Vaccines Initiative
GC	Governance Commission
gCHV	General Community Health Volunteer
GDP	Gross Domestic Product
GFATM	Global Fund for AIDS, Tuberculosis and Malaria
GHI	Global Health Initiatives
GIS	Geographic Information System
GOL	Government of Liberia

GRC	Governance Reform Commission
HC	Health Center
HIPC	Heavily Indebted Poor Country
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HP	Health Promotion
HR	Human Resources
HRCR	Human Resources Census Report
HRH	Human Resources for Health
HRIS	Human Resources Information System
HSCC	Health Sector Coordination Committee
HSPF	Health Sector Pool Fund
ICD	International Classification of Diseases
ICT	Information Communication Technology
IEC	Information, Education, Communication
IMCI	Integrated Management of Childhood Illnesses
IMF	International Monetary Fund
IMNCI	Integrated Management of Neonatal and Childhood Illnesses
INGO	International Non-Governmental Organization
IPT	Intermittent Preventive Treatment
JFKMC	John F. Kennedy Medical Center
ITN	Insecticide-Treated Nets
LDHS	Liberia Demographic and Health Survey
LIBR	Liberia Institute for Biomedical Research
LISGIS	Liberia Institute for Statistics and Geo-Information Services
LMHRA	Liberia Medicines and Health Products Regulatory Authority
LMIS	Liberia Malaria Indicator Survey
LNGOs	Local Non-Governmental Organizations
LPN	Licensed Practical Nurse
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MDGs	Millennium Development Goals
MD	Medical Doctor
MOE	Ministry of Education
MOF	Ministry of Finance
MOGD	Ministry of Gender and Development
MOHSW	Ministry of Health and Social Welfare
MOJ	Ministry of Justice
MOPEA	Ministry of Planning and Economic Affairs
MOU	Memorandum of Understanding
MYS	Ministry of Youth and Sports
NCD	Non-Communicable Diseases
NDP	National Decentralization Policy
NDP	National Drug Policy
NDS	National Drug Service
NFP	Not-for-Profit
NGO	Non Governmental Organization
NHA	National Health Account
NHP	National Health Policy

NHPP	National Health Policy and Plan
NMCP	National Malaria Control Program
NPHC	National Population and Housing Census
NRL	National Reference Laboratory
NTD	Neglected Tropical Diseases
OFM	Office of Financial Management
OGC	Office of General Council
OOP	Out-of-Pocket
OPD	Outpatient Department
PBC	Performance-Based contract
PA	Physician Assistant
PCT	Program Coordination Team
PCU	Program Coordination Unit
PFP	Private-for-Profit
PHC	Primary Health Care
PMTCT	Prevention of Mother-to-Child Transmission
PMI	President's Malaria Initiative
PNC	Post-Natal Care
PRS	Poverty Reduction Strategy
RBHS	Rebuilding Basic Health Services
RN	Registered Nurse
SCMP	Supply Chain Master Plan
SCMU	Supply Chain Management Unit
SDP	Service Delivery Point
SHI	Social Health Insurance
SOP	Standard Operation Procedures
SRH	Sexual and Reproductive Health
STDs	Sexually Transmitted Diseases
TB	Tuberculosis
TMP	Traditional Medicine Practitioner
TNIMA	Tubman National Institute for Medical Arts
TTM	Trained Traditional Midwives
UNDAF	United Nations Development Assistance Framework
UNDP	United Nations Development Program
UNICEF	United Nations Children Fund
US$	United States Dollar
USAID	United States Agency for International Development
VCT	Volunteering Counseling and Testing
WAHO	West African Health Organization
WB	World Bank
WHO	World Health Organization

Photographs provided by: Rebuilding Basic Health Services, Clinton Foundation Health Access Initiative, Liberia Poverty Reduction Strategy, and the Ministry of Health and Social Welfare.

Republic of Liberia

Ministry of Health and Social Welfare

National Health and Social Welfare **Policy**

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Summary

Background. Liberia has established a national vision of becoming a middle-income country by 2030 and the health and social welfare of the population are critically important to reach that vision. Therefore, in order to substantially improve the health status and social welfare of the population, the government led a participatory process of establishing one holistic, evidence-based policy framework explicitly aimed at guiding decision-makers through the next ten years. The process included analyzing the health and social welfare situation and the experience of implementing the 2007 National Health Plan, revising the National Health and Social Welfare Policy and ultimately developing the 2011-2021 National Health and Social Welfare Plan.

Situational analysis. The situational analysis determined that Liberia's growing population is young and increasingly urban, while the majority continue to live in rural areas. It found that the Basic Package of Health Services (BPHS) established by the Ministry of Health and Social Welfare has been successfully rolled out across the country, and evidence indicates that the health status of the population is improving. However, maternal and child mortality remain high and major killers like malaria and diarrhea continue to be among the most common illnesses, while new diseases reflecting changes in lifestyle and diet threaten the population.

The analysis process also identified the extent to which social resilience and capacity to cope, or social capital, has deteriorated as a result of the civil conflict and the extent to which the population is vulnerable. And despite the success of the BPHS, the public facility network continues to leave out a large proportion of the population living more than one hour's walk from a health facility. Resources allocated for service delivery in both urban and rural areas do not closely reflect the size of the catchment population and facility workload. Hospitals are huge consumers of resources, but their size and use have not been closely studied, and referral linkages between the various levels of the system do not function well. The workforce lacks the right mix of skills, it should be deployed according to service delivery needs, and skilled providers should be retained where they are needed most. In terms of spending, households carry a high burden of the total expenditure, and although the domestic economy is growing again, because donor support is expected to gradually reduce, the funds available for health and social welfare are projected to remain at the current relative level over the next ten years.

Thus, while progress has been made and the health and social welfare status of the population is getting better, the sector must become more effective by improving the responsiveness of services and strengthening referrals between all levels of the system. It must improve the interrelationship between strengthening the existing workforce, producing additional workers, and deploying and retaining workers according to service delivery needs. The system as a whole must become more efficient by equitably allocating resources according to population size, utilization and workload, improving coordination, and creating a culture that values and strives to do more for the population within existing levels of resources.

Goal, objectives and principles. To achieve Liberia's vision of becoming a middle-income country, the goal of this policy is therefore to improve the health and social welfare status of the population of Liberia on an equitable basis. Sustained leadership, stakeholder commitment, resources and effort are needed to achieve this by: (1) Increasing access to and utilization of a comprehensive package of quality health and social welfare services of proven effectiveness, delivered close to the community, endowed with the necessary resources and supported by effective systems; (2) making health and social welfare services more responsive to people's needs, demands and expectations by transferring management and decision-making to lower administration levels; and (3) making health care and social protection available to all people in Liberia, regardless of their position in society, and at a cost that is affordable to the Country.

The underlying principle to this policy is that health is a state of complete physical, mental and social well-being, and access to quality health and social welfare services is a precondition for individual and societal development. The guiding principles to this policy are that health is a universal human right, equity, quality,

efficiency, sustainability and accountability. The Primary Health Care approach encompassing community empowerment, decentralization and partnership shall be followed in the implementation of the policy.

Service delivery. The system shall be based on three main levels of service delivery: primary, secondary and tertiary. Two distinct packages of services will serve as the cornerstones of the national strategy to improve the health and social welfare of all people in Liberia: the gender-sensitive Essential Package of Health Services (EPHS) and a planned Essential Package of Social Services (EPSS). The EPHS prioritizes services that reflect the prevailing disease burden and health conditions affecting the population. The EPSS prioritizes those services that are necessary for the social well-being of the population, especially those considered most vulnerable. The components of the two packages are affordable, sustainable, high-impact interventions that have been chosen due to their effectiveness at preventing or treating the major causes of morbidity and mortality or increasing social welfare.

Implementation. Commitment to this policy by all stakeholders is a precondition for its success. Therefore, the policy development process has been participatory and consultative throughout, and it will be updated and enriched by new elements as experience is gained and knowledge accumulates. Based on this policy and its guiding principles and strategic approaches, sub-sector policies shall be maintained to provide a detailed understanding and policy guidance across a multitude of inter-related sub-sector issues. Finally, the National Health and Social Welfare Plan is the instrument devoted to the implementation of this policy.

1. Introduction

1.1 Policy context

This National Health and Social Welfare Policy has been formulated at an important juncture in Liberian history. Within a context of stability and economic growth under a legitimate, accountable government, the country is shifting its focus from short-term recovery to long-term national development. The Government is leading the process of moving toward a system that will substantially improve the health status and social welfare of the population by establishing one holistic, evidence-based policy framework explicitly aimed at guiding decision-makers through the next ten years.

Through the Ministry of Planning and Economic Affairs, the Government is developing the Medium-Term Social and Economic Development and Growth Strategy to set the stage for Liberia becoming a middle-income country by 2030. Recognizing that health and social welfare are key determinants of human development, and in the context of this national vision, in 2010 the MOHSW began analyzing the health and social welfare situation in the country since 2007 and determining the best ways to improve it today, tomorrow and beyond.

This policy builds on the 2007 version of the National Health Policy, the 2008 Governance Commission Report, the 2009 National Decentralization Policy, the 2009 National Social Welfare Policy as well as the 2011 Country Situational Analysis Report. It draws upon the knowledge gained by implementing these policies/reports as well as from numerous sources of new data about the status of the Liberian population. Thus, the MOHSW is confident that this 2011 policy's orientation is evidence-based and reflects the best information and guidance available at the time it was developed.

The policy development process has been participatory and consultative throughout. Representatives from communities, civil society and religious groups as well as district, county and national government officials have discussed and deliberated on policy content and orientation; their views shape this document. It has been revised many times and will continue to evolve as additional data become available and as systems improve.

This policy will be updated and enriched by new elements as experience is gained and knowledge is accumulated. By maintaining a robust analytical capacity to understand the changing environment, the outcomes of the chosen interventions and their side effects, appropriate and timely adjustments will be made whenever necessary.

1.2 Policy priorities

In light of multiple national priorities and demands on what are limited resources, establishing an equitable health and social welfare system requires a sustained commitment by all stakeholders to wisely use every available resource and to do so in an inclusive, participatory manner. Therefore this National Health and Social Welfare Policy focuses upon nationally set priorities on which all concerned partners are asked to concentrate their efforts in order to develop the accessible, responsive system necessary to substantially improve the health and social welfare of the population. Because the needs of the population exceed the resources available, the impact on *efficiency* and *effectiveness* must become the measures by which all efforts are assessed in order to ensure their maximum contribution to the development of the system.[1] The health and social welfare sector can and must become more *effective* by

1. Health systems *efficiency* refers to the degree of extracting the greatest potential health gains from a set of measurable inputs. Health systems *effectiveness* equates to the timeliness of access to the full array of needed services, quality and safe care leading to improvement in health outcomes.

- Improving the timely access to high-impact, evidence-based interventions and strengthening referral between all levels of the system;
- Increasing the utilization of services by improving the population's care-seeking behavior, the quality of care and the availability of essential drugs and equipment; and
- Improving the coherence between strengthening the existing workforce, producing additional workers with the right skills mix, deploying according to service delivery needs and retaining skilled providers where they are most needed.

At the same time, the health and social welfare sector must become more *efficient* by:

- Allocating resources among counties according to equitable criteria and optimally distributing resources to health facilities according to population size, utilization and workload;
- Improving the coordination of all efforts to support health and social welfare services, eliminating duplication and minimizing gaps; and
- Creating a culture at all levels of the system that values and strives to do more for the population within existing levels of resources.

Commitment to a shared policy by all stakeholders is a precondition for success. Based on this policy and its guiding principles and strategic approaches (see Section 3, below), sub-sector policies shall be maintained to provide a detailed understanding and policy guidance across a multitude of inter-related sub-sector issues. The *National Health and Social Welfare Plan* is the instrument devoted to the implementation of this policy.

2. Situation Analysis

2.1 Socio-economic situation

According to the 2010 UNDP Human Development Report's Human Development Index, Liberia ranked 162nd out of 169 countries and 13th out of the 15 ECOWAS member countries included in the report. The report stated that the average life expectancy in Liberia was 59 years, the adult literacy rate was 55 percent and the combined gross school enrollment was 57 percent. Progress is being made on some of the Millennium Development Goals (MDG)—for example, access to improved drinking water[2] and school enrolment are both improving—but the impact of the civil conflict will make it difficult to achieve most of the MDGs. According to the World Bank and IMF's 2010 *Economic Outlook*, Liberia's 2010-estimated per-capita gross domestic product (GDP) was US$247, down US$970 (80 percent) from the 1980 peak of US$1,217 in real terms. Liberia recently completed the Heavily Indebted Poor Countries process and a total external debt burden of US$4.6 billion (equivalent to 800 percent of GDP) was cancelled by June 2010. However, while the economy is growing again, in light of the global economic contraction, gradually reducing donor support and the number of competing national priorities, the funds available for health and social welfare are expected to remain at the current level over the next ten years.

2.2 Demography

The 2008 National Population and Housing Census (NPHC) reported 17 major ethnic affiliations. Most Liberians (86 percent) identified themselves as Christian, while Muslims made up 12 percent and "Other" 2 percent. Of the 15 administrative counties, the "big six" (Montserrado, Nimba, Bong, Lofa, Grand Bassa and Margibi) accounted for 75 percent of the total population. The census identified a population growth rate of 2.1 percent and a total population of 3,476,608, an increase of 65 percent from the 1984 census (2,101,628). Fifty-two percent of Liberians were 19 years of age or younger in 2008. The population of Montserrado County more than doubled (from 491,078 to 1,118,241) since 1984 and one-third of all Liberians lived in Monrovia. Nationally, 47 percent of the entire population lived in urban areas. Over 20 percent (832,030) of census respondents were displaced during the civil conflict and over 90 percent had resettled by 2008; however, an estimated 150,000 refugees have recently arrived in Liberia from neighboring Ivory Coast, placing an unplanned burden on the system.

2.3 Morbidity and mortality

2.3.1 Maternal health

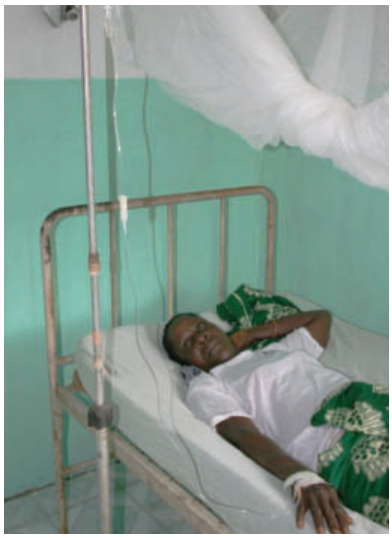
The 2007 Demographic and Health Survey (DHS) calculated the maternal mortality ratio at 994 deaths per 100,000 live births. The total fertility rate was 5.2 and the contraceptive prevalence rate was just 11 percent. The DHS also reported that only 37 percent of deliveries take place in a health facility (70 percent in Monrovia and 26 percent in rural areas), 30 percent of women who deliver do not receive any postnatal care and ado-

2. See section 2.3.6, "Water and Sanitation."

lescent pregnancy increased from 29 percent in 2000 to 32 percent in 2007. The Roadmap for the Reduction of Maternal and Child Mortality was developed and revised in line with Millennium Development Goal 5 to reverse the alarming trends identified in the DHS.

2.3.2. Child health

The 2007 DHS reported that the infant mortality rate in Liberia declined from 144 deaths per 1,000 live births in 1986 to 71 deaths per 1,000 live births in 2007, thus contributing toward achievement of Millennium Development Goal 4. The under-5 mortality rate followed the same trend, declining from 220 deaths per 1,000 live births in 1986 to 110 deaths per 1,000 live births in 2007. However, despite the progress that has been made, many health problems persist. The full vaccination coverage rate remains low (51 percent) and malaria, acute respiratory infections, diarrheal diseases and malnutrition remain the main causes of under-5 deaths.[3] To address these persistent challenges, a number of interventions to increase child survival were developed, including the 2009 Community Health Strategy.



2.3.3 Communicable and neglected tropical diseases

Malaria remains the leading cause of morbidity and mortality in Liberia, with 38 percent of outpatient attendance and 42 percent of inpatient deaths attributable to malaria.[4] However, the under-five malaria prevalence has been significantly reduced from 66 to 32 percent since 2005.[5] The 2007 DHS found the HIV prevalence to be 1.5 percent in the general population ages 15-49 years, which was lower than previously thought. Nevertheless, the MOHSW has scaled up HIV and AIDS counseling, testing, care and treatment sites and the antiretroviral therapy coverage in the general population has increased to 34 percent. The 2008 WHO-estimated incidence rate for all forms of tuberculosis was 326 per 100,000, smear positives were 132 per 100,000 and the mortality estimate was 28 per 100,000. Results of epidemiological mapping of neglected tropical diseases (NTDs) show a wide distribution and overlap of onchocerciasis, lymphatic filariasis, schistosomiasis and leprosy in all 15 counties.

2.3.4 Mental health

Studies suggest a high prevalence in the general population of mental health disorders, including major depression, post-traumatic stress disorder and substance abuse. However, there is only one practicing psychiatrist in the country and only a handful of trained mental health nurses. The National Mental Health Policy was established in 2009, accompanied by a Basic Package of Mental Health Services. The policy mandates a decentralized approach to integrating mental health and neuropsychiatric care into the health care system. It provides for increasing the clinical capacity of mental health professionals and the health care workforce to meet the mental health needs of the population. Although stigmatization remains a major challenge, gradual screenings and referrals for mental health conditions are making basic outpatient and inpatient treatment options available at the primary and secondary levels.

3. 2010 MOHSW/World Health Organization EPI vaccination verification survey and routine HMIS.
4. 2009 Health Facility Survey.
5. 2009 Liberia Malaria Indicator Survey.

2.3.5 Nutrition

In contrast to declining infant and child mortality rates, the 2010 Comprehensive Food Security and National Survey (CFSNS) found that nationally 42 percent of children under 5 were chronically malnourished (stunted) and 3 percent were acutely malnourished. Stunting usually occurs by the age of 2 and increases a child's risk of dying from normal childhood illnesses. This suggests that improving infant and young child feeding practices would make even greater declines in infant and child mortality. The National Nutritional Policy was developed in 2009 to improve the nutritional status of the population and the MOHSW has committed to institutionalizing the Essential Nutrition Actions to accelerate coverage of nutrition interventions.

2.3.6 Water and sanitation

The proportion of houses with improved sources of water is gradually increasing, signifying progress toward Millennium Development Goal 7.[6] The 2007 DHS and 2009 Liberia Malaria Indicator Survey (LMIS) show an improvement from 67 to 75 percent of households with access to improved sources of water.[7] The 2009 LMIS also found that 43 percent of households have access to an improved sanitary facility, while significant rural/urban disparities exist. Improved sanitation is available to 63 percent of urban households but only 27 percent of rural households.

2.4 Social welfare

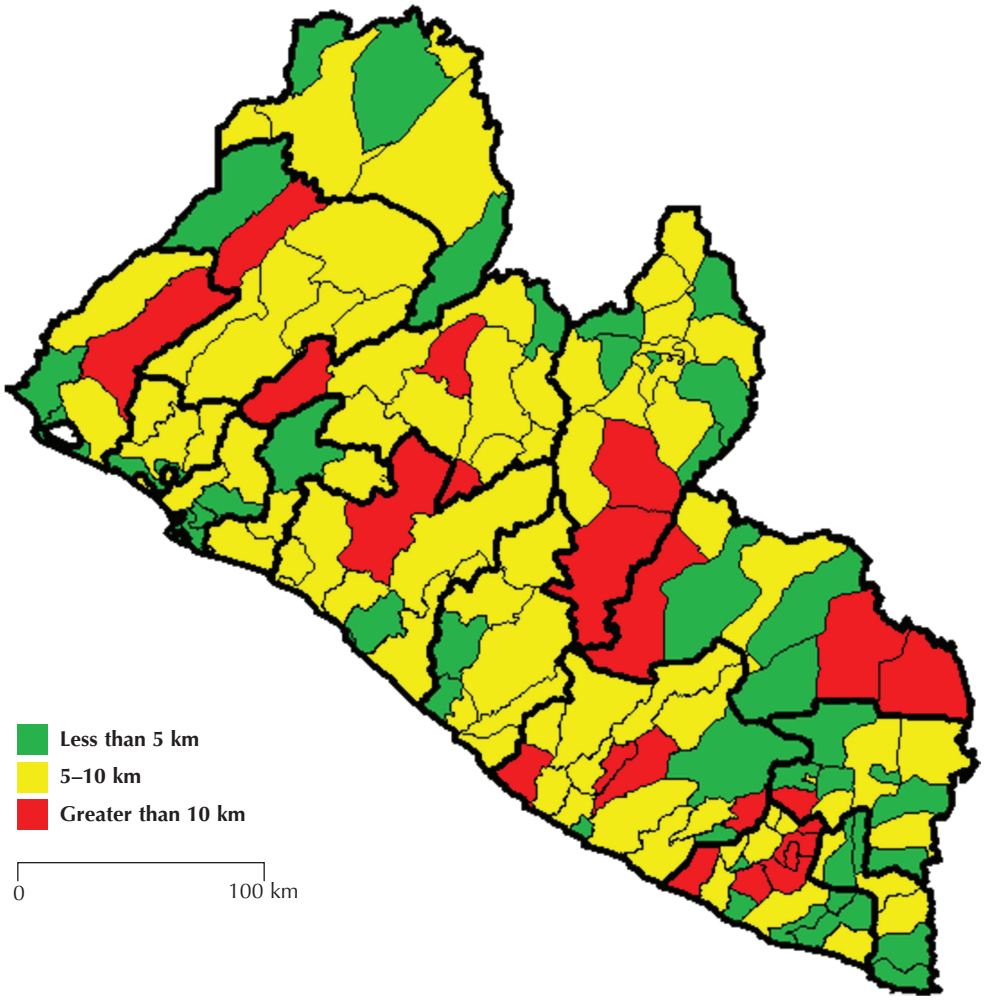
The 2008 census data provide ample evidence of the social problems in Liberia and the extent to which social resilience and capacity to cope, or social capital, has deteriorated as a result of the civil conflict. Nevertheless, the social welfare policy draws its authority from and must be read in conjunction with prevailing legislation and legal conventions. Six target groups and their related institutions emerge from the legal mandates: (1) Children and adolescents who are vulnerable, in conflict/contact with the law and/or have special education needs; (2) the aging; (3) prisoners; (4) substance abusers; (5) victims of natural and man-made disasters; and (6) welfare institutions. The census results identified a special population of about 51,367 people who were institutionalized or whose status was "floating" and susceptible to harm due to forces outside of their control (vulnerable). Another 110,260 people live with various types of physical disabilities and 2,317 were mentally challenged. The elderly (60 years and above) typically comprise about 5 percent of the total population, which in 2008 would have been equivalent to 173,830 persons. There are approximately 1,500 persons held in prisons at any given time—the vast majority are adult males.

2.5 Infrastructure

In the 2010 Basic Package of Health Services Accreditation Final Results Report, the MOHSW reported 550 open health facilities (378 public and 172 private).[8] Only 31 percent of private facilities met minimum facility accreditation criteria, while 80 percent of open government facilities successfully met the criteria. The 2008 National Population and Housing Census reported that 41 percent of all households must travel one hour or more to reach the nearest facility.[9] The current status of accessibility to health facilities is shown in the map below.

6. Sources that are likely to provide water suitable for drinking are identified as "improved sources."
7. Bottled water is considered an improved source.
8. The Basic Package of Health Services Accreditation Final Results Report, MOHSW, 2010.
9. The MOHSW has established five kilometers (equivalent to one hour's walk) as the effective distance for a primary care facility catchment population.

Figure 1. Average Distance of Communities from Facilities, by District



Fifty percent of government clinics are serving catchment populations smaller (40 percent) or larger (11 percent) than catchment criteria established by the MOHSW.[10] The absence of infrastructure design standards and building codes for construction, reliance on an expensive clinic prototype and inadequate project delivery processes have constrained optimization of public facilities.

2.6 Service delivery

Implementation of the Basic Package of Health Services (BPHS) to date is considered to have been very successful. Eighty percent of functioning government facilities were credited for provision of the BPHS in 2010, up from 36 percent in 2008.[11] However, although significant progress has been made to ensure that the BPHS is provided in functioning health facilities, service utilization and health outcomes remain low.[12] Anecdotal reports

10. Liberia Rebuilding Basic Health Services (RBHS) Geographic and Demographic Distribution of Health Facilities in Liberia Report, November 2010.

11. The Basic Package of Health Services Accreditation Final Results Report, MOHSW, 2010.

12. Liberia Malaria Indicator Survey, MOHSW, 2009.

cite health workers' attitude toward patients, long waiting times and a lack of drugs as reasons for low utilization of public services. Poor health-seeking behavior also affects utilization and health outcomes.[13] Moreover, the BPHS does not take into account that people still present at the facility for the treatment of illnesses that are not included in the Basic Package, such as non-communicable and neglected tropical diseases, in some instances placing an unrecorded, undue burden on the resources allocated to facilities.

With most rural households more than one hour's walk away from the nearest health facility, inadequately supervised community health volunteers (CHVs) are in many cases the first provider of the community-based BPHS. At health facilities, clinics provide basic preventive and curative care, including immunization and maternal and child healthcare. Skilled delivery attendance is only available if a clinician (midwife, physician or nurse) is assigned to the clinic. Emergency care usually requires referral from the clinic to the nearest secondary-level care facility. Many patients self-refer and enter the health system at the wrong level, creating an unnecessary burden on the secondary level of care. Most counties have only one government hospital and one or two health centers providing 24-hour care for conditions requiring hospitalization, emergency services and diagnostic services.

Hospitals are a huge provider of services and consumer of resources; 38 percent of Government funds and 24 percent of all health funds are spent on hospitals.[14] However, hospital services, including at the tertiary-level, have not been comprehensively assessed and rationalized according to service delivery needs. The size of the catchment population being served and utilization are not objective determinants of resource allocation made to hospitals. Some very small–capacity hospitals are serving large catchment populations with inadequate resources, while some hospitals are too large for the populations they serve. The inefficiency in resource allocation (human, material and financial) to the secondary level of service delivery undermines the ability to improve the overall quality of care. Hospitals risk remaining in generally poor physical condition, being overstaffed, and providing low quality of care until a rationalization of secondary level facilities is completed.

2.7 Human resources

In 2009, a national human resources census recorded 8,553 public sector health and social welfare workers. Of those who reported their cadre, 62 percent (5,346) were clinical and 38 percent (3,207) were non-clinical (including security guards, registrars and cleaners). However, only 48 percent (2,568) of the clinical workers were skilled providers (e.g., physicians, physician assistants, nurses, midwives, pharmacists, lab technicians) and almost 70 percent of the total workforce was either non-clinical or unskilled. Reflecting the variations in size of catchment populations indicated in section 2.5, one-size-fits-all staffing patterns have resulted in under- and over-staffing at facilities. Progress has been made toward increasing the number and quality of pre-service training institutions, however, there has been higher production of some cadres than was planned (especially registered nurses), while shortages persist for other critical cadres (e.g. physicians, physician assistants and certified midwives). Deployment to rural areas has been difficult because of the inflexibility of the salary scale and generally inadequate incentives to retain skilled providers in remote areas. Thus, in addition to establishing flexible staffing criteria that respond to local conditions, there is a need to improve the coherence between strengthening the existing workforce, producing additional workers with the right skills mix and effectively deploying and retaining the workforce where it is needed.

2.8 Financing

The 2009 National Health Accounts Report (NHA) for fiscal year 2007–2008 reported a total health and social welfare expenditure of US$103,496,421, or over $29 per person in Liberia. Donors and out-of-pocket

13. Annual Report, MOHSW, 2010.
14. National Health Accounts Report, MOHSW, 2009.

(OOP) financing accounted for most of the expenditure (47 and 35 percent, respectively). Government spending was 15 percent according to the NHA and has remained stable as a percentage of the national budget (between 7 and 8 percent) over the last four years, although it more than doubled in absolute terms from $10,913,584 in fiscal year 2006 to $25,767,030 in fiscal year 2009.[15] While donor funds are expected to gradually decrease over the next ten years, 59 percent of current donor funds (either directly or through the health pool fund) are spent on contracts with NGOs to support 292 health facilities, representing 75 percent of the functioning government facilities in 2010, of which funding for 232 are performance-based.[16] No national formula exists for determining the level of resource allocation between counties based on population, utilization and access criteria.

2.9 Pharmaceuticals, procurement and supply chain

When the 2007 DHS asked women what barriers they faced to seeking timely health care, 51 percent of respondents cited a lack of drugs in the government health facility (60 percent in rural areas). Stock-outs are a persistent problem in facilities across the country for many reasons. Often stock-outs are due to bad road conditions and irregularity of drug supply. Under-regulated private pharmacies are flourishing, despite the fact that the quality of drugs being sold in them is unreliable, and uncontrolled cross-border trafficking exacerbates this situation. Central- and county-level warehousing and distribution lacks adequate investment and funding for procurement of pharmaceuticals is fragmented. The Government pays for drugs at facilities that it is exclusively supporting, bi-lateral donors pay for drugs at facilities supported by NGOs, and vertical program donors pay for drugs that are provided free to all facilities. A ten-year Supply Chain Master Plan (SCMP) and Supply Chain Operating Procedures were developed in 2010 to address the issue of drug accessibility and recurring stock-outs. The 2010 Liberian Medicines and Health Product Regulatory Authority (LMHRA) Act established the legal framework for a new era of pharmaceutical management in Liberia. However, pharmaceutical regulations that should accompany the LMHRA Act need to be established and enforced on drug imports and pharmacies. The 2001 National Drug Policy, 2007 Essential Drug List, the National Formulary and Standard Treatment Guidelines are all under revision.

2.10 Decentralized support systems

The National Decentralization Policy (NDP) was established in 2009 but many aspects of the legal and administrative framework for health sector decentralization remain to be resolved. Currently, the County Health and Social Welfare Team (CHSWT) is the operational arm of the MOHSW. Under the direction of the central MOHSW, CHSWTs manage all Ministry-owned facilities, Ministry-employed human resources and Ministry-provided material resources in their county. A county health and social welfare board, chaired by the county superintendent, advises on county-level policy and planning, assists with resource mobilization and coordination and monitors the performance of the CHSWT. A county health officer heads the CHSWT and is responsible for delivery of all health and social welfare services in the county. Guidelines for decentralization of the support system functions and standard operating procedures have been developed for several key support system responsibilities. Administrative capacity is increasing at the county level and financial policies, procedures and accountants have been assigned to each county, as have HR and M&E officers. However, the CHSWTs continue to manage only a small proportion of the resources used in their respective counties. Building upon the progress already made, the challenge for the MOHSW is to progressively allocate and transfer resources to the county level according to the responsibilities it has been assigned and the activities it has planned. This will require developing an administrative framework that will align the health and social sector support systems with a national vision for local governance.

15. The Government fiscal year starts on July 1 and continues through June 30 of the following year.

16. National Health Accounts Report, MOHSW, 2009; MOHSW External Aid Coordination Unit, BPHS Accreditation Final Results Report, MOHSW, 2010.

2.11 Challenges

The overriding challenge is to equitably expand the coverage of health and social welfare services, of improved quality, by increasing the efficiency and effectiveness of the system. Specific challenges to accomplishing this include:

- A large but imbalanced service-delivery facility network that leaves out a large portion of the population, especially in rural areas.
- Limited access to facilities that results in most rural households being out of reach from skilled providers, requiring a controlled redistribution of the network.
- Long waiting times, poor health worker attitudes toward patients and a lack of drugs that result in low service utilization.
- The under-studied but costly hospital component must be rationalized and developed based on the findings of a thorough assessment.
- The provision of priority services at the community level is not rationalized according to an appropriate skills mix. There is a need to reassign the priority services provided at the community level.
- The now large workforce cannot deliver quality health services without a massive effort to upgrade their skills. Priority workers will remain in short supply until production of workers with the right skills mix and effective motivation and remuneration prevail.
- Institutional capacity is imbalanced in favor of the central ministry over the counties as well as imbalanced among the counties.
- A fragmented pharmaceutical area and poorly functioning supply chain increases the costs of service delivery, does not ensure the availability of quality medicines and restrains both the delivery and expansion of services.
- A worrisomely high out-of-pocket expenditure, unpredictable donor funding and limited government capacity to assume an increasing financial burden necessitate increasing the equity and efficiency of resource allocation, especially to CHSWTs.
- The waste and use of resources for purposes other than were intended must be reduced through improved systems, accountability and appropriate sanctions.
- Expected as well as unexpected developments must be identified and understood as they take place and must be timely and effectively addressed by health authorities and development partners.

3. Policy Foundations

3.1 Mission, vision, goal and objectives

The mission, vision and goal of the National Health and Social Welfare Policy may be articulated as follows:

Mission The *mission* of the Ministry of Health and Social Welfare is to reform and manage the sector to effectively and efficiently deliver comprehensive, quality health and social welfare services that are equitable, accessible and sustainable for all people in Liberia.

Vision Liberia's *vision* is a healthy population with social protection for all.

Goal The *goal* is to improve the health and social welfare status of the population of Liberia on an equitable basis.

Sustained leadership, stakeholder commitment, resources and effort are needed to achieve this by accomplishing the following *objectives*:

- Increase access to and utilization of a comprehensive package of quality health and social welfare services of proven effectiveness, delivered close to the community, endowed with the necessary resources and supported by effective systems;
- Make health and social welfare services more responsive to people's needs, demands and expectations by transferring management and decision-making to lower administration levels, thereby ensuring a fair degree of equity;
- Make health care and social protection available to all Liberians, regardless of their position in society, at a cost that is affordable to the Country.

3.2 Guiding principles and strategic approaches

Health is a state of complete physical, mental and social well-being.[17] The principles guiding this policy are health and social welfare as a universal human right, equity, efficiency, sustainability and accountability. Community empowerment, decentralization, and partnership shall be followed in the implementation of the policy.

3.2.1 Health and social welfare as a human right

Access to quality health and social welfare services is a human right and is a precondition for individual and societal development. Recognizing the importance of health and social welfare, both the executive and legislative branches of government are committed to investing adequate political capital, financial and human resources to ensure sector development. Development partners have demonstrated a shared commitment to support the national development goals.

17. Preamble to the Constitution of the World Health Organization, as adopted by the International Health Conference, New York, 19–22 June 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April, 1948.

3.2.2 Equity with a gender and poverty focus

All people in Liberia shall have access to effective health and social welfare services irrespective of socio-economic status, origin, ethnicity, gender, age and geographic location without discrimination. Women and girls in particular will participate in the planning, design and implementation of programs that reflect the social, economic and cultural determinants of health. The government's pro-poor commitment and prioritization of gender equity, as articulated in the Liberia National Gender Policy, will be demonstrated by concrete measures taken at all levels to ensure that appropriate services are available and utilized by all persons, regardless of gender or status.

3.2.3 Quality of care

The delivery of quality services is fundamental to improving the health and social welfare status of the population. Concerted effort will be made to improve the degree to which services increase the likelihood of desired outcomes by striving for excellence in the standards for quality of care. Decision-making will be predicated on doing the right thing, in the right way, at the right time and making the best use of the resources available in order to satisfy patients.

3.2.4 Efficiency

The greatest potential gains will be extracted from the inputs of all stakeholders in order to maximize efficiency, creating a culture at all levels of the system that values and strives to do more for the population within existing levels of resources. Allocation of resources among counties and distribution resources to facilities and communities will be according to population size, utilization and workload. Priority will be given to improving the coordination of all efforts to support health and social welfare services, thereby eliminating duplication and minimizing gaps.

3.2.5 Sustainability

This policy promotes an approach that emphasizes the positive economic benefits of striking a balance between prevention, promotion and quality curative care based on adherence to standards for high-impact interventions that address the main causes of morbidity and mortality. Developing appropriate solutions that are locally manageable, sustainable and that develop local and systemic capacity is critical to ensuring long-term success. Cost ceilings considered affordable in the foreseeable fiscal framework will be the determining factor in the development of sustainable plans.

3.2.6 Accountability and transparency

Adequate political, financial and administrative mechanisms are needed from the Government and all stakeholders to ensure that decision-makers are accountable for the transparent use of health and social welfare resources. These mechanisms must encompass the whole sector, enabling the public to understand how decisions are taken, how resources are allocated and how results are achieved. To this effect, all resources, internal and external, public and private shall be judiciously monitored, accounted for and transparently reported on. The monitoring system will be designed to enable stakeholders to verify adherence to laws and regulations and to the Primary Health Care principles underpinning this policy.

3.2.7 Primary health care and social welfare services

Primary Health Care (PHC) complemented by social welfare services shall be the foundation and model for improving the service delivery system. The PHC approach focuses on promoting physical health by preventing disease, but it also includes essential care at the level closest to users, where they have first contact with services. This approach means being sensitive to and addressing the many factors in people's social, economic and physical environments, from diet, lifestyle, relationships, income, vulnerability and education, to housing, workplace and culture. The approach places citizens and patients in an equal partnership with providers in decision-making. Interventions draw upon global experiences and focus on community empowerment and innovation, seeking to enhance a community's informed ability to identify, mobilize and address the issues that they face to improve their overall health and social welfare status. To work effectively, the system must be supported by adequate referral capacity. Therefore, an optimal network of referral facilities shall cover the entire country.

3.2.8 Decentralization

The Government of Liberia remains committed to decentralization and many of the characteristics of the future decentralized public structure are now clear. Health and social welfare departments will be formed in each county administration. Therefore, the de-concentration of MOHSW management responsibilities and the building of performing systems at the county level will adapt to the county administrative structure in an incremental and pragmatic way. The MOHSW will progressively relinquish responsibilities to County Administrations as they are equipped to assume them. Caution will be exerted in the decentralization process to ensure continuity of service delivery. Officials at the county level shall be responsible for service delivery and partner oversight, while the central level will focus on establishing policies and standards, resource mobilization and allocation, aggregate planning, monitoring and evaluation and research.

3.2.9 Partnerships

The diverse group of partners, including international donors, Non-Governmental and Faith-Based Organizations (NGOs and FBOs), and Private-for-Profit (PFP) providers working in the health and social welfare sector are motivated by a range of different mandates, interests, resources and ways of working. The Government, in order to enable their participation and ensure their actions are coherent with the principles of this National Health and Social Welfare Policy, will continue to guide partnerships for health and social welfare in order to create long-term, sustainable working relationships. Continuous and frank consultations, information sharing, clear rules, transparent transactions and explicit incentives will characterize partnerships.

4. Policy Orientations

4.1 Organizational policy

Pursuant to its mission, the Ministry of Health and Social Welfare (MOHSW) shall lead all Government ministries, departments and agencies that have a role to play in delivering health and social welfare services, including but not limited to the Civil Service Agency and Ministries of Finance, Justice, Internal Affairs, and Planning and Economic Affairs. In particular, MOHSW will ensure that the Ministries of Education, Gender and Development, and Youth and Sports are consistently involved in developing integrated service delivery strategies, especially for women and girls. Collaboration with these other ministries is also vital to addressing the social determinants of health.

4.1.1 Central level

In consultation with relevant stakeholders and in accordance with prevailing law, key functions of the central-level Ministry shall include:

- Monitoring and advising on health and social welfare laws and establishing regulations for their enforcement;
- Formulating and revising national policy and strategic plans for health and social welfare or their sub-sector components;
- Establishing national goals, objectives and long-term national planning targets for the equitable protection and improvement of health and social welfare;
- Maintaining technical oversight of standards for service delivery, regulation, major research and development initiatives;
- Strengthening and managing health systems, especially those related to human resources, drug management, HMIS, financing, infrastructure and coordination;
- Coordinating a research agenda to inform policy, planning and sector performance;
- Mobilizing and allocating resources in accordance with transparently established formulas and the National Policy for Health and Social Welfare Financing;
- Coordinating broad national programs that shall be implemented by the CHSWTs (e.g. malaria control, expanded program on immunization, national health promotion campaigns);
- Maintaining a dynamic analytical capacity to monitor sector performance, understand the changing environment and introduce appropriate adjustments.

Presently, the MOHSW structure is headed by a minister and includes four departments, each headed by a deputy minister:

- Health Services
- Planning
- Administration
- Social Welfare

The departments are currently sub-divided into bureaus headed by assistant ministers. The bureaus are comprised of divisions and units (sub-divisions) headed by directors.

The Department of Planning is responsible for all planning, research, human resource development and statistics, including birth registration, policy development and partner coordination. Administration manages all financial management–related issues, including procurement, personnel and transport. Social Welfare coordinates all welfare institutions and Health Services is responsible for all health service delivery, including all national programs and county health services. All departments within the MOHSW share cross-functional services provided by other departments. Several program offices, for example the National Lishtimiasis and Tuburculocicis Control Program, are located outside of the MOHSW. In these cases, functional support areas within these programs (e.g. procurement and M&E) shall be consolidated into the equivalent central MOHSW functional unit to increase efficiency and reduce fragmentation of functions.

The Governance Commission (GC) reviewed the structure and function of each ministry and recommended that the number of departments be condensed and the number of politically appointed officials reduced. Therefore, the future Ministry will be streamlined and include only essential functions, staffed by a competent and highly motivated staff in order to lead the decentralized sector. The Ministry's responsibility for direct health and social welfare service delivery shall be devolved to autonomous government institutions and the CHSWTs.

4.1.2 Operational levels

When the National Decentralization Policy (NDP) becomes law and is fully implemented, a Department of Health and Social Welfare, headed by a director, will form part of the County Administration and be equivalent to the current CHSWT. The Director of the County Health and Social Welfare Department will be the County Health Officer (CHO) and other positions within the department will be equivalent to the CHSWT structure and functions established by the MOHSW. The CHSWT will continue to administer a county health system and all national health and social welfare programs in the county, including:

- Implementing and monitoring adherence to all health and social welfare laws, regulations, policies and plans;
- Formulating county-specific plans for the achievement of county and national goals and targets;
- Overseeing and supervising the delivery of services at both the facility and the community level to ensure that they are readily accessible, high quality, efficient and responsive to the population's needs;
- Implementing broad national programs that are coordinated at the national level for leading causes of morbidity and mortality;
- Coordinating, managing and distributing resources for the provision of health and social welfare services in the communities, in facilities and in public institutions such as prisons and at border-crossings in the county;
- Encouraging more healthful behaviors among the community, through integration of facility- and community-based health promotion activities, as well as implementing periodic campaigns on key health issues;
- Reporting on health information collected in the communities and facilities, providing feedback to providers and community members and making appropriate adjustments to service delivery when necessary.

The Ministry will invest heavily in engaging and building human resource capacity at the county level, with the objective of enabling CHSWTs to assume their expanded role as part of the County Administration in a decentralized system. Some counties with very large populations have multiple sub-health systems known as

health districts under the responsibility of the CHSWT; health districts constitute a different geographical territory than the Government political district. CHSWTs shall invest in strengthening health districts (where they are required), health facilities and communities to fulfill their role in the service delivery system.[18] Specific guidelines will be elaborated to articulate central and peripheral remits and responsibilities when the legal and administrative framework for decentralization is finalized and enforced.

4.2 Levels of service delivery

4.2.1 Referral between levels

The national health system shall be based on three main levels of service delivery: primary, secondary and tertiary. Each level will screen patients and social welfare clients for care requirements using clear criteria before transferring to the next level of care. Access to a higher level of care will require written referral from the referring facility, except in cases of emergency if written referral is not practical. Innovative community strategies to support referral, especially patient transportation and community social support mechanisms, will be encouraged and supported with resources. Specific referral procedures will be formulated by the Ministry to guide care providers, patients, families and communities in referral-related decisions.

4.2.2 Primary level of care

The primary level of care consists of both community- and facility-based services. Facility-based services include essential preventive, curative and health promotion services, including maternal and newborn health, child health, communicable diseases, sexual and reproductive health, mental health and basic emergency care. Community-based services are vital to the primary health care goal of achieving maximum participation in decision-making and focus on preventing common conditions, health promotion and education, providing basic services that can be easily delivered in the community and linking communities to facility-based services.

4.2.3 Secondary level of care

The secondary level of care encompasses all aspects of the primary level for the immediate catchment population and permanent, 24-hour care for most conditions requiring hospitalization, as well as emergency services, diagnostic services, comprehensive emergency obstetrics care, emergency surgical services, and other secondary level services, according to whether the facility is a health center or hospital.

4.2.4 Tertiary level of care

The tertiary level is based on referrals and encompasses all aspects of the secondary level care as well as specialized consultative care such as orthopedics and control of some types of non-communicable diseases. Because it has the potential to provide important training opportunities, the tertiary level will emphasize contributing expertise to clinical guidelines, providing a learning environment and providing technical support to regional referral hospitals. This means the tertiary level shall be learning- and teaching-oriented but modest in scale and shall not divert excessive resources away from the primary and secondary levels of care.

18. Not to be confused with the existing administrative district, "health districts" have a distinct catchment population of about 50–100,000 people and include several primary-level service delivery points and a designated secondary care facility.

4.2.5 Service delivery points

The Ministry shall establish standards for the structural, spatial, material, human resources and utility (power, water and waste etc.) requirements for all types of service delivery points (SDPs) according to their level in the health system, the services provided and the size and geographic location of the catchment population.

At the primary level, the following types of SDPs will be available:

- *Community-based services:* Within the radius of a PHC facility catchment population (equivalent to one hour's walk), general Community Health Volunteers (CHVs), Household Health Promoters and Trained Traditional Midwives link the communities to the nearest facility. These volunteers are an important component of the health system, however, they do not receive a health worker salary from Government and provide only limited components of the primary level of services.
- *Non-facility-based SDPs:* These may take different forms (e.g. mobile clinics or community-based providers) but in general they exist where services are offered by a skilled provider on a regular basis outside of a health facility. They consist of the basic outpatient components for a defined catchment population that is not large enough for, or is expecting, a health facility.
- *Clinics:* The most basic public sector health facility is the clinic. It may take many forms and sizes and may have a laboratory, but the common feature is that it offers the entire Essential Package of Health Services (EPHS) for the level, that is, it includes curative care, maternal and child care with immunization and delivery attendance on a permanent basis. In remote areas with clustered catchment population of 1,000–3,500 people, level one clinics are small facilities with basic teams, each composed of a professional and a non-professional with multiple skills. In urban areas, clinics are large structures with the capacity to deal with many outpatient users and occasionally offer double shifts. Clinics do not offer round-the-clock attention, although health workers are on call in rural areas. In principle, level two clinics should provide services for catchment populations of between 3,500 and 12,000 people.

The secondary level is composed of the health center and hospital:

- Health centers: Health centers are the transition between primary and secondary levels of care. While providing mostly primary care, their inpatient capacity makes them a referral facility. They offer 24-hour primary care services complemented by a small laboratory and inpatient capacity of up to 40 beds for a catchment population of up to 25,000 to 40,000. Where catchment population, network of clinics and distance from a county hospital warrant, health centers may be replaced by small hospitals with higher clinical capacities that can occasionally include emergency surgery. Health centers and small hospitals should provide Basic Emergency Obstetrics and Neo-natal Care.
- County hospitals: Each county will have a county hospital serving a catchment population of up to 200,000 people. The county hospital is the referral facility with direct territorial responsibility, playing the role of primary care facility for the neighboring population and serving as the referral facility for the county network of clinics and health centers. To ensure that the neighboring population can access hospital services through referral, an Outpatient Department facility for the provision of primary care will be attached to, but physically separated from, the hospital.

  County hospitals provide the necessary laboratory and basic radiology services to meet the needs of general surgery, pediatrics, general medicine, obstetrics and gynecology services at least to a level sufficient to ensure the permanent provision of Comprehensive Emergency Obstetrics and Neo-natal Care. Bed capacity will reflect the size of the catchment population, but on average it should be about 100 beds including an intensive care unit. As huge consumers of resources, all hospitals in Liberia will be thoroughly studied to develop and rationalize the services provided.

The tertiary level has exclusively referral functions, without territorial responsibility. Tertiary care is provided by the John Fitzgerald Kennedy Medical Center (JFKMC), the national referral hospital in Monrovia, as well as by

a limited number of county hospitals serving as regional referral hospitals.

- Regional referral hospitals: The designation of regional referral hospital is intended to improve access to tertiary level care while ensuring that the functioning of the tertiary level is consistent with the PHC priorities established in this policy. Regional hospitals will be located within reasonable access of the county hospitals that refer to them and will provide specialized consultative care such as orthopedics and ear, nose and throat services. Each regional hospital will have a bed capacity of approximately 250 beds serving a catchment population of around 500,000 people. These facilities are also expected to play an active technical role in capacity-building of other county hospitals, as well as acting as training sites complementary to the national referral hospital.
- National referral hospital: JFKMC is the national referral facility and shall re-establish itself as the top teaching hospital for physicians and medical doctors by operationalizing a residency program and expanding the number of medical specialties, including areas such as cardiology and oncology. As the national referral facility, it will expand services to include a Metabolic Center, a Kidney Dialysis center and an improved Emergency Department.

Resource allocation to service delivery points will be accomplished according to the standards established by the Ministry. However, CHSWTs shall have the authority to redeploy resources within their counties to achieve an optimal service delivery system according to actual utilization and workload.

4.3 Health and social welfare services

4.3.1 Content

Two distinct packages of services will be cornerstones of the national strategy to improve the health and social welfare of all people in Liberia: the gender-sensitive Essential Package of Health Services (EPHS) and a planned Essential Package of Social Services (EPSS). The two packages will list in detail the services that the MOHSW assures will be available throughout the public system.

The EPHS prioritizes services that reflect the prevailing disease burden and health conditions affecting the population. It includes all elements of the Basic Package of Health Services (maternal, child and newborn health, communicable diseases, reproductive and adolescent health, mental health and emergency care) as well as a phased-expansion to include non-communicable diseases, essential child nutrition, neglected tropical diseases, environmental and occupation health, school health, eye health and prison health. To best manage the work associated with these services, new organizational structures will be added including a Non-communicable Disease Unit at the MOHSW as well as Mental Health Wellness Units at hospitals.

The EPSS prioritizes those services that are necessary for the social wellbeing of the population, especially those considered most vulnerable. It is a detailed package of services that will be prioritized and made available incrementally, including services for people with physical and mental health disability, prevention of disabilities, child and family services, child protection, as well as aged, juvenile, youth development, substance abuse and prison services.

The components of the two packages are affordable, sustainable, high-impact interventions that have been chosen due to their effectiveness at preventing or treating the major causes of morbidity and mortality or increasing social welfare. The services included in the two packages shall be appropriately adjusted according to ongoing analysis of relevant information as it becomes available.

4.3.2 Provision of health and social welfare services

The service provision requirements vary across the 15 counties in Liberia. Many rural communities are remote and sparsely populated, while urban communities are close to facilities but densely populated. Thus,

both packages of services will be provided in flexible ways to respond to local conditions in order to obtain maximum outcomes from available resources. At the decentralized level, the type of facility and distribution of service delivery points will reflect distance, utilization rates and size and density of the catchment populations they serve. Few larger facilities will serve high population-density urban areas and numerous small facilities will serve low population-density rural areas, with provisions for expansion as population and utilization increase.

4.4 Health and social welfare financing

4.4.1 Financing policy

The Government of Liberia is committed to financing health and social welfare at the highest level possible. However, considering competing national budget priorities, the anticipated gradual reduction in donor funding that typically occurs after a post-conflict spike in funding and an already high out-of-pocket expenditure, the total health and social welfare expenditure is unlikely to significantly increase in relative terms during the next ten years. In order to maximize the resources available from all sources as well as to ensure the long-term sustainability of financing for health and social welfare, a National Health and Social Welfare Financing Policy will establish a mixed approach to funding health and social welfare that includes a sustainable level of Government financing, predictable donor support, affordable user fees for certain services and potential mechanisms for risk-pooling.

4.4.2 Resource mobilization

The Government of Liberia shall do its part by maintaining the current share of the national budget apportioned to the health and social welfare sector in order to at least maintain relative levels of current expenditure. Different forms of hypothecated taxes (e.g. value-added tax levies, taxes on mobile phone usage, tobacco and alcohol) that could provide additional resources for health and social welfare will be explored and implemented when possible. Donors will be encouraged to use more predictable and efficient ways of channeling their support through the Government's national systems, initially via the pool fund and eventually through sector and general budget support, in line with the Liberia Aid Policy. At the national level, pooling of resources will occur within a sector budget and medium-term expenditure framework, based on the findings of a costing exercise and through which all donor and Government of Liberia funds will be programmed. Resources will be harnessed from all sources, including the major disease prevention and control programs, to satisfy the components of the sector budget. The costing exercise will be done to determine the cost of the service delivery system by component, including human resources, drugs and supplies, equipment, capital assets, energy and other cost categories.

4.4.3 User fees

An administrative system for the collection of affordable user fees for certain services shall be put in place by the MOHSW, be administered by the CHSWTs and be subject to the Ministry's procedures for financial management. In order to minimize the prevalence of catastrophic costs associated with user fees, a range of prepayment schemes will be explored, such as community-based financing and social insurance, with attention to the proportion of the population covered and potential resources raised. Where new options prove effective, they will be gradually scaled up to attain maximum benefit. Because it will take time to implement strategies for health and social welfare financing, the current suspension of user fees shall be extended until at least 2013, except in cases of approved pilot activities for the purposes of exploring the feasibility of financing options. Because even low fees can deter health-seeking behavior, a limited variety of free services shall continue beyond 2013 to encourage uptake of priority services by all people as well as other services for vulnerable groups in need of

social protection. Mechanisms will be established to ensure the availability of a limited number of free, priority services, including community oversight and punitive measures against facility staff found to be charging fees for otherwise free priority services.

4.4.4 Resource allocation

Stakeholders will make decisions concerning the allocation and use of resources at all levels of the system, based on criteria established by the central MOHSW. At a minimum, all financial support to health and social welfare shall be consistent with this health and social welfare policy and its accompanying plan, which are based on the primary health care (PHC) approach. In the PHC approach, the household, community, district and county levels serve as loci for decision-making in relation to resource management and service delivery; therefore, resource allocation and planning will consistently include representatives from the affected communities. Evidence-based high-impact interventions will continue to be prioritized as well as innovative payment mechanisms such as performance-based contracting and provider payment schemes to increase efficiency. An informed balance will be maintained when allocating resources to the different levels of the system to avoid over- and under-funding levels of care. Among counties, in order to ensure access to quality health services, an equitable, population-based resource formula will be established that includes a standard minimum level of resources for each county as well as increments that reflect variations in population, density and geographic location. The National Health and Social Welfare Plan will elaborate on mechanisms for setting ceilings considered affordable in the long term.

4.5 Human resources for health and social welfare

One of the most important steps to be taken in expanding coverage of priority services is improving the coherence between strengthening the existing professional workforce, producing additional workers with the right skills mix, evidence-based health worker (re)distribution and effective management, motivation and retention schemes.

4.5.1 Human resource management and planning

The Ministry will introduce measures to improve workforce performance by linking recruitment, career development, remuneration and hardship incentives to service delivery and health management priorities. Deployment, benefit and remuneration packages will be established by the Ministry to increase motivation, gender balance and retention of skilled providers in rural areas, including accommodation allowances where necessary. The MOHSW shall formulate optimal staffing criteria with multiple increments according to the services to be delivered at all levels, utilization and staff workloads, with the intent of eliminating over- and under-staffing at facilities. Within the resource ceilings assigned by the MOHSW, CHSWTs shall assign skilled service providers to serve communities according to the characteristics of the population being served and actual utilization. Redundant workers, particularly unskilled and low-skilled ones, will be progressively retrenched in order to free up resources to retain additional skilled providers.

4.5.2 Human resource development

The MOHSW will design and launch a large-scale training program to upgrade the skills of active, professional workers. Quality of care will constitute a crosscutting component of all training modules. In the face of severe shortages of critical cadres, especially medical doctors, strategies to enable task-shifting to mid-level health professionals shall be used to close the workforce gap for priority clinical skills as quickly and efficiently

as possible. The Ministry will assess the need for changing existing professional profiles or creating new categories of health and social welfare workers to accomplish the priorities established by this policy, in particular for multi-purpose, skilled providers who may work independently or as part of small teams in remote areas.

To address the imbalanced production of health workers, measures devoted to reining in the growth of some cadres, improving productivity and controlling the size of the total workforce will be introduced. The MOHSW will coordinate higher education and pre-service training institutions by developing an accreditation and investment program to strengthen the capacity of pre-service training institutions and improve the effectiveness of workforce production. Because of the uneven rate of improvement in competencies for the social welfare sector, special attention will be devoted to the social welfare staffing challenges as part of the human resources policy implementation.

Coordination of ongoing, vertical in-service training activities will be progressively absorbed into a comprehensive, institutionalized in-service training program under the Ministry's Training Unit. In order to improve the performance of active workers, program managers and supervisors will be consulted to determine training priorities according to documented service delivery needs.

4.5.3 Human resource policy

Based on these priorities, the MOHSW has developed a National Human Resources for Health and Social Welfare Policy and Plan with sufficient detail to accomplish the long-term strengthening and management needs of the workforce. The Ministry will contribute to adapting public health legislation related to human resources, particularly concerning professionalizing certain cadres of the workforce for Civil Service employment and decentralizing the employment of some cadres of unskilled workers. The Ministry will study the impact of private providers (NFP and PFP) on the sector and introduce measures to enable the regulatory bodies to effectively control the private provider market.

4.6 Infrastructure

4.6.1 Infrastructure policy

The Ministry will develop a National Health and Social Welfare Infrastructure Policy and accompanying Plan in order to expand coverage of appropriate, standards-based service delivery space as well as criteria for efficient facility distribution. This will allow for incremental variances in facility design based on the services to be provided, the size and density of the catchment population, the geographic location of the facility and the need for accommodation for critical health workers in remote areas. The Government will develop building codes to address the requisite quality of engineering techniques and materials used in construction, site selection, essential energy requirements and access to safe water and sanitation. Design standards will apply to construction of all new facilities as well as to existing facilities when major renovation work occurs. The blanket use of

expensive, one-size-fits-all facility prototypes shall be discontinued. Privately owned facilities will gradually be required to meet standards for service delivery space, especially those receiving Government subsidy.

4.6.2 Distribution of infrastructure

Based on the distribution criteria established by the Ministry in consultation with other stakeholders, county and district administrations will determine the location of facilities within their counties. The overarching priority for infrastructure distribution will be to support expansion of access to priority services by optimizing facility distribution and facility characteristics according to the services to be provided, catchment population and utilization. In densely populated urban areas, few larger facilities will serve large populations living in close proximity to the facility. In sparsely populated rural areas, many small facilities and non-permanent service delivery points (SDPs) will provide services to rural communities. Where a privately owned facility is providing services to the catchment population, formal partnership may be used to meet service delivery needs. In essence, the infrastructure network will be planned as a coherent whole, within country and county financial ceilings considered affordable in the mid- and long-term. To ensure sustainability and equity, the central Ministry will set criteria for establishing an SDP or facility and counties will project the number of SDPs or facilities needed for their county based on these criteria.

4.6.3 Construction and maintenance

The infrastructure policy and plan will also establish a transparent Project Delivery Process to be implemented at the county level that comprises preconstruction reviews and approvals that assess the adaptation of standards to specific needs, building codes for construction, regular quality control monitoring and pre-occupancy approval at the conclusion of the construction phase. The Project Delivery Process will address construction of new infrastructure as well as renovation of existing infrastructure, while routine maintenance of facilities will be covered in the infrastructure policy and plan by a maintenance sub-policy.

4.7 Technology

All levels of the health and social welfare system shall be provided with the equipment necessary to discharge the functions assigned to them. The Ministry will ensure that all technology used is safe, secure and properly utilized through continuous staff training, routine maintenance and renewal and that adequate funds will be allocated to all levels for this purpose. The Ministry will ensure the standardization of basic equipment through the EPHS accreditation process as well as by implementing the MOHSW's Healthcare Technology Management Framework. Moreover, a comprehensive donation policy will be maintained and enforced for medical equipment. The Information Technology network will be strengthened to enhance efficiency in storing and transmitting health and social welfare data between the different levels of the system. The network will be developed to interconnect the various databases that exist to enhance the Health Management Information System, including human resources, financial management, facility inventory and epidemiological information.

4.8 Pharmaceuticals, vaccines and medical supplies

4.8.1 Policy and regulation

The MOHSW will ensure access to efficacious, high-quality, safe and affordable medicines for all people in Liberia. To accomplish this, the Ministry will revise the National Drug Policy to reflect the priorities established in this policy. In the drug policy, the functions of financing, regulating, selecting, quantifying, procuring, distrib-

uting and storing, prescribing and dispensing medicines will be kept as distinct as possible and the mandates of each involved agency and the way agencies interact among themselves will be clearly articulated. The Human Resources Plan will reflect the human resource requirements of the National Drug Policy in terms of the number of pharmacists produced as well as the skills necessary to expand the rational use of medicines. Special attention will be given to the demand for skilled staff posed by private drug operators and managing the impact of that demand on the availability of skilled pharmacists. The Essential Drug List, National Formulary and Standard Treatment Guidelines will be revised to reflect the Essential Package of Health Services and the National Drug Policy. While the Liberian Medicines and Health Product Regulatory Authority (LMHRA) Act establishes the legal framework for pharmaceuticals, regulations and mechanisms for enforcement will be developed and implemented to accompany the authority.

4.8.2 Implementation

The Supply Chain Master Plan and Supply Chain Standard Operating Procedures guide quantification, procurement, financing, storage and distribution of drugs and materials. Based upon compiled facility and county consumption and morbidity reports, the MOHSW will be responsible for the quantification of pharmaceutical and medical supply requirements. To reduce the fragmentation of budgeting and expenditure for pharmaceuticals, the sector budget and medium-term expenditure framework will become a mechanism for coordinating support for pharmaceuticals. Wherever possible, the pool fund will be used to consolidate funds for drugs and adopt national procurement and financial management systems.

The Ministry shall strengthen the National Drug Service (NDS) to become the principal drug procurement agent for the public sector. In this role, NDS will provide procurement services, under the direction of the MOHSW's Procurement Unit, as well as end-to-end warehousing and distribution services. NDS will be encouraged to procure high-quality generic drugs in large volumes through aggressive competitive bidding. Measures aimed at encouraging healthy competition between public and private drug procurement agencies will also be introduced. In accordance with government procurement regulations, such measures will include purchasing quality drugs from local and international providers, including NDS, at competitive market prices.

4.9 Diagnostics services

Clinical laboratory services in Liberia will be decentralized according to a tiered laboratory network comprised of large clinics with mini-labs, as well as health centers, hospitals and regional reference laboratories and the National Reference Laboratory (NRL). The NRL will provide technical support to all laboratories in the network through reference diagnostic services, quality assurance programs, training, continuing education and operational research. The Ministry's National Diagnostic Unit will provide policy guidance to all laboratories (public, private and blood bank laboratories). To strengthen diagnostic capacity and achieve the priorities established in this policy, the Ministry will develop and implement a National Laboratory Policy to strengthen the organizational framework for certification and delivery of improved laboratory diagnostic services and blood safety. The Ministry will integrate the laboratory activities related to disease control programs into general laboratory services so that the whole sector benefits from the contributions of all programs.

4.10 Emergency preparedness and response

Given the vulnerability of national structures within the sub-region, emergencies are likely to be recurrent, occasionally severe and widespread in their consequences. Working through strong, inter-sectoral working groups that include United Nations agencies, not-for-profits and other government agencies, particular attention will be given to comprehensive emergency preparedness planning, coordination and acquisition of an adequate capacity to respond to population displacement and disease outbreaks with epidemic potential. Effective emergency preparedness and response will be two-pronged. The immediate response must take place at the local and county levels. Community members, facility workers and local health and social welfare authorities must maintain readiness to identify and respond to emergencies in a timely and effective manner. County health and social welfare plans will therefore adopt elements that include emergency preparedness and response that link to central level plans. When large-scale emergencies do occur, the MOHSW will coordinate resource mobilization and responsive health activities. Priority will be given to the use of national systems and multi-donor mechanisms, such as the Health Sector Pool Fund, in order to strengthen system-wide capacity and minimize the undermining effect of the emergency on the system.

4.11 Complementary services

4.11.1 Traditional medicine

The MOHSW shall encourage research in the area of complementary medicine in order to capitalize on its strengths and minimize its weaknesses. It will foster collaboration between traditional and modern medicine in areas where one complements the other. As part of this process, the Ministry will work with traditional practitioners to develop an operational framework and guidelines for delivering complementary medical services.

4.11.2 Water, sanitation, and hygiene

As water, sanitation and hygiene (WASH) interventions play a key role in environmental and community health, programs and strategies for enhancing WASH activities in communities will be linked to the community health policy and strategy. Building on its success in developing the Medical Waste Management Policy, the Ministry will develop specific environmental health guidelines for communities as well as health facilities. The Ministry shall also work with other ministries, departments and agencies to establish appropriate occupational health guidelines; occupational health and safety will be considered for all types of employment.

4.12 Partnership

Faith-based and non-governmental organizations (Not-for-Profits, NFPs) and private health and social welfare service providers (Private-for-Profits, PFPs) will continue to be major contributors to the health and social welfare delivery system. Because relationships gain in transparency, efficiency and effectiveness when they are formalized into mutual binding commitments, contracts will be used for the provision of public health and social welfare services. In the initial three to five years of implementing this policy, performance-based contracts (PBCs) will primarily be used between the Government and NFPs (faith-based and non-governmental organizations) to support continuity of service provision at Government-owned facilities (management contracting). On an increasing basis, PBCs will be used between the central MOHSW and CHSWTs (contracting-in). The intent is to gradually reduce the role of NFPs and increase the role of CHSWTs in managing government facilities. CHSWTs may in turn contract directly with government health facilities for service delivery as well as with privately owned facilities (primarily non-governmental and faith-based). In all instances where contracts are used, emphasis will be placed on establishing distinct catchment populations in a given health system to ensure appropriate allocation of resources and measureable performance.

4.13 Coordination

In order to minimize the fragmenting effects of multiple/different donor fund management structures and improve coordination of donor funds, an administrative Program Management Unit (PMU) will be established within the MOHSW. All special units for donor funds, including but not limited to Global Funds, Pool Funds and World Bank funds, will fall under the PMU structure and report to the Minister for Health and Social Welfare through a principal director. Working closely with all relevant departments and relying upon standard Ministry systems and procedures, the PMU will be adequately resourced to ensure effective reporting and oversight of all grant agreements with donors as well as of all performance-based contracts with CHSWTs, NFPs and PFPs. However, budgetary authority and implementation responsibility shall remain with the respective program units.

Mechanisms to strengthen coordination between the Government, donors, NFP and PFP organizations will continue to be used at national and county levels, including the Health Sector Coordinating Committee, the Health Coordinating Committee and various technical committees. Mutually reinforcing measures to be introduced in the pursuit of effective coordination include:

- Improving information systems and making reliable data easily accessible to all interested parties so that they are able to make informed decisions that are coherent with the national policy and plan.
- Establishing appropriate venues for regular discussion at the central and county levels, where participants can harmonize their activities in a structured way.
- Developing a common annual planning cycle that includes inputs from and allocates responsibilities to all stakeholders.
- Rationalizing interventions so that a reduced number of competent and committed organizations are active in each specific field.
- Standardizing operations, through the issuance of guidelines, norms and evaluation criteria, to be adopted across the whole health and social welfare sector.
- Establishing a strategy for donor support to the health and social welfare sector to rationalize, coordinate and increase the efficiency of donor assistance.

4.14 Health and social welfare promotion

Health and social welfare promotion plays a key role in improving the health and social welfare of the population. It creates an enabling environment for individuals, households and communities to take action that prevents the spread of diseases and improves people's overall health and social welfare. As articulated in the National Health Promotion Policy, health and social welfare literacy will be at the core of activities aimed at improving the population's ability to understand and make evidence-based decisions that affect their own lives. A health and social welfare promotion and communication framework will be developed to guide all stakeholders in providing accurate, relevant and appropriate information. Special emphasis will be given to cultivating partnerships and empowering traditional and religious leaders and local communities in spreading knowledge and influencing positive health and social welfare behaviors within families.

The MOHSW recognizes that good policy communication, management, reporting and monitoring and evaluation are based on the timely availability of quality information. The Ministry will develop strong internal and external communication capacities so that it can convey the rationale behind policy and resource allocation decisions in clear, understandable ways in order to foster trust and openness. The Ministry will strengthen its Public Affairs Unit and public relations capacity in order to regularly inform other branches of government, politicians, the media, civil society organizations and the public at large of events taking place in the sector.

4.15 Research and development

The Ministry will promote a culture of inquiry into the best methods for delivering health and social welfare services. To achieve this and ensure coordination of research activities, the MOHSW will first ensure that the existing Research Unit is allocated funds to recruit adequate staff and acquire necessary research skills to carry out action-oriented research. To avoid an abundance of expensive studies that are neither analyzed to their full potential nor assembled to form a coherent understanding of the whole sector, the Research Unit will ensure that only a limited number of well-coordinated studies are carried out each year. The national health plan will identify the major research priorities.

The Research Unit will also coordinate closely with the Liberia Institute for Biomedical Research (LIBR), which will remain an autonomous institution created to organize and conduct biomedical research. The Ministry shall be consulted in all matters regarding health and social welfare related to research by third parties, including LIBR. An Ethics Committee for research will be guided by approved ethics guidelines and internationally accepted standards. The Ethics Committee will apply approved guidelines and internationally accepted standards to determine the appropriateness of all health and social welfare–related research. The health and social welfare sector will participate actively in sub-regional, regional and global exchanges in order to further the health and social welfare interests of the country, learning from the best practices of others as well as sharing its own experience.

4.16 Institutional capacity development

Enforcing this policy and implementing the accompanying ten-year plan implies a continued strengthening of existing MOHSW institutional capacity. The Ministry, in collaboration with committed development partners, will find effective ways to identify and hire professionals with appropriate expertise and to use them effectively. Preference will be given to the hiring of fewer senior, long-term experts instead of many short-term consultants. Concrete measures to reduce the reliance of the Ministry on short-term outside experts will be introduced, including pre-approval of consultant recruitment for the MOHSW by the Ministry's Program Coordination Team. Meanwhile, a long-term institutional capacity assessment, gap analysis and development strategy will be developed. It will consist of several inter-connected elements that will be promoted in a balanced and integrated way, including:

- Career paths and career development opportunities including mentoring, educational and training measures that equip future managers with the knowledge and skills they will need to implement the governance and decentralization processes.
- Institutional provisions that promote workforce transparency, accountability, fair competition, rewards and sanctions, flexibility and innovation.
- A favorable administrative, political, economic and judicial environment.
- Resources adequate to fuel the growth of the sector.
- Donor agencies supportive of the efforts made in the sector and committed to ensuring its development, respectful of mutual commitments, restrained in pushing individual donor priorities and patient with results that cannot materialize quickly.

5. Monitoring, Evaluation and Policy Review

5.1 Basic monitoring framework

The National Monitoring and Evaluation Policy and Strategy will be adapted to accommodate the goals and agreed-upon set of indicators established by this health and social welfare policy. The Ministry will monitor adherence to the policy against the overall performance of the health and social welfare sector and the impact of development initiatives through analysis of routine information, surveillance data, reviews and periodic survey results. The unintended effects of policy measures will be studied alongside the intended ones. The Ministry will strive to become more results oriented through strengthening its evidence-building capacities and in turn strengthening its policy analysis capability. Real-time correspondence must be established between the results of interventions, health outcomes and evidence-based decision-making.

5.2 Health Management Information System

The National Health Management Information System (HMIS) Policy and Plan will be adapted to this policy and maintain a simple, coherent, scientifically sound and easily understandable overall information system for tracking the degree of achievement. The HMIS will collect data in ways that will allow stakeholders to study how resources are allocated across levels of care, between central and peripheral administrative bodies, between urban and rural areas and across counties. This will encourage an informed policy discussion about equity, efficiency, decentralization and adherence to the primary health care approach. The national HMIS will consist of various sub-systems specially designed for data collection, processing and reporting. The information will be used to improve services through better planning and management at all levels. It will draw upon the following area databases:

- The Integrated Financial Management Information System
- The Human Resources Information System
- The Physical Assets and Management Information System
- The Health Information System

These systems will be complemented by vital statistics registration, such as births and deaths, and their collection will be revitalized through the National Birth Registration Policy and Plan. The HMIS will be developed in a way that is consistent with the decentralized health and social welfare structure. The rationale is that officials in charge of different levels of care must rely on data appropriate to their level of decision-making. Facility-level staff will be trained and supervised to review their own monthly HMIS reports so that they can more effectively monitor their own performance. At the county level, the system will generate detailed, disaggregated data to guide decision-making on programmatic and operational issues affecting the whole or parts of the county. Information will be consolidated and aggregated at the central level to inform policy-making, planning, resource allocation and operational oversight. Feedback will be given to those who have collected and

provided data. Routine information will be complemented and validated by a limited number of field surveys, for which adequate capacity must be acquired. Surveys will be planned in an integrated way, with a view to shed light on those components and issues not adequately reflected by routine information systems. The type of surveys carried out will reflect the need for information at the various levels, including the primary, secondary and tertiary levels.

5.3 Performance evaluation and reviews

The enforcement of the policy will be continuously monitored. The Ministry will produce an annual report that will present in a condensed way inputs, outputs, health and social welfare status indicators, assessments of efficiency, effectiveness and equity in service delivery and trends. Progress and constraints shall be regularly communicated to the public. Specific new components will be added if considered necessary. Imbalances and distortions affecting the enforcement of the policy will receive special attention. The MOHSW and key stakeholders will carry out annual reviews to assess adherence to this policy and implementation of the National Health and Social Welfare Plan, to identify operational best practices and lessons learned and to prepare work plans for the following year. The Ministry expects to conduct the next major policy review in three to five years.

6. Enabling Environment

6.1 Legislation

The Public Health Law of 1976 shall be revised in order to effectively govern the decentralized health sector and accommodate the massive changes that have taken place since its enactment. The MOHSW will manage the revision by collecting relevant information, clarifying the legal implications of the measures it intends to introduce and promoting an open debate among stakeholders about the future legislation needed to govern the health and social welfare sector. In order to play this role, the Ministry will continue to strengthen its legal and legislative expertise.

6.2 Regulation of service provision

The MOHSW shall invest in the establishment of effective regulatory capacity through legislation, standards setting, inspection and operational guidance. A long-term institutional plan will be formulated, aimed at establishing adequate, independent regulatory capacity within the sector. The Ministry's Office of General Council will contribute to this effort. As part of the long-term institutional plan, the Ministry will strengthen the technical and procedural capacity of the professional boards, including the Medical and Dental Council, the Nursing and Midwifery Board and the National Association of Social Workers, to provide regulatory oversight. The Ministry will provide adequate resources to ensure independent regulatory operations according to objective and transparent criteria. Thus, particular care will be given to separating regulatory responsibilities from the Ministry's service delivery duties in order to avoid conflicts of interest. A phased approach will be used to progressively expand operations in critical areas, especially in the area of private sector regulation within and outside of Monrovia. In the next three to five years, efforts will focus on the following selected areas:

6.2.1 Technical standards

In collaboration with the MOHSW, the Medical and Dental Council will develop procedures and requirements for establishing new health facilities and other related services consistent with each level of care. Potential elements include minimum investment, equipment requirements, staffing qualifications, licensure and accreditation requirements. As private organizations will continue to provide health and social welfare services to the public for profit, the professional boards will develop appropriate regulations for the private sector and evaluate these services to ensure the delivery of a standardized quality of care.

6.2.2 Licensure

All health and social welfare delivery and training institutions, both public and private, shall be periodically assessed and will be licensed and accredited based upon set standards of operation. The same criteria will be applied to public and private providers. Institutions below par will be required to conform to standards within a specified time period to avoid being downgraded, having their licenses revoked or closed down. Public subsidies through contracts will be awarded to private providers upholding the required standards.

6.2.3 Ethical standards

The MOHSW shall foster a climate of respect for ethical standards in the area of research by ensuring that all research studies meet criteria and guidelines set by the Ethics Committee. The study of ethics will be promoted in professional training programs and the MOHSW will support the Medical and Dental Council and other professional bodies in fulfilling their functions in this area. These functions will include informing the public about behavior expected from health professionals and routine inspection of health practices so that ethical behavior is transparently rewarded and encouraged.

6.2.4 Peer review boards

The Ministry will encourage and assist county health and social welfare teams, regional referral hospitals and the national referral hospital to establish and maintain peer review boards to promote quality case management, technical efficiency and professionalism, starting with the largest facilities.

6.3 Law enforcement

The MOHSW will promote the enforcement of the public health and social welfare law in collaboration with judicial and police authorities. The Ministry will formulate codes of conduct for health and social welfare workers. Pre- and in-service professional training programs will reinforce these codes as well as the study of the legal aspects of health and social welfare service provision. The Ministry will advise officials on proper procedures for managing cases of professional misconduct. Experience gained in this area will be documented and consolidated in order to improve existing legislation. The Ministry will also develop a public awareness program to inform the public about health and social welfare–related practices that are allowed and those that are forbidden by law and how to proceed when legal infringements are suspected.

7. Policy Implementation

7.1 Assumptions

This policy is based on the following assumptions:

- That sub-regional and national stability will prevail and ethical standards of governance remain a national priority, sustaining growth in the Government's capacity and credibility.
- The National Decentralization Policy will be enacted into law and an administrative legal framework will enable the process of decentralization in the sector.
- Improvement of roads and telecommunications, particularly in rural areas, will enable effective linkages between the different levels of the service delivery system.
- Economic recovery will continue, coupled with expansion of state revenues for health and social welfare services to compensate for gradual reductions in donor funds.
- The support of external donors and other partners will conform to the priorities established by this policy.
- The analytical capacity will be developed to understand the changing environment and introduce appropriate adjustments to the policy and the plan.

7.2 Risks

Among the many risks to be taken into account while enforcing the policy and implementing the plan, the following will be considered:

- Inconsistent leadership, political turnarounds or corruption cause the deterioration of the Government's credibility and push the health sector in different directions.
- Emergencies (within and outside Liberia) draw attention and resources away from the sector or require a significant reallocation of resources within it.
- Divergence from the national strategy for decentralization result in unforeseen implications on this policy and plan.
- The resources available are less than anticipated to implement this policy and increased efficiency cannot compensate for the shortfall.
- Proliferating, competing priorities, including donor preferences and political pressures, can compromise the enforcement of this policy and implementation of the plan.
- Inadequate monitoring results in the National Health Policy and Plan becoming a collection of dead documents that may sometimes be referred to but not be used consistently to guide decisions.

7.3 Prioritization

The numerous tasks included in this policy must be sequenced according to their priority and according to when they must be accomplished. The most urgent issues that must be accomplished within the first two years of this policy coming into effect include:

- Focusing attention on improving quality of care to increase uptake and utilization of services, especially maternal and child health services to improve health outcomes.
- A nation-wide assessment of hospital care must be designed and approved, adequately funded, carried out and hospital services rationalized in accordance with the findings of the assessment.
- An incremental plan to expand access in underserved areas must be established.
- The National Drug Policy must be revised to begin to consolidate the pharmaceutical area, procurement, storage and distribution of drugs.
- The National Infrastructure Policy must be finalized to inform the sector budgeting process and accompany the expansion of services plan.
- The National Health Financing Policy must be established according to this policy, addressing potential alternative financing schemes, including insurance, user fees and hypothecated taxes necessary to finance the sector.
- The Human Resources Workforce Plan must be developed and the workforce salary scale must be revised and adopted with allowances for deploying the workforce according to urban, rural and very remote rural areas.
- The National Health Sector Decentralization Policy will be finalized and be aligned to the national framework for administrative decentralization when it is available and fully implemented.

After completion of this initial set of priorities, beyond-year-two additional priorities include:

- Continued development of the CHSWTs' capacity to gradually assume the responsibilities allocated to them in a decentralized system.
- Gradual implementation of the expansion of the package of services and geographic coverage of service delivery.
- Development of the long-term investment plan for the health sector.
- Consolidation of smaller service delivery points in densely populated urban areas.
- Ongoing analysis of information and policy effectiveness, adapting policies and plans accordingly.

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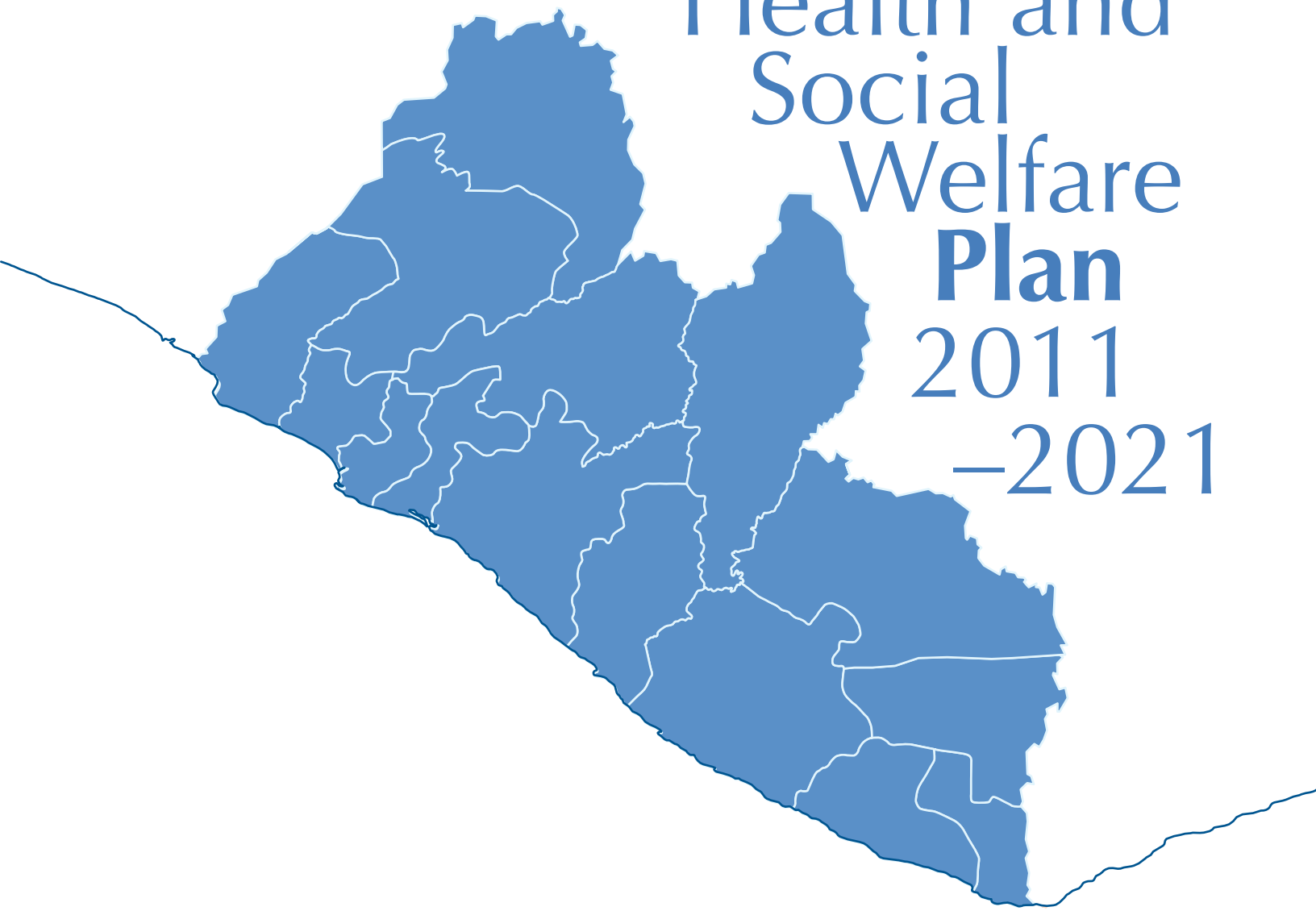
Republic of Liberia

Ministry of Health and Social Welfare

National Health and Social Welfare **Plan** 2011 –2021



Contents

Summary

The National Health and Social Welfare Plan 2011–2021 has been elaborated with the contribution of a myriad of participants, within and outside the Ministry of Health and Social Welfare. Above all, the plan has benefited from active participation of the counties, therefore reflecting ample consensus across the country.

With the overall goal of improving health and social welfare status of the population of Liberia on an equitable basis, the plan objectives are to increase access and utilization of quality health and social welfare services, to improve responsiveness to people's expectations by increasing equity and by taking decision-making closer to the communities, and to make services available at a cost affordable to the country.

These objectives will be reached by applying the principles of equity, efficiency, accountability and sustainability to service provision and also to the systemic components in charge of producing the resources—personnel, facilities, drugs and commodities, funding, and know-how—that will make it possible to provide the services. The framework is completed with sector coordination, which will allow a more effective relationship with partners while increasing resource predictability.

In terms of **service provision,** the plan's main aims are ensuring basic health services within 5 km of most communities, strengthening the existing services to increase coverage and utilization, and expanding the **Essential Package of Health Services** with additional ones. Small clinics will be built and outreach services delivered in communities currently underserved. Upgrading clinics to health centers will ensure that the network has the technical capacity to implement the priority programs. High-quality referral services will reach counties through the upgrading of some county hospitals to regional ones. A more complex network requires restructuring; health services will be organized in hierarchical, county and sub-county systems. Overall, the network will be composed of more than 500 facilities, an increase of almost 40 percent from the present situation. Human resources will increase even more, to exceed 15,000. As a reflection of the complexity of the projected network, more than half will be skilled professionals.

Quality improvement and new ways of reaching target populations will be used to strengthen existing maternal and child care services. Contents of health services packages will be shaped with prevalence assessments of non-communicable diseases like hypertension and diabetes likely to become major public health problems in the future. Other services—mental health, neglected tropical diseases, school health, prison health, among others—will be added to the essential package.

The hospital sector will be revised in detail. A 10-year development plan will be produced for every hospital. Health and social welfare promotion will be strengthened through empowerment of individuals and communities, multi-sectoral collaboration, and targeted communication interventions.

Direct provision of social services will reach rural areas by deploying social workers at health facilities and by ensuring their presence at district level. Institution-based (orphanages, foster care homes, residential centers) services will be provided by partners through performance-based contracts to ensure efficiency and quality. The real need for social services among the population will be established through baseline assessments.

Regarding **health financing,** the MOHSW will increase resource mobilization and predictability by improving budget execution, by expanding the number of donors using budget support mechanisms, and by exploring alternative financial sources, such as pre-payment (health insurance) schemes and user fees. Equity and efficiency in resource allocation and utilization will be improved with the development of allocation formulas and by using performance-based contracts.

Human resources will remain the system's biggest asset. Rationalization measures (development of workload indicators, establishment of performance standards) will shape their county and facility deployment. In remote areas, retention will be sought by a combination of incentives. A 10-year training plan will be produced.

Professional associations will be strengthened.

A survey of the physical status of **health facilities**, particularly hospitals, will precede the elaboration of a 10-year investment plan. The MOHSW will define building standards and design a transparent project process. Maintenance will become part of annual operational plans at all levels.

Under the supervision of the MOHSW Procurement Unit, **drugs and commodities** will be centrally procured by the National Drug Service and distributed to facilities through a network of county depots. Responsiveness to clients (providers) will be guaranteed by allocation of drugs funds to the County Health and Social Welfare Teams.

The **Health Management Information System** will be completed with data and indicators on social welfare, human resources, drugs, facilities and expenditure. Use of information for decision-making will be strengthened in operational planning exercises. Reports of timeliness and quality will be improved.

Some **cross cutting system components** will be strengthened. Quality assurance will be institutionalized, patient safety improved. and quality of practice enhanced. A common annual planning cycle for the health sector will be developed and implemented. Supervision will be strengthened with the rolling out and institutionalization of the standard operating procedures. A National Research Agenda will be designed; research activities will be part of annual operational plans. Emergency Preparedness and Response will expand its scope, and annually updated contingency plans will include man-made disasters.

Following a comprehensive functional analysis of the MOHSW at all levels, a de-concentration package will be prepared, to ensure all county teams are endowed with sufficient capacities to manage **decentralized health and social welfare services.**

Sector coordination will be based on transparency, accountability and efficiency. Common planning and financing mechanisms will be strengthened. International implementing partners will be gradually replaced by the public sector and local, permanent service providers.

The 10-year plan will be **implemented** through annual operational plans. The overall period is divided into three phases. The first three years will be devoted to develop the many plans and pilots that will shape service provision and the systemic components. During the second phase of two years, new services will be added and implementation will start of sub-sector plans. After a medium-term revision in the fifth year, the remaining period will be devoted to implementation.

A preliminary **cost estimate** projects health expenditure per capita in 2021 at US$44 for the public sector.

A m**onitoring framework** has been provisionally produced to follow up the plan implementation as well as its impact. Indicators selected cover health status, health system objectives, and health system performance.

1. Drafting Process for the 10-year National Health and Social Welfare Plan

The four-stage process leading to the development of the 10-year National Health and Social Welfare Plan started in September 2010. In the first stage, a roadmap for the exercise as a whole was adopted and the Country Situational Analysis Report was drafted. The second stage was a revision of the previous National Health and Social Welfare Policy. Next came a revision of the previous service provision priorities, from which originated the revised Essential Package of Health Services (EPHS) and the Essential Package of Social Services (EPSS), the realization of county planning exercises, the discussion of sub-sector plans and the production of the draft 10-year National Health and Social Welfare Plan. The final stage involved the finalization and submission of the plan document to the Government of Liberia for validation and endorsement.

Much effort has been devoted to making sure that all counties' priorities, plans and targets are accommodated in the national plan. Various training workshops and county planning exercises were carried out, ending with the production of 10-Year County Health and Social Welfare Plans, a summary of which is attached to the final version of this document. The definitive targets will be a balance between those that are normative, those that are central MOHSW–defined, and those proposed by the CHSWT.

Drafting the 10-year plan was, therefore, a collective achievement. All objectives and strategies presented in this document have been produced by, and discussed and agreed with, the relevant sub-sector and county teams. Its implementation will require even more involvement from all stakeholders.

2. Plan Framework

The plan is based on the WHO health systems framework (Figure 1). It is composed of three main elements: service provision, resource generation/management, and key relations.

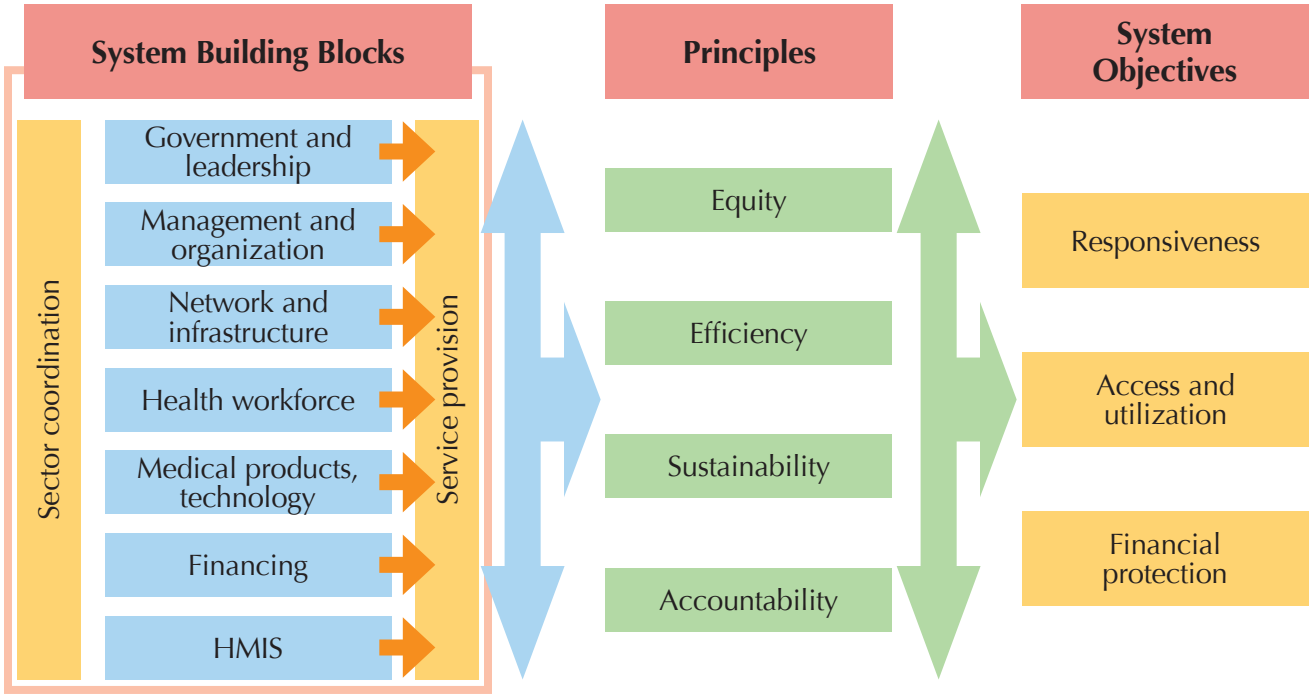
Service provision is the primary focus of the plan, as it is the component that involves interaction with the population to produce improvements in health status. Service provision encompasses not only priority health programs, but also the resources (network, staff, drugs) used for delivering care.

Generating and managing the necessary resources is another of the key health system's functions and coincides with the organizational structure of the MOHSW. These "building blocks" are collectively called Systemic Components. Decentralization and governance are included among them because they will determine the structure and relations between management bodies and service delivery networks.

The third element of the plan framework is defined by the relations established among all health sector actors, domestic and international, providers, users and financers, private and governmental.

Interventions on these main elements are designed to take into account the policy principles relied upon to achieve the health system's goals of improved health status, responsiveness and financial protection.

Figure 1. Health Systems Framework (adapted from WHO)



3. Mission and Vision; Plan Goals and Objectives

The mission of the Ministry of Health and Social Welfare is to reform and manage the sector to effectively and efficiently deliver comprehensive, quality health and social welfare services that are equitable, accessible and sustainable for all people in Liberia.

The MOHSW's vision is a healthy population with social protection for all. The shared goal of Policy and Plan is to improve the health and social welfare status of the population of Liberia on an equitable basis. This goal will be achieved through the following General Objectives:

- Increase access to and utilization of quality health and social welfare services, delivered close to the community, endowed with the necessary resources and offering a comprehensive package of interventions of proven effectiveness.
- Make health and social welfare services more responsive to people's needs, demands and expectations by transferring management and decision-making to lower administration levels, ensuring a fair degree of equity.
- Make health care and social protection available to all of Liberia's population, regardless of an individual's position in society, at a cost that is affordable to the Country.

The purpose of the National Health and Social Welfare Plan document is to translate policy priorities into strategies that can be implemented as part of the government's Annual Operational Plans.

Other objectives of this document are:

- Provide strategic guidance to the health sector;
- Present a framework where sub-sector and county plans can be aligned with the main policy principles and the system's intermediate and long-term goals; and
- Project a reasonable cost estimate for the most important plan components to feed the long-term financial framework

4. Service Provision

Increasing access to and utilization of health and social welfare services by the population of Liberia is the main focus of this plan. A summary description of each of the components is presented in the next sections, as well as a projection of what results are expected at the end of the plan's implementation.

4.1.Health Services

Provision of health services is described in certain detail, from the way facilities are organized to the framework that helps to organize the relation between formal and community health services.

4.1.1 Organization of the public system of health care provision

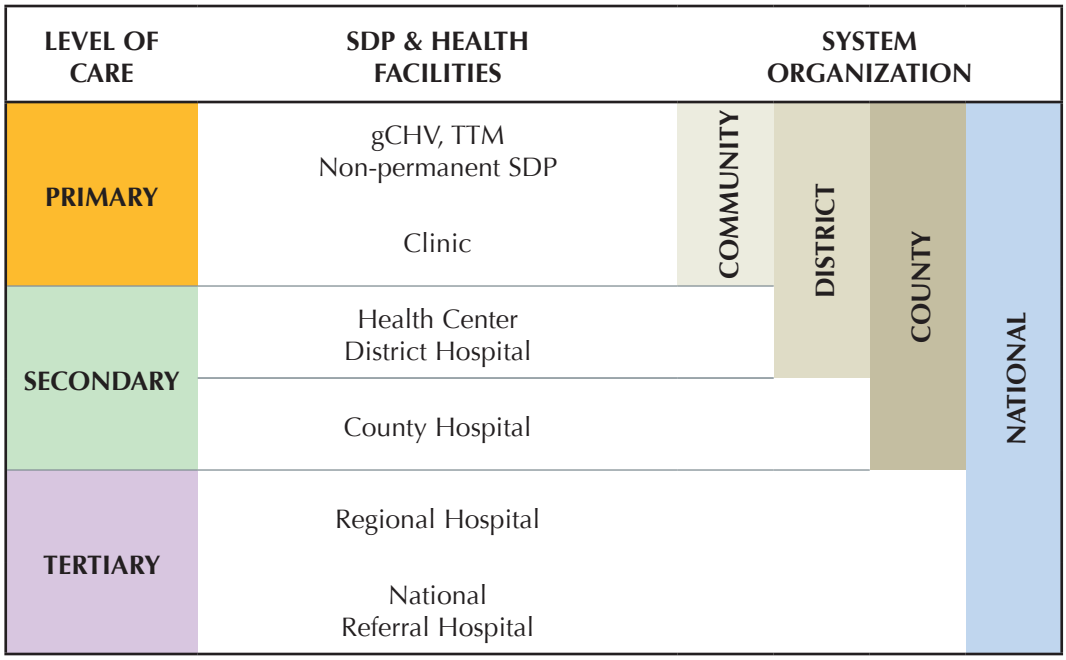
The health care delivery system is structured in three levels of care:

- The Primary level is composed of services provided at community level, either by community health volunteers (CHVs) or by non-permanent, formal services from the relevant/most basic health facility.
  - Community-based volunteers are expected to promote good health practices, provide first aid for selected conditions and support the implementation of priority programs. Trained Traditional Midwives (TTMs), General Community Health Volunteers (gCHVs) and the newly defined Household Health Promoters (HHPs) are the cadres involved.
  - Non-facility-based service delivery points (SDPs) may take different forms. In general, a non-permanent SDP is a service that is offered outside a facility but on a regular basis that consists of the essential outpatient components, excluding birth attendance. SDPs have defined catchment populations and are related to a permanent health facility (usually the closest one).
  - The most basic public sector health facility is the clinic. It may take many forms and sizes and may have a laboratory, but the common feature is that it offers the entire Essential Package of Health Services (EPHS) for the level, that is, it includes curative care, maternal and child care with immunization and delivery attendance on a permanent basis. In remote areas with clustered catchment population of 1,000–3,500 people, clinics are small facilities with basic teams, each composed of a professional and a non-professional with multiple skills. In urban areas, clinics are large structures with the capacity to deal with many outpatient users and occasionally offer double shifts. Clinics do not offer round-the-clock attention, although health workers are on call in rural areas. In principle, regular clinics should provide services for catchment populations of between 3,500 and 12,000 people.
- The Secondary level is composed of the first and second tiers of referral, health centers and hospitals.
  - Health centers (HCs) are facilities that offer 24-hour primary care services complemented with inpatient care (up to 40 beds) and laboratory for catchment populations of 25,000 to 40,000 beneficiaries. HCs are the transition between the Primary and Secondary levels of care; while providing mostly primary care, their inpatient capacity makes them a first referral unit. Where catchment population, network of clinics and distance from a county hospital warrant it, health centers may become district hospitals, with higher clinical capacities that can occasionally include emergency surgery. Most HCs and all district hospitals should provide Basic Emergency Obstetric and Newborn Care (BEmONC).

- The County Hospital is the main referral facility. This facility has a catchment population of about 200,000. It provides general surgery, paediatrics, general medicine, obstetrics and gynecology services, at least to ensure the permanent provision of Comprehensive Emergency Obstetric and Newborn Care (CEmONC). It should have laboratory and basic radiology services. Bed capacity should be about 100, with an intensive care unit. This is the last facility with direct territorial responsibility, playing the role of primary facility for the surrounding population and serving as the referral facility for the county network of clinics and health centers. To ensure that hospital services are used with a referral function, an OPD facility for the provision of primary care should be attached to, but physically separated from, the hospital.

- The Tertiary level of care has exclusively referral functions, without relation to any territory. Two types of hospitals comprise this level:
  - Regional hospitals incorporate additional specialties. They are located within reasonable access of the county hospitals that refer to them. Each regional hospital will have a bed capacity of approximately 250 beds, serving a catchment population of over 500,000 people. These facilities are also expected to play an active role in capacity-building of the county hospitals, as well as training sites complementary to the National Referral Hospital. They will develop from existing county hospitals.
  - JFKMC, the National Referral Hospital, plays the role of specialized referral facility and teaching hospital for physicians, MD specialties, and other specialties, in collaboration with regional-level facilities. It should accommodate around 500 beds.

Figure 2. Relation between facilities, levels of care and system organization



If individual health facilities provide care according to their appropriate levels, none will be sufficient by itself to deliver the whole array of services that compose the EPHS. The facilities are organized within coherent systems, territorially based and with defined management responsibilities, becoming sub-national health systems, of which four can be recognized, each with its referral facility:

- The Community System is the simplest one; it is organized around each clinic and composed of the outreach services the clinic provides as well as the community-based volunteers in clustered households. Managerial responsibilities are limited to proper use of resources (personnel, drugs, vehicles).

- The District Health System is a sub-county organization composed of a health center or district hospital and a number of clinics (usually three to six in number) that feed in to the health center/hospital. Despite the name, the District Health System is not constrained by administrative district boundaries; a cluster of small administrative districts may compose a single district system and, on the other hand, populous administrative districts can have more than one such system. Health centers assume some managerial responsibility over clinics, including in the human resources area, HMIS analysis and supervision.
- County Health Systems are organized around County Hospitals and composed of a number of District Health Systems. The network is managed technically and administratively through a collaboration of both the CHSWT and the County Hospital. Because of administrative reasons, all counties will have a County Hospital, regardless of size and population. Moreover, some counties with large populations may have more than one hospital, although they may only have one CHSWT. In such instances, the county system will be organized around the county hospital, while the rest of the hospitals will become sub-county systems known as District Health Systems.
- The National Health System does not have a defining facility, since regional and national hospitals play a referring role; they do not participate in territorial network management. The National Health System is managed by the MOHSW.

Within the context of decentralization, the MOHSW will define in detail the managerial responsibilities of each organizational level (particularly the health district) in terms of supervision, monitoring, analysis and planning, not to mention what access each level will have to resources, including financial ones.

4.1.2 Essential Package of Health Services—Primary level

The Essential Package of Health Services aims to describe a standardized primary package of services, provide equitable access to essential hospital services, strengthen the service delivery network and provide the basis for operational plan development. These purposes translate into the following three broad objectives:

1. Locate reliable service delivery points that are capable of providing the most critical EPHS interventions within 5 km of all relevant communities
2. Reinforce the provision of the following original package components to improve utilization, efficiency and quality:
3. Mother and Newborn Care (Family Planning, Malaria in Pregnancy, PMTCT, Mother and Newborn nutrition), Child Health (Growth Monitoring, Micronutrient supplementation), Mental Health and Communicable Diseases.
4. Expand the contents of the revised EPHS to include interventions for neglected conditions and for those likely to become important in the future.

New services will be phased-in incrementally, in five additional areas: Environmental and Occupational Health, Neglected Tropical Diseases, Non-Communicable Diseases, School Health Services and Prison Health Services.

The EPHS is the main operational arm for implementing, in a comprehensive and integrated way, priority service delivery strategies such as the following:

- The Roadmap for Accelerating the Reduction of Maternal and Newborn Morbidity and Mortality in Liberia, whose general goals are to reduce maternal mortality from 994 per 100,000 live births in 2007 to 497 in 2021 and reduce newborn mortality from 38 per 1,000 live births in 2009 to 19 in 2021. Key objectives of the Roadmap are:
  - To increase by 50 percent the number of skilled attendants at all levels of the health care delivery system

- To increase the coverage and access of quality CEmONC (to one service per 50,000–200,000 population) and BEmONC (to four services per 50,000–200,000 population) as well as PMTCT and fistula services
- To increase access to and utilization of family planning services, to reach a Contraceptive Prevalence Rate of 20 percent in 2021

- The National Malaria Control Program Strategic Plan has the goal of reducing by 50 percent (from a December 2010 baseline) malaria-related morbidity and mortality among the population, especially in children under five and pregnant women. Objectives are set up to 2015, when they will be reviewed, and include:
  - To increase access to prompt and effective ACT treatment for 80 percent of the population by 31 December 2010 and sustain this reduction through 2015
  - To increase the use of insecticide-treated nets (LLIN) among the whole population, especially among vulnerable groups such as pregnant women and children under five, to 80 percent by 31st December 2010 and sustain this use through 2015
  - To increase the population protected by indoor residual spraying (IRS) from 5 percent in 2009 to 40 percent in 2010 and 2011 and to scale up to full coverage by 2015 (after evaluation of the first three years of use)
  - To increase the use of Intermittent Preventive Treatment (IPT) among pregnant women in Liberia to 80 percent by 31 December 2010 and sustain this use through 2015
- The National AIDS Control Program has as overall goals containing the spread of the epidemic and mitigating its impact on the health and wel-lbeing of those infected. Its main service-related objectives are:
  - To reduce the percentage of young women and men aged 15–24 who are HIV-infected from 1.1 percent in 2010 to below 1.1 percent by 2014
  - To increase the percentage of adults and children with HIV known to be receiving treatment 12 months after initiation of antiretroviral therapy from 63 percent in 2010 to 69 percent in 2012 and 79 percent by 2014
  - To reduce the number and percentage of HIV-infected infants born to HIV-infected mothers who are infected (TBD)
- The National Leprosy and Tuberculosis Control Program has as its goals increasing the detection and successful treatment of tuberculosis cases. Its main objectives are:
  - To improve case notification of new smear positive TB cases from 103 per 100,000 in 2010 to 127 per 100,000 population by 2015
  - To provide High Quality DOTS with increased success rate from 83 percent to 85 percent by 2015
  - To expand effective TB and HIV collaborating mechanisms by increasing access to integrated TB/HIV services.
  - To establish the management and treatment of MDR-TB cases from 2011
- The National Mental Health Program has a goal of providing quality mental health and substance abuse services to the people of Liberia. Its main objectives are:
  - To improve the accessibility and availability of quality mental health treatment at all levels of health care provision
  - To desensitize communities about mental health and illness and modify negative perceptions about the mentally ill, thereby minimizing stigmatization and negative behaviors toward the mentally ill

4.1.2.1 Taking service provision closer to the population

The MOHSW will expand the network of public facilities with the establishment of new SDPs in communities presently underserved. Potential locations and SDP types were identified during County Planning Exercises, based on community size and distance to existing facilities.

In total, the counties identified 231 locations where a new SDP should be operated (Table 1), producing a network growth close to 50 percent. According to the county teams, 150 should be permanent facilities and 81 non-facility-based services. The identification of sites for new SDPs was carried out separately in each county. As a result, the level of priority may not be directly comparable.[1] More detailed exercises, coinciding with the elaboration of operational plans and the actual budget allocation, will shape the rhythm of implementation by county.

Table 1. New SDPs proposed, by county

COUNTY	Facility-based	Non Facility-based	TOTAL
Bomi	4	2	6
Bong	12	15	27
Gbarpolu	20		20
G. Cape Mount	4		4
Grand Bassa	6	19	25
Grand Gedeh	13		13
Grand Kru	4		4
Lofa	13	8	21
Margibi	3	6	9
Maryland	12	9	21
Montserrado	3	4	7
Nimba	27	14	41
Rivercess	19	4	23
River Gee	5		5
Sinoe	5		5
TOTAL	**150**	**81**	**231**

4.1.2.2 Reinforcing existing EPHS components

The Essential Package of Health Services is composed of a primary package of eleven service delivery areas, a secondary package of hospital services and five priority support systems. A summary of the main strategies in each of the component areas is presented below. Detailed description of the EPHS components is available in the EPHS document.[2]

A. Maternal and newborn health services

1. **Antenatal Care.** The coverage target will remain four consultations of the full package of ANC per pregnant woman. Collaboration with TTM will be strengthened especially to help ensure that pregnant women who attend first ANC continue up to at least the fourth ANC. PMTCT services will be offered at all levels, as will Malaria Intermittent Preventive Treatment. ITN will be distributed to pregnant women through clinics and community health volunteers to help prevent malaria in pregnancy.
2. **Labor and Delivery Care.** Quality of care, especially maternal and newborn care, will be improved to increase coverage of institutional delivery. Coverage will also be increased through SDP expansion (all of the permanent ones shall provide delivery services) and all mid-level health workers will be trained in midwifery skills. All deliveries in health facilities will be monitored using the partograph.
3. **Emergency Obstetric and Newborn Care.** All health facilities shall provide delivery and EmONC at their appropriate level of care.

1. For some counties, communities beyond 10 km from the nearest health facility are a priority; for others, the boundary is set at 5 km.
2. EPHS, MOH&SW 2011.

4. **Postpartum Care.** At least two post-partum visits for new mothers within the first six weeks after delivery will be targeted.
5. **Newborn Care.** Newborn survival techniques will be taught to all skilled health workers.
6. **Maternal and Newborn Nutrition** will focus on supplementation with iron and vitamin A and on promoting breastfeeding.
7. **Family Planning Services.** Counselling will be initiated at ANC and PNC, while FP commodities will be made available at community level.

B. Child health services

1. **Expanded Program on Immunization.** The program will strengthen the Reach Every District (RED) approach, in collaboration with community health volunteers. National Immunization Days, including supplemental immunization activities (SIAs) and other special outreach efforts at community level, shall be organized to complement routine immunization coverage.
2. **Integrated Management of Neonatal and Childhood Illnesses (IMNCI).** IMNCI guidelines will be implemented at each level of the network. Referral systems will be strengthened. In hospital outpatient clinics, priority will be given to referred patients and those identified through a system of emergency triage.
3. **Child Nutrition.** The Essential Nutrition Actions approach, an integrated package of preventive nutrition actions encompassing infant and young child feeding, micronutrient supplementation and women's nutrition, will be utilized. Rapid nutrition assessments will be carried out quarterly in selected communities by community volunteers using a MUAC tape. Growth monitoring will be re-introduced as part of the routine services at all levels.
4. **Infant and Young Child Feeding.** Early initiation of breastfeeding, and its continuation, first exclusively and later with complementary food, will be promoted.
5. **Management of Acute Malnutrition (MAM).** Therapeutic and supplementary feeding programs will be integrated in existing health facilities with a phased approach.
6. **Micronutrient Supplementation.** The MOHSW will advocate for food fortification. General CHVs will be trained to provide information on proper nutrition and to distribute vitamin A supplements and de-worming medications every six months.

C. Reproductive health

1. **Adolescent Sexual Reproductive Health.** IEC/BCC programs on SRH, HIV/STI and SGBV will be strengthened by targeting adolescents and youth. Peer educators will be trained and youth-friendly services will be integrated at the health facility level to increase youth participation in sexual and reproductive programs.
2. **Sexual and Gender-Based Violence.** Communities will be trained on creating awareness among the population on sexual and gender-based violence. PHC personnel will be trained to provide counselling, post-exposure prophylaxis for HIV and STIs and treatment.
3. **Reproductive Cancer.** Research will be undertaken to establish the baseline prevalence for breast, cervical and prostate cancers and appropriate strategies will be designed.
4. **Obstetric Fistula.** Management of obstetric and other traumatic fistula will be provided at county, regional and national hospitals. Community health volunteers will provide education on this problem.

D. Communicable disease prevention and control

1. **Prevention and Control of STI/HIV/AIDS.** ART, PMTCT and HCT services will be expanded to additional facilities, from the existing sites (22 ART, 156 PMTCT, 162 HCT), to increase access to these services.
2. **Prevention and Control of Tuberculosis.** Improved diagnosis and high-quality DOTS will be expanded to additional health facilities, as well as the community-based DOTS. TB/HIV services will be effectively integrated.
3. **Prevention and Control of Malaria.** Adults as well as children will generally be treated on the basis of a positive laboratory test using the rapid diagnostic test (RDT) or microscopy. Prevention strategies will include the use of insecticide-treated mosquito nets (ITNs) and indoor residual spraying in selected communities.
4. **Prevention and Control of other Diseases with Epidemic Potential.** The Disease Surveillance System will be strengthened.

4.1.2.3 Expanding EPHS contents

New service components will be developed and added to the existing EPHS to face growing challenges from conditions that so far could not be properly addressed by the health system.

1. Mental health

The MOHSW will increase inpatient capacity through the establishment of wellness units at all county hospitals. At the Primary level, selected professionals will be trained in identifying, managing and referring mental health cases. Social workers will be required to do follow-up for patients in their homes and communities. Families will be encouraged to be involved in the care and management of their loved ones. Community-based social volunteers will be trained to recognize signs of mental illness and make referrals to the appropriate health facilities.

2. Emergency health

All health workers will be required to have skills on basic stabilization of emergency cases, cardio-pulmonary resuscitation (CPR) and early referral. Specific capacity to manage emergencies will be deployed according to facility level and distance to referral hospitals.

3. Non-communicable diseases (NCDs)

Awareness and behavior change communication (BCC) campaigns will be launched with messages on the non-communicable disease (NCD) risk factors. Primary Health Care (PHC) providers will be trained on the identification of NCDs and routine blood pressure (BP) measurement will be introduced. A nationwide survey will be conducted by MOH&SW to determine the prevalence of diabetes, hypertension, obesity and other NCDs. An NCDs unit will be established at the MOHSW for the prevention and control of NCDs.

4. Neglected tropical diseases

Countrywide surveys will be carried out to establish the baseline prevalence of diseases such as leprosy, filariasis, schistosomiasis, onchocerciasis or soil-transmitted helminthes. Primary health providers will be trained on early detection, timely treatment and referral of complicated cases.

5. Environmental and occupational health

With the support of environmental health (EH) technicians, environmental health in the community shall focus on water and food safety and environmental sanitation. At the health facility level, EH services will

focus on waste disposal, water supply, health education and water testing. Each facility will design and implement an Environmental Management and Mitigation Plan (EMMP).

6. School health services

The School Health Program will be implemented in collaboration with the Ministry of Education and the package of services will consist of immunization screening; growth monitoring; micronutrient supplementation (vitamin A and iron–folic acid); de-worming; screening for eye, ear, dental and skin problems; family planning counselling; life skills and health promotion.

7. Eye care

Community ophthalmic nurses (CONs), teachers and CHVs will be trained on the early recognition of eye problems and how to teach about hygiene, nutrition and safety to prevent blindness within the community. At clinics and health centers, trained staff will recognize, treat and/or refer visual acuity, simple eye conditions and eye injuries.

8. Prison health services

A package of health services to be provided to all prison inmates has been developed and will be implemented by County Health and Social Welfare Teams (CHSWTs). Depending on the size and population of the prison, the CHSWTs will coordinate regular medical outreach and/or on-site care. All prisoners will receive entry health examinations, preventative, curative and, where necessary, specialized care that meets EPHS service standards.

4.1.3 Hospital care: Essential Package of Hospital Services

In addition to the PHC-focused packaged described above, and with the same criteria of efficiency and cost-effectiveness, the MOHSW will make a package of hospital services available through the upper levels of the system. The package encompasses services of increasing complexity to be offered at county, regional, and national hospitals.

The Essential Package of Hospital Services has the following purposes:

- Prioritize a standardized package of services at each level of hospital
- Provide guidance to health practitioners in the public and private sectors
- Promote a referral system that inter-links with the EPHS from the Primary level of care to the different hospitals
- Define staffing, equipment, medical supply and diagnostic needs and services
- Give guidance on the content of training programs by defining the technical and management competence required in the different hospitals
- Enhance equity and affordability.

The hospital sub-sector requires a complete revision. Some hospitals seem too small, and there is little information on their utilization levels and workloads. With the support of the MoH&SW and its partners, each County Hospital will produce a development plan, based on an analysis of the network and population to be served, the existing and projected service utilization and the efficiency targets in resource use.

The Role of JFK Medical Center

With around 500 beds and more than 500 staff, JFKMC is the largest facility in the country. However, to a certain extent the hospital is disengaged from the functioning of the system, as it is not even a part of the regular HMIS.

Probably the most important role JFKMC can play is to become a center of excellence offering multiple training possibilities for health workers of various professional categories. The Medical Center acknowledges this and proposes the following objectives for the future:

- Re-establish itself as the top teaching/referral center by
  - Increasing the number of specialties
  - Expanding services to include a Metabolic Center, a Kidney Dialysis Center and an improved Emergency Department
- Operationalize a residency program
- Expand continuous education in collaboration with other hospitals

For most of these improvements, JFKMC is also the recipient institution in terms of new services or trained personnel. Its collaboration with the health system should probably expand to include these strategies:

- Contribute technical expertise for the design and update of clinical guidelines
- In collaboration with the University of Liberia and other academic partners, participate in operational research on issues important for lower levels of the health system
- Help prepare, in terms of methodology, guidelines and trained mid-level staff to the system to face new service delivery challenges, such as the introduction of NCD, cancer screening and management
- Participate in technical supervision missions to regional and county hospitals
- Participate in the HMIS, both with JFKMC–generated data and with analytical skills.

4.1.4 Priority support systems

1. Facility infection prevention and control

The EPHS will support improvement efforts in infection prevention by ensuring that operational and technical capacities are available in all health facilities. Designated individual(s) will be responsible to ensure effective and efficient implementation of infection prevention activities. Equipment, supplies and facilities/infrastructure necessary for infection prevention and control should be available at all health facilities. National standard operational guidelines shall be followed accordingly.

2. Waste management

The waste management policy establishes guidelines for waste minimization, separation, identification, handling, treatment and final disposal. National standard operational guidelines for waste management are expected to be followed and will be strengthened through regular supervision.

3. Pharmaceutical services

Standard operating procedures for supply chain management, essential drug lists, treatment guidelines and pharmaceutical waste management guidelines will be disseminated to all primary facilities by county health and social welfare teams. General community health volunteers will receive drugs and supplies from primary catchment facilities. All primary facilities will be regularly supplied with medical and non-medical consumables, including drugs, based on a supply chain plan by county pharmacists. The EPHS emphasizes periodic training, monitoring and supportive supervision on the rational use of drugs for OICs, screeners and dispensers.

4. Diagnostic services

The laboratory system in Liberia will be strengthened by the development of a National Laboratory Policy and Plan. This is an essential part of an effective public health system as defined in documents such as the 2005 WHO health regulations, the 2008 Maputo declaration on strengthening health systems and the 2008 WHO/AFRO regional HIV/AIDS public health laboratory network. The development of the national laboratory policy and plan will systematically strengthen and achieve adequate laboratory capacity, and shall outline roles and responsibilities for planning and implementing laboratory services at all levels.

At the Primary level, routine laboratory tests such as the rapid diagnostic test for malaria; urine tests for albumin and sugar, for physical examination, for microscopic examination, and for pregnancy and syphilis; stool tests; blood tests for haemoglobin; and sputum tests for AFB will be conducted.

5. Health Management Information Systems

At the primary level the EPHS emphasizes quality data, timely reporting, regular feedback and actions taken where necessary.

Forms and registries at the community, Primary and Secondary health care levels will be available. Reports from facilities of all levels and communities will be collected on a monthly basis, while information on reportable diseases be collected on a weekly basis. Maternal deaths will be reported within 24 hours and surveillance officers will carry out death audits within 48 hours, both at communities and health facilities.

4.1.5 Complementary medicine

The MOHSW will foster collaboration between traditional and modern medicine in areas where one complements the other.

The Traditional and Complementary Medicine (TCM) policy will be updated. The MOHSW will set up the institutional framework to promote research, regulate training of TCM Practitioners and guarantee the quality of traditional medicine products.

4.1.6 Community health serices

Community health services are and will remain an important part of the health system. They complement the network of health facilities ensuring that most catchment populations have at least a minimum level of access to health care. Based in communities not directly served by health facilities, Community Health Volunteers (CHVs) and Household Health Promoters will work closely with the formal sector on health promotion, early recognition, management or referral of common conditions and provision of support to health services at the health facility or by outreach teams.

Trained Traditional Midwives (TTMs) will provide health education before, during and after pregnancy. They will plan facility deliveries with their clients and will identify and refer danger signs. TTMs will provide family planning commodities and participate in antenatal dispensing of ITN, IPT, iron, etc. They will also carry out postnatal home visits and newborn care activities.

General CHVs will provide case management of the most common conditions (malaria, pneumonia, diarrhea) and recognize and refer early danger signs. They will identify and refer severe malnutrition cases. gCHVs will participate in health promotion activities and in community mobilization to support outreach activities carried out by facility-based teams.

Household Health Promoters (HHPs) will be involved in water and food safety, waste management, vector control and occupational health and safety, among other things.

Interaction of CHVs with the community will be ensured by the Community Health Committee (CHC), which will play a significant role in identifying potential gCHVs for training, providing support for health-related activities and for the CHVs themselves, and liaising with the health facilities and other communities in the catchment area through the Community Health Development Committee (CHDC).

At each facility, a Community Health Services Supervisor will be appointed, with the function of providing technical support and supervision to the CHVs in the catchment population. CHVs will be supplied drugs and commodities from facility stocks. Each facility will include community services consumption in its projection of needs. External support will be necessary for some years to scale up and maintain community health services.

CHVs are not entitled to government salaries, directly or through contracted implementing partners. However, options to design an incentive package provided by the community or with the support of external agencies can be decided locally.

4.1.7 Health and social welfare promotion

Lifestyle choices and socio-economic, religious, cultural and environmental factors have significantly contributed to the declining state of the health of the population of Liberia. These factors serve as a driving force to reform the health sector to provide quality and accessible health and social welfare services to the people of Liberia. A robust health promotion framework is being created to draw support from multiple levels for cross-sector participation and involvement in the promotion of healthy lifestyles at the county, district, and community levels.

4.1.7.1 Build capacity for health promotion implementation in Liberia

The National Health and Social Welfare Promotion Division (NHSWPD) will ensure that the capacity for health promotion is established at the county and district levels.

- Facilitating intra- and inter-divisional and multi-sectoral collaboration around projects and programs aimed at promoting good health.
- Ensuring individual and community empowerment through advocacy, mobilization, media, health education and evidence-based research.
- Networking with partners and programs for effective planning, coordination and implementation of Health Promotion (HP) interventions.

4.1.7.2 Empower and promote active involvement and participation of individuals, groups, and communities in health promotion interventions at all levels

- Intensifying the campaign for the use of the "healthy life" logo on messages and materials for health promotion in Liberia.
- Developing and monitoring an institutional framework for health promotion at the national, county and district levels.
- Providing operational guidelines and standards for health promotion practice, including advocacy, social mobilization, message design and development.
- Advocating for supportive policies for HSWP practice in Liberia.

4.1.7.3 Promote the use of evidence-based research as a prerequisite for the development of health promotion interventions

- Providing supportive and technical leadership in health promotion (HP)research in collaboration with the Research Unit and setting priorities for the research agenda. This will entail establishing and maintaining a research data base.
- Monitoring operationalization of the HP Policy and providing technical guidance.

4.1.7.4 Promote multi-sectoral and multi-disciplinary approaches to health promotion development and implementation.

- Establishing and supporting multi-sector collaboration or partnerships through the Health and Social Welfare Promotion Technical Working Group, including all relevant stakeholders for the purposes of developing integrated and comprehensive programs.
- Facilitating and supporting general and specialized training in health promotion, together with higher educational institutions and other relevant organizations, and identifying the training needs among other structures relevant for health promotion implementation in the country.

4.1.7.5 Develop harmonized and concerted strategic health communication interventions

- Establishing a coordination and monitoring system for health promotion programming at the national, county and district levels to ensure their relevance and effectiveness.
- Coordinating the production and guiding the development and dissemination/distribution of all health promotion (HP) messages and materials for the Essential Package of Health Services.
- Ensuring consistency in all developed and duly pretested HP messages and materials.

4.1.8 Health services targets

A set of targets will be defined for the most important health services. The MOHSW has proposed targets on selected services, which will be adjusted to the counties' projected capacity. A definitive table will be produced with the targets by county and this will be used to monitor progress of county and central level performance.

4.1.9 Phased implementation

Implementation of the revised EPHS is planned in two clearly identifiable periods to allow time for gathering epidemiological information on some of the conditions to be included in the new package and for preparing teams for their management.

Phase 1 (Years 1–3)

- Strengthen and expand Reproductive Health Services, Emergency Health and Communicable Diseases management and control
- Introduce of the following services: mental health, school health, environmental health and prison health.
- Assess and plan for Neglected Tropical Diseases (NTD) and Non-Communicable Diseases (NCD), including the realization of epidemiological surveys, the drafting of clinical guidelines, and the development of a training program for the professionals involved.
- Strengthen essential support services.
- The upgrading and improvement of the existing network will be prioritized, particularly at the Health Center level, as will the organization of sub-county networks into local health systems.
- The expansion to underserved communities will be done mostly through non-permanent SDPs.
- At the end of this period an assessment of the EPHS implementation and the system's capacity to absorb additional services will advise on the rhythm of new incorporations to the package actually offered.

Phase 2 (Years 4–10)

- Initiate and roll out NCDs and NTDs services.
- Strengthen and expand mental health, school health, environmental health and prison health.
- Services currently provided and those added in the first phase will be continued.
- Interventions on the network will include expansion to underserved communities with new clinics, improvement of county hospitals and upgrading of some of these to regional hospital level.

4.1.10 Projecting the necessary network

The 2021 network of public facilities will be the result of building new clinics (SDP as identified by the CHSWT), upgrading the busiest clinics to HC, and transforming four county hospitals into regional facilities. Only one county hospital will be built, to cover the needs of River Gee County. The projected mix of facilities is shown in Table 2.

The network of public facilities will experience an increase of 40 percent, mostly because of the augmented number of clinics. The type of facility which will grow most (percentage-wise) is health center/district hospital, a level of facility that is to become essential to organizing sub-county networks and offering more-advanced maternal and newborn care. A more rational healthcare pyramid will be obtained.

Existing facilities will evolve according to populations served and workload. Underperforming clinics serving too-small communities can be downgraded or even closed, while service provision is guaranteed by a better-placed facility or efficient outreach services.

4.1.11 Facility-based human resources

Projections for 2021 for the workforce necessary to operate the expanded network, adjusting for the total number of facilities by type, exceed 15,000 workers, 55 percent of them professionals. Also, about one-half of all personnel would be positioned at county hospitals. See Table 3, page 59.

Most of the professionals mentioned above fall into three critical categories: nurses, midwives and physician assistants (in absolute terms, nurse aides are the biggest category). Physicians, most of whom are expected to be specialists, will also experience an important increase by 2021.

Average teams by type of facility have to be read as orientative. Actual teams will be decided incrementally, on the basis of workload. For new facilities, the initial team will be kept to a minimum; for example, for newly

Table 2. Network of GOL health facilities, 2011–2021, by county

County	Population 2021	Public Network 2011					Projected Public Network 2021				
		NH	CH	HC	Clinic	Total	R&NH	CH	HC/DH	Clinic	Total
Bomi	110,211		1		19	20		1	4	19	24
Bong	436,923		3		32	35	1	2	9	35	47
Gbarpolu	109,254		1		14	15		1	4	28	33
Grand Bassa	290,460		1		20	21	1		6	19	26
Grand Cape Mount	167,458		1	2	29	32		1	5	30	36
Grand Gedeh	164,111		1	2	14	17		1	5	24	30
Grand Kru	75,877		1	4	12	17		1	4	16	21
Lofa	362,743		3	3	42	48		3	8	50	61
Margibi	275,039		1	4	13	18		1	7	13	21
Maryland	178,104		1	1	19	21	1		5	27	33
Montserrado	1,465,109	1	4	8	33	46	1	4	20	23	48
Nimba	605,342		4	4	37	45	1	3	12	54	70
Rivercess	93,690		1		16	17		1	2	33	36
River Gee	87,506			3	13	16		1	3	17	21
Sinoe	134,151		1		30	31		1	4	31	36
COUNTRY	**4,555,985**	**1**	**24**	**31**	**343**	**399**	**5**	**21**	**98**	**419**	**543**

opened SDP (most of which will serve small populations) the team will be composed of two or three workers, one of which a multi-purpose professional (nurse, PA or midwife).

4.2 Social welfare services

The goal of the social welfare component of the health plan is to broaden coverage of social assistance and/or social insurance services transforming operations from a centralized to a decentralized client-centered delivery system.

4.2.1 The Essential Package of Social Services (EPSS)

The sector will provide a range of social services using different implementation arrangements: (1) direct service delivery, largely through early intervention, case management, and referrals through social workers assigned to service delivery points at community, district, and county-level facilities; (2) performance-based contracting using the framework of the National Health Policy on Contracting; (3) short-term consulting services used largely for administrative systems and process development, baseline research and pilot insurance products.

4.2.1.1 To provide social assistance and/or insurance coverage to reach at least 66 percent of persons falling in each target group over the next 10 years

Interventions for direct service delivery through central divisions, regional centers and CHSWT will include the following:

- Outreach services
- Intake and assessments
- Child protection issues, home visits, school monitoring
- Training programs for parents
- Early intervention–awareness and counselling programs for substance abuse
- Training interventions for caregivers and implementation of norms and accreditation standards
- Mediation services and psychosocial counselling
- Protection services and case management for juveniles in detention and in prison
- Case management of vulnerable prisoners
- Referral services
- Means-tested free medical care
- The strengthening of local systems of self-governance
- Building capacity of community groups

Interventions for performance-based contracting of partner institutions. Performance standards will be developed for:

- Temporary shelters—foster care and transient homes
- Drug treatment and rehabilitation programs (including harm reduction)
- Child placement through strengthened alternative care unit
- Revitalization of the Doloken Rehabilitation Center and the establishment of three regional centers
- Provision of assistive devices
- Residential care for the homeless
- Time-limited means-tested subsidies
- Monitoring and case management of adults with disabilities
- Acute treatment facilities for the mentally challenged
- Post-treatment rehabilitation including counselling

4.2.1.2 Within the next three years, transform from a centralized to a decentralized client-centered delivery system while putting in place policies, administrative systems, and eligibility rules that build capacities to continue service delivery and adapt to emergent social problems well into 2021.

Responsibility for direct social welfare service delivery will be transferred to sub-national authorities and thereafter authority will devolve as capacities improve. Relevant here is the proper delivery of social programs and services within a decentralized administrative framework. Also relevant here are linkages to social transfer interventions, enforcement of standards for new and continuing accreditation of care-givers and oversight of the performance of partner agencies. A critical element in the decentralization process will be workforce capacity development and workforce deployment within counties and between facilities, taking into account population density and adjusting for sparsely populated locals, to meet the requirements for delivering the Essential Package of Social Services (EPSS) to the demographic targets.

4.2.1.3 Beginning Year 2, increase social trust and enhance the family responsibility system through community-level actions

A residual effect of years of civil conflict is societal mistrust and the collapse of a family responsibility system that served as the primary means of support for a vulnerable population. Therefore, local systems of self-governance

Table 3. Projected Human Resources, by category, 2021

Cadre	Facility Clinic	No. 2021 419	Facility HC	No. 2021 98	Facility C.H.	No. 2021 21	Facility RH	No. 2021 4	Facility JFKMC	2021
Physician					8	178	15	60	115	353
Hosp Admin					1	21	1	4	1	26
Nursing Dir					1	21	1	4	1	26
P. Assistant	1	419	2	196	12	252	24	96	24	987
R .Nurse			2	196	42	882	99	396	144	1,618
C. Midwife	1	419	4	392	46	966	99	396	143	2,316
Nurse Midwife					20	420	120	480	120	1,020
Pharmacist					3	63	4	16	4	83
Anesthetist					10	220	15	60	28	308
OR Tech.					10	220	16	64	24	308
Lab Tech.			1	98	3	63	5	20	9	190
Lab Assistant				0	10	220	12	48	20	288
Environ. Health. Tech.			1	98	3	63	4	16	6	183
Social Worker*			1	98	6	126	8	32	8	494
Xray Tech.					3	63	4	16	8	87
Adm. Assist.					7	147	8	32	12	191
Radiologist					3	63	4	16	8	87
Nutrition					3	63	5	20	5	88
Physiotherapist					3	63	4	16	8	87
Professional Staff	**2**	**838**	**11**	**1078**	**196**	**4,116**	**448**	**1,792**	**688**	**8,742**
Nurse Aide	1	419	1	98	90	1,890	160	640	160	3,207
Dispenser	1	419	1	98	10	220	12	48	20	805
Lab Aide					15	315	20	80	20	415
Recorder	1	419	1	98	3	63	4	16	4	600
Skilled, Non-Prof.	**3**	**1,257**	**3**	**294**	**118**	**2,488**	**196**	**784**	**204**	**5,027**
Non Skilled	**1**	**419**			**41**	**861**	**103**	**412**	**165**	**1,857**
Total	**6**	**2,514**	**14**	**1,372**	**355**	**7465**	**747**	**2,988**	**1057**	**15,626**

Note: HC = Health Center; CH = County Hospital; RH = Regional Hospital; JFKMC = John F. Kennedy Medical Center.
Totals do not include MoHSW and CHSWT staff. In 2011, total does not include JFKMC staff.
*Total includes district-based Social Workers.

will be strengthened through social welfare committees organized in communities within 5 miles of the service delivery points. These committees will help find durable solutions to local social problems. Furthermore, and through their member associations, clients will be brought into the decision-making process on policies and strategies as right-holders (actively participating in efforts to define the way forward, as is crucial in a developmental social welfare approach).

4.2.2 Multi-tiered system for direct service delivery

The multi-tiered delivery system is the key focus in decentralization. The EPSS will be delivered using service delivery points (SDPs). Direct service delivery at the county and district levels will be supervised by the Senior Social Welfare Officer, under the umbrella of the Community Services Director of the CHSWT. While emphasis will be on expanding outreach and coverage through performance-based service contracting to partner institutions in the initial years, intake assessments, case management, eligibility determinations and referrals are critical elements in service provision. These will be managed by social workers.

Within the delivery tiers, staff must be deployed close to where clients reside. Community social welfare volunteers and general volunteerism will be encouraged. Community volunteers will be trained to deliver basic social support services at the community level and to make referrals.

Staff will be deployed/re-deployed to the following places:

1. Districts with estimated caseloads at 2,900 and above
2. All other districts, where the emphasis will be on participating in outreach services provided through the health SDPs.

4.2.3 Assessing needs and potentialities

Assessments will be conducted in the following areas to provide the sector with the necessary knowledge about actual needs and the possibilities of using innovative financing schemes.

- Assessment and design of pilot tax-financed social insurance scheme
- Assessment to determine numbers and identify types and needs of substance abusers
- Baseline social research on pervasive risky traditional practices and behaviors
- Baseline assessment on scale and scope of human trafficking
- Baseline assessment of children in contact with the law
- Development of policy instruments, eligibility rules and policies and procedures manual for social welfare services
- Training institutions' assessment and curriculum modification for social workers
- Broadening the CHSWT reporting framework to include social welfare–related indicators

4.2.4 Phased implementation

Implementation of the EPSS will follow a three-phase approach, considering the reliability of the existing baseline information and the actual sector capacity.

Year One: Baseline assessments and/or program development

Capacity will be at its lowest at the start of the Strategic Plan implementation. As a result, partner support will be used extensively to gather necessary baseline information and design/develop programs aimed at addressing capacity gaps in service delivery to target groups.

Years Two to Five: Early program implementation

During this time, government capacity should be increasing and dependence on outside technical assistance should steadily decrease. Focus will be on the GOL and donor funding to enable performance-based partner contracts to standardize services.

Years Five to Ten: Late program implementation and review

During this time, dependency on partners should have significantly decreased and most partner assistance should amount to developing capacity to self-manage all programs and projects. Inter-ministerial partnerships will continue with annual review and revision.

5. Systemic Components

System components not directly related to service provision are discussed below. However, as decentralization takes shape, most of what is here described will be divided among the different system levels according to their functions.

This material has sections on financing, network of facilities, infrastructure and SDP, human resources, drugs and commodities, monitoring and evaluation and other more cross-cutting issues. This discussion ends with a section on decentralization and addresses how the MOHSW envisions the process of handing over responsibilities to the county level.

5.1 Health and social welfare financing

The goal of health and social welfare financing is to ensure that the services provided to the population of Liberia are affordable to the country, while preventing catastrophic household health and social welfare expenditure.

The MOHSW will seek a mixed approach to funding health and social welfare that includes a sustainable level of government financing, predictable donor support and affordable user fees for certain services. Alternative pre-payment schemes will be explored. Allocative efficiency and equity will be obtained through the use of appropriate allocation criteria and the participation of all stakeholders, as well as by expanding performance-based financing mechanisms.

Objectives and strategies

5.1.1 Increase mobilization and predictability of financial resources for health

Establish a common planning cycle that includes the projection of donor support with a medium-term horizon. An annual planning cycle will be developed that includes all resources and all activities. Tools and events comprising the cycle will be part of both the annual operational plan and the Medium Term Expenditure Framework (MTEF).

Conduct a study to assess the viability of additional financing mechanisms, including hypothecated taxes such as the VAT levy, mobile phones tax, sin taxes and other options. The study will include discussions with the Ministry of Finance (MOF) and will eventually be followed by implementation measures.

Pilot both social health insurance and community-based health insurance schemes and assess the modality under which they can be successfully implemented in Liberia.

Review policy of charging at primary health care facilities and clarify guidelines and tariffs for fees at Secondary/Tertiary care facilities. Assess the administrative structure necessary for collecting, managing and accounting for such fees. Rather than as a source of funding, the relevance of user fees will focus on preventing unnecessary utilization of referral services for minor conditions and also as an incentive for beneficiaries to enroll in pre-payment schemes.

Negotiate with MoF the allocation of government budget for health in the context of multi-year expenditure frameworks. Specific issues to consider are forecasting personnel and capital expenditure, as well as the possibility of allocating debt relief funds to the health sector.

Expand the number of donors using the Pool Fund mechanism by making its proceedings clear and transparent and by simplifying planning and execution procedures.

Increase budget execution by identifying and solving bottlenecks. Low budget execution has been blamed for cash-flow problems, accounting problems and even planning problems. The whole budget execution process will be analyzed and streamlined.

5.1.2 Improve resource allocation

Determine the criteria to be considered for resource allocation and discuss the possibility of developing one or more allocation formulas.

The system may need different formulas or criteria to distribute resources destined to diverse purposes. For example, running costs are linked with actual service output, while investment plans are related to the existing network; both may be related to population. The different allocation processes will be identified and formulas developed accordingly. Likely criteria are population to be served, network size, workload and population dispersion.

Work with partners to develop comprehensive reporting of all external investments, using standard classifications, and encourage pooling and harmonization.

Resource pooling greatly facilitates resource allocation in single, comprehensive exercises. The MoH&SW will try to integrate financial management procedures in the following order:

- On plan: annual operational or multi-annual investment plans will be produced considering all resources available.
- On accounting: to the possible extent, common accounting procedures for resources spent in the public system will be agreed upon and followed, simplifying the production of expenditure accounting into a single exercise.
- On budget: in a later stage, funds can be integrated during the whole process, from planning through disbursement, expending and accounting.

Develop and use medium-term expenditure framework. Working with the MOF and starting with the two-year operational plan the methodology will be developed and followed to produce and update a MTEF where priorities are discussed, resources identified and projected and allocation decided with a three- to five-year horizon.

5.1.3 Increase efficiency of resource utilization

Develop capacity at county health department, district and facility levels to manage decentralized health sector, including in planning, budgeting, purchasing and financial management, along with the strategies contained in the decentralization policy.

Conduct a study on the expected costs of implementing the EPHS and Secondary and Tertiary referral services. The exercise, which is expected to shed light on unit costs per contact and per capita, will develop into the institutionalization of the costing tools.

Undertake public expenditure tracking surveys to ascertain whether resources get to the facility level and where the blockages and delays can be found.

Strengthen MOHSW capacity for strategic budgeting and public financial management.

5.1.4 Increase efficiency and equity through a harmonized provider payment mechanism

Replace gradually the block budget with performance-based contracts as the provider payment mechanism, even for CHSWT, with the aim of stimulating the development of a more responsive, results-oriented health system. County teams will be strengthened to improve their capacity to set and monitor performance targets, negotiate contracts and manage funds from different sources.

Undertake an assessment of the performance-based contracting mechanism and make the necessary improvements.

Much funding is channelled through performance-based contracts without clear contract pricing, target setting or performance monitoring criteria. Unit costs per type of service will be developed and revised regularly to facilitate contract negotiation. County and district health systems, rather than facilities, will be identified as settings of contractual arrangements to give targets a territorial, population and network context.

Analyze and implement price-setting and payment mechanisms, weighing advantages and inconveniences of capitation, fee-for-service, case mix or a combination of these things, for services delivered at different (primary facilities and hospitals) levels. Alternatives will be piloted.

5.1.5 Strengthen the evidence base for management and policy making

Strengthen financial management systems to integrate financial information from all sources—donors, local authorities, user fees, etc. Selected data will be integrated into the HMIS.

Institutionalize National Health Accounts and other key sector monitoring tools such as Public Expenditure Reviews and Benefits Incidence Analysis. To this end, arrangements will be made with LISGIS to ensure that there is a component on health expenditure in all relevant population-based surveys.

5.2 Network of facilities and service delivery points

The main goals of the MOHSW infrastructure policy are to guarantee the appropriateness and quality of health infrastructure through the development of Health Infrastructure Standards and to increase the efficiency of the construction process by designing Project Delivery Process guidelines that help implementers avoid unnecessary delays.

Objectives and strategies

5.2.1 To improve access to well-maintained health and social welfare facilities of sufficient size, reasonable quality

A series of county surveys, covering all publicly-owned health facilities of the country, will be carried out, assessing different structural components such as size, building materials, physical condition, completeness (water supply source, waste management, etc.) and functionality.

A similar survey, more detailed and technically demanding, will be performed for all **public hospitals as part of a Hospital Development Plan process.**

A 10-year investment plan, with interventions on major rehabilitation works, upgrading, re-construction (replacement) and new constructions, will be produced, including prioritization criteria (e.g. access, potential efficiency, continuity of care, referral system comprehensiveness). The CHSWT identified 124

priority interventions on the existing network, almost evenly split between rehabilitations, upgrading and reconstructions.

The responsibility for securing funding for the different investment components will be coordinated with the MOHSW in collaboration with various institutions depending on size, complexity and cost of the interventions, as well as whether the involved facilities serve more than one administrative unit.

- The MOHSW will remain responsible for planning and financing interventions on hospitals, some of which may serve more than one county, are costly and require the recruitment of human resources that cannot be found locally. It will also be in charge of coordinating interventions of large aggregate size, even if each intervention is relatively small.
- CHSWT will become responsible for planning and securing funds locally for interventions on smaller facilities, either building new clinics or completing existing units with housing, water supply, etc.

Each administrative unit (MOHSW and CHSWT) will prepare a **portfolio of priority, ready-to-make interventions** to take advantage of all funding possibilities. The portfolio may not be exclusively composed of facilities but may also include interventions on water supply or housing, for example.

An **annual routine maintenance plan** will be prepared by all CHSWT, sospitals and MoH&SW, to be included in the Annual Operational Plan and Budget. This will be based on the Maintenance Guidelines to be developed by the MOHSW. In principle, maintenance works will be guaranteed by CHSWT/hospital maintenance teams, but contracting external companies will be piloted where the market exists.

Guidelines will be established to lead the development of existing facilities. Where performance is suboptimal, some facilities may merge or even be closed down.

5.2.2 To establish clear building standards for all health facilities and to ensure minimum compliance by participant stakeholders

The Infrastructure Unit will produce **Infrastructure Design Standards** on facility distribution components, minimum acceptable construction techniques, material and built-in equipment specifications and others.

New prototypes will be developed for facilities whose construction is expected to reach substantial numbers (e.g, dozens of new small SDPs, staff houses) in order to simplify design and contract processes. Utilization of these prototypes will be optional rather than normative, with the aim of reducing costs associated with pre-construction project development.

Specific technical alternatives will be offered for:

- Outpatient departments for county hospitals, to separate primary care (to be offered to the surrounding population) and referral, for which the whole county primary (and HC) network is considered.
- Primary facilities for urban settings, where the objective is offering outpatient care to a large population gathered in a relatively small area. Primary clinics, or even health centers in urban areas, will be larger than their equivalents in rural zones, composed almost exclusively of outpatient services,[3] and occasionally offering double-shift attention.
- Housing, as part of infrastructure interventions in rural areas.

3. In urban environments there is no need for health centers to offer hotel-like facilities (inpatient beds that are occupied because of the distance between the facility and the person's residence, rather than for the seriousness of the conditions being treated). Therefore, inpatient care should be limited to a number of well-located hospitals.

5.2.3 To establish a transparent Project Delivery Process

Strategies will include pre-construction reviews and approvals that assess the adaptation of Standards to specific sites and project needs, regular quality control monitoring during construction and pre-occupancy approval at the conclusion of construction.

A **simple set of ground rules** to ensure transparency will be provided for each area covered by the Project Delivery Process, to be supported by clear guidelines outlined in the Health Infrastructure Standards, covering technical aspects as well as the path to be followed from conception to implementation.

5.3 Human resources (HR)

The HR Policy is guided by the following principles: equitable access to health and social welfare services as a basic human right; addressing stigma and discrimination in the sector; leadership and management of excellence; evidence-based and decentralized decision-making in planning, training and development of the workforce; effectiveness; equity; gender-sensitivity; partnership; fairness; transparency; accountability; and safety and security.

The main goal is improving the coherence between strengthening the existing professional workforce, producing additional workers with the right skills mix, evidenced-based health worker (re)distribution and effective motivation and retention schemes.

Objectives and strategies

5.3.1 Increase the number of equitably distributed qualified and high-performing workers at all levels by:

Promoting equitable distribution of the workforce

Establish a human resources database with relevant information on personal details, academic background, including in-service training, work experience and performance assessments and include selected data in the HMIS.

Review and update staffing norms for each type of facility in line with the sector's service delivery priorities, using catchment population and service utilization (translated into productivity) as the main criteria.

Depending on population, network and utilization, counties will be given a ceiling of professional staff positions with budgetary coverage, reviewed periodically (every two years, in connection with planning and MTEF exercises) to adjust to changing factors. The ceilings will be set according to payroll funding availability. In order to ensure that professional staff remain within the public sector, they will be given priority for payroll integration, while non-professional workers will be contracted and paid with county resources. To keep total salary packages under limits likely to be set by the MoF, the contracting out of non-professional services (e.g. cleaning, laundry, security, etc.) will be piloted in large health facilities.

Developing and implementing differential competitive benefit packages geared to hard-to-reach areas, including e.g. a moving and transport allowance, transport and/or housing, is an important strategy. Housing has two main purposes: on the one hand it helps deploy workers in places where even renting a house may prove difficult; on the other hand, it may ensure that some critical staff (e.g. anaesthetists, physicians, midwives, lab techs) are close to health facilities when no shifts can be organized. Two approaches will therefore be taken: each clinic located in a rural area will be provided with one-to-two simple staff houses. For larger facilities, housing will be part of the development plan. Housing allowances will be used when appropriate and feasible.

For staff trained with the financial support of the MOHSW, compulsory service in hardship areas for a limited period will be piloted and instituted were appropriate.

Improving performance of students and the workforce

Based on the Workload Indicators for Staffing Needs (WISN) and Task Analysis methodologies, workload indicators will be developed and acceptable levels (minimum and maximum) of productivity by staff categories will be determined. These indicators will be used to project staff needs and for the redeployment of workers with sub-optimal productivity; in case of overworked staff, additional staff will be added as necessary according ot the indicators.

A performance appraisal system will be instituted and annual evaluations of each worker conducted, with the aim of improving individual workers' performance and development, using standardized performance management tools.

Performance-related incentives will be developed, in the form of financial awards, career progression (e.g. scholarships for further academic education) and relocation to softer sites, among others. Different incentives will be awarded by different management bodies. For example, relocation and limited financial incentives will be awarded by the CHSWT, while scholarships for masters degrees will be granted by the MOHSW. incentives and their awarding criteria will be disclosed to all workers.

The MOH&SW will develop and implement career progression schemes for each cadre and support career counselling and mentoring of and coaching to all students and workers at all levels.

5.3.2 Increase the number of high-performing facilities and institutions promoting continuous learning and assuring quality

This will be achieved through the following strategies:

Strengthening the planning, management and coordination of the human resources (HR) Unit within the MOHSW by upgrading, restructuring and expanding the Unit, consolidating all HR functions in the Ministry within the Unit and recruiting and/or redeploying workers for the Unit as needed.

Developing and implementing an **evidence-based national 10-year sector training plan.** Based on the network projected needs, draft a training plan that transfers to regional institutions the training of the most numerous and multi-purpose cadres (e.g. midwives, nurses, physician assistants, lab technicians), while country-level institutions concentrate on specialized categories less present in primary facilities (e.g. anesthetists, physiotherapists, x-ray technicians, operating room technicians, mental health clinicians, etc.).

The MOHSW will coordinate health worker production (both in terms of courses and students' county of origin) by implementing the right mix of regulation, scholarships and direct financing to the relevant schools.

Strengthening the management performance of facilities and institutions by developing a set of HRH management tools to be used by HR directors and as part of a general management methodology for county health officers. In the absence of a body of professional managers, selected officers will be trained in management concepts and practices. At a later stage, prior attendance at training courses will become a requisite to taking a management position.

Strengthening the quality of pre-service training. Review and update standardized curricula, core competences and job descriptions for each clinical cadre every two years to ensure that curricula integrate new knowledge, skills and 'good practices,' meet service needs and consist of a significant part of non-clinical subjects.

Upgrade and expand training institutions to increase the training of key cadres in line with national 10-year sector training plan. The establishment of new training institutions will be decided after consideration of long-term projection of needs and the output (in quality and quantity) of the existing ones. Strengthening existing institutions will take priority over expansion.

Strengthening the capacities of regulatory and professional bodies. The MOHSW will support, technically and financially, the establishment and functioning of professional bodies. Standard operating procedures (SOPs) regarding registration and accreditation procedures will be developed and implemented.

Strengthening the quality of in-service training by reviewing existing methods of and modules for all in-service training and developing new methods of in-service training that reduce the time that workers spend away from their job, through e.g. ongoing mentoring, integrated supportive supervision, on-site training and e-learning.

In-service training activities will focus on acquiring a mass of frontline staff members, sharing common skills (e.g. birth attendance, immunization, diagnosis and treatment of common conditions for any nurse, PA or midwife to be deployed in remote facilities), as well as the transmission of new, specific capacities.

5.3.3 Develop a strengthened gender-sensitive, service-oriented and people-centered workforce by:

Promoting a gender-sensitive workforce through the full implementation of the **National Gender Policy** in all activities of HR training, recruitment and management.

Promoting a **workforce that is service-oriented** and people-centered by monitoring professional and ethical conduct of the workforce.

Developing, printing, distributing and implementing an **Employee Handbook** that includes professional and ethical codes of conduct.

Developing and implementing a system whereby full-time professionals will not **work in private practice during official working hours** without written permission from their immediate supervisors.

5.3.4 Increase the number of safe and conducive working and learning environments equipped with the 'tools of the trade' through the following strategies:

Improving safety in working and learning environments. Develop and implement a program on occupational health, safety, security and risk reduction at all institutions and facilities, including (a) maintaining records of work-related injuries, sicknesses, accidents and fatalities to help assess and mitigate future risks, (b) training and supervising workers in the maintenance and use of equipment and supplies to prevent accidents and reduce risks and vulnerabilities, and (c) providing HIV/AIDS prevention, post-exposure prophylaxis, treatment and care.

Increasing the number of learning and working environments with the 'tools of the trade' by assessing the availability and quality of the required 'tools of the trade' during annual accreditation.

5.4 Pharmaceuticals and health commodities

The MOHSW shall ensure access to efficacious, high-quality, safe and affordable medicines for all people in Liberia. The functions of financing, regulating, selecting, quantifying, procuring, distributing and storing, prescribing and dispensing medicines will be kept as distinct as possible and the mandates of each involved agency and the way agencies interact among themselves will be clearly articulated. Technical and management tools will be updated according to the evolving needs of the system.

Objectives and strategies

5.4.1 Ensure a continuous supply of medicines and commodities of acceptable quality for use in the prevention, diagnosis and treatment of disease

Periodically revise the Essential Medicines List (EML) by the Pharmacy Division/MOHSW. The Division will coordinate the revision of the EML periodically, as often as developments in the sector make it advisable, coinciding with revision of the Essential Package of Health Services, for example. New issues of the EML will incorporate an indication of the level of priority attributed to each item included, using the Vital, Essential and Non-Essential (VEN) classifications.

Revise and implement the Supply Chain Master Plan. The Supply Chain Master Plan will be partially revised to articulate accountability relationships between the MOHSW units and agencies involved. The Supply Chain Management Unit at the MOHSW will coordinate and oversee all aspects of the public sector drugs supply, including quantification of needs and procurement planning, as well as managing the Logistics Management Information System. In the short term, the National Drug Service (NDS) will remain the preferred, but not exclusive, procurement and distribution (through satellite county depots) agency for the public sector, whose activities will be demand-driven by counties and health facilities as budget holders and main NDS clients. Drug procurement will be gradually placed under the supervision of the unified MOHSW Procurement Unit.

Periodically assess NDS performance. The Master Plan effectively places the NDS in a position of relative monopoly during a period of time. To ensure that the NDS keeps high standards of performance, an external evaluation will be performed periodically (every two years) to assess prices obtained, timely functioning of the procurement/supply pipeline and client satisfaction.

Allow alternative procurement means (resource to the local market) to be used by county teams and facilities to face emergency situations and cases where the small amounts of drugs needed make it improbable for the NDS to achieve economies of scale. Quality of medicines purchased in this way will be ensured by drug registration and importer licensing by the Liberia Medicines and Health Products Regulatory Authority (LMHRA) and by retailer licensing and supervision by the Pharmaceutical Board of Liberia.

Explore all alternatives for drug financing. While most funding for drug supply will come from regular sources (GoL, Pool Fund, other donors), there is some tradition of drug revolving funds, tried in the past with reportedly good results. This approach will be explored, and eventually tested, for specific items in selected facilities.

Private sector financing through increase in public-private partnerships for procurement of approved quality essential drugs and equipment will be explored as a complement to current donor and government financing schemes.

5.4.2 Ensure equitable access for the population to medicines of acceptable quality

Design and implement a Drug Expenditure Tracking System. The value of drugs and commodities distributed to individual health facilities will be recorded and included in the HMIS. Periodically, summary indicators such as drug expenditure per head (catchment population) and drug expenditure per consultation will be produced and analzsed.

Allocate drugs funds to county teams and selected facilities. For county teams and hospitals to be the driving force influencingthe selection, procurement, distribution and use of essential medicines, they need to become the budget holders. To promote equity and efficiency, drug budget allocation will be part of a general allocation formula taking into account at least catchment population and service utilization.

5.4.3 Encourage and promote quality use of medicines by prescribers, nurses, midwives, pharmacists, dispensers and patients

Rational use of drugs will be enhanced by periodic revision and implementation of Clinical Guidelines. Besides technical adequacy, revised guidelines will take into account efficiency and cost-containment, particularly when drugs for non-communicable diseases (NCD) (anti-hypertensive, anti-diabetic) start being commonly used.

Add rational drug use monitoring tools to periodic activities (e.g. during supervisory visits, accreditation surveys) to assess some indicators, such as average number of drugs per prescription or percent of prescriptions with antibiotics. Indicators for rational drug use will also be included in performance-based contracts (PBCs).

5.5 Health Management Information System (HMIS), monitoring and evaluation

The goal is to monitor the performance of CHSWTs and NGOs contracted by the MOHSW in order to provide MOHSW and donors with reliable information products for planning and decision-making.

The MOHSW will maintain a simple, coherent, scientifically sound and easily understandable information system with the capacity to produce reports related to health and social welfare sector development, including the analysis of trends, in order to understand the evolution of the sector over time. The integrated HMIS will be composed of databases on integrated financial management, human resources, physical assets and management, and health information systems, complemented by vital statistics, such as births and deaths, whose collection will be revitalized through the National Birth Registration Policy and Plan.

The HMIS will be developed in a way that is consistent with the decentralized health and social welfare structure.

Objectives and strategies

5.5.1 Harmonize the HMIS functions

Involve the HSCC in overseeing the HMIS and establish technical working groups on the various HMIS components.

Endorse core and common health indicators. The national Monitoring, Evaluation, and Research Division has developed standardized datasets with key variables. A common set of Health Indicators has been agreed upon and provided periodically for the monitoring of performance-based contracts. A core set of indicators of broader scope will be endorsed for the follow up of the 10-year plan implementation. A working group will be set up, with partners' collaboration, to establish the definitive monitoring framework for Plan and Policy.

5.5.2 Update the HIS component of HMIS on a periodic basis

Revise periodically the DHIS database according to the revised indicators and datasets. The database will be harmonized so that the data requirements of each stakeholder are satisfied and the data elements that are not owned by any stakeholder are removed.

Review and update data collection instruments, including source documents such as registers, tally sheets, etc. used by the HMIS.

Review and update standard operating procedures (SOPs) and trainers' guides based on the role each health system member is expected to play in terms of collection, analysis, interpretation, dissemination and archiving.

5.5.3 Develop/strengthen all other sub-systems/data sources

Develop and implement a Social Welfare Information System. A complete set of collecting and reporting tools, as well as the indicators for monitoring, will be designed by the MOHSW.

Complete the HMIS databases with information on pharmacy matters, human resources and finances. Sub-systems on all relevant health system assets will be gradually added to the core HIS component.

Conduct a health facility census. Currently, there are no reliable data on health personnel, infrastructures and equipment. A health facility census will be conducted to establish baseline information on the indicators related to these areas.

Update GIS database and disseminate thematic maps. Data on assets and human resources will be analyzed, generated in reports and presented in GIS maps. Maps of programmatic interest will be provided to the concerned program. Additionally, maps on all indicators as specified in the strategy will be made available on the MOHSW Web site.

Estimate annual target population for each health facility catchment area. Each facility must know the population it is to serve each year and the population for each programmatic target group. The Monitoring, Evaluation, and Research Division in the MOHSW headquarters will work with LISGIS to derive population data for each health facility catchment and estimate the target population for different services.

Integrate death registration into universal birth registration initiatives as part of Vital Registration.

Strengthen the disease surveillance system. The surveillance system will be expanded to facilitate reporting by community-based health workers. Also, hospital reporting according to the ICD-10 will be piloted in three hospitals.

5.5.4 Develop an HMIS portal

A Web-based HMIS information portal with interface software for each sub-system (human resources, finance, physical assets, infrastructure) will be developed using the appropriate software. Hardware requirements will be assessed.

5.5.5 Improve the use of information for decision-making

Improve the data presentation skills of HMIS staff. Data compilers, statisticians and data managers will be trained in tailoring data to client needs and in presenting data in standardized and consistent tabular and graphic form.

Improve the skills of data users. Data users will receive short, focused training courses to help them understand data sources and limitations, interpret data presented in tabulated form and use information for decision-making.

5.5.6 Promote access to information

Produce regular health reports. Information dissemination will be ensured through the regular production and monitoring, at the national and sub-national levels, of health reports, disease surveillance reports and health performance assessment reports.

Using data generated by monthly facility HMIS reports, CHSWT and MOHSW will produce and disseminate quarterly and annual reports.

Access information electronically. Electronic data standards will be developed for computerized databases and, as far as possible, for interactive updating and access to these databases through the Internet.

5.5.7 Develop the institutional, human and material capacity of M&E at central and county levels to effectively monitor and evaluate the implementation of the EPHS

The MOHSW will recruit and deploy skilled personnel with competencies in data collection and management, analysis and interpretation. M&E personnel will participate actively in all the steps of the planning cycle.

Periodic in-service training will be carried out, coinciding with expansion or updating of HMIS tools.

The MOHSW will make sure that sufficient equipment is available for the correct realization of duties at all levels. Software packages and applications will be acquired, developed and updated to keep M&E able to collect and manage increasing amounts or increasingly complex sets of data.

5.6 Other cross-cutting and systemic issues

5.6.1 Procurement

The MOHSW will increase effectiveness and efficiency of procurement by harmonizing and coordinating planning and procedures among the existing procurement units.

Objective and Strategies

5.6.1.1 Increase effectiveness and efficiency of procurement activities

Review and update standard operating procedures for procurement and update the MOHSW Procurement Manual.

Enhance collaboration between the divisions and units with procurement responsibilities by setting up a liaison team to develop cooperative plans and feed a common procurement database.

Establish a unified MOHSW Procurement Unit. In the medium term, all MOHSW procurement will be handled or supervised by a single unit, responsible for responding to the needs of each of the stakeholders. Ultimately, the MOHSW Procurement Unit will coordinate and control the preparation of requests and procurement procedures for goods, services and civil works for medical supplies, equipment and drugs; healthcare facilities and related projects; vehicles and other transportation items; office and information technology equipment and supplies; consultant services; and administrative and transportation services.

All elements of the procurement process shall be supervised by the Procurement Unit, including planning, processing, supply chain management, warehousing and distribution.

5.6.2 Quality assurance

Improving quality is a cross-cutting issue that will be part of all sub-sector and county plans when implementing activities from health and social welfare services delivered to clients, to management procedures for health systems.

Objectives and strategies

5.6.2.1 Institutionalize quality assurance (QA) systems

Create quality improvement teams (MOHSW and CHSWT levels). All facilities, public as well as private, will create QA teams. The MOHSW will develop a mechanism for reporting on quality of care. Rather than becoming an organic part of the institutional structure, QA teams will be created by selecting existing supervisors from various departments, facilitating the integration of QA into routine supervision activities. ???ToR will be drafted and implemented.

Create quality improvement committees at all hospitals. Their mission will be to prepare plans and monitor quality improvement activities in all hospital departments.

5.6.2.2 Improve patient safety

The MOHSW will design and pilot a **pharmacovigilance or severe adverse event (SAE) report system for all EPHS components.** Initially, the system will focus on conditions for which standard reporting and investigating procedures exist, such as maternal and newborn deaths, malaria treatment with Artemisinin-based combination therapy (ACT) etc., and later expand to include other conditions.

Implement infection prevention and control system. Designated individual(s) will be responsible for ensuring effective and efficient implementation of infection prevention activities at each facility, following the existing National Standard Operational Guidelines including Monitoring and Reporting. Equipment, supplies and facilities/infrastructure necessary for infection prevention and control will be made available at all health facilities

5.6.2.3 Enhance quality of practice

Review standards, guidelines and SOPs for program implementation and management of common conditions. Guidelines, currently available, will be revised to include services included in the EPHS and used as a basis for staff training and supervision.

Pilot and expand clinical audit systems. With the contribution of specialized cadres, clinical records and procedures will be initially assessed in three selected hospitals and expanded to cover all hospitals.

Improve referral practices. Referral and counter-referral guidelines will be reviewed and implemented and collaboration between facilities at all levels (Primary, Secondary and Tertiary) will be established for the shared management of the most common conditions requiring referral.

5.6.2.4 Improve management systems

Increase the use of HMIS. Evidence gathered through the different information system components will be used for decision-making, planning and monitoring.

Carry out EPHS accreditation surveys covering all facilities. The exercises will have annual periodicity and will include quality indicators. In the short term, the MOHSW will ensure its continuation in collaboration with the regulatory bodies; in the medium term (3–5 years), this activity will be assumed by regulatory professional bodies.

Collaborate with professional bodies. The MOHSW will establish collaboration with professional associations involved in defining and monitoring standards of practice.

5.6.3 Planning and budgeting

In accordance with the GoL planning cycle, a common annual planning cycle for the health sector will be developed and implemented, with tools and events and involving all financers and providers and both central and county levels. Guidelines will be designed to fullfil the planning cycle components, from situational analysis, priority setting, budgeting and plan drafting.

In line with the MoF stated plans, the MOHSW will implement a multi-year planning and budgeting approach, in the form of a Medium-Term Expenditure Framework.

5.6.4 Supervision

Supervision is a cross-cutting activity that has to be performed by every worker with managerial responsibility. Standard Operational Procedures have been produced, along with checklists. They will be rolled out and institutionalized.

Practice in supervision will be included in all management training activities. Following the guidelines, supportive supervision will be carried out by skilled teams to the level immediately below. Supervision reports will contribute to the monthly and quarterly reports and feed the planning and monitoring cycle.

5.6.5 Communication

The health sector will undergo important changes over the course of the 10-year Plan implementation, requiring appropriate communication with all relevant stakeholders.

A communication strategy will be developed and implemented with the following targets in mind:

- Partners within and outside the government will be informed of the policy and plan implementation developments, challenges ahead and decisions to be made.
- Health workers' understanding and engagement will be actively sought by disseminating and discussing the relevant documents and messages. Staff will be informed on a timely basis of changes to occur in health services organization.
- Beneficiaries and the population at large will be updated on the expected changes in the way they relate with the health services, as well as regarding their expected contribution. A different communication approach will be devoted to health promotion, with recommendations on lifestyle and health care–seeking behavior.

5.6.6 Research

A National Health Research Agenda will be developed, with the main issues relevant to the Liberia health sector to be investigated. Some of the topics have already been mentioned in different parts of this document, and they include health financing, health care–seeking behavior, and health systems organization, among others. Research will be part of the annual operational plan.

5.6.7 Emergency preparedness and response (EPR)

Natural disasters are uncommon in Liberia. The focus of EPR has been on identifying and controlling epidemic outbreaks. Active participation on the preparedness and response to man-made disasters, such as inflow of refugees, has been limited because of the substantial presence of international organizations.

EPR scope will expand to include the range of emergencies most likely to occur in Liberia. Contingency plans, including an inventory of resources at county level, will be prepared and updated. International guidelines and SOPs will be adapted to the Liberian situation. During emergencies, specifically when displacement

occurs across borders, there are many refugees who are health professionals with experience and skills. Where necessary and appropriate, adapted guidelines will define the use of such expertise during emergencies. County teams will be trained on EPR procedures.

5.7 Decentralization and governance

Following the National Decentralization Policy, the de-concentration of health and social welfare management responsibilities and the building of performing systems at county level will adapt to the county administrative structure in an incremental and pragmatic way. The MOHSW will progressively relinquish responsibilities to county administrations as they are equipped to assume them, while counties will incrementally assign responsibility to district health officers as district government is progressively established. Caution will be exerted in the process to ensure continuity of service delivery.

Objectives and strategies

5.7.1 To develop and implant a coherent de-concentration that shifts functions, authority and resources to the local level (counties, districts and communities).

This strategy will focus on creating the local capabilities of County managers to run efficiently and effectively a de-concentrated County Health System.

Finalize and make operational the establishment of a **MOHSW decentralization unit,** as part of the Planning, Decentralization, Research and Development Department.

Develop a comprehensive supportive de-concentration package for the central Ministry and the CHSWTs, with guidelines, SOP and training packages for the support services to be decentralized, after a functional analysis shows alternatives and options.

Provisionally, the main responsibilities to be assumed by each of the main levels are the following:

- The MOHSW will remain the main repository of functions related to policy making, regulation, financing (resource mobilization, pooling and allocation), monitoring, emergency preparedness and response on a national scale, setting national standards and guidelines for health workers management and development, procurement of drugs, setting the investment framework, etc.
- The CHSWT will be responsible for county planning, budgeting and implementation following national priorities, facility management, maintenance and supervision, management of personnel, collection and analysis of HMIS-generated data, coordination with local and international partners at this level, and collaboration with the County Health and Social Welfare Board, among others.

Produce maps of interventions and gaps by geographical location: institutional, operational, geographic, to regularly update and widely distribute them

Incrementally make uniform, harmonize and homogenize the planning, management and financial capacities of the fifteen CHSWTs by transferring technical and financial capabilities to them and by developing a comprehensive capacity building package founded on a mentoring, regular, supportive technical assistance and close monitoring.

5.7.2 Re-structure the Ministry of Health and Social Welfare

In compliance with the National Health Policy, in order to meet the realities detected by the decentralization policy, a reform process will be needed to make it more effective and efficient to respond to the operational challenges of decentralization.

Carry on the restructuring at central, county and district levels according to the evolving discussions with the Governance Commission, the Inter-ministerial Task Force and the Civil Service Agency (CSA).

Carry out a comprehensive functional analysis involving all levels of the system, identifying the functions that currently are assumed at each of the Administration levels (MOHSW, county, district), their relevance and how they should be split between MOHSW and counties. The result will be an organizational chart for each of these institutions, to be implemented as resources are made available.

Analyze specifically the split purchaser/provider scheme of health system.[4] Devolved health systems increase the risk of fragmentation, with potentially negative consequences on equity. The MOHSW will explore the possibility of setting up a National Health Service (care delivery system) offering continuity across counties and being monitored by the relevant CHSWT at that level.

The MOHSW will also examine the option of setting up a **semi-autonomous contracting facility,** with the functions of pooling funds (GoL, Social Health Insurance schemes, donors) and contracting a mix of public and private providers for the delivery of the EPHS in each county.

5.7.3 Establish the appropriate and relevant organizational framework to support the decentralization process, providing good coordination and avoiding duplication of functions and promoting integrated service delivery at all levels

The MOHSW department of Planning, Research and Development will be in charge of planning and monitoring the implementation of the Health and Social Welfare Decentralization Policy and the NHSWPP in a de-concentrated setting up to full administrative devolution.

5.7.4 Strengthen local government structures

The management structure of the County Health and Social Welfare Team will be subject to changes, revisions and modifications during the process from de-concentration to devolution. In the meantime, the MOHSW will intervene in **strengthening the operational capacities of County health bodies** such as the CHSW Board, the CHSWT and the Community Health Development Committee, plus General Community Health Volunteers.

The setting up and shaping of a **district health management body** will also be considered, taking into consideration that, because of size, population and network of health facilities, not all administrative districts will be in need of a specific health management institution. These functions may be linked to existing health facilities.

4. In this system, the purchaser is the institution that commissions service delivery on its behalf, directly or through an agency. The provider is the institution that actually delivers the services. In the health sector, providers are the facilities, staff and other resources that offer health care to the population. In the present situation, the MOHSW is both purchaser and provider. In a devolved system, and unless there is some split of functions, the CHSWT may also become responsible for purchasing and providing services.

6. Sector Coordination and Partnerships

Increasing effectiveness and efficiency of collaboration among partners will be obtained by enhancing coordination mechanisms, streamlining planning and reporting procedures, and improving the perception of trust and collaboration.

6.1 Improving efficiency and effectiveness through donor coordination

Donor support will be necessary for the whole plan implementation period, and probably beyond it. Coordination mechanisms will focus on systematizing collaboration in common planning exercises where the resource envelope is identified, priorities agreed upon, and resource allocation (by level, by county) decided.

The Health Sector Coordination Committee (HSCC) will continue to serve as the main coordination body. Membership will be expanded to include other stakeholders. Its terms of reference (ToR) will be revised and updated. Its functions will include approval of annual plan and resource mobilization and allocation.

A joint **Program Management Unit (PMU)** will merge existing single-project units to increase aid effectiveness by unifying grant management.

The **Medium-Term Expenditure Framework** will be implemented as the main planning tool, and its cycle will facilitate the timely projection of donor contributions.

A common **Annual Operational Plan** will be produced, including all sources of funds and all interventions, for its integration into the GoL Annual Plan.

The HMIS will be modified to accommodate financial information relevant to producing the necessary indicators of availability, equity and efficiency. Data collecting and analyzing tools will consider the complexity of using funding from different sources.

6.2 Revising the roles played by each type of implementing partner, transferring most responsibility to the public sector and local, permanent partners

The MOHSW and CHSWT will increasingly assume managerial responsibilities over public facilities and their primary catchment areas. This management responsibility will include collaboration with not-for-profit (NFP) and private-for-profit (PFP) facilities to play similar roles as public facilities with a designated primary catchment area.[5] That collaboration will be formalized as contracts to NFP and PFP facilities to provide public services for catchment areas where GOL-owned facilities are not present.

The role of international NGOs will transition to providing specialized support in areas where they have proven experience, for example for the institutional development of local management institutions. Performance-based, NGO-implemented contracts may also be used to provide technical assistance to facilities in complete county or sub-county health systems

The MOHSW will assist CHSWT in designing and implementing tools to replicate coordination mechanisms at the county and sub-county level and will support the production of integrated annual plans and budgets.

5. It is noteworthy that currently more than 60 NFP and PFP facilities already function formally or informally in this capacity, i.e., coordinating and reporting on health care services for a designated primary catchment area.

6.3 Providing community-based health volunteers and institutions with a coordination framework to structure their relationship with the formal sector

The MOHSW will draft the guidelines to help CHSWTs organize and manage the collaboration between facilities and communities with community health development committees. This may, depending on the distance of communities from the relevant facility, include a combination of outreach from the health facility into the communities and the work of community-based volunteers and Trained Traditional Midwives.

7. Broad Plan Cost Estimate

Table 4, below, presents the result of the cost projection exercise. It is a conservative cost estimate based on a number of assumptions and calculated only for the public network, composed of government and selected NFP facilities. Actual figures, to be reviewed later in the process, are likely to be higher.

Expenditure per head (at 2011 prices) will increase from US$ 18 to US$ 29 over the period. However, if a conservative 5 percent annual inflation rate is applied (the result being the actual money necessary every year), expenditure per capita grows to reach US$ 44 in 2021.

Table 4. Projected Costs by Selected Components, FY 2012–2021

Component	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
Service Provision										
Personnel	10,289,453	12,717,779	15,146,104	17,574,430	20,002,755	22,431,080	24,859,406	27,287,731	29,716,057	32,144,382
Drugs	25,060,041	28,210,140	31,481,492	34,877,800	38,402,869	42,060,610	45,855,041	49,790,288	53,870,595	55,001,877
Infrastructure	8,874,225	8,874,225	8,874,225	8,874,225	8,874,225	8,874,225	8,874,225	8,874,225	8,874,225	8,874,225
10% Other Expend.	4,422,372	4,980,214	5,550,182	6,132,645	6,727,985	7,336,592	7,958,867	8,595,224	9,246,088	9,602,048
Sub-Total	48,646,092	54,782,359	61,052,003	67,459,100	74,007,834	80,702,507	87,547,539	94,547,469	101,706,964	105,622,533
Management (MOHSW & CHSWT)										
Personnel	1,543,418	1,907,667	2,271,916	2,636,164	3,000,413	3,364,662	3,728,911	4,093,160	4,457,408	4,821,657
NDS	8,275,820	6,914,053	2,402,961	3,086,797	2,886,741	2,886,741	2,886,741	2,886,741	2,886,741	2,886,741
HRH-Other	1,913,385	1,913,385	1,913,385	1,913,385	1,913,385	1,913,385	1,913,385	1,913,385	1,913,385	1,913,385
Other Expenditure	6,227,046	6,849,751	7,534,726	8,288,198	9,117,018	10,028,720	11,031,592	12,134,751	13,348,226	14,683,049
Sub-Total	17,959,669	17,584,855	14,122,987	15,924,545	16,917,557	18,193,507	19,560,628	21,028,036	22,605,760	24,304,832
Total	**66,605,761**	**72,367,214**	**75,174,991**	**83,383,644**	**90,925,391**	**98,896,015**	**107,108,167**	**115,575,505**	**124,312,724**	**129,927,364**
Per Head	18	19	19	21	22	24	25	26	28	29
Adjusted for 5% annual inflation	66,605,761	75,985,575	82,880,427	96,526,991	110,520,381	126,219,160	143,535,187	162,626,343	183,666,511	201,559,986
Per Head	18	20	21	24	27	30	34	37	41	44

8. Plan Implementation, Monitoring and Revision

The 10-Year National Health Plan will be implemented through Annual Operational Plans that include all relevant activities and all sources of funding. Operational plans will establish a clear link with the 10-Year Plan in their objectives and activities.

The features and implementation pace of the National Decentralization Policy will be crucial for the Health Plan implementation because of the different time CHSWT will need to adapt and assume their increasing responsibilities.

In line with the EPHS implementation plan, execution of the 10-Year Plan will be phased.

Years 2012–2014. While the existing services are reinforced with the objectives of increasing utilization and quality, MOHSW departments and sub-sectors will undergo assessments, evaluations and research. These include, but are not limited to, the MOHSW Functional Analysis, 10-Year Training Plan, development of a MTEF, revision of the PBC, assessment of user fees re-introduction, epidemiology surveys, etc. The aim is to prepare the system for the next phase, where expanded services will bring additional challenges to the management system.

After the third year of implementation, and coinciding with the revision of the EPHS contents, the MOHSW will carry out a medium-term evaluation. This exercise will focus on the eventual integration of the policy recommendations emanating from the assessments performed during the first phase.

After the fifth year of implementation, a standard medium-term evaluation will be completed and the plan targets and strategies for the final period reviewed.

The MOHSW has produced provisionally a monitoring framework (Annex 1) with selected indicators and estimated baselines and targets that reflect the plan's main goals. Thus, the framework includes impact indicators such as those on health-related Millennium Development Goals (MDGs). Other indicators reflect the wider health system's goals of access, equity and responsiveness and financial protection. The remaining indicators, most of which can be calculated at county level, reflect the system's performance, in service provision, in the functioning of the systemic components, and on the result of sector coordination. This set of indicators will be complemented with some additional ones on the social welfare component and will be endorsed by sector stakeholders.

Most performance indicators can be calculated with information already collected through the HMIS. They will also be used by CHSWT to monitor plan implementation at their level. Using HMIS as the source of verification has the risk that under-reporting is currently commonplace. However, it has the advantage that county and central levels will share the same monitoring framework. Some initial effort will be necessary to calculate a reliable baseline for most of the selected indicators and adjust the targets where necessary.

Annex 1. Proposed Monitoring Framework

Goal/Objective		Indicator	Baseline	Year	Source	Target 2021
Indicators monitoring overall Liberia's goal of improved health status (these indicators are not exclusive of the health sector and should be measured every 5 years)						
Healthier population		Maternal mortality rate (per 100,000 live births)	994	2007	LDHS	497
		Child mortality rate (per 1,000 live births)	114	2009	LMIS	57
		Life expectancy at birth (years)	59	2010	UNDP	TBD
Indicators monitoring Health System's goals (to be monitored every 1–3 years, are specific for the health system)						
Increased access and utilization of health services		% population living within 5 km from the nearest health facility	69%	2010	RBHS	85%
Responsiveness to users' expectations through decentralization, ensuring a fair degree of equity		Equity index: ratio contacts (head count)/ head in the 25% of population (counties) with highest consumption over 25% population with lowest consumption	2.39	2010	HMIS	1.5
Financial protection		Public expenditure in health & social welfare as % of total public expenditure	7.8%	2010	MOF/ OFM	>10%
Indicators monitoring Health System Performance (these indicators, to be monitored annually, focus on the system's components and their performance. Most should be used also at County level)						
Service Provision	Maternal health	# and % of deliveries that are facility-based with a skilled birth attendant	22%	2010	HMIS	80%
	Family planning	Couple-years protection with family planning methods	45,798	2010	HMIS	TBD
	Child health/ EPI	# and % of children under 1 year who received DPT3/pentavalent-3 vaccination	74%	2010	HMIS	90%
	Service consumption	OPD consultations per inhabitant per year	0.9	2010	HMIS	2
	Malaria	# and % of pregnant women provided with 2nd dose of IPT for malaria	29%	2010	HMIS	80%
	HIV/AIDS	Number of pregnant women testing HIV+ and receiving a complete course of ARV prophylaxis to reduce the risk of MTCT	1,613	2011	HMIS	TBD
	Tuberculosis	Number of smear positive TB cases notified per 100,000 population	103	2010	NTLCP	127

Table continues →

Goal/Objective		Indicator	Baseline	Year	Source	Target 2021
Systemic components	Human resources	Number of skilled birth attendants (physicians, nurses, midwives & physician assistants)/10,000 population	5.7	2010	HMIS	14
	Drugs	# and % of facilities with no stock-out of tracer drugs during the period (amoxicillin, cotrimoxazole, paracetamol, ORS, iron folate, ACT, FP commodity)	TBD		HMIS	95%
	HMIS	# and % of timely, accurate and complete HIS reports submitted to the MOH&SW during the year	76%	2010	HMIS	90%
	Financing	% of execution of annual allocation of GoL budget for health	64%	2010	MOF/ OFM	95%
	Quality	# and % of facilities reaching two star level in accreditation survey including clinical standards (public network facilities)	9.3%	2011	Accreditation report	90%
Sector coordination		Percentage of bilateral aid that is untied (increasing predictability and decision-making space)	TBD			>50%

As mentioned before, this framework is provisional, both in the selected indicators and the baselines and targets. Discrepancies exist at present between figures obtained from the HMIS and national surveys, the latter frequently capturing the impact of private facilities. Similarly, different results for some indicators appear in the HMIS and the relevant programs, although the source of data is in principle the same.

A working group with members from different MOHSW departments and partner organizations will produce for endorsement by the HSCC a definitive set of indicators, their definitions and the agreed upon baselines and targets.

Annex 2. Selected References

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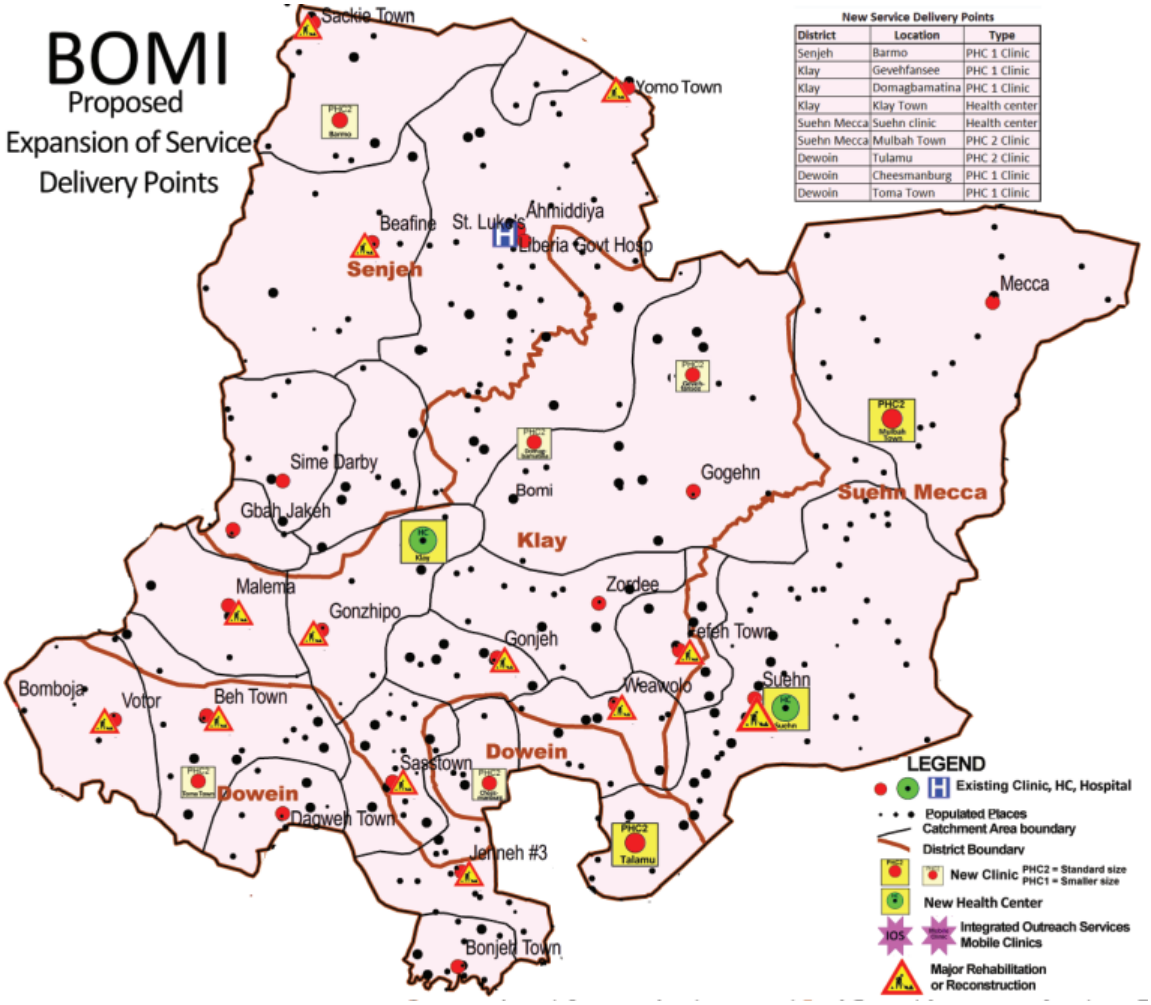
Photo courtesy USAID

County Plan Executive Summaries

Bomi County, with a population of 89,147, has 23 health facilities, i.e., one hospital and 22 clinics. Health care access is good with 69% of the population living within 5 km (or one hour walk) of a health facility. However, only 25% of deliveries occur in facilities with skilled assistance. OPV3/Penta3 vaccination coverage for children under one year is very good at more than 95%. The Bomi ten year health plan will increase access to the EPHS with the addition of 9 Service Delivery Points, including health centers, clinics, outreach and community-based strategies (see map). The plan will also reinforce systemic components to support services. Specific objectives, baselines (2010) and targets (2021) include the following[1]:

- Increase the population living within 5 km of a health facility from 69% to 90%;
- Maintain children under 1 year who received OPV3/Penta3 at 95% or more;
- Increase facility-based deliveries with a skilled birth attendant from 25% to 80%;
- Increase pregnant women provided with 2nd dose of IPT for malaria from 34% to 80%;
- Increase public facilities with a two star accreditation from 0% to 90%;
- Maintain timely, accurate and complete HIS reporting at more than 90%; and
- Increase facilities with no stock-out of tracer drugs to 95%.

1. Baselines and targets will be refined and adjusted as more reliable data become available.



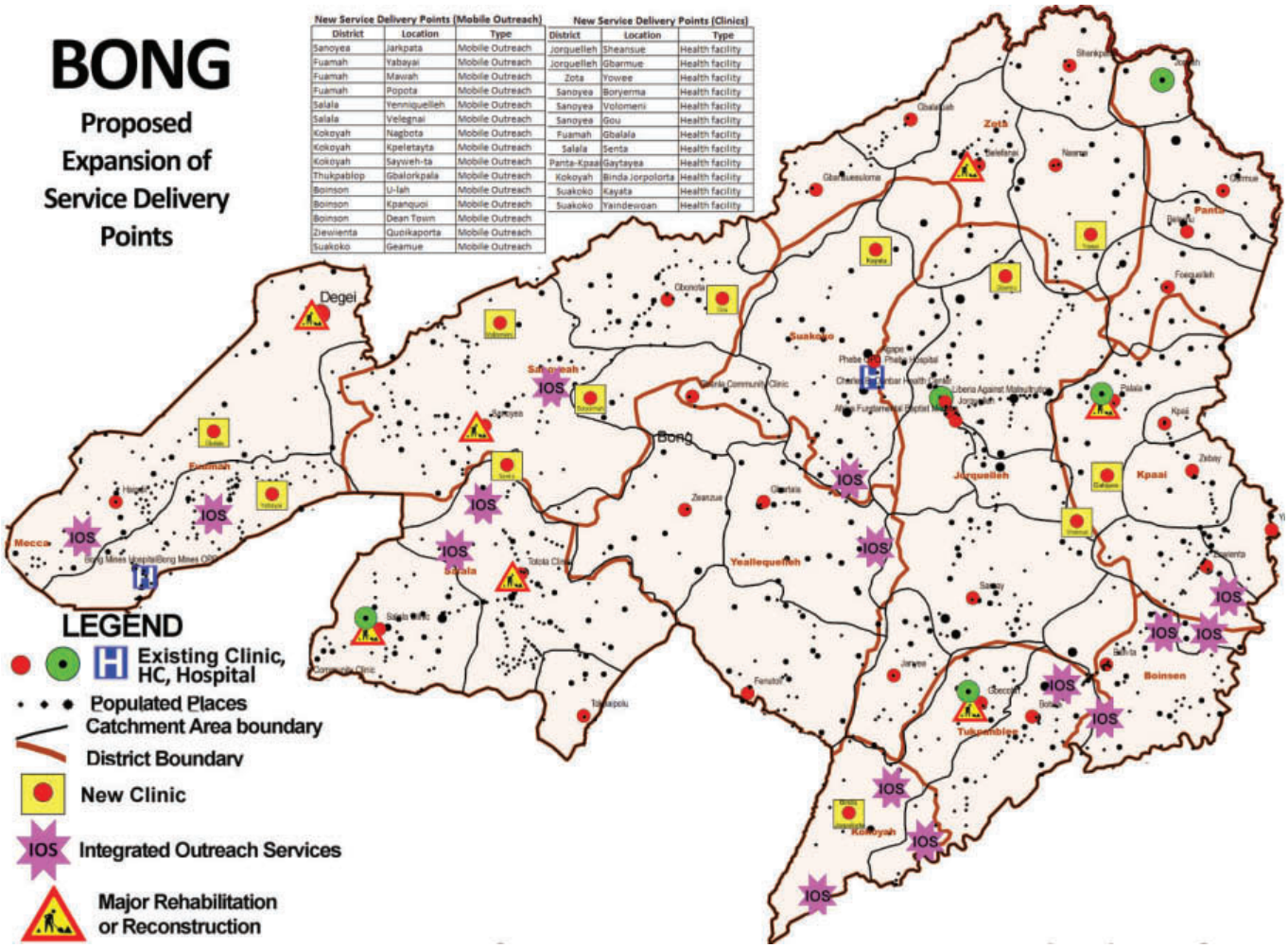
Bong County Health Plan (2011–2021) Executive Summary

Bong is one of Liberia's most populous counties with more almost 350,000 inhabitants. Its health infrastructure of 38 health facilities includes 3 hospitals; and 35 clinics. However, only 48% of the population lives within 5km (one hour walk) of a health facility. 23% of deliveries occur in health facilities with skilled assistance. While OPV3/Penta3 vaccination coverage for children under one year averages more than 90%, some districts have coverage of less than 60%.

The Bong County Ten (10) Year Health Plan will improve access to the EPHS with the addition of 27 Service Delivery Points, including a combination of clinics, upgrading some clinics to health centers, building new health centers, outreach and community-based strategies (see map). The Plan will also reinforce systemic and community components to support services. Specific objectives, baselines (2010) and targets (2021) will strive to[1]:

- Increase the population living within 5 km of a health facility from 48% to 85%;
- Maintain children under 1 year who receiveOBV3/Penta3 at 95% or more;
- Increase facility-based deliveries with a skilled birth attendant from 23% to 80%;
- Increase pregnant women provided with 2nd dose of IPT for malaria from 37% to 80%;
- Increase public facilities with a two star accreditation from 3% to 90%;
- Maintain timely, accurate and complete HIS reporting at more than 90%; and
- Increase facilities with no stock-out of tracer drugs to 95%.

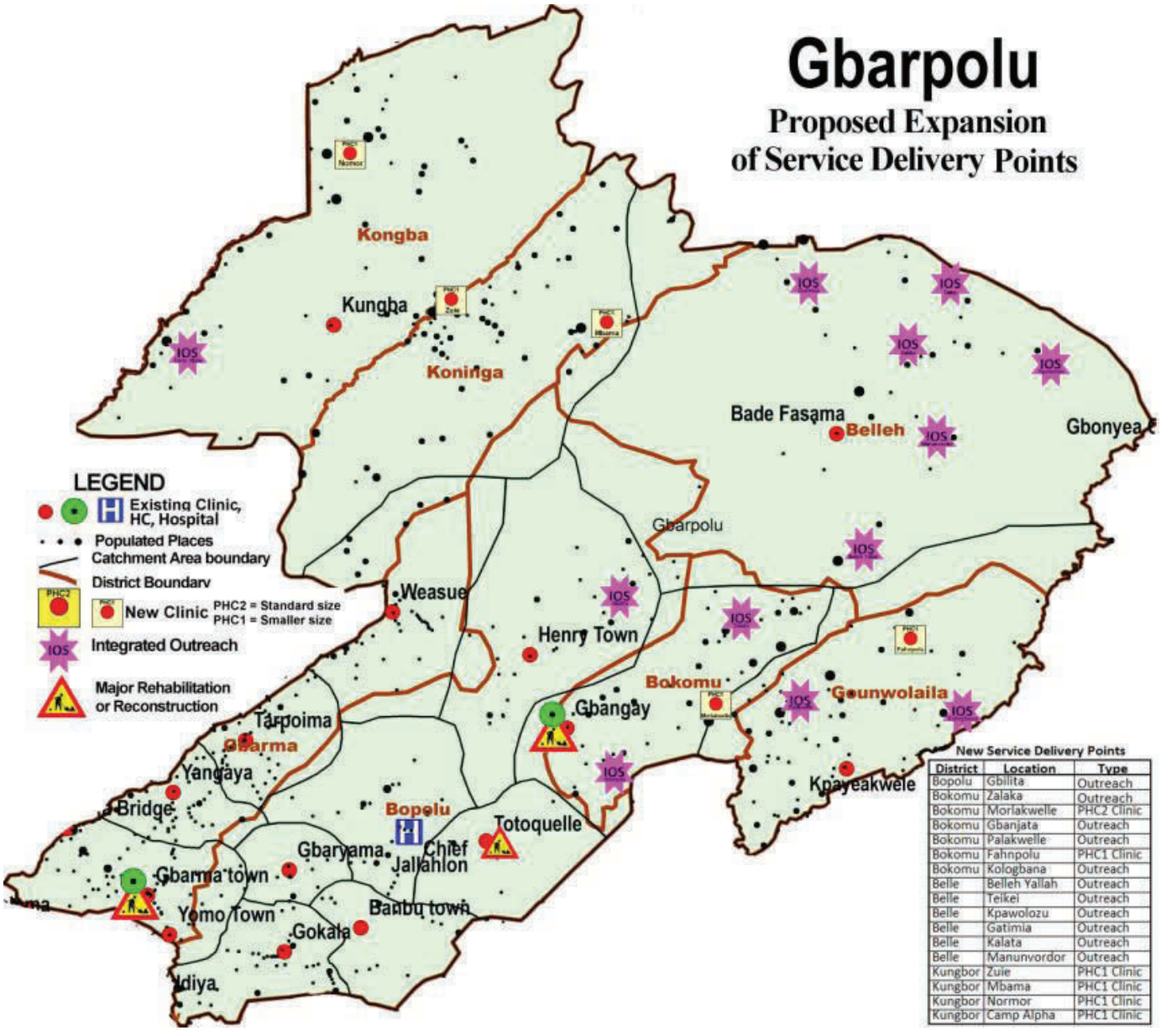
1. Baselines and targets will be refined and adjusted as more reliable data become available.



Gbarpolu has a population of approximately 85,000 with one hospital, one health center, and 12 clinics. 32% of the population lives within 5km (or a one hour walk) of a health facility, the lowest rate in Liberia. Only 19% of deliveries occur in facilities with skilled assistance. OPV3/Penta3 vaccination coverage for children under one year is 67%. The Gbarpolu ten-year health plan will improve access to the EPHS with the addition of 18 Service Delivery Points. Those SDPs will include standard size clinics, smaller clinics and outreach sites (see map). The plan will also reinforce systemic components to support services. Key objectives, baselines (2010), and targets (2021) include the following:[1]

- Increase the population living within 5 km of a health facility from 32% to 85%;
- Increase children under 1 year who received OPV3/Penta3 from 70% to 95%;
- Increase facility-based deliveries with a skilled birth attendant from 19% to 73%;
- Increase pregnant women provided with 2nd dose of IPT for malaria from 20% to 80%;
- Increase public facilities with a two star accreditation from 0% to 90%;
- Maintain timely, accurate and complete HIS reporting at more than 90%; and
- Increase facilities with no stock-out of tracer drugs to 95%.

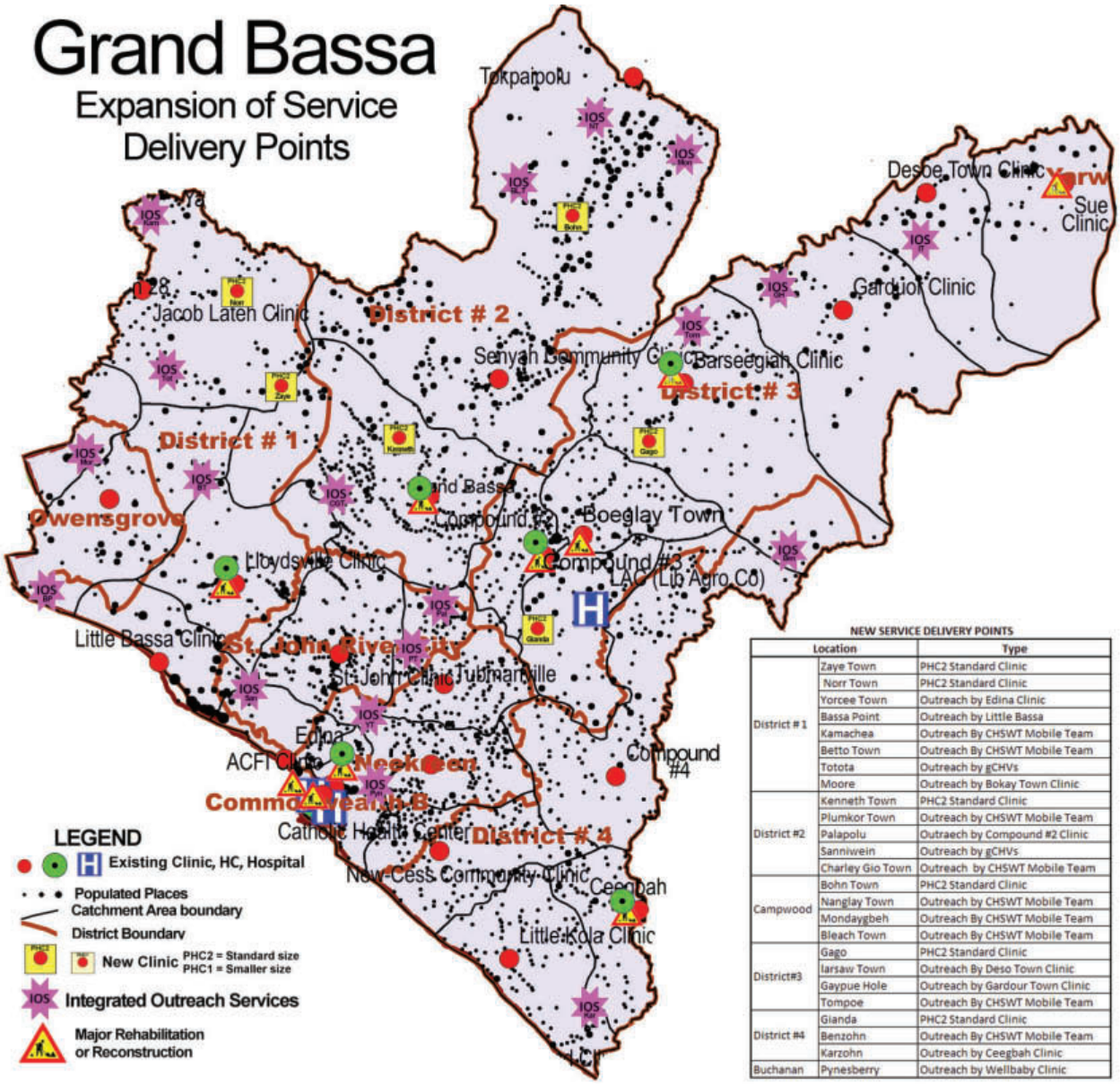
1. Baselines and targets will be refined and adjusted as more reliable data become available.



Grand Bassa has a population of 231,000 with 26 clinics, 1 health center and 3 hospitals. While 51% of the population live within 5km (one hour walk) of a health facility, only 16% of deliveries are facility-based with skilled assistance. OPV3/Penta3 vaccination coverage for children under one year is 64%. The Grand Bassa ten year health plan will improve access to the EPHS by adding 25 facility-based and non-facility based Service Delivery Points. The plan will also reinforce systemic components to support services. Specific objectives, baselines (2010) and targets (2021) include the following[1]:

- Increase the population living within 5 km of a health facility from 51% to 85%;
- Increase children under 1 year who received OPV3/Penta3 from 64% to 90%;
- Increase facility-based deliveries with a skilled birth attendant from 16% to 80%;
- Increase pregnant women provided with 2nd dose of IPT for malaria from 34% to 80%;
- Increase public facilities with a two star accreditation from 28% to 90%;
- Increase timely, accurate and complete HIS reporting from 79% to 90%; and
- Increase facilities with no stock-out of tracer drugs to 95%.

1. Baselines and targets will be refined and adjusted as more reliable data become available.



NEW SERVICE DELIVERY POINTS

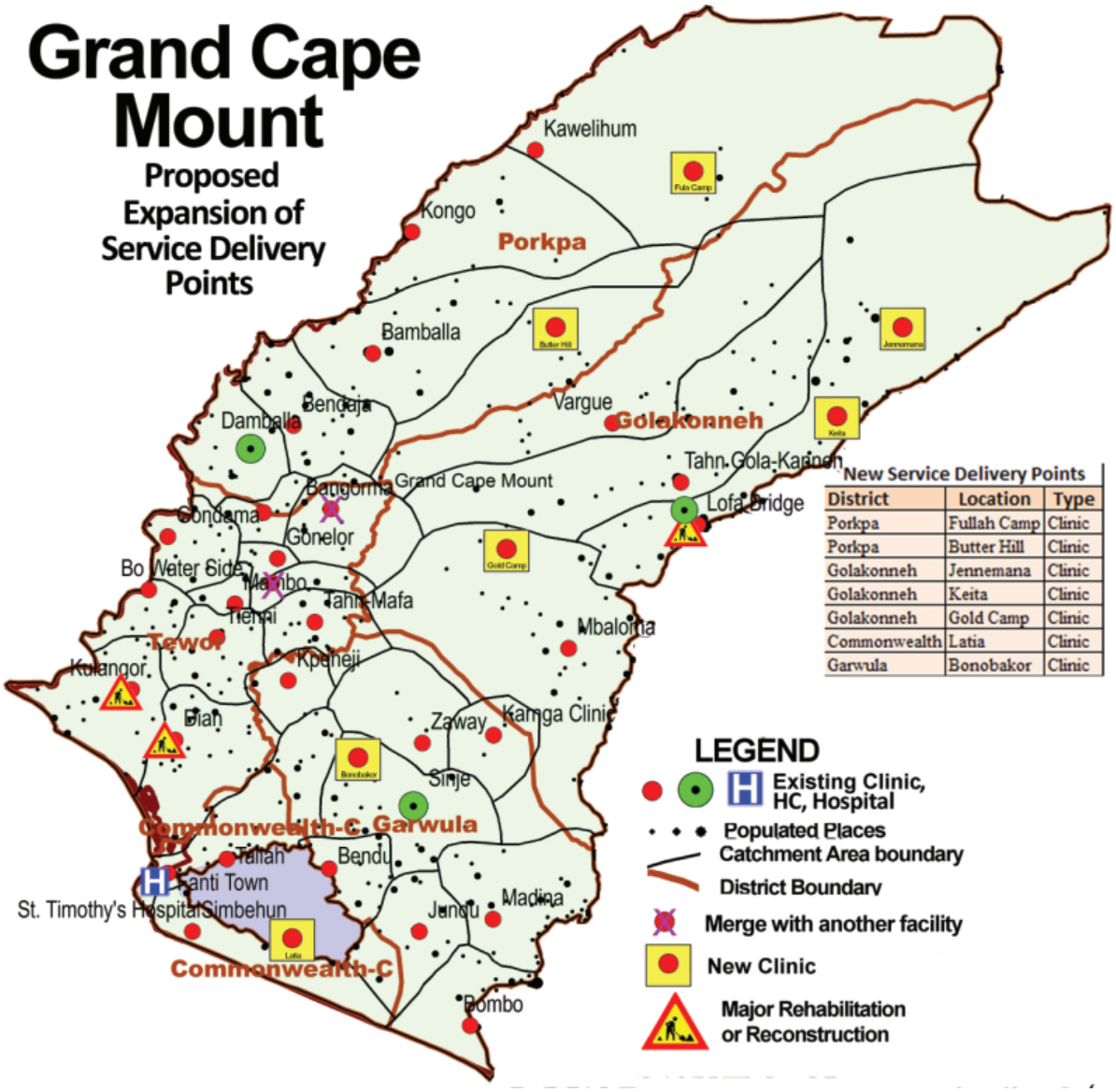
Location		Type
District # 1	Zaye Town	PHC2 Standard Clinic
	Norr Town	PHC2 Standard Clinic
	Yorcee Town	Outreach by Edina Clinic
	Bassa Point	Outreach by Little Bassa
	Kamachea	Outreach By CHSWT Mobile Team
	Betto Town	Outreach By CHSWT Mobile Team
	Totota	Outreach by gCHVs
	Moore	Outreach by Bokay Town Clinic
District #2	Kenneth Town	PHC2 Standard Clinic
	Plumkor Town	Outreach by CHSWT Mobile Team
	Palapolu	Outraech by Compound #2 Clinic
	Sanniwein	Outreach by gCHVs
	Charley Gio Town	Outreach by CHSWT Mobile Team
Campwood	Bohn Town	PHC2 Standard Clinic
	Nanglay Town	Outreach by CHSWT Mobile Team
	Mondaygbeh	Outreach By CHSWT Mobile Team
	Bleach Town	Outreach By CHSWT Mobile Team
District#3	Gago	PHC2 Standard Clinic
	Iarsaw Town	Outreach By Deso Town Clinic
	Gaypue Hole	Outreach by Gardour Town Clinic
	Tompoe	Outreach By CHSWT Mobile Team
District #4	Gianda	PHC2 Standard Clinic
	Benzohn	Outreach By CHSWT Mobile Team
	Karzohn	Outreach by Ceegbah Clinic
Buchanan	Pynesberry	Outreach by Wellbaby Clinic

Grand Cape Mount County Health Plan (2011–2021) Executive Summary

Grand Cape Mount has a population of 133,000 inhabitants. Its 32 health facilities include one hospital, two health centers and 29 clinics. 66% of the population lives within 5km (one hour walk) of a health facility, yet only 21% of deliveries occur with skilled assistance in health facilities. OPV3/Penta3 vaccination coverage for children under one year is very good at 84%. The county ten year health plan will improve access to the EPHS by adding seven Service Delivery Points (see map). The plan will also reinforce systemic components to support services. Specific objectives, baselines (2010) and targets (2021) will include the following[1]:

- Increase the population living within 5 km of a health facility from 66% to 90%;
- Increase facility-based deliveries with a skilled birth attendant from 21% to 80%;
- Increase pregnant women provided with 2nd dose of IPT for malaria from 41% to 80%;
- Increase children under 1 year who received OPV3/Penta3 from 84% to 95%;
- Increase public facilities with a two star accreditation from 0% to 90%;
- Increase timely, accurate and complete HIS reporting from 78% to 90%; and
- Increase facilities with no stock-out of tracer drugs to 95%.

1. Baselines and targets will be refined and adjusted as more reliable data become available.



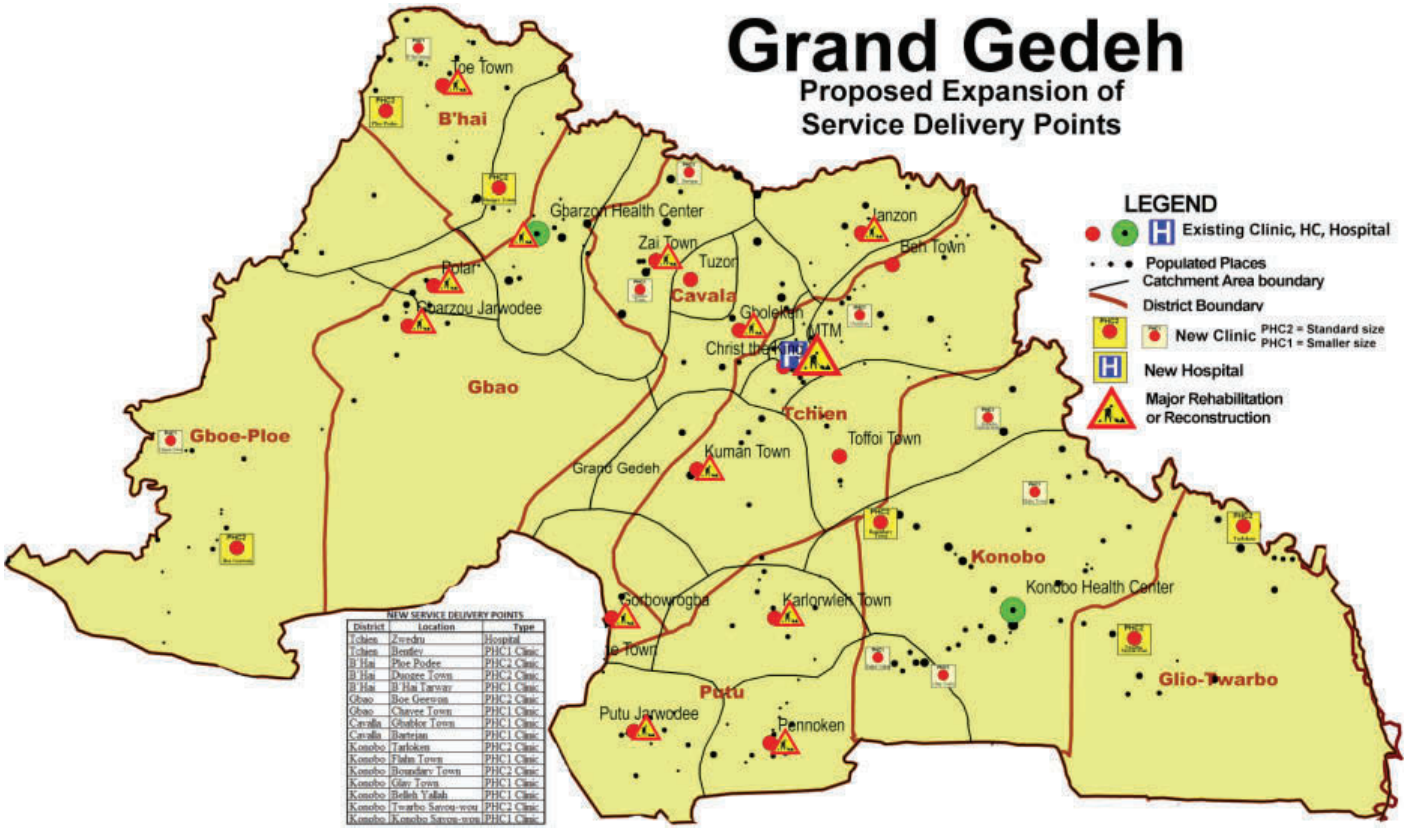
Grand Gedeh County Health Plan (2011–2021) Executive Summary

Grand Gedeh's, with a population of 130,000, has 18 health facilities, i.e., one hospital, two health centers and 15 clinics. 55% of its population lives within 5km (one hour walk) of a health facility, but only 31% of deliveries actually occur in a facility with skilled assistance. Due to the scattered nature of communities, OPV3/Penta3 coverage for children under one year is 51%, the lowest rate in the country.

The Grand Gedeh ten year health plan will increase access to the EPHS through the strategic addition of 16 Service Delivery Points including a combination of clinics, outreach and community-based strategies (see map). The plan will also reinforce systemic components to support services. Key objectives, baselines (2010) and targets (2021) include the following:[1]

- Increase the population living within 5 km of a health facility from 55% to 85%;
- Increase children under 1 year who received OPV3/Penta3 from 51% to 90%;
- Increase facility-based deliveries with a skilled birth attendant from 31% to 80%;
- Increase pregnant women provided with 2nd dose of IPT for malaria from 22% to 80%;
- Increase public facilities with a two star accreditation from 39% to 90%;
- Maintain timely, accurate and complete HIS reporting at more than 90%; and
- Increase facilities with no stock-out of tracer drugs to 95%.

1. Baselines and targets will be refined and adjusted as more reliable data become available.

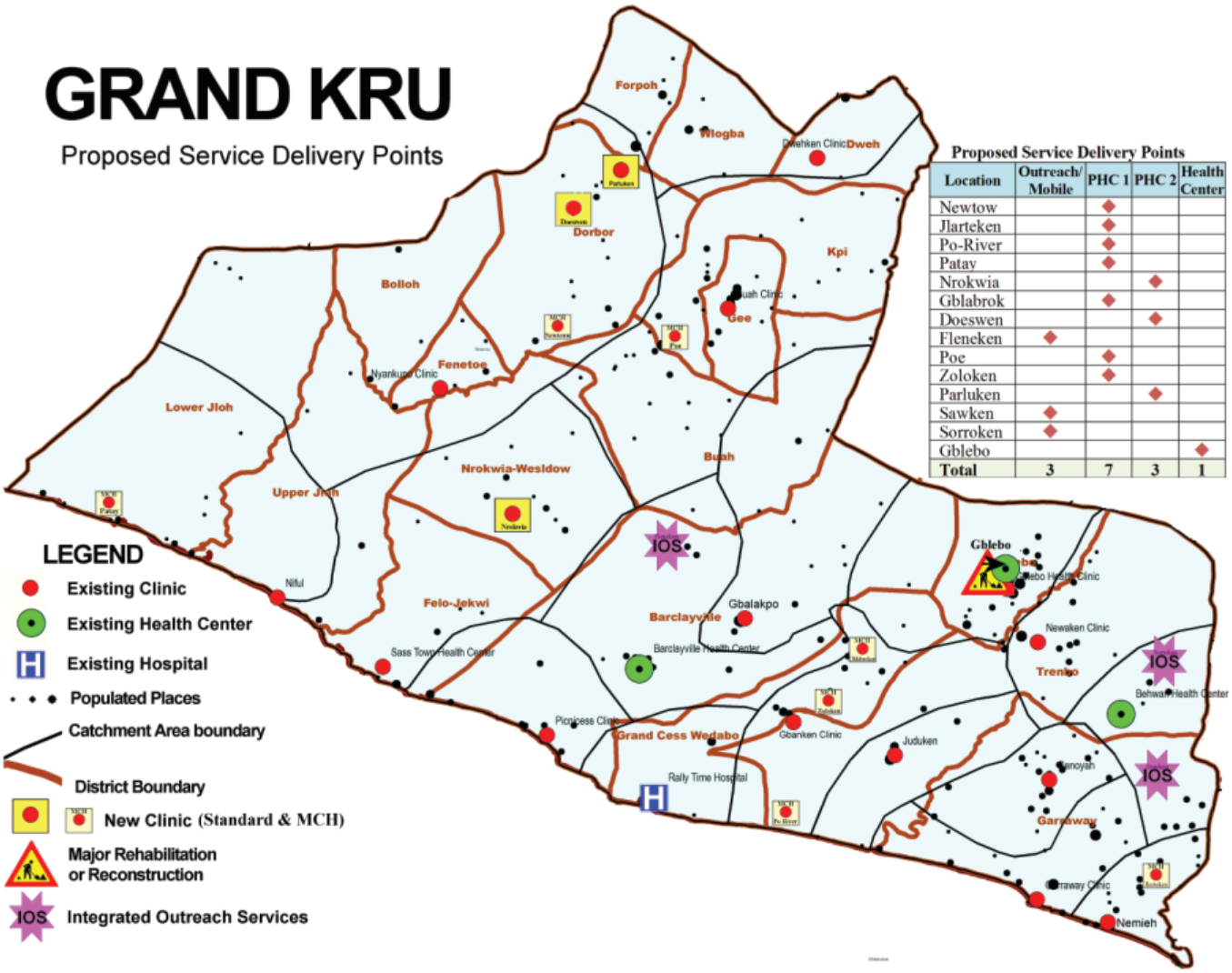


Grand Kru County Health Plan (2011–2021) Executive Summary

Grand Kru is one of Liberia's most neglected counties in terms of infrastructure and basic services. Its 17 health facilities include one hospital; four health centers and 12 clinics. However, only 59% of the population of 60,000 lives within 5km (one hour walk) of a health facility. Currently less than 20% of deliveries occur in facilities and OPV3/Penta3 vaccination coverage for children under one year is 64.5%. The Grand Kru ten year health plan will increase access to the EPHS by adding 14 new Service Delivery Points including a combination of clinics, outreach and community-based strategies (see map). Specific objectives, baselines (2010) and targets (2021) include the following[1]:

- Increase the population living within 5 km of a health facility from 59% to 90%;
- Increase children under 1 year who received OPV3/Penta3 from 64.5% to 90%;
- Increase facility-based deliveries with a skilled birth attendant from 15% to 70%;
- Increase pregnant women provided with 2nd dose of IPT for malaria from 30% to 80%;
- Increase public facilities with a two star accreditation from 0% to 90%;
- Increase timely, accurate and complete HIS reporting from 88% to 90%; and
- Increase facilities with no stock-out of tracer drugs to 95%.

1. Baselines and targets will be refined and adjusted as more reliable data become available.



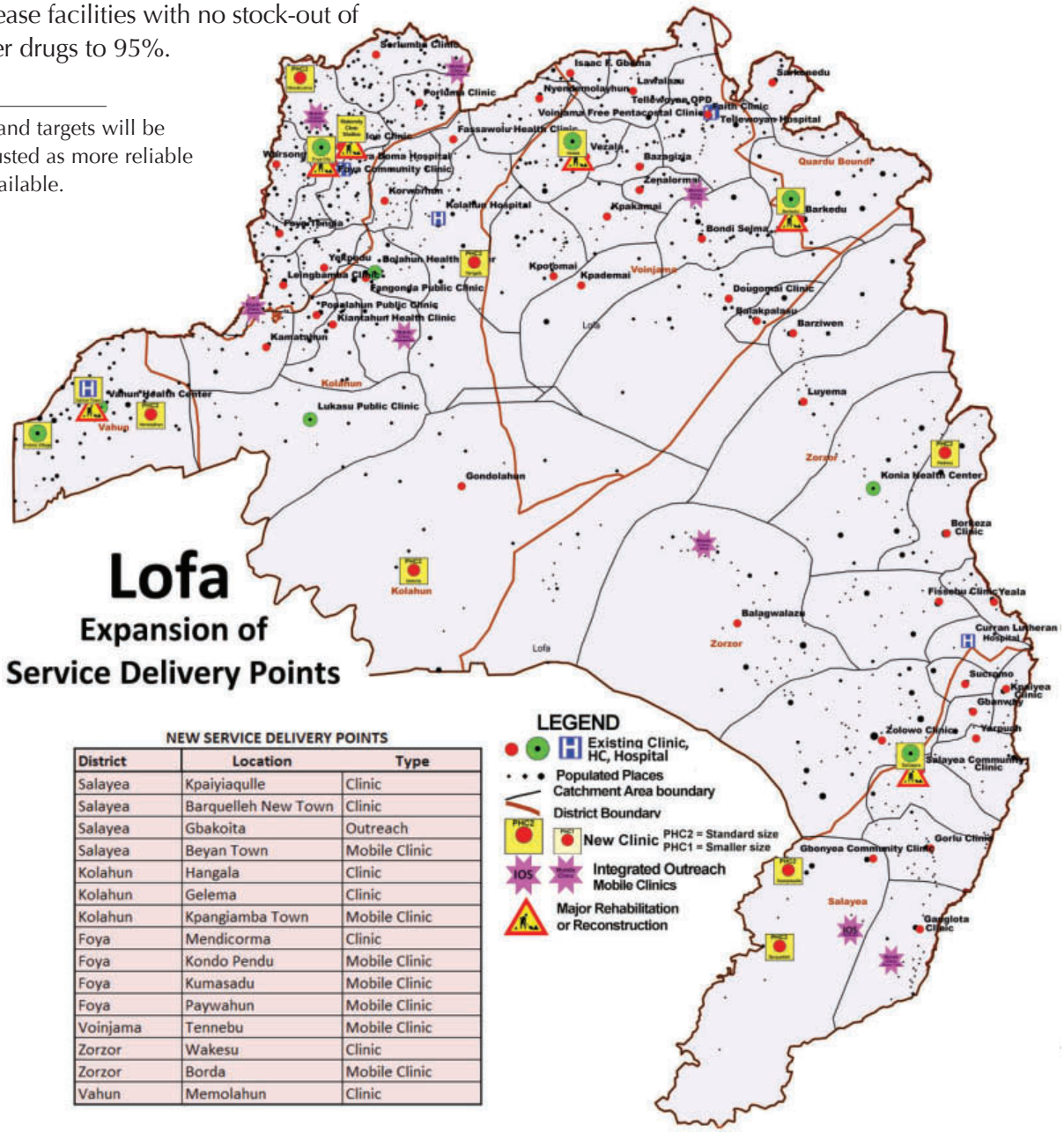
Proposed Service Delivery Points

Location	Outreach/ Mobile	PHC 1	PHC 2	Health Center
Newtow		◆		
Jlarteken		◆		
Po-River		◆		
Patay		◆		
Nrokwia			◆	
Gblabrok		◆		
Doeswen			◆	
Fleneken	◆			
Poe		◆		
Zoloken		◆		
Parluken			◆	
Sawken	◆			
Sorroken	◆			
Gblebo				◆
Total	**3**	**7**	**3**	**1**

Lofa has a population of the 288,000 with six districts and 22 clans. Its health infrastructure includes 55 facilities -- 4 hospitals; 3 health centers and 48 clinics. 70% of the population lives within 5km (one hour walk) of a health facility. Vaccination coverage (OPV3/Penta3) for children under one year is very good at 90%. The Lofa ten year health plan will improve access to the EPHS by adding 15 Service Delivery Points, including clinics, outreach and community-based strategies (see map). This will also include upgrading a number of existing facilities. The plan will also reinforce systemic components to support services. Specific objectives, baselines (2010) and targets (2021) include the following[1]:

- Increase the population living within 5 km of a health facility from 70% to 90%;
- Increase children under 1 year who received OPV3/Penta3 from 90% to 95%;
- Increase facility-based deliveries with a skilled birth attendant from 37% to 85%;
- Increase pregnant women provided with 2nd dose of IPT for malaria from 42% to 80%;
- Increase public facilities with a two star accreditation from 0% to 90%;
- Increase timely, accurate and complete HIS reporting from 84% to 90%; and
- Increase facilities with no stock-out of tracer drugs to 95%.

1. Baselines and targets will be refined and adjusted as more reliable data become available.



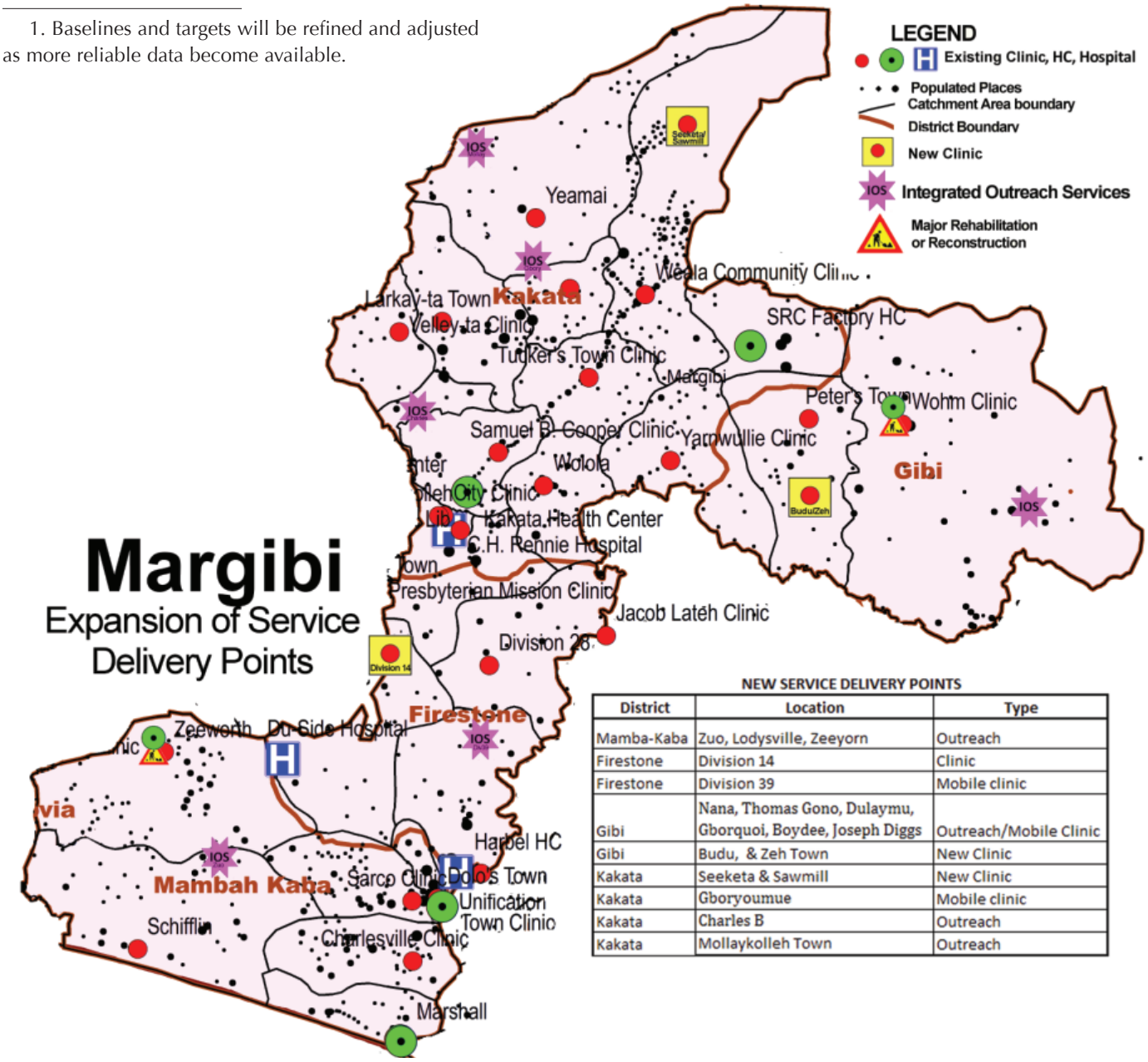
NEW SERVICE DELIVERY POINTS

District	Location	Type
Salayea	Kpaiyiaqulle	Clinic
Salayea	Barquelleh New Town	Clinic
Salayea	Gbakoita	Outreach
Salayea	Beyan Town	Mobile Clinic
Kolahun	Hangala	Clinic
Kolahun	Gelema	Clinic
Kolahun	Kpangiamba Town	Mobile Clinic
Foya	Mendicorma	Clinic
Foya	Kondo Pendu	Mobile Clinic
Foya	Kumasadu	Mobile Clinic
Foya	Paywahun	Mobile Clinic
Voinjama	Tennebu	Mobile Clinic
Zorzor	Wakesu	Clinic
Zorzor	Borda	Mobile Clinic
Vahun	Memolahun	Clinic

Margibi has a population of 219,000 inhabitants with 21 clinics, 10 health centers and 2 hospitals. 74% of the population lives within 5km (one hour walk) of a health facility, yet only 31% of deliveries are facility-based with skilled assistance. OPV3/Penta3 vaccination coverage for children under one year is excellent at more than 95%. Margibi's ten year health plan will improve access to the EPHS by adding 9 facility-based and non-facility based Service Delivery Points. The plan will also reinforce systemic components to support services. Specific objectives, baselines (2010) and targets (2021) include the following[1]:

- Increase the population living within 5 km of a health facility from 74% to 90%;
- Maintain OPV3/Penta3 coverage for children under 1 year at 95% or more;
- Increase facility-based deliveries with a skilled birth attendant from 31% to 80%;
- Increase pregnant women provided with 2nd dose of IPT for malaria from 20% to 80%;
- Increase public facilities with a two star accreditation from 0% to 90%;
- Maintain timely, accurate and complete HIS reporting at more than 90%; and
- Increase facilities with no stock-out of tracer drugs to 95%.

1. Baselines and targets will be refined and adjusted as more reliable data become available.



NEW SERVICE DELIVERY POINTS

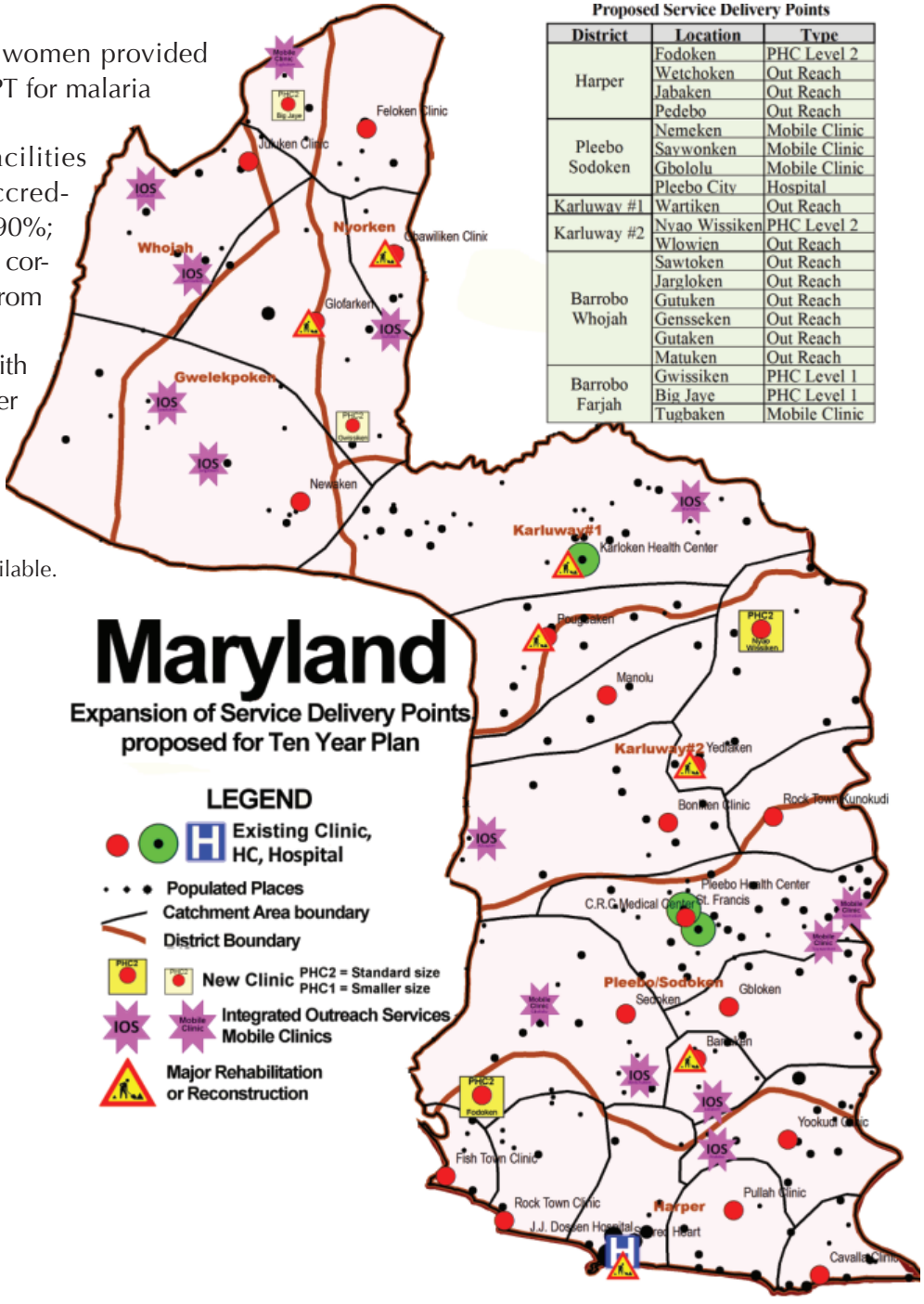
District	Location	Type
Mamba-Kaba	Zuo, Lodysville, Zeeyorn	Outreach
Firestone	Division 14	Clinic
Firestone	Division 39	Mobile clinic
Gibi	Nana, Thomas Gono, Dulaymu, Gborquoi, Boydee, Joseph Diggs	Outreach/Mobile Clinic
Gibi	Budu, & Zeh Town	New Clinic
Kakata	Seeketa & Sawmill	New Clinic
Kakata	Gboryoumue	Mobile clinic
Kakata	Charles B	Outreach
Kakata	Mollaykolleh Town	Outreach

Maryland County has a population of 142,000. Its 24 functional health facilities include one hospital; one health center and 22 clinics. Access to health care is generally good with 78% of the population living within 5km (or one hour walk) of a health facility. However, only 22% of deliveries are performed in health facilities by skilled attendants and coverage of OPV3/Penta3 is 54%. Maryland's ten year health plan will improve access to the EPHS by adding 20 Service Delivery Points (see map), including a combination of new clinics, outreach and community-based strategies (see map). Key objectives, baselines (2010) and targets (2021) will strive to:[1]

- Increase the population living within 5 km of a health facility from 78% to 90%;
- Increase OPV3/Penta3 coverage in children under 1 year from 54% to 90%;
- Increase facility-based deliveries with a skilled birth attendant from 22% to 80%;
- Increase pregnant women provided with 2nd dose of IPT for malaria from 22% to 80%;
- Increase public facilities with a two star accreditation from 5% to 90%;
- Increase timely and correct HIS reporting from 75% to 90%; and
- Increase facilities with no stock-out of tracer drugs to 95%.

Proposed Service Delivery Points

District	Location	Type
Harper	Fodoken	PHC Level 2
	Wetchoken	Out Reach
	Jabaken	Out Reach
	Pedebo	Out Reach
Pleebo Sodoken	Nemeken	Mobile Clinic
	Saywonken	Mobile Clinic
	Gbololu	Mobile Clinic
	Pleebo City	Hospital
Karluway #1	Wartiken	Out Reach
Karluway #2	Nyao Wissiken	PHC Level 2
	Wlowien	Out Reach
Barrobo Whojah	Sawtoken	Out Reach
	Jargloken	Out Reach
	Gutuken	Out Reach
	Gensseken	Out Reach
	Gutaken	Out Reach
	Matuken	Out Reach
Barrobo Farjah	Gwissiken	PHC Level 1
	Big Jaye	PHC Level 1
	Tugbaken	Mobile Clinic



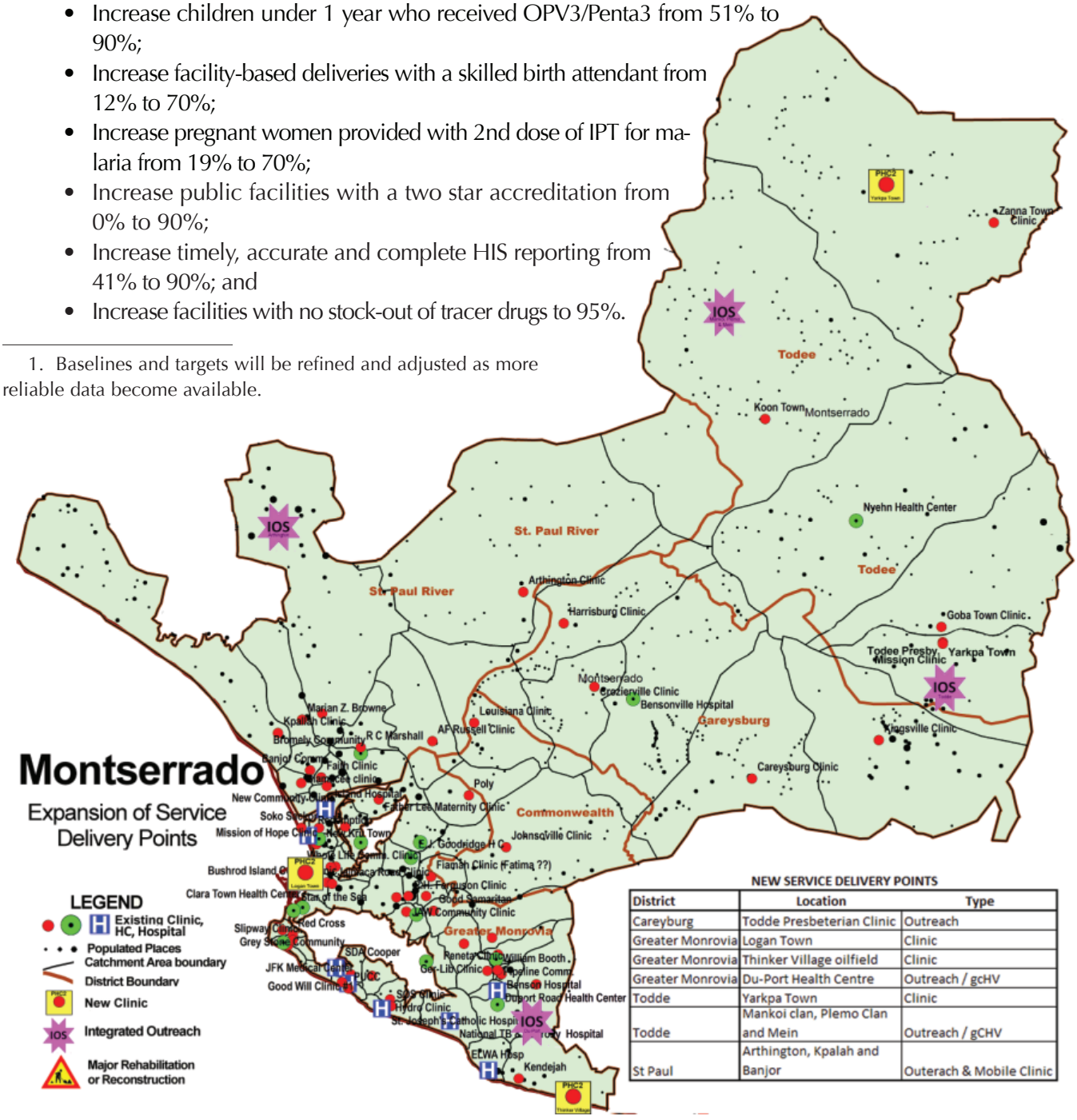
1. Baselines and targets will be refined and adjusted as more reliable data become available.

Montserrado County Health Plan (2011–2021) Executive Summary

Montserrado is Liberia's most populous county with a population 1.2 million. Its health infrastructure includes some 280 health facilities, including 9 hospitals; 14 health centers and 250 clinics (many in the private sector). 96% of the population lives within 5km (one hour walk) of a health facility, yet only 12% of deliveries are facility-based with skilled assistance. OPV3/Penta3 vaccination coverage for children under one year is low at 51%. Under-reporting from the private sector certainly contributes to those low figures. The Montserrado ten year health plan will strategically add a few Service Delivery Points (3 clinics and 4 outreach sites) to improve the provision of EPHS. The plan will also reinforce systemic components to support services. Specific objectives, baselines (2010) and targets (2021) include the following[1]:

- Increase the population living within 5 km of a health facility from 96% to 98%;
- Increase children under 1 year who received OPV3/Penta3 from 51% to 90%;
- Increase facility-based deliveries with a skilled birth attendant from 12% to 70%;
- Increase pregnant women provided with 2nd dose of IPT for malaria from 19% to 70%;
- Increase public facilities with a two star accreditation from 0% to 90%;
- Increase timely, accurate and complete HIS reporting from 41% to 90%; and
- Increase facilities with no stock-out of tracer drugs to 95%.

1. Baselines and targets will be refined and adjusted as more reliable data become available.

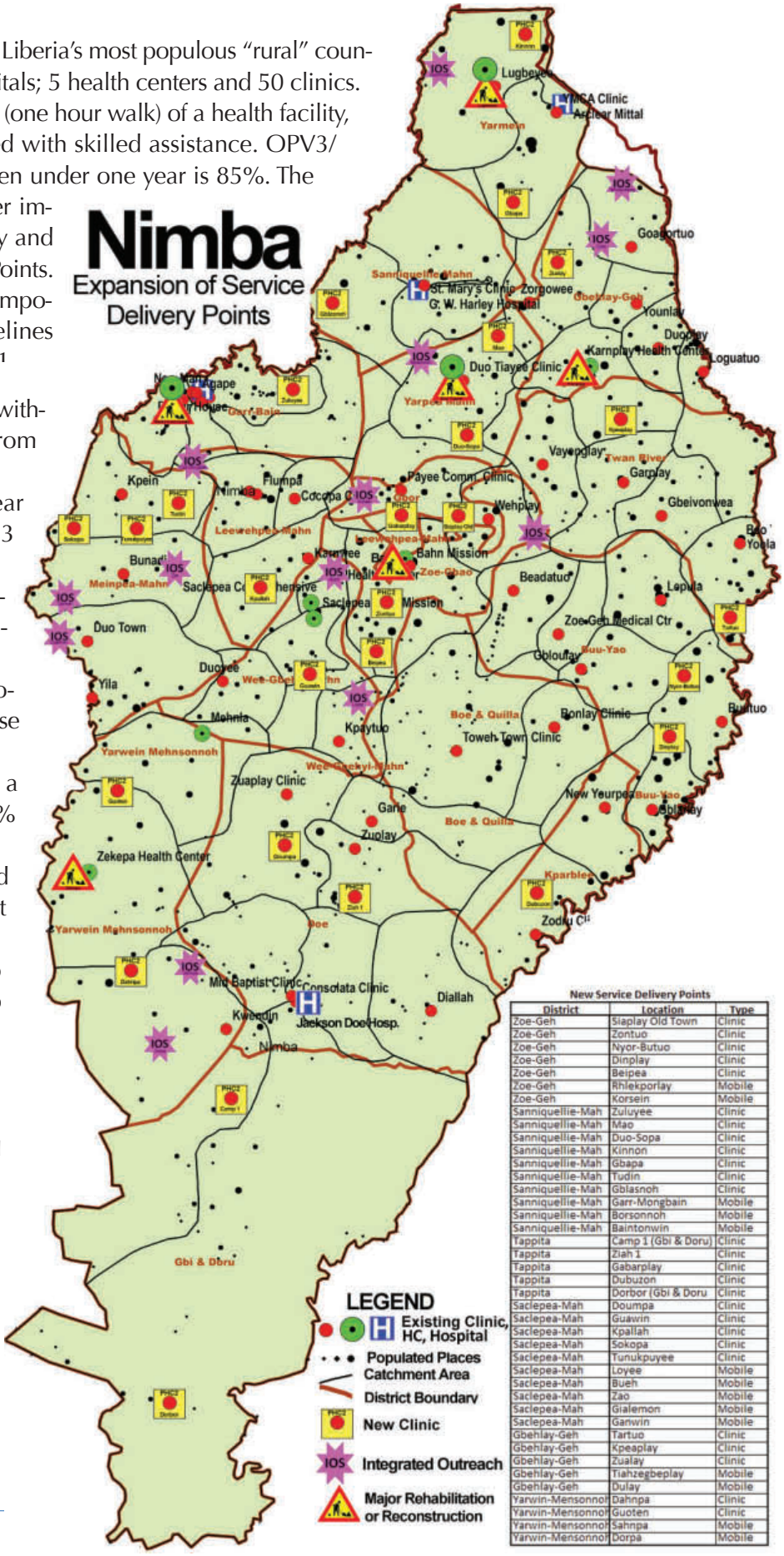


NEW SERVICE DELIVERY POINTS

District	Location	Type
Careyburg	Todde Presbeterian Clinic	Outreach
Greater Monrovia	Logan Town	Clinic
Greater Monrovia	Thinker Village oilfield	Clinic
Greater Monrovia	Du-Port Health Centre	Outreach / gcHV
Todde	Yarkpa Town	Clinic
Todde	Mankoi clan, Plemo Clan and Mein	Outreach / gCHV
St Paul	Arthington, Kpalah and Banjor	Outerach & Mobile Clinic

With a population of 482,000 Nimba is Liberia's most populous "rural" county. Its 60 health facilities include 5 hospitals; 5 health centers and 50 clinics. 58% of the population lives within 5km (one hour walk) of a health facility, and 35% of deliveries are facility-based with skilled assistance. OPV3/Penta3 vaccination coverage for children under one year is 85%. The Nimba ten year health plan will further improve to the EPHS by adding 27 facility and 14 non-facility-based Service Delivery Points. The plan will also improve systemic components for services. Key objectives, baselines (2010) and targets (2021) will strive to:[1]

- Increase the population living within 5 km of a health facility from 58% to 90%;
- Increase children under 1 year who received OPV3/Penta3 from 85% to 95%;
- Increase facility-based deliveries with a skilled birth attendant from 35% to 80%;
- Increase pregnant women provided with 2nd IPT malaria dose from 51% to 80%;
- Increase public facilities with a two star accreditation from 2% to 90%;
- Maintain timely, accurate and complete HIS reporting at more than 90%; and
- Increase facilities with no stock-out of tracer drugs to 95%.

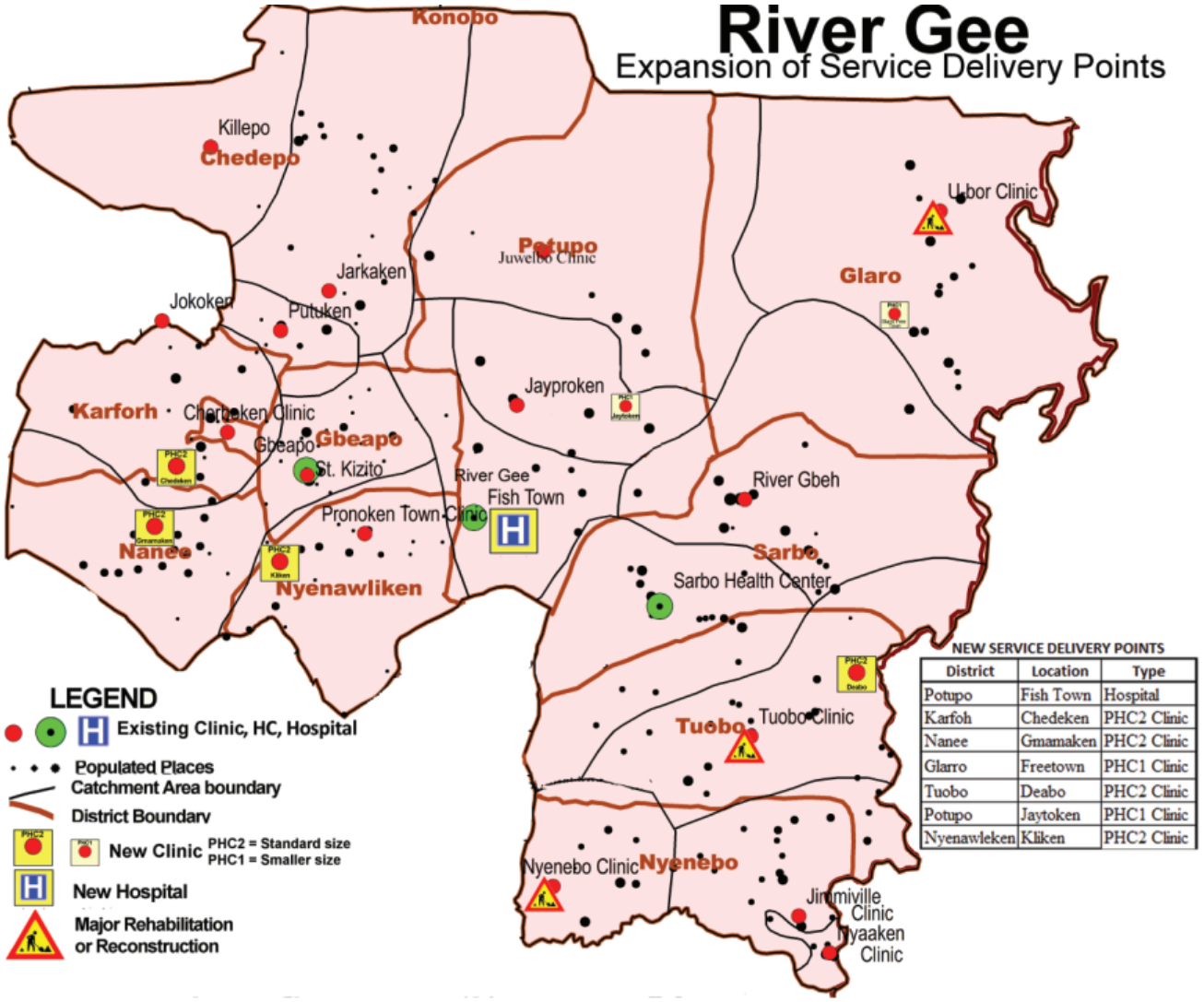


1. Baselines and targets will be refined and adjusted as more reliable data become available.

River Gee has a population of 75,000. Access is difficult with only 46% of the population living within 5km (one hour walk) of a health facility (the lowest rate of all counties). Its 17 health facilities include three health centers and 14 clinics. 36% of deliveries occur with skilled assistance in facilities. Vaccination coverage for OPV3/Penta3 vaccination for children under one year is only 64%. The River Gee ten year health plan will increase access to the EPHS by strategically adding 7 Service Delivery Points including standard-size and smaller-sized clinics (see map). The plan will also reinforce systemic components to support services. Specific objectives, baselines (2010) and targets (2021) include the following[1]:

- Increase the population living within 5 km of a health facility from 46% to 80%;
- Increase children under 1 year who received OPV3/Penta3 from 64% to 90%;
- Increase facility-based deliveries with a skilled birth attendant from 36% to 80%;
- Increase pregnant women provided with 2nd dose of IPT for malaria from 39% to 80%;
- Increase public facilities with a two star accreditation from 0% to 90%;
- Maintain timely, accurate and complete HIS reporting at more than 90%; and
- Increase facilities with no stock-out of tracer drugs from 44% to 95%.

1. Baselines and targets will be refined and adjusted as more reliable data become available.



Rivercess has a population of 72,000 with. Its infrastructure of 17 health facilities includes one hospital and 16 clinics. 64% of the population lives within 5km (one hour walk) of a health facility. Currently 26% of deliveries occur in health facilities, and OPV3/Penta3 coverage for children under one year is more than 95%. The Rivercess ten year health plan will increase access to the EPHS through by adding 23 Service Delivery Points including a combination of clinics outreach and community-based strategies (see map). The plan will also reinforce systemic components to support services. Specific objectives, baselines (2010) and targets (2021) include the following[1]:

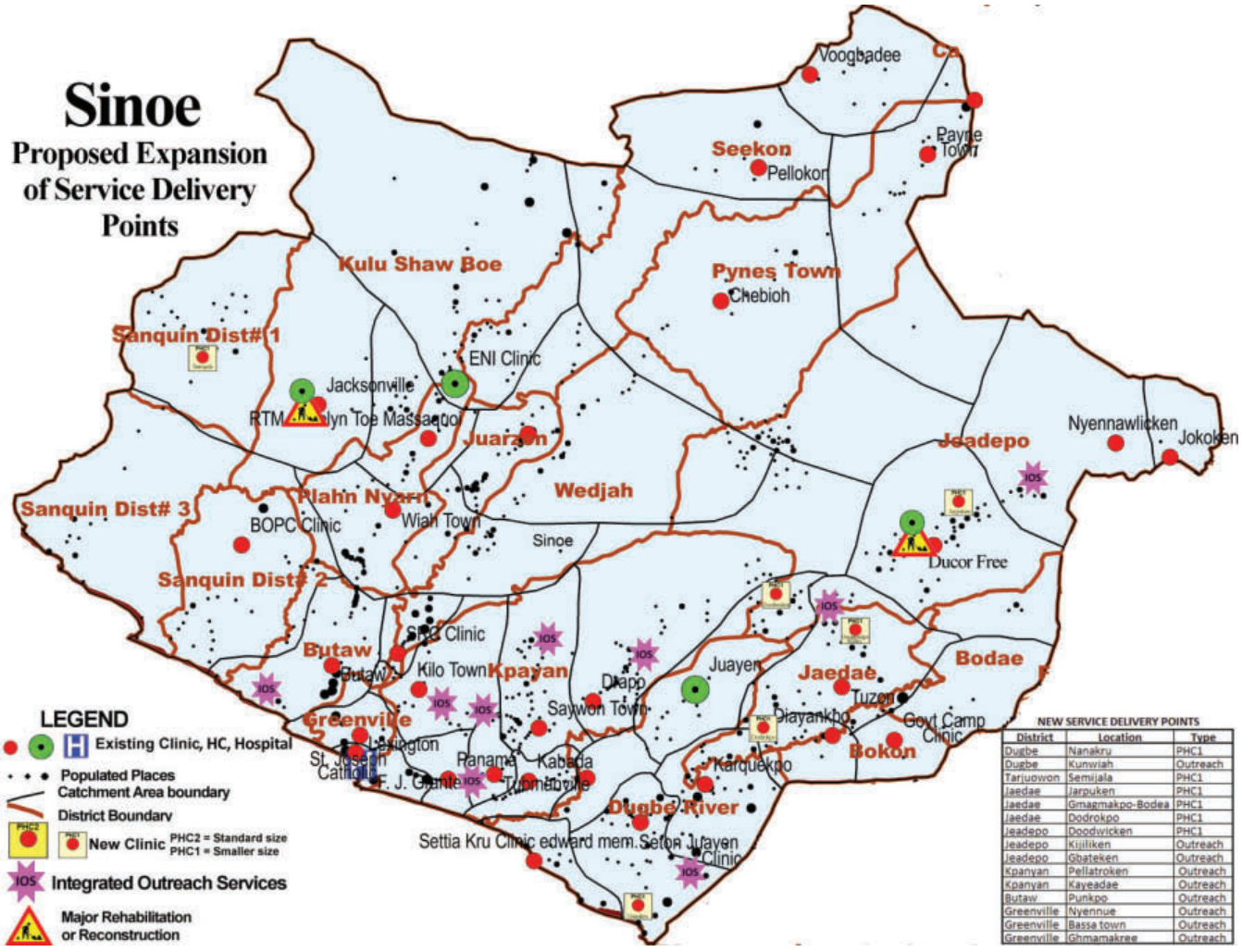
- Increase the population living within 5 km of a health facility from 64% to 85%;
- Maintain OPV3/Penta3 coverage for children under 1 year at 95%;
- Increase facility-based deliveries with a skilled birth attendant from 26% to 85%;
- Increase pregnant women provided with 2nd dose of IPT for malaria from 28% to 80%;
- Increase public facilities with a two star accreditation from 0% to 90%;
- Maintain timely, accurate and complete HIS reporting at more than 90%; and
- Increase facilities with no stock-out of tracer drugs to 95%.

1. Baselines and targets will be refined and adjusted as more reliable data become available.

Sinoe has a population of 102,000 inhabitants. Its health infrastructure consists of 32 health facilities including one hospital and 31 clinics. However, only 61% of the population lives within 5km (one hour walk) of a health facility. Less than 20% of deliveries are performed in a health facility with a skilled attendant. OPV3/Penta3 coverage for children under one year is 58%. The Sinoe ten year health plan will increase access to the EPHS through the addition of 15 Service Delivery Points including a combination of clinics, outreach and community-based strategies (see map below). The plan will also reinforce systemic components to support services. Specific objectives, baselines (2010) and targets (2021) include the following[1]:

- Increase facility-based deliveries with a skilled birth attendant from 14% to 80%;
- Increase children under 1 year who received OPV3/Penta3 from 58% to 90%;
- Increase pregnant women provided with 2nd dose of IPT for malaria from 16% to 80%;
- Increase the population living within 5 km of a health facility from 61% to 85%;
- Increase public facilities with a two star accreditation from 0% to 90%;
- Increase timely, accurate and complete HIS reporting from 78% to 90%; and
- Increase facilities with no stock-out of tracer drugs to 95%.

1. Baselines and targets will be refined and adjusted as more reliable data become available.



Republic of Liberia

Ministry of Health and Social Welfare

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