



REPUBLIC OF LIBERIA
MINISTRY OF HEALTH

LIBERIA NATIONAL STRATEGIC PLAN

TO

END

TUBERCULOSIS (TB)

2027-2031



A HEALTHY LIBERIA
FREE FROM TB
IS POSSIBLE



PEOPLE
CENTERED



EVIDENCE
DRIVEN



MULTISECTORAL
COLLABORATION



EQUITY
FOCUSED



IMPACT
ORIENTED

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Executive Summary: Liberia National Strategic Plan 2027-2031

Background

Liberia, a low-income country located in West Africa, has a large tuberculosis disease burden. This is driven by a complex interplay of socio-economic factors, primarily poverty and its consequences and a fragile health system. Liberia is among the 30 high TB burden countries globally, with an estimated incidence of approximately 207 cases per 100,000 population translating to about 12,000 people developing TB annually. However, due to the absence of a national TB prevalence survey and limitations in routine data systems, these estimates are characterized by wide uncertainty intervals.

Over recent years, Liberia has made modest progress in strengthening its TB response. Notifications increased from 7,454 cases in 2021 to over 8,000 cases in 2024, and treatment coverage reached approximately 69%. Nevertheless, significant gaps persist across the TB care cascade. Approximately one-third of people who develop TB remain undiagnosed or unreported, treatment success rates remain suboptimal at around 79%, and coverage of TB preventive treatment (TPT) among eligible populations is low and poorly documented. In addition, an estimated 92% of people affected by TB incur catastrophic costs, reflecting profound socio-economic vulnerability.

These programmatic challenges are compounded by broader health system constraints, including limited domestic health financing, heavy reliance on external funding, shortages and maldistribution of skilled health workers, gaps in diagnostic capacity, and weaknesses in data quality and use. At the same time, Liberia is undergoing health sector reforms aligned with Universal Health Coverage (UHC) and its national development agenda, the ARREST Agenda for Inclusive Development, which emphasizes equity, resilience, and inclusive growth.

Rationale for the New TB-NSP (2027–2031)

The previous TB National Strategic Plan (2020–2026) sought to reverse the TB epidemic by improving access to high-quality TB services, strengthening supportive systems, and promoting research and innovation. While the plan led to measurable gains, many of its ambitious targets, particularly those related to treatment success, case detection, and catastrophic cost reduction were not achieved.

The need for a new TB-NSP is therefore driven by three key considerations:



Persistent Programmatic Gaps

Significant deficiencies remain in case detection, quality of care, treatment outcomes, and TB prevention, indicating the need for a more effective and integrated response.



Evolving epidemiological and technological Landscape

Advances in TB diagnostics (e.g., near point-of-care molecular tests, tongue swab testing, pooling of specimens), treatment (e.g., shorter, all-oral regimens such as BPaLM for RR/MDRT), preventive treatment (shorter regimens such as 1HP and 3HP) and digital health systems present new opportunities to accelerate progress.



Health system and policy shifts

Ongoing reforms toward UHC, decentralization, and digital transformation, alongside increased political engagement, including the establishment of a TB legislative caucus, create an enabling environment for a more resilient and sustainable TB response.

These factors necessitate a new strategic plan that is more people-centered, integrated, adaptive, and aligned with both national priorities and global commitments, particularly the WHO End TB Strategy.

Methods for Developing the TB-NSP

The development of the TB-NSP 2027–2031 followed a structured, evidence-based, and consultative process. It began with a comprehensive situational analysis, integrating epidemiological data, external program performance review and assessment, and a review of the broader health system using the WHO health system building blocks framework.

An External Program Review (EPR) provided an independent assessment of the National TB Program, identifying key strengths, bottlenecks, and missed opportunities. Strategic analysis tools, including SWOT (Strengths, Weaknesses, Opportunities, Threats) and PESTEL (Political, Economic, Social, Technological, Environmental, and Legal) frameworks, were applied to contextualize internal and external factors influencing the TB response.

A Theory of Change approach was used to map pathways from interventions to outcomes and impact, ensuring clarity in assumptions and expected results. Priority interventions were identified through a consultative process involving government entities, technical partners, and civil society, with emphasis on feasibility, equity, and potential impact.

A costing exercise was used to estimate cost requirements and monitoring; evaluation and learning framework was developed to track progress in the implementation of the new strategic plan. Finally, the new strategic plan was validated at a workshop where a wide range

of stakeholders participated. While the process was highly participatory, engagement of affected communities was identified as an area for strengthening in future planning cycles.

Goal and Objectives

Goal

To reduce the burden of tuberculosis in Liberia by ensuring equitable access to integrated, high-quality TB prevention, diagnosis, care, and treatment services, to reduce the proportion of TB-affected households experiencing catastrophic costs from 92% in 2024 to below 20% by 2030.

This goal reflects a deliberate shift toward a people-centered and equity-focused measure of impact, recognizing that reducing catastrophic costs captures improvements in access, quality of care, and social protection.



Key Strategic Interventions

To achieve these objectives, the TB-NSP 2027–2031 prioritizes a set of interrelated strategic interventions:

1. Closing the TB Detection Gap

- Scale up systematic and targeted screening in communities and health facilities.
- Expand access to sensitive diagnostic tools, including molecular testing and digital X-rays.
- Strengthen private sector engagement and mandatory notification.
- Improve sample transport and referral systems.

2. Improving Quality of Care and Treatment Outcomes

- Strengthen adherence support through community-based models.
- Expand patient-centred support, including transport, nutrition, and psychosocial services.
- Decentralize drug-resistant TB care enabled by shorter, safe and more efficacious oral regimens.
- Institutionalize quality improvement systems.

3. Scaling Up TB Prevention

- Expand household contact management and TPT delivery.
- Prioritize high-risk groups, including children and people living with HIV.
- Strengthen community-based delivery and monitoring of TPT.

4. Strengthening Health System Foundations

- Address human resource shortages through recruitment, training, and retention strategies.
- Expand laboratory capacity and diagnostic networks.
- Strengthen supply chain systems and pharmacovigilance.

5. Building a Robust TB Information System

- Improve data quality, integration, and interoperability with national systems (e.g., DHIS2).
- Enhance real-time data use for decision-making and performance management.
- Strengthen surveillance and cohort monitoring.

6. Strengthening Governance and Financing

- Enhance coordination and accountability mechanisms at all levels.
- Develop and implement a TB financing sustainability plan.
- Increase domestic financing and align TB planning with broader health sector reforms.

The TB-NSP 2027–2031 is projected to cost approximately US\$64.14 million over the five-year period, representing a 9.3% increase from the previous NSP. This increase reflects the planned intensification of TB care, prevention, surveillance, and system-strengthening efforts.

The largest share of the budget is allocated to objective 3 (quality of care), at US\$18.29 million, accounting for 29% of the total. This is followed by objective 2 (case detection) at US\$15.69 million (25%), and objective 6 (governance and leadership) at US\$15.56 million (24%). Objective 5 (TB surveillance) is estimated at US\$6.96 million (11%), while objective 1 (TB prevention) is budgeted at US\$6.39 million (10%). Objective 4 (community engagement), has the smallest allocation, at US\$1.24 million, representing 1.9% of the total budget.

7. Empowering Communities and Addressing Social Determinants

- Strengthen community health worker systems and community-led monitoring.
- Implement stigma and discrimination reduction strategies.
- Expand social protection and multisectoral action to address poverty and vulnerability.

8. Harnessing Innovation and Research

- Scale up new diagnostic and treatment technologies.
- Promote operational and implementation research to inform program improvement.
- Prepare for future tools, including novel diagnostics and treatment, preventive therapies and TB vaccines.

Conclusion

The TB-NSP 2027–2031 represents a strategic shift toward a more integrated, people-centred, and resilient TB response in Liberia. It builds on lessons from the previous plan while addressing persistent gaps across the TB care cascade. By aligning with national development priorities and leveraging emerging innovations, the plan provides a comprehensive roadmap to accelerate progress toward ending TB in Liberia.

Successful implementation will depend on strong leadership, adequate and sustained financing, effective partnerships, and coordinated multisectoral action. If fully implemented, this strategy

has the potential not only to reduce the burden of TB, but also to advance equity, protect households from financial hardship, and strengthen Liberia's overall health system.

Foreword

Tuberculosis (TB) remains a major public health and development challenge in Liberia, disproportionately affecting the poorest and most vulnerable populations. While progress has been made in expanding TB services and increasing case notifications, the disease burden remains high, with persistent gaps in case detection, treatment outcomes, prevention, and financial protection. Too many people with TB are still missed, and too many households face catastrophic costs because of the disease.

The National Tuberculosis Strategic Plan 2027–2031 reflects renewed commitment to ending TB in Liberia. Building on lessons from the 2020–2026 plan, it addresses persistent programmatic gaps while leveraging advances in diagnostics, shorter and safer regimens, digital health innovations, and ongoing reforms aligned with Universal Health Coverage and the ARREST Agenda for Inclusive Development.

Central to this strategy is a shift to a people-centred, equity-focused approach, with a national goal of reducing catastrophic costs among TB-affected households from 92% to below 20% by 2030. This reflects the recognition that ending TB requires not only effective medical interventions, but also strong community engagement, social protection, resilient health systems, collaboration with programs such as the National Aids Control Program (NACP), and integration into public health services.

The TB-NSP 2027–2031 was developed through a rigorous, evidence-based, and consultative process involving government institutions, technical partners, civil society, and other stakeholders. It provides a clear, costed, and measurable roadmap aligned with the WHO End TB strategy.

The success of this Plan depends on collective action. We call upon all stakeholders, political leaders and government officials at all levels, religious leaders, business leaders, public and private health providers, development partners, civil society organizations, communities and individuals, to commit their leadership, resources, and expertise to its full implementation. Together, we must translate this strategy into action, mobilize adequate and sustainable financing, strengthen accountability, and ensure that no one affected by TB is left behind.

Let us work towards a TB free Liberia!

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List of acronyms

AAID	ARREST Agenda for Inclusive Development
ACF	Active Case Finding
ANC	Antenatal Care
ART	Antiretroviral Therapy
ARREST	Agriculture, Roads, Rule of Law, Education, Sanitation and Tourism
BPaLM	Bedaquiline, Pretomanid, Linezolid and Moxifloxacin
CHA	Community Health Assistant
CHB	County Health Board
CHD	County Health Director
CHIS	Community Health Information System
CHP	Community Health Promoter
CHT	County Health Team
CHW	Community Health Worker
CXR	Chest X-ray
DAT	Digital Adherence Technology
DHIS2	District Health Information Software 2
DOT	Directly Observed Treatment
DR-TB	Drug-Resistant Tuberculosis
DST	Drug Susceptibility Testing
DS-TB	Drug-Susceptible Tuberculosis
EPR	External Program Review
EPTB	Extrapulmonary Tuberculosis
FBO	Faith-Based Organization
GC7	Grant Cycle 7
GEHR	Gender, Equity and Human Rights
GLRA	German Leprosy Relief Association
GoL	Government of Liberia
HIS	Health Information System

HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HRH	Human Resources for Health
IEC	Information, Education and Communication
IDSR	Integrated Disease Surveillance and Response
IMF	International Monetary Fund
IMNCI	Integrated Management of Newborn and Childhood Illness
IPC	Infection Prevention and Control
KP	Key Population
KPI	Key Performance Indicator
LHEF	Liberia Health Equity Fund
LIGIS	Liberia Institute of Statistics and Geo-Information Services
LMIS	Logistics Management Information System
M&E	Monitoring and Evaluation
MHPSS	Mental Health and Psychosocial Support
MoH	Ministry of Health
MNS	Mental, Neurological and Substance Use
NACP	National AIDS Control Program
NCD	Non-Communicable Disease
NFM	New Funding Model
NGO	Non-Governmental Organization
NLTCP	National Leprosy and Tuberculosis Control Program
nPOC	Near Point of Care
NSP	National Strategic Plan
NTD	Neglected Tropical Disease
NTP	National Tuberculosis Program
OPD	Outpatient Department
OSDV	On-Site Data Verification
PESTEL	Political, Economic, Social, Technological, Environmental and Legal

PHC	Primary Health Care
PIH	Partners In Health
PLHIV	People Living with HIV
PPM	Public-Private Mix
PTB	Pulmonary Tuberculosis
QI	Quality Improvement
RMNCAH+N	Reproductive, Maternal, Newborn, Child and Adolescent Health and Nutrition
RMNCH	Reproductive, Maternal, Newborn and Child Health
RR/MDR-TB	Rifampicin-Resistant / Multidrug-Resistant Tuberculosis
SBC	Social and Behavior Change
SDG	Sustainable Development Goal
SOP	Standard Operating Procedure
SPO ₂	Peripheral Oxygen Saturation
SWOT	Strengths, Weaknesses, Opportunities and Threats
TB	Tuberculosis
TB-NSP	Tuberculosis National Strategic Plan
THE	Total Health Expenditure
ToC	Theory of Change
ToR	Terms of Reference
TPT	Tuberculosis Preventive Treatment
TWG	Technical Working Group
UHC	Universal Health Coverage
WHO	World Health Organization

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1. Country context

1.1 Basics about Liberia

The Republic of Liberia is located on the West African coast. It covers a land area of approximately 11, 369 square kilometers and is administratively divided into 15 counties with 156 administrative districts (LIGIS 2022) and 98 health districts. The projected 2026 population based on the 2022 census and 3% growth rate is estimated to be about 5.9 million and is young with a median age of 18 to 20 years.



Figure 1: Map of Liberia

<https://ontheworldmap.com/liberia/>

According to LIGIS 2022 census, currently it is estimated that about 34% of the population is under 15 years old, and about 58% is under 25. The working-age population (15–64) makes up roughly 63% of the population, with only a small proportion, estimated at about 3%, aged over 65. There are as many males as females with a ratio 1:1. The annual population growth is about 3%.

About 30% of the population lives in rural areas, however, the proportion of urban population varies by county, being highest in Montserrado county where Monrovia, the capital, is located. The annual urban population growth rate is about 3.2% and it is projected that by 2050, close to 50% of the population will be residing in urban areas. In 2021, life expectancy at birth was 63.5, with females living longer at 64.3 and males at 62.6

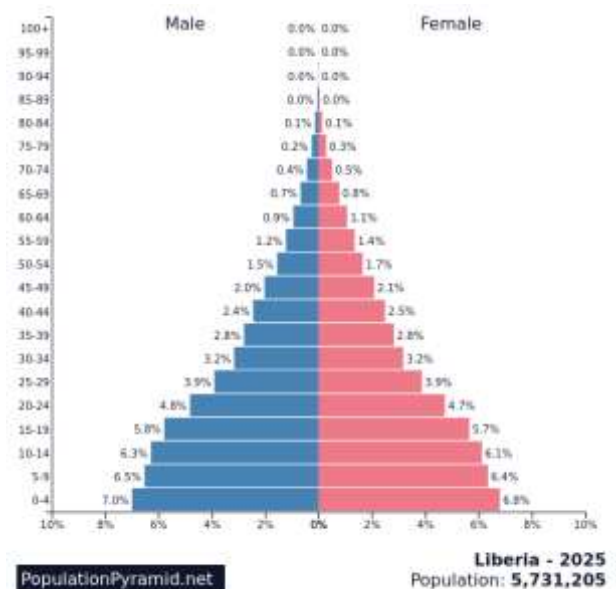


Figure 2: Liberia population pyramid 2025

Source: <https://www.populationpyramid.net/Liberia/2025/>

Liberia's GDP per capita is estimated at USD 964, and the country is classified by the World Bank as low-income. Poverty remains widespread and severe: approximately 45% - 52.3% of the population lives in multidimensional poverty, meaning that about half of Liberians struggle to meet basic needs, including access to health care, education, electricity, and clean water.

About 30% of the population lives in extreme poverty, defined as living on less than USD 2.15 per day, while approximately 51% lives below the national poverty line. Poverty is markedly higher in rural areas, at 72%, compared with 22.5% in urban areas. Poverty levels also vary by county: Montserrado, where Monrovia is located, has the lowest poverty rate, while River Cess and Gbarpolu have among the highest rates, at 76.9% and 72%, respectively.¹

Liberia's current national development framework is the ARREST Agenda for Inclusive Development (AAID), which builds on earlier plans such as the Pro-Poor Agenda for Prosperity and Development and is aligned with Vision 2030, the SDGs, and the African Union's Agenda 2063. The AAID sets out a people-centered, inclusive development vision aimed at reducing poverty and inequality, promoting sustainable and inclusive economic growth, strengthening governance, peace, and state institutions and advancing Liberia toward lower-middle-income status by 2030. A central theme is to ensure "no one is left behind", with a strong emphasis on equity, resilience, and human development.

The core strategic pillars of the **ARREST** framework include:

A: Agricultural transformation intended to increase agricultural productivity and food security, promote agro-processing and value chains and support job creation and rural livelihoods. The goal is to reduce poverty and strengthen economic resilience.

R: Roads and infrastructure development intended to expand and rehabilitate road networks, improve connectivity between counties and markets and strengthen transport systems. The goal is to ensure access to services, markets, and to enhance economic integration.

R: Rule of law including strengthening governance and institutions and promoting accountability; improving justice systems and reducing corruption; and enhancing

¹ Source: World Bank Poverty and Inequality Platform, Liberia Country Profile. <https://pip.worldbank.org/country-profiles/LBR>

transparency and citizen trust. This is intended to lead to effective and accountable state institutions.

E: Education and human capital development encompassing expansion of access to quality education, improving skills development and workforce readiness and strengthening technical and vocational training. The goal is to build human capital for long-term growth.

S:Sanitation, health and social services which includes improving access to healthcare; enhancing access to water, sanitation and hygiene (WASH); strengthening health systems and service delivery and addressing public health challenges. The overall goal is to improve population health and wellbeing.

T: Tourism and economic diversification intended to promote tourism as a growth sector, develop cultural and natural assets and attract investment and create jobs. The goal is to achieve economic diversification beyond traditional sectors.

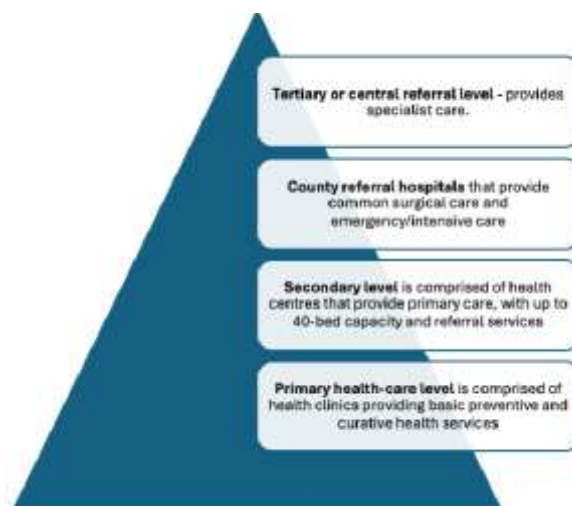
The ARREST framework emphasizes poverty reduction and shared prosperity; youth and women empowerment, job creation and livelihoods, decentralization and county-level development, climate resilience and environmental sustainability, and digital transformation and ICT expansion. It aims to achieve a sustained annual GDP growth rate of 5-6%.

The ARREST Agenda for Inclusive Development (AAID) is explicitly aligned with the Sustainable Development Goals (SDGs), African Union Agenda 2063, ECOWAS Vision 2050 and Liberia’s Vision 2030.

1.2 Liberia’s Health care system

The Liberian health system consists of a national public health care system that is organized into three tiers: primary, secondary and tertiary care; and a non-public healthcare system that includes private and faith-based health care facilities. The national health service delivery system has endured several shocks in recent years including a protracted civil war, the Ebola pandemic and more recently the COVID-19 pandemic. Perennial challenges in the public health care system include limited financing, an inadequate health infrastructure and low numbers of health care workers.

Figure 3: Liberia Health system levels



Based on the 2025 Liberia Master facility list, there were 28 public hospitals, 43 health centres and 430 public sector clinics making a total of 501 public sector facilities. This number represents 52.8% (501/948) of the total number of health facilities that are actively reporting in DHIS2. Similarly, private health sector facilities (14 hospitals, 55 health centers and 378 clinics) account for 47.2% (447/948).

1.3 Liberia's health financing

Health financing in Liberia is characterized by donor dependence and high out-of-pocket expenditures, despite efforts to increase domestic funding and achieve Universal Health Coverage (UHC). According to the Liberia Health Financing Strategy 2022-2026 the out-of-pocket expenditure accounts for about 62% of total health expenditure (THE)². On average the country has been spending less than 7.8% of the government budget on health. (Liberia National Budget 2026). The country is making efforts to improve sustainability of health financing using various mechanisms including implementing a national health insurance scheme, tax reforms, and better management of donor funds, alongside initiatives such as the Liberia Health Equity Fund (LHEF), which is a government led financial protection mechanism intended to remove financial barriers to healthcare for poor and vulnerable populations. It is funded by the GoL and development partners using a pooling mechanism. The Ministry of Health (MoH) is also working to get the GoL to increase the proportion of its budget that is allocated to health. In addition, the MoH has initiated a Community Health Assistant (CHA) program aimed at reaching communities with basic health services for common ailments.

1.4 Health governance and leadership

1.4.1 Health governance and leadership at the National level

The MoH provides governance and leadership on all health matters in Liberia. It is responsible for the formulation, implementation, monitoring and evaluation of health policies, strategies and plans. It also monitors adherence to specified health standards. Other responsibilities of the MoH include delivering and coordinating decentralized medical care in public facilities; developing health manpower; and undertaking preventive and promotive health services,

² Ministry of Health Liberia (2022) *National Health Financing Strategy 2022–2026*. Monrovia: Ministry of Health, Republic of Liberia. Available at: [Link](#) (Accessed: 2 June 2026).

including specific health interventions. The MoH is structured into divisions, sections, and units in line with its core functions (see figure 4 below).²

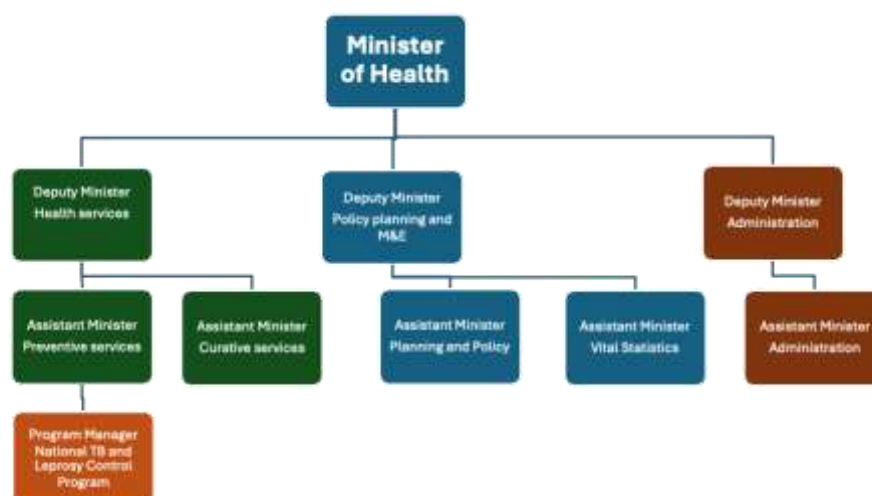


Figure 4: National level organogram-Ministry of Health

1.4.2 National Leprosy and Tuberculosis Control Program (NLTCP)

The Leprosy and Tuberculosis Control Programs were two separate entities until they were merged into one program in 1989. This followed a request by the government of Liberia to the German Leprosy Relief Association (GLRA) to incorporate TB into its leprosy control program support, in 1988. However, in line with WHO's recommendation, in 2016, leprosy services under the NLTCP were transitioned to the Neglected Tropical Diseases (NTDs) Program under the Ministry of Health leaving the TB program with the core function of TB prevention and care. The program has since then been supported by both the government and international partners until the 1990s when it suffered a setback following a decline in financial support due the continuous political instability in the country. The TB program was revived in 1994 and had to survive through the years of political instability, the 2014 Ebola crisis and the COVID-19 pandemics.

Over the years, the program has received six (6) grants from the Global Fund in the various funding mechanisms and cycles: 2004 -2007 (Round 2), 2008 – 2011 (Round 7), 2015 -2017 (New Funding Model [NFM]–1), TB/HIV grant (NFM 2 – 2018 – 2020), TB/HIV grant (NFM 3 – 2021 – 2023) and TB/HIV grant cycle 7 (GC7 – 2024 – 2026) . The program is preparing to be funded by the Global Fund in the next grant cycle (GC8-2027-2029).

1.4.2.1 Organizational units of the NLTCP

The NLTCP is responsible for the organization and coordination of Tuberculosis care and prevention activities in Liberia. The program is headed by the Program Manager who reports to

the Assistant Minister for Preventive services, Ministry of Health. There are three deputy program managers (Programs, Monitoring and Evaluation, and Finance and Administration) who support the Program Manager in achieving the Programs' Goals and Objectives.

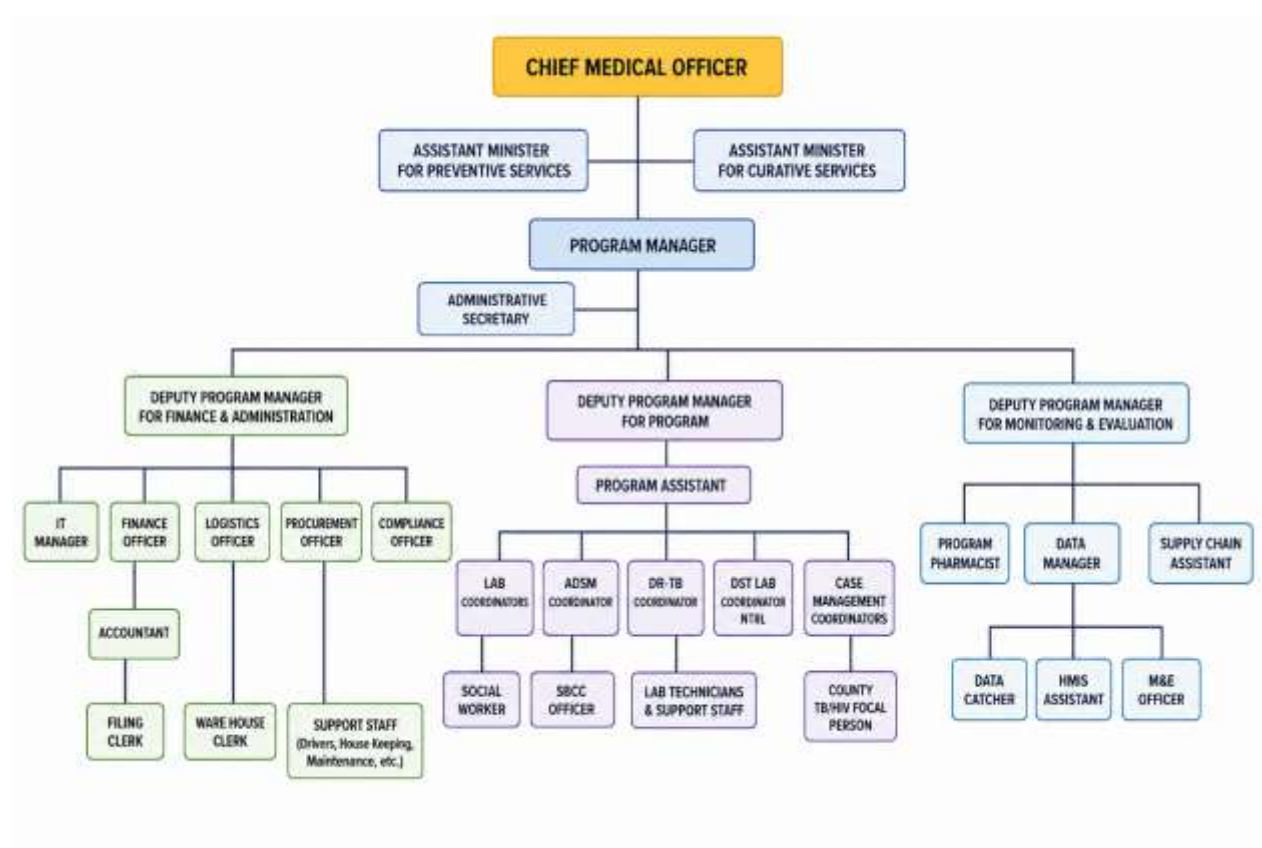


Figure 5: National Leprosy and Tuberculosis Control Program organogram

The key roles and responsibilities of the NLTCP include:

- ⇒ Formulation of leprosy and TB care and prevention policies and strategies.
- ⇒ Resource identification and mobilization.
- ⇒ Coordination of the procurement and distribution of anti-TB medicines and other commodities.
- ⇒ Coordination and implementation of capacity-building programs, including long- and short-term training, mentorship, and supervision of TB field activities.
- ⇒ Strengthening laboratory systems and improving quality of services.
- ⇒ Surveillance of drug resistance.
- ⇒ Health promotion.
- ⇒ Improvement of data quality.
- ⇒ Data aggregation, analysis, and conduct of operational research.
- ⇒ Coordination of the central TB reference laboratory with the National Public Health Reference Laboratory.
- ⇒ Partner coordination, including NGOs and private institutions.

⇒ Inter-sectoral collaboration.

1.4.3 Health governance and leadership at the county level

The major responsibility of county level health governance units is the coordination of health service delivery, collection and use of health-related data. In every county there is a County Health Board (CHB) to which a County Health Director reports (CHD). Under the CHD are technical units, each led by a specifically designated head. These include a county health administrator, a county public health officer, a county medical officer, a county pharmacist, a county planning, monitoring and evaluation officer, and county compliance officer. Together these units are called the County Health Teams (CHTs).

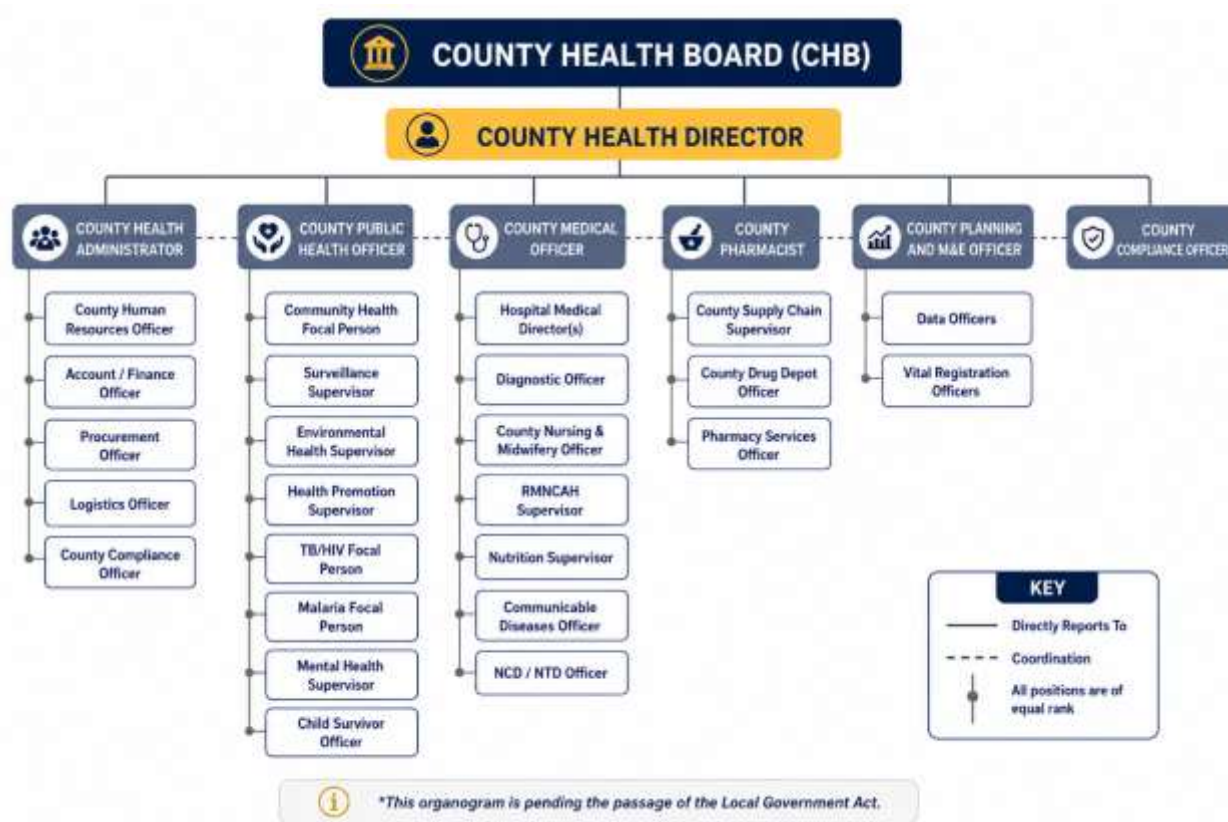


Figure 6: Liberia County Health Management Teams organogram

Under Liberia's health sector decentralization framework and the Ministry of Health Act, CHTs are primarily implementers and managers and not autonomous policymakers. They are mandated to implement national health policies, strategies, and guidelines; manage county-level public health service delivery, supervise public and accredited private health facilities, coordinate partners and NGOs operating in the county, collect, validate, and report health data (HMIS, IDSR, DHIS2), support community health structures (CHAs, HFDCs, CHCs) and participate in county development planning processes.

In essence Liberia's health decentralization model fits what is at times referred to as deconcentration with partial delegation and not full decentralization. CHTs can make decisions on facility supervision schedules, redistribution of staff within the county (with MoH approval for senior cadres), outreach planning and community health activities, micro-planning for immunization, TB, HIV, malaria and MCH and emergency response coordination at the county level, e.g. for outbreaks or environmental disasters such as floods. County health teams are also responsible for partner coordination and NGO alignment and chair or co-chair county health coordination meetings and approve workplans of NGOs to align these to county priorities. Even then, CHTs do not have the power to approve large budgets and cannot re-direct donor funding independently. Thus, while the power of CHTs is real, it must be negotiated and is not authoritative. Their input into national health policies and priorities is meaningful, however, decision authority is preserved for the central Ministry of Health.

1.4.4 Health governance and leadership at the district level

At the district level, health leadership is under a district health board to which a district health director reports. These district health teams, under the leadership of the district health director, include officers responsible for reproductive, maternal, neonatal and child health (RMNCH), surveillance, environmental health, health promotion, data officer, Child survival and mental health. The district health teams report to the CHTs and have even less decision-making authority compared with the CHTs.

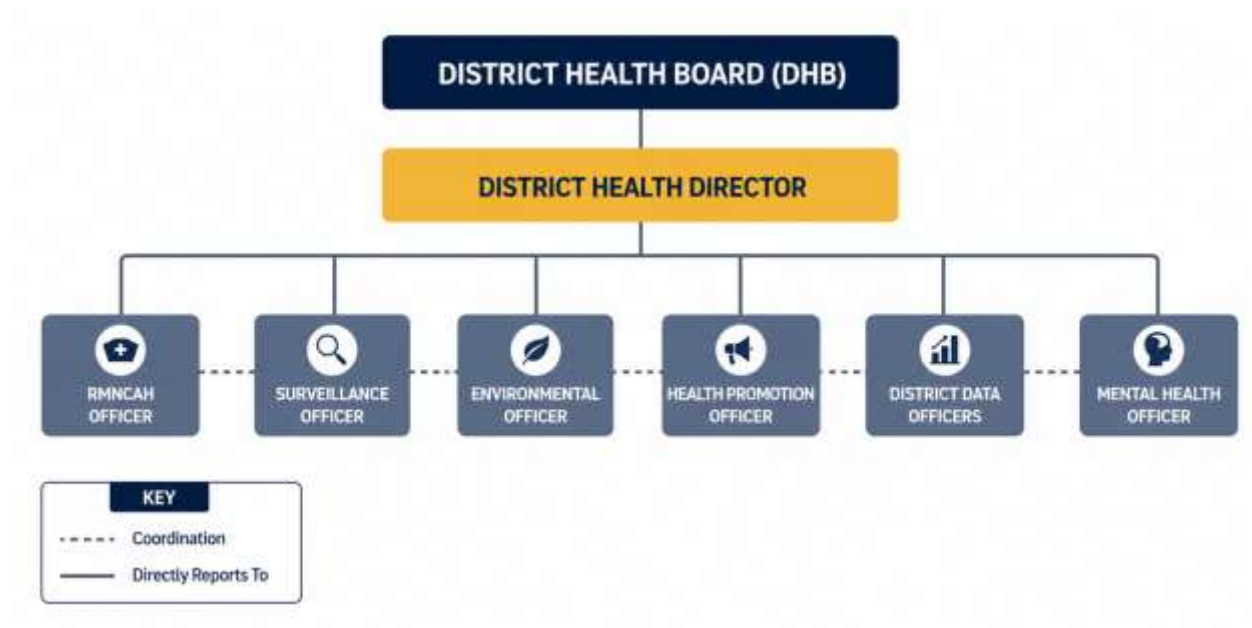


Figure 7: Liberia District Health Governance and leadership organogram

1.5 Human Resources for Health (HRH) Situation

Even though Liberia, at face value, appears to have a large pool of health workers, it is among the countries that has a severe shortage of critical skilled healthcare workers needed to deliver Universal Health Care (UHC). The workforce remains severely undersized. Currently, there are 20,395 healthcare workers and 5,673 community health workers in Liberia. At 13 doctors, nurses, and midwives per 10,000 population, Liberia stands at approximately 30% of the global benchmark, far below the WHO minimum of 23 per 10,000 for basic coverage of health services.

Geographic maldistribution is acute: Montserrado County accounts for 40.7% of the national workforce while hosting only 24% of the population. Over 4,300 health workers, representing 21% of the workforce, serve as unpaid or underpaid volunteers, many for six years or more. The health system lacks validated staffing norms, integrated workforce data, functional performance management, and the fiscal space to absorb the workforce it has already trained.

In addition to the low numbers, Liberia has the challenge of maldistribution of these health care workers that favors urban counties compared to rural ones. To mitigate this situation Liberia is implementing measures such as task shifting, training and capacity building, and the exploration of incentive and retention measures.

1.6 Health Information System (HIS)

Liberia's HIS has evolved significantly since the Ebola outbreak of 2014–2016 and is now largely standardized, digital, and DHIS2-based, however, capacity and quality challenges persist.

Governance of the HIS lies with the MoH, principally in the division of HIS within the department of planning. The guiding framework for the HIS is the national health and social welfare policy and plan (2022-2031) and the national HIS strategic plan.

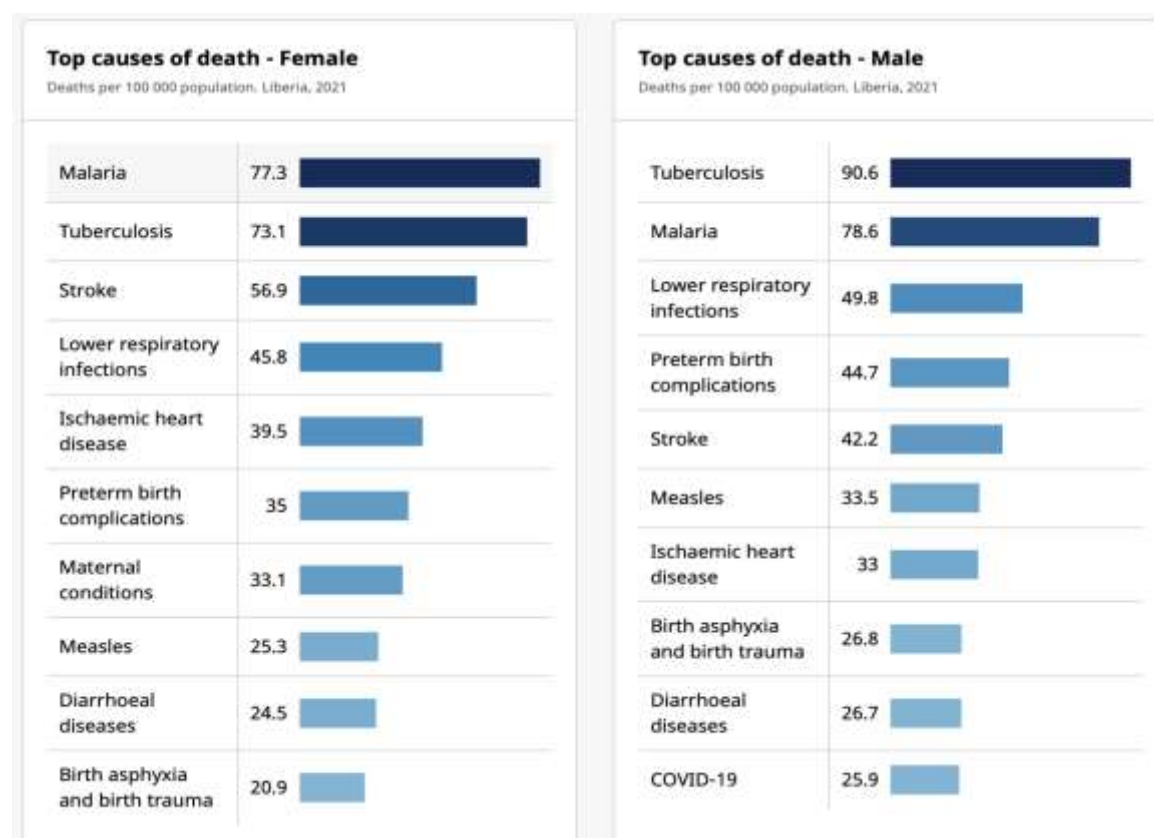
The MoH sets the standards, indicators, data norms, and develops the reporting tools. The HIS system is anchored on DHIS2, whose national rollout has been completed. DHIS2 now covers all public healthcare facilities, all the way from the primary to the tertiary level. Most faith-based facilities are also linked to the DHIS2 system, while for private facilities, even though many are linked to the system, reporting completeness is variable. Data flows from the facility to the district, the county and then to the national DHIS2 server. Most indicators are reported monthly.

Liberia is also implementing a Community Health Information System (CHIS) that tracks the Community Health Assistant (CHA) Program. Community level data such as referrals are tracked and the data is aggregated and increasingly captured in DHIS2. For disease outbreak and epidemic intelligence there is an information system that provides data on a weekly basis for priority diseases. Most of this data is currently recorded on paper. Although the country is attempting to roll out civil registration (births, deaths and causes of deaths) currently the system is constrained by reporting challenges and under- registration.

1.6.1 1.8. Health and disease in Liberia

Liberia is facing a double burden of disease with communicable diseases such as TB, malaria, lower respiratory tract infections remaining prevalent and imposing a large mortality burden while non communicable diseases, especially cardiovascular disease, are increasingly contributing to the mortality burden. The figure below (Figure 8) shows the top causes of death for males and females in Liberia.

Figure 8 :Top causes of death in Liberia, source WHO Data



2. Tuberculosis in Liberia

Tuberculosis is a disease of major public health concern in Liberia. However, no TB prevalence surveys or vital registration data is available to provide more precise estimates of the disease burden. Consequently, estimates of the disease burden (incidence and mortality) have wide uncertainty intervals. The country is listed by WHO among the 30 high TB burden countries with an estimated TB incidence of 207 (95% UI 126-402) per 100,000 population translating to 12,000 (7,100-23,000) people falling ill with TB annually.³

Despite a gradual increase of notified persons with TB from 7,454 to 8,188 between 2021 and 2024 (Figure 9), the national notification gap remains substantial (31%), driven by under-diagnosis, which is worse in hard-to-reach areas.⁴ There is limited access to diagnostic tools which is also worse in rural and probably sparsely populated counties.³ As in other TB endemic countries, the productive age groups of between 15 and 54 are the most affected with a male predominance in all age groups except those under the age 15 (Figure 10). Based on WHO estimates, HIV and alcohol/drug use disorders are important drivers of TB while undernutrition, diabetes and tobacco smoking have smaller population attributable fractions. It is important to note that the population attributable fractions imposed by the five risk factors monitored by WHO (undernutrition, HIV infection, diabetes, tobacco smoking and alcohol/drug use disorders) can explain only about a half of the incidence of TB in Liberia.²

In the 2025 Global TB report, estimates of the TB incidence and mortality for 2024 were revised downwards and were projected to have fallen by 29% and 49% respectively between 2015 and 2024. However, Liberia remains off track to achieve the End TB strategy targets of reducing TB incidence and mortality by 80% and 90% respectively by 2030, which is only five years away



³ World Health Organization (WHO) (2025) *Global Tuberculosis Report 2025*. Geneva: World Health Organization. Available at: [WHO Global Tuberculosis Report 2025](#)

⁴⁴ Liberia NLTCP data 2024

A TB epidemiological review carried out in February 2026 revealed that TB notifications have been rising annually since the dip that occurred in the first half of 2022. In 2024, a total of 8,188 people with TB were notified representing about 69% of all estimated incident cases of TB that year.⁵ At about 80% of all forms of TB notified, pulmonary TB (PTB) is the predominant form of TB Tuberculosis. In the years 2022-2024, children of the age group 0-14 years accounted for 10-12% of all TB notifications (Figure 10).

Figure 9:Liberia Trends in TB notifications, 2021- 2024

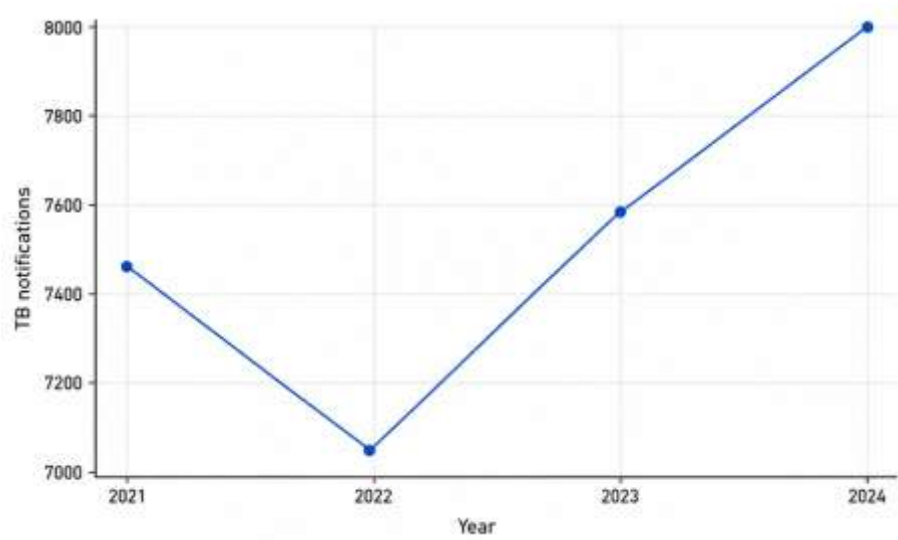
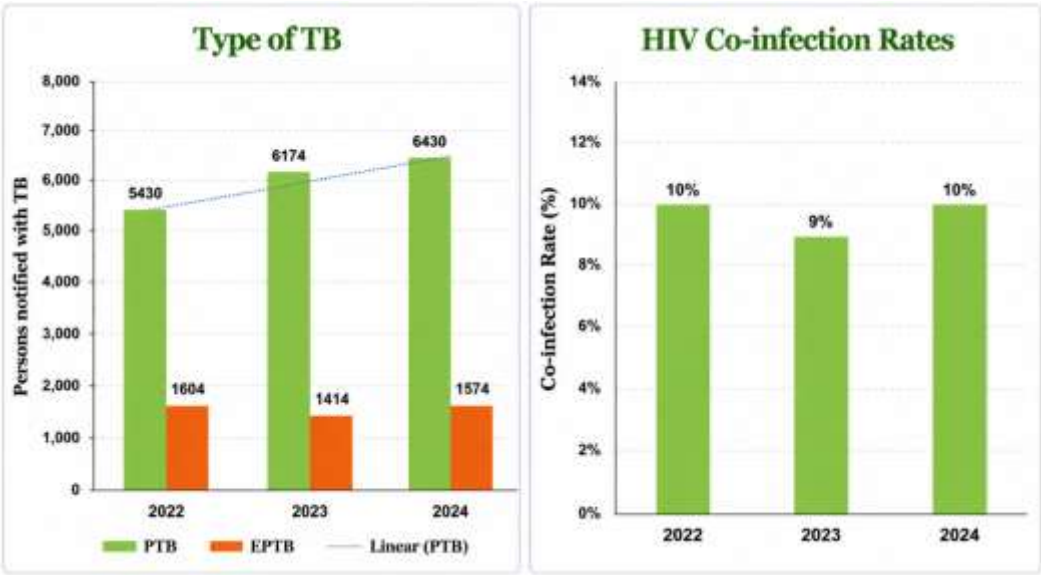


Figure 10: Age- and Sex distribution of notified persons with TB in 2024 in Liberia



⁵ Liberia NLTCP data 2024

Figure 11: Liberia TB notification 2022-2024 by TB type (PTB or EPTB, HIV co-infection rates 2022-2024

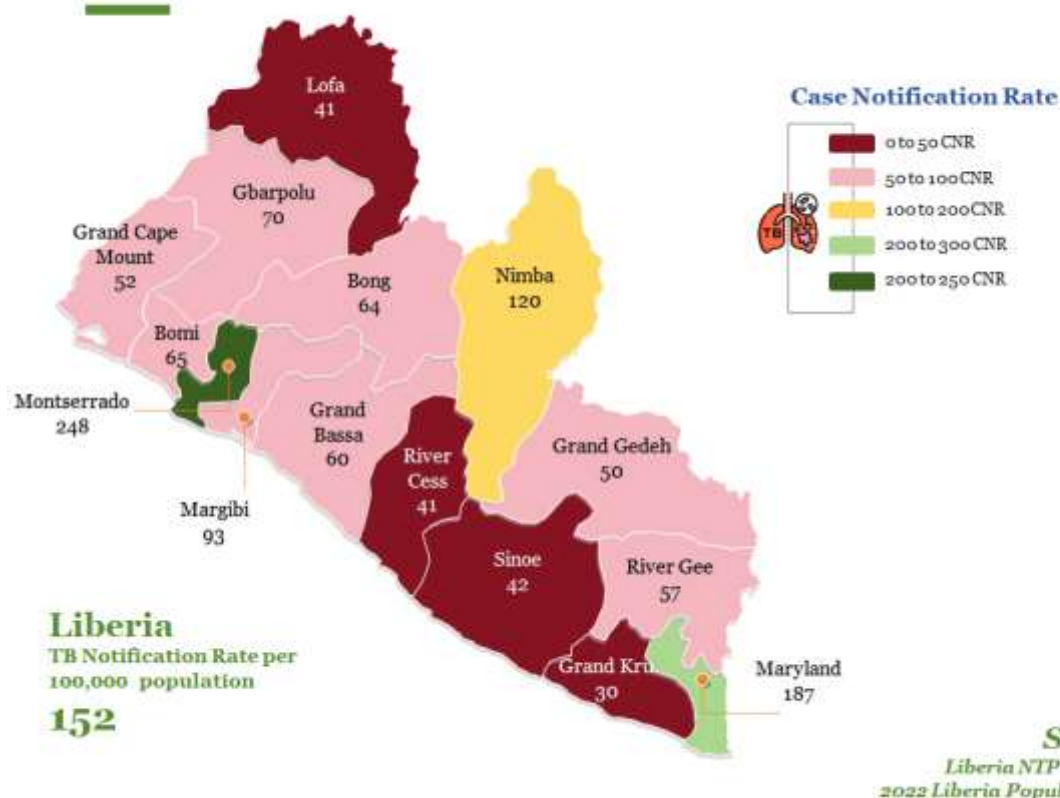


1.6.2 TB Notification rates per county

Tuberculosis notifications vary widely by county, with Montserrado accounting for 65% of all notifications despite carrying only about 37% of the total Liberian population. This observation may be related to risk factor distribution (% of the population who have risk factors that increase vulnerability to TB disease) or inequities in access to TB diagnostics.



2024 Case Notification Rate



1.6.3 TB treatment outcomes in Liberia

Among people with drug-susceptible TB, the highest treatment success rate was achieved so far was in the 2024 cohort; however, it was still only 79% against the target of 90%.

Figure 12: Trends of TB treatment success rate in Liberia 2018-2024

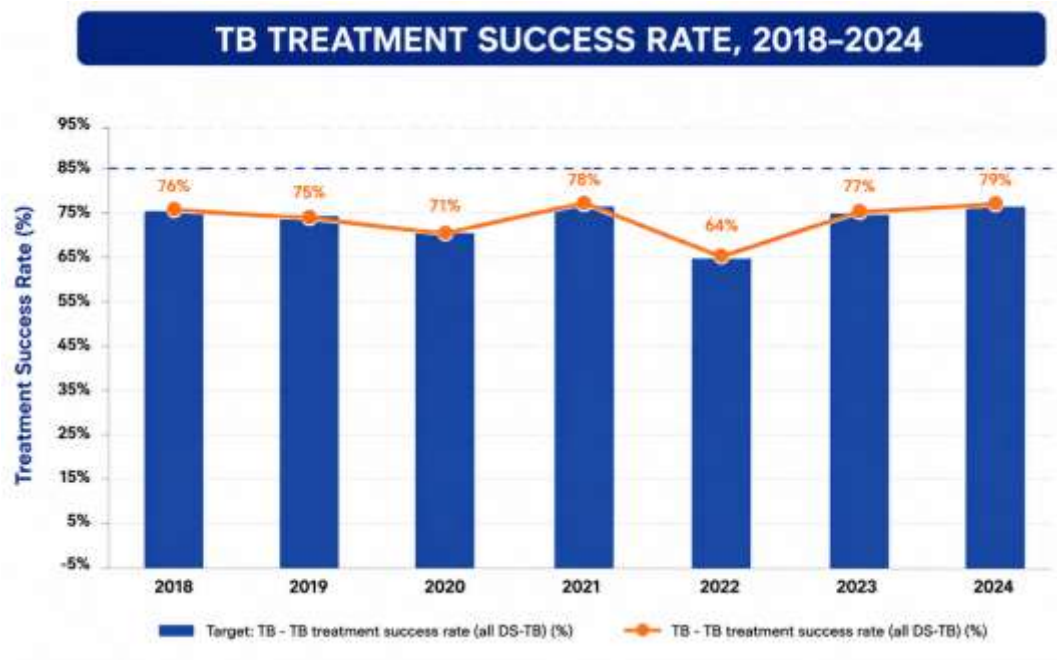
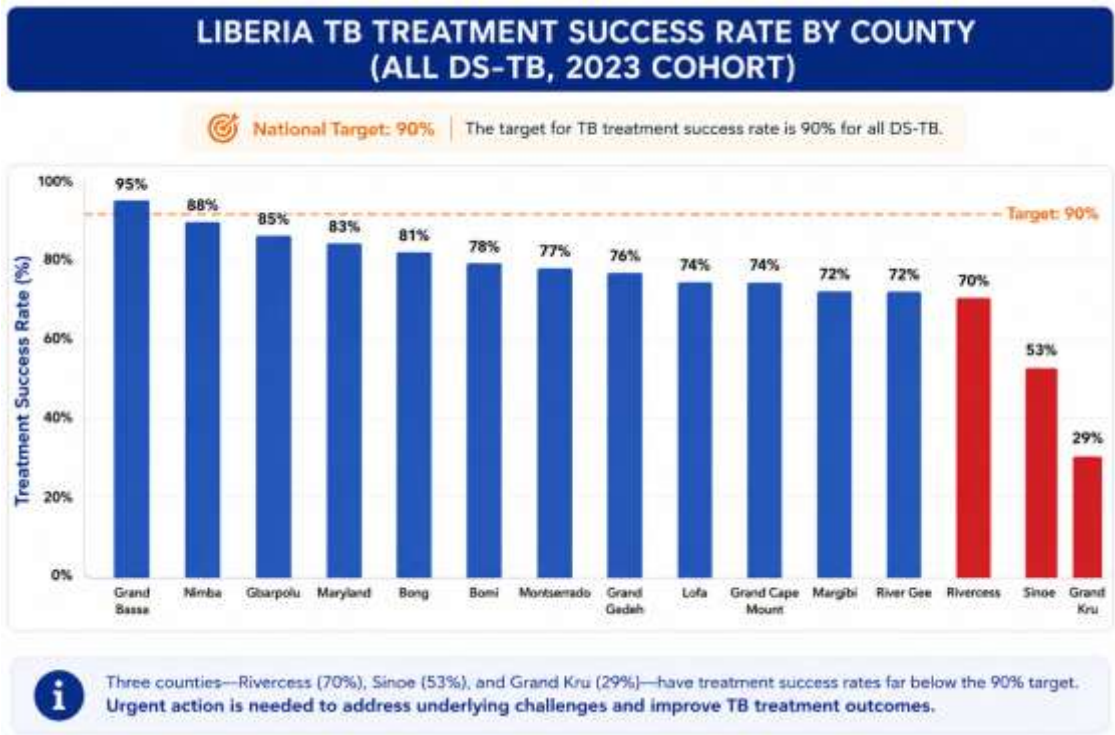


Figure 13: Liberia TB treatment success rates for DS TB by county for 2023 cohort



Rivercess, Sinoe, and Grand Kru recorded very low treatment success rates in 2024, ranging from 70% in Rivercess to 29% in Grand Kru. This is a serious concern and warrants urgent review of its causes and implications for TB care in Liberia.

Together, these three counties notified 164 people with TB in 2024, of whom 79 did not achieve a favorable outcome: 17 of 57 in Rivercess, 27 of 37 in Grand Kru, and 35 of 70 in Sinoe. This

major gap in timely and effective care appears largely driven by high loss to follow-up. Outcomes for RR/MDR-TB are also poor, with only 59% treatment success in the 2022 cohort.

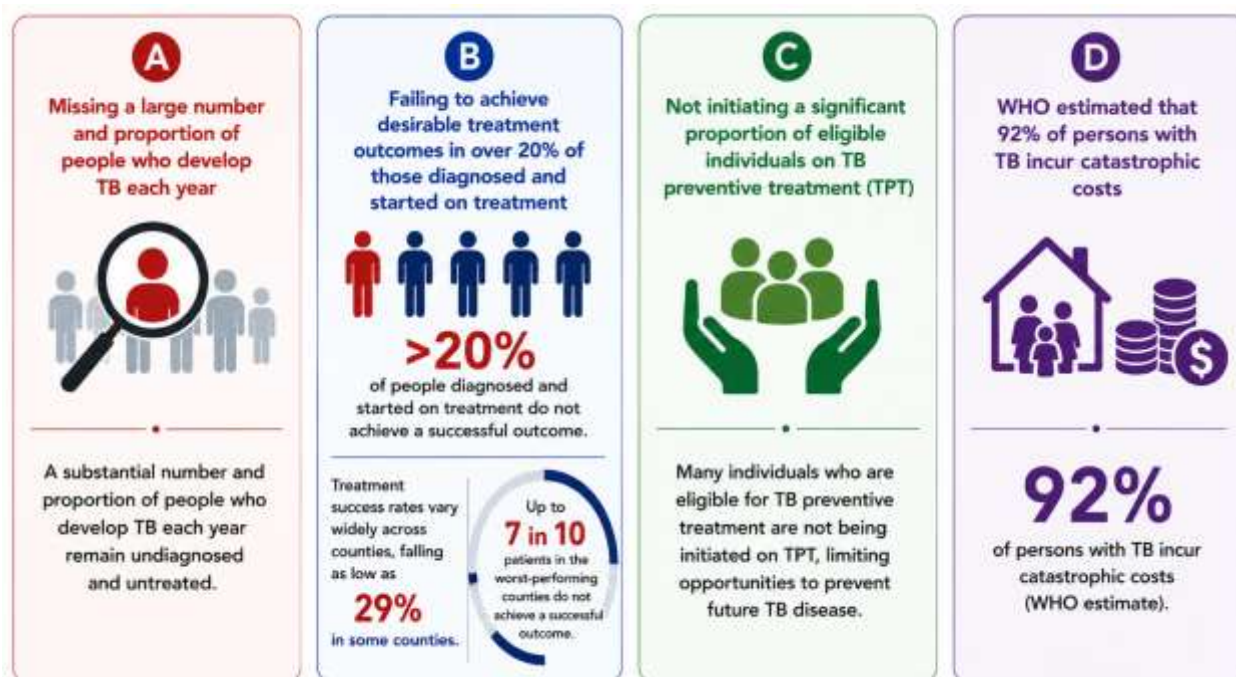
1.6.4 Liberia TPT uptake

TB preventive treatment (TPT) is recommended for people at high risk of progressing from *Mycobacterium tuberculosis* infection to active disease. These include child household or close contacts of infectious TB cases, especially those under five years; older child and adult household contacts; and people with immunosuppressive conditions, particularly those living with HIV.

Although Liberia has adopted these recommendations, TPT coverage among eligible groups remains very low and is often poorly documented. This is a major missed opportunity to prevent TB, reduce transmission, and lower the national burden of disease.

1.6.5 Summary of Liberia TB program key challenges

Liberia faces a substantial TB burden alongside an inadequate programmatic response.



Together, these gaps reflect critical weaknesses across the TB care cascade and underscore the urgent need for strengthened case finding, improved quality of care, and expanded delivery of preventive services.

Progress towards the End TB Strategy targets is constrained by several factors, including weak diagnostic capacity. In 2024, only 43% of new and relapse TB notifications were tested with a WHO-recommended rapid diagnostic test. However, performance improved: 80% of people with pulmonary TB were bacteriologically confirmed, and among these, 98% of new cases and 83% of previously treated cases were tested for rifampicin susceptibility. A total of 162 people with rifampicin-resistant TB were identified, all of whom were started on second-line treatment, but none were tested for fluoroquinolone susceptibility. In addition, Liberia did not report 2024 data to WHO on TB preventive treatment among household contacts or newly enrolled people living with HIV.

3. Rationale for the new TB National Strategic Plan

The Liberia TB response over the past seven years has been guided by the National TB Strategic Plan (TB-NSP) for the period 2020–2026. The overarching aim of this plan was to initiate a reversal of the TB epidemic by 2026, thereby contributing to the long-term national goal of ending TB in Liberia by 2035. The objectives and strategic interventions of the plan were closely aligned with the World Health Organization’s End TB Strategy, Liberia’s National Health Plan, and the Essential Package of Health Services (Version II).

The 2020–2026 TB-NSP was structured around three strategic goals:

- (i) to provide high-quality TB preventive, diagnostic, treatment, and care services to all individuals without exposing them to catastrophic costs;
- (ii) (ii) to institute bold policies and supportive systems for TB prevention, diagnosis, treatment, and care; and
- (iii) (iii) to intensify research and innovation.

The plan was designed to address two major programmatic challenges: low treatment coverage for both drug-susceptible and drug-resistant TB, and suboptimal treatment success rates.

To this end, the TB-NSP set ambitious impact targets, including reducing TB incidence by more than half, from 56 per 100,000 population in 2018 to 23 per 100,000 by 2026 and reducing the proportion of people with TB and their households experiencing catastrophic costs to below 20%. It also established key outcome targets, such as increasing the TB notification rate from 163 to 277 per 100,000 population, expanding detection of rifampicin-resistant and multidrug-resistant TB from 73 to 548 cases annually, and improving treatment success rates to above 90% for drug-susceptible TB and above 80% for RR/MDR-TB.

The 2020–2026 TB-NSP has now reached its conclusion. While many of its ambitious targets were not achieved, implementation of the plan nonetheless resulted in important gains. TB notifications increased from 7,454 in 2022 to 8,004 in 2024, and treatment coverage reached an estimated 69% by 2024 from 45% in 2021. In addition, the number of people diagnosed with RR/MDR-TB doubled, from 73 in 2018 to 142 in 2024.

Over this period, the TB landscape has evolved considerably. Advances in diagnostics, including the introduction of near point-of-care molecular assays, offer the potential to replace smear

microscopy as the primary diagnostic approach. For individuals unable to produce sputum, emerging methods such as tongue swab sampling and testing are expanding access to bacteriological confirmation and reducing reliance on empirical treatment. Innovations such as pooled sputum testing also present opportunities to improve the efficiency of screening and diagnostic services.

Significant progress has also been made in TB treatment, particularly for drug-resistant TB. Shorter, safer, and more effective regimens recommended by the World Health Organization, including Bedaquiline, Pretomanid, Linezolid and Moxifloxacin (BPaLM) , are transforming the management of what was previously a highly complex and difficult-to-treat condition.

Taken together, these epidemiological, programmatic, and technological shifts provide a strong justification for the development of a new TB-NSP for Liberia that, that is more responsive to current realities, leverages recent innovations, and accelerates progress toward ending TB.

4. Methodology of the development of the TB -NSP 2027-2031

The development of this strategic plan followed an iterative process that began with an epidemiological review, followed by a program review and finally a stakeholder engagement to define the strategic direction of the country including identifying goals, objectives, interventions and activities of the new TB-NSP. Both quantitative and qualitative data was used in the synthesis of information related to the TB response and the context of Liberia's health system. The process was inherently consultative, involving government entities, technical partners and civil society, however, it did not engage affected communities as strongly as was desired.

The process began with a comprehensive situational analysis, which established a shared understanding of the burden and drivers of TB in the country. This included examining epidemiological trends, such as incidence, mortality, drug resistance patterns, and affected geographical areas and populations, alongside an assessment of program performance, including case detection, treatment outcomes, and preventive therapy coverage. At the same time, the broader health system was reviewed, using the World Health Organization health system building blocks framework, to assess governance, human resources, financing, service delivery, supply chains, and information systems in addition to examining community responses. These foundational steps were intended to ensure that the NSP is grounded in reality rather than aspiration.

The epidemiological analysis of the TB burden was followed by an External Program Review (EPR), which provided an independent and systematic assessment of the TB program. Through field visits, data validation, and stakeholder consultations, the EPR identified key strengths, bottlenecks, and missed opportunities. The recommendations of the EPR served as a central reference point for shaping the NSP's priorities and interventions.

In addition to the TB epidemiological review and EPR, SWOT and PESTEL strategic frameworks were applied to help distinguish internal programmatic strengths and weaknesses from external political, economic, social, and technological influences. These frameworks were used in combination with the epidemiological and program

data, allowing for a more nuanced understanding of feasibility and risk. A Theory of Change (ToC) approach in which specific interventions are mapped in the pathway to the desired outcomes and long-term impact, was used to make explicit the assumptions underpinning the strategy.

The TB-NSP development did not employ mathematical modelling and scenario analysis to estimate the potential impact and cost-effectiveness of different strategic options, such as scaling up preventive therapy, introducing new diagnostics, or expanding active case finding.

An inherent feature of the new plan is a proposal to build in flexibility and adaptability that would allow mathematical modeling and scenario analysis to be carried out during the implementation of the new plan and which could lead to changes in the choice of interventions in this resource-constrained environment.

Using an online consultative process, priority interventions were identified. Priority setting was based on the burden of disease, expected outcomes of the interventions, feasibility of implementation, equity considerations, and available resources. While the NSP is generally aligned with the World Health Organization End TB Strategy, the development of priority interventions was based on good practices which emphasize adapting global frameworks to national realities rather than replicating them rigidly.

Once priorities were defined, these were translated into a set of clear goals and objectives that were Specific, Measurable, Achievable, Relevant and Time bound (SMART). A detailed costing of the plan's activities was then undertaken to estimate resource needs.

A robust monitoring, evaluation and learning framework was developed to track progress, alongside an assessment of key risks and sustainability considerations, such as reliance on external funding or human resource constraints. Once all elements of the TB-NSP, it was validated in a workshop that included government entities, technical partners and civil society, and affected communities. The resulting NSP is therefore not just a planning document, but a strategic instrument that integrates evidence, policy, and implementation considerations into a coherent roadmap.

5. The TB response in Liberia: Strengths, Weaknesses, Opportunities and Threats (SWOT)

5.1 Introduction

A SWOT analysis is a critical step in the development and revision of a national strategy for tuberculosis (TB). It enables systematic identification of internal strengths and weaknesses within the National TB Program, while also examining external factors that present opportunities or pose threats to the TB response.

To ensure a comprehensive and forward-looking assessment, the SWOT analysis was complemented by a PESTEL framework, examining Political, Economic, Social, Technological, Environmental, and Legal factors. Together, these approaches provide a holistic understanding of the context within which the TB response operates and help inform the feasibility, prioritization, and design of strategic interventions.

The findings of the SWOT and PESTEL analyses were informed by the epidemiological assessment and the TB program review conducted as part of the NSP revision process. The key findings are summarized below.

Overall, the SWOT and PESTEL analyses highlight a TB program with a solid foundation, characterized by established policies, a nationwide service delivery platform, and committed leadership, however, it is constrained by critical systemic weaknesses. These include heavy reliance on external financing, human resource shortages, gaps in data quality and use, suboptimal service integration, and weaknesses in patient support systems that contribute to poor treatment outcomes and high loss to follow-up.

At the same time, there are significant opportunities to transform the TB response. Ongoing health sector reforms toward universal health coverage and primary health care, digital transformation of health information systems, advances in diagnostics and treatment, introduction of Community Revolving Drug Fund (CRDF), Onboarding of the Community Health Services Supervisors (CHSSs), improvement in Supply Chain and health infrastructures and renewed political engagement, including the establishment of a TB legislative caucus, provide a strong platform for accelerating progress.

However, these opportunities are tempered by substantial threats, including a fragile and uncertain global financing landscape, persistent poverty and high levels of social determinants of health, health system shocks, and governance risks. Without deliberate strategies to address these risks, particularly around sustainability, decentralization, and patient-centered care, progress may stall or even reverse.

Taken together, these findings underscore the need for a new TB-NSP that is more resilient, better integrated within the broader health system, financially sustainable, and explicitly focused on closing gaps across the TB care cascade, from early detection to treatment completion, TB prevention and post TB care.

5.2 Key Findings from SWOT/PESTEL Analysis

5.2.1 Leadership and Governance

STRENGTHS	WEAKNESSES
● Established National TB Program (NTP) with clear policies, guidelines, and strategic direction. ● Defined TB focal points across the county and national levels of the health system. ● Strong alignment with global strategy and targets, including the End TB Strategy. ● Demonstrated political commitment, including integration of TB into national policy frameworks (e.g., National Health Policy 2025–2035 aligned with the ARREST Agenda for Inclusive Development). ● Functional coordination mechanisms, including technical working groups and partner platforms. ● Existing policy frameworks for public–private engagement and community-based service delivery.	● Fragmented accountability between national and sub-national levels. ● Delays in decision-making and slow adoption of updated global guidance. ● Limited supervisory capacity due to inadequate transport and logistics, human resources, limited financial resources, no realtime supervision tools..
OPPORTUNITIES	● THREATS
● Establishment of a national TB legislative caucus to strengthen political commitment and mobilize domestic financing. ● Ongoing health sector reforms toward UHC/PHC that can strengthen governance, accountability and equitable service delivery. ● Decentralization reforms with clearer roles, budgets, and accountability structures.	● Political transitions that may disrupt policy implementation and prioritization of TB. ● Weak domestic resource mobilization capacity. ● Governance risks, including partner fragmentation and parallel systems.

OPPORTUNITIES

- Institutionalization of quality improvement and supportive supervision systems.

● THREATS

- Climate change related environmental threats, including flooding, in the setting of a fragile health system.

5.2.2 Health Financing

STRENGTHS

- Continued support from international partners and donors.

WEAKNESSES

- Heavy reliance on external financing with minimal visible domestic budget allocation.
- Lack of a sustainability plan for TB financing.
- Limited financial tracking and visibility of government contributions.

OPPORTUNITIES

- Potential to leverage legislative and policy reforms to increase domestic financing.
- Opportunities for blended financing and integration into broader health sector budgets.

● THREATS

- Declining global health financing and uncertainty of donor support.
- Competing national priorities limiting fiscal space for TB.

5.2.3 Human Resources for Health (HRH)

STRENGTHS

- Ongoing investments in training, reaching large numbers of healthcare workers annually.
- Enrollment of volunteers on payroll.

WEAKNESSES

- Critical shortages of skilled clinical and laboratory personnel at all levels.
- High attrition, particularly at primary health care level.
- Heavy reliance on unpaid or irregularly paid volunteer staff.

OPPORTUNITIES

- Integration of TB program staff into broader HRH planning and national health workforce strategies.
- Potential for task-shifting and capacity-building through PHC reforms.

● THREATS

- Continued staff attrition due to low remuneration and poor incentives.
- Demotivation of trained workforce affecting service quality.

5.2.4 Health Information System

STRENGTHS	WEAKNESSES
● Established TB data collection and cohort monitoring systems. ● Routine reporting supporting program performance review. ● Evidence based planning and decision making and policy development.	● Significant data quality and reporting gaps across all levels. ● Weak integration with national systems (e.g., DHIS2). ● Limited capacity of use of data for decision-making at the generation points.
OPPORTUNITIES	● THREATS
● Ongoing transition to digital health information systems. ● Potential to strengthen surveillance, data use, and real-time monitoring.	● Persistent data gaps undermining planning and resource allocation. ● Weak interoperability across systems.

5.2.5 Service Delivery

STRENGTHS	WEAKNESSES
● Nationwide integration of TB services within primary health care. ● Free TB diagnosis and treatment services. ● Established laboratory network with microscopy and molecular testing (GeneXpert). ● Standardized diagnostic and treatment guidelines and referral systems. ● Introduction of shorter, all-oral regimens (e.g., BPaLM) for RR/MDR-TB. ● Existing integration efforts with other health programs.	● High levels of catastrophic costs due non-optimized TB diagnosis and treatment services compounded by a lack of social and nutritional support. ● Weak engagement and regulation of private sector providers. ● Limited integration of TB with care and treatment of comorbidities (e.g., diabetes, mental health, nutrition). ● Over-centralization of DR-TB services (only three treatment centres). ● Non-existent laboratory capacity for a comprehensive assessment of resistance beyond rifampicin including lack of culture and DST. ● Inefficient sample transport systems and referral tracking. ● Significant losses across the care cascade, including pre-treatment loss to follow-up. ● Limited access to sensitive screening tools (e.g., digital X-ray). ● Persistently low treatment success rates and high loss to follow-up. ● Weak patient-centred support systems (transport, counselling, social protection). ● High levels of stigma and misinformation.

STRENGTHS

WEAKNESSES

OPPORTUNITIES

- Integration of TB services with other programs (diabetes, nutrition, child health, mental health)
- Expansion of AI-enabled digital X-ray for screening.
- Decentralization of DR-TB care enabled by shorter regimens.
- Strengthening of referral and care pathways within PHC.

● THREATS

- Persistent poverty and high levels of social determinants of health
- Geographic and transport barriers, especially in rural areas.
- Competing health emergencies disrupting service delivery.
- Rising drug resistance linked to treatment interruptions

5.2.6 Product Supply System

STRENGTHS

- Established supply chain system with SOPs and monitoring mechanisms.
- Generally consistent availability of TB medicines and diagnostics.
- Standardized treatment protocols supporting forecasting and quantification.

OPPORTUNITIES

- Strengthening LMIS and digital stock monitoring systems.
- Integration with broader national supply chain reforms.

WEAKNESSES

- Stock-outs of key commodities (e.g., Xpert cartridges, DR-TB medicines, TPT drugs).
- Poor data quality affecting quantification and procurement.
- Weak LMIS reporting and stock visibility.
- Inadequate storage and inventory practices at facility level.
- Limited pharmacovigilance systems.

THREATS

- Supply disruptions due to funding instability
- Procurement inefficiencies and last-mile distribution challenges

5.2.7 Community Engagement and Empowerment

STRENGTHS

- Established community health worker (CHW) network supporting screening, referral, and adherence support.
- Existing IEC materials and community outreach activities.
- Partnerships with civil society and patient groups.
- Provision of patient support (e.g., transport vouchers).
- Increased awareness and some reduction in stigma.

OPPORTUNITIES

- Revised community health policy integrating TB into community platforms.
- Potential to scale up community-based case finding, contact tracing, and TPT.
- Expansion of community-led monitoring systems.

WEAKNESSES

- Limited support and incentives for CHWs.
- Weak community feedback and accountability mechanisms.
- Limited community-led monitoring.
- Persistent stigma and misinformation.

THREATS

- Persistent stigma reducing care-seeking and adherence
- Weak community engagement undermining trust and uptake of services

5.2.8 Gender, Equity and Human Rights (GEHR) in the TB Response

STRENGTHS

- Existing policy recognition of people-centered, equitable TB services within the national strategy.
- Integration opportunities with HIV programs, particularly for reaching PLHIV and improving TPT uptake.
- Availability of Global Fund and partner support for GEHR-related interventions (stigma reduction, KP programming, social protection).

OPPORTUNITIES

- Existence of Gender unit at the MoH for collaboration.
- Strong foundation of community health worker (CHW) platforms that can be leveraged for equitable TB service delivery.
- Digital health and DHIS2 improvements enabling better disaggregated data collection and use.
- Opportunities to integrate TB services into PHC, RMNCAH+N, and HIV platforms for more equitable reach.
- Potential to leverage multi-sectoral collaboration (gender, private-cooperate sector, justice, labor, social protection) to reach high-risk populations.

WEAKNESSES

- Limited systematic integration of gender and human rights approaches across TB programming and service delivery.
- Limited integration of TB services into RMNCAH+N and mental health platforms for more equitable reach.
- Stigma and discrimination in the community affecting care-seeking and adherence.
- Limited capacity for diagnosing TB in children.
- Poor health seeking behavior among men.
- Limited social protection support thereby exposing TB patients to high out of pocket costs.
- Limited community-led monitoring mechanism for the TB response.

THREATS

- Deep-rooted social norms and stigma associated with TB and TB/HIV co-infection.
- Limited domestic financing leading to heavy reliance on donor funding.

5.2.9 Cross-cutting PESTEL Insights

- **Political/Economic:** Risk of reduced donor funding; limited domestic fiscal space, changing political priorities.
- **Social:** High poverty, stigma, and misinformation sustaining delays in TB diagnosis and thus promoting community TB transmission.
- **Technological:** Rapid advances in diagnostics (molecular tests, AI CXR, tongue swabs) and treatment (shorter regimens) with limited agility to rapidly adopt and scale up new tools.
- **Environmental:** Climate change and geographic barriers affecting access to care.
- **Legal:** TB is a notifiable disease, providing a foundation for stronger regulatory enforcement.

6. The Vision, Goals and Objectives of the TB-NSP 2027-2031

6.1 Guiding principles

The tuberculosis (TB) response under the TB National Strategic Plan (TB-NSP) 2027–2031 will be guided by the following principles:

- **Alignment with national and global priorities:** Ensuring coherence with national development frameworks, the health sector strategic plan, and global commitments including the WHO End TB Strategy.
- **Integrated and people-centred approach:** Placing integration at the core of service delivery, linking TB with broader health services (including HIV, non-communicable diseases, and primary health care) while ensuring care is responsive to the needs of individuals and communities.
- **Flexibility and adaptability:** Maintaining the ability to respond to evolving epidemiological trends, emerging evidence, and contextual challenges, including humanitarian and climate-related shocks.
- **Patient-centred care:** Ensuring that all TB services are designed and delivered around the needs, preferences, and rights of people affected by TB.
- **Data-driven and quality-oriented programming:** Promoting the use of high-quality data for decision-making, continuous quality improvement, and performance management at all levels.
- **Human rights and gender responsiveness:** Upholding human rights principles and ensuring equitable, stigma-free, and gender-responsive TB services.

6.2 Core Values of the TB Response (2027–2031)

The implementation of the TB-NSP 2027–2031 will be underpinned by the following core values:

- **Compassion:** Every person affected by TB will be treated with dignity, respect, and empathy.
- **Integrity:** Commitment to transparency, ethical practice, and accountable use of resources, with zero tolerance for corruption.
- **Equity:** Ensuring fair and equitable access to TB services regardless of gender, income, geography, or social status.

- **Excellence:** Striving for the highest standards in diagnostics, treatment, care, and program management.
- **Collaboration:** Fostering strong partnerships across government, communities, civil society, the private sector, and development partners.
- **Innovation:** Embracing new technologies, digital solutions, and improved tools for prevention, diagnosis, and treatment.
- **Accountability:** Establishing clear roles, responsibilities, and measurable performance targets across all levels, including national and subnational government structures, private providers, and communities.
- **Stewardship:** The Government of Liberia will remain in a clear leadership position, with overall responsibility for implementation of the activities of this National Strategic Plan

6.3 Strategic Priorities for the National TB Strategic Plan, 2027-2031.

Based on the findings of the TB epidemiological review, the external TB program review and the SWOT/PESTEL analysis the following strategic priorities were identified for the forthcoming planning and implementation cycle.

6.3.1 Priority 1: Close the TB Detection Gap through People-Centred and Integrated Case Finding

Liberia must substantially increase TB case detection to reduce the large proportion of people with TB who remain undiagnosed or unnotified. This will require a shift from passive, facility-based approaches to proactive, targeted, and integrated case finding.

Key directions:

- Profiling/characterizing people with TB to scale up systematic screening among populations that are observed to have high rates of TB. As recommended by WHO, these should be populations that have an estimated TB prevalence of at least 0.5%.
- Expand use of sensitive screening and diagnostic tools (e.g., digital X-ray, molecular diagnostics)
- Strengthen private sector engagement and mandatory notification.
- Improve sample transport and referral systems to reduce diagnostic delays.
- Integrate TB screening into PHC, HIV, maternal and child health, and NCD services.

6.3.2 Priority 2: Improve Quality of Care and Treatment Outcomes Across the TB Care Cascade

The persistently low treatment success rates and high loss to follow-up require urgent action to strengthen quality, continuity, and patient-centeredness of care.

Key directions:

- Strengthen adherence support systems, including community-based models.
- Expand patient-centred support (transport, nutrition, psychosocial care, social protection linkages).
- Decentralize DR-TB services enabled by shorter regimens (e.g., BPaLM).
- Strengthen referral tracking and reduce pre-treatment and on-treatment loss to follow-up.
- Institutionalize quality improvement systems at all levels.

6.3.3 Priority 3: Scale Up TB Prevention through Expanded and Systematic Delivery of TPT

Tuberculosis prevention remains a major missed opportunity. The program must significantly expand access to TB preventive treatment (TPT) among all eligible populations.

Key directions:

- Scale up household contact management and TPT delivery.
- Prioritize high-risk groups, including children under five and people living with HIV.
- Strengthen community-based delivery of TPT.
- Improve monitoring and reporting of TPT coverage and outcomes.
- Address demand and supply-side barriers including stigma and hesitancy

6.3.4 Priority 4: Strengthen Health Systems Foundations for TB (HRH, Supply Chain, and Diagnostics)

Achieving TB targets will require sustained investments in core health system building blocks that underpin service delivery.

Key directions:

- Address critical HRH shortages through recruitment, retention, and incentives.
- Strengthen laboratory capacity, including expansion of molecular testing and introduction of culture/DST where feasible.
- Improve functionality of sample transport systems.
- Strengthen supply chain systems, including LMIS, forecasting, and last-mile distribution.
- Establish pharmacovigilance systems for TB medicines.

6.3.5 Priority 5: Build a Robust, Integrated, and Digital TB Information System

A strong TB response requires high-quality, timely, and actionable data. Key directions:

- Strengthen data quality assurance systems across all levels.
- Integrate TB data systems into national digital platforms (e.g., DHIS2).
- Improve real-time data use for decision-making and performance management.
- Strengthen surveillance, including case-based and cohort monitoring systems.
- Enhance interoperability across programs and levels of care.

6.3.6 Priority 6: Strengthen Governance, Financing, and Sustainability of the TB Response

Ensuring long-term impact will require stronger leadership, accountability, and financial sustainability.

Key directions:

- Strengthen coordination and accountability mechanisms across all levels.
- Leverage the TB legislative caucus to increase political commitment and domestic financing.
- Develop and implement a TB financing sustainability plan.
- Align TB planning and budgeting with broader health sector reforms (UHC/PHC).
- Strengthen public–private partnerships and reduce system fragmentation.

6.3.7 Priority 7: Empower Communities and Address Social Determinants of TB

Ending TB will require robust implementation of biomedical interventions in combination with strong efforts to tackle upstream social determinants of TB, especially poverty and

all its consequences. Strong community level responses that go beyond biomedical interventions will be critical.

Key directions:

- Strengthen and incentivize community health worker systems.
- Scale up community-led monitoring and engagement.
- Implement targeted stigma reduction and risk communication strategies.
- Expand social protection and economic support interventions.
- Integrate TB responses within broader community health platforms.
- Ensure a whole government response that addresses poverty and its consequences.

6.3.8 Priority 8: Gender, Equity, Human Rights in the TB Response

Tuberculosis in Liberia is shaped by gender dynamics, socio-economic inequalities, stigma, and structural barriers that affect access to prevention, diagnosis, care, and treatment services. Despite progress, gaps persist across the TB care cascade, particularly among men (who often present late), women (who face access and stigma-related barriers), children (who are underdiagnosed), and key and vulnerable populations. Addressing these disparities is critical to achieving an effective and inclusive TB response.

This priority focuses on embedding gender-responsive, equity-driven, and human rights-based approaches across all TB interventions to ensure that services are accessible, acceptable, and of high quality for all populations, particularly those most at risk or under-served.

Key directions:

- Integrate gender and human rights approaches into TB policies, strategies, and service delivery models.
- Conduct gender and equity analyses to identify and address barriers to TB service access and utilization.
- Implement targeted interventions to reach under-served and high-risk populations, including gender responsive interventions (men, women), children, adolescents, people living with HIV, prisoners, miners, urban poor, and mobile populations.
- Strengthen stigma and discrimination reduction interventions at community and facility levels.

- Promote people-centred TB care that ensures dignity, confidentiality, informed consent, and respectful service delivery.
- Build capacity of healthcare workers on gender responsive, gender-sensitive, stigma-free, and rights-based TB service provision.
- Ensure community engagement and community-led monitoring to enhance accountability and responsiveness of TB services.
- Expand social protection interventions (e.g., transport, nutrition, psychosocial support) to reduce catastrophic costs and improve treatment adherence.
- Ensure equitable access to TB prevention services, including TPT, with attention to gender-specific and structural barriers.
- Strengthen data systems to capture and use dis-aggregated data (sex, age, population group) to inform equitable programming.

6.3.9 Priority 9: Harness Innovation, Research, and Emerging Technologies

Liberia should position itself to rapidly adopt and scale innovations that can accelerate progress. Additionally, Liberia will need to undertake key studies to obtain data/information that is critical for program planning and decision making.

Key directions:

- Scale up new diagnostic approaches (e.g., AI-enabled CXR, nPOC, tongue swabs, sputum specimen pooling)
- Rapidly adopt and expand access to shorter and more effective treatment regimens.
- Promote operational and implementation research to inform program improvements.
- Prepare for introduction of new tools, including TB vaccines and novel preventive therapies.
- Strengthen partnerships for innovation and capacity building.

These strategic priorities reflect a shift toward a more people-centred, integrated, and resilient TB response. They address critical gaps across the TB care cascade while leveraging emerging opportunities in health system reform, technological innovation, and political commitment. Successful implementation will require strong leadership, sustained financing, and coordinated action across sectors to accelerate progress toward ending TB in Liberia.

6.4 Vision:

A TB free Liberia.

6.5 Goal.

To reduce the burden of tuberculosis in Liberia by ensuring equitable access to integrated, high-quality TB prevention, diagnosis, care, and treatment services, thereby minimizing the impoverishing effects of the disease and reducing the proportion of TB-affected households experiencing catastrophic costs from 92% in 2024 to below 20% by 2030.

6.5.1 Rationale for the choice of this goal

According to the guidance from WHO, the goal(s) of a national TB strategic plan should reflect the desired long-term impact that is to be achieved by implementing the strategic plan. The End TB strategy has three impact targets to be achieved by 2030: **reduction in TB incidence by 80% compared with the 2015 baseline, reduction in TB mortality by 90% compared to the 2015 baseline and zero financial impact (Zero percent of people with TB and their household experience catastrophic costs)**. Choosing the catastrophic cost reduction as the primary goal by which to measure the overall success of implementing this NSP aligns with the holistic vision of health and well-being. Reductions in catastrophic costs incurred by people with TB, their families, and impacted communities can be sustainably achieved to lead to long and healthy lives that are free of TB for these individuals, their families and communities. Broader, cross-cutting support for this TB NSP can further be mobilized around this goal, with multi-sectoral investments made to address factors such as population poverty, nutrition and housing, that play a major role in TB incidence and mortality.

In addition to these important health and human rights justifications for selecting the catastrophic cost reduction as the goal, reducing catastrophic costs is also a practical choice. Unlike TB incidence and mortality, which rely on modelling and are difficult to measure directly, catastrophic costs can be tracked through relatively simple patient cost surveys. This goal also aligns Liberia's TB NSP with the End TB Strategy, while remaining realistic given that 92% of people with TB in Liberia currently face catastrophic costs. In addition, it is strongly equity-

focused and consistent with the NSP's core values and guiding principles. Most importantly, it is achievable through actions within the mandate of the national TB program:

(a) TB prevention through implementation of IPC measures including at the community level; ensuring high coverage of TB preventive treatment for eligible individuals, the roll out of nutritional programs to not just treat undernourished people with TB but also to use food as a TB preventive measure as observed in the RATIONS trial and potentially by rapid scale up of an efficacious and effective vaccine when one becomes available; (b) Early and complete TB case finding with rapid initiation of appropriate treatment, especially when diagnostic and treatment services are available at the initial point of care and (c) implementation of robust patient support systems.

6.6 Objectives of the TB-NSP 2027-2031

1. **Strengthen TB prevention** at community and health facility levels by ensuring active case finding is linked to provision of TPT to at least 90% of eligible persons and ensuring at least 90% of health care facilities are implementing facility specific IPC measures that are aligned to national IPC standards by 2030.
2. **Increase TB case detection** with early diagnosis, and notification through efficient use of screening and diagnostic tools, including new tools, to reduce the TB incidence/prevalence-detection gap to less than 20% by 2030 (achieve a treatment coverage of at least 80% by 2030).
3. **Enhance quality of care** including patient support systems to improve TB treatment success rate from 79% to at least 90% before 2030 and sustain this performance for both drug susceptible and drug-resistant TB.
4. **Empower communities and key populations** to contribute effectively to the TB response, reduce TB associated stigma and ensure TB service provision is human rights based and gender responsive. By 2030, 90% of facilities providing TB services should have undertaken stigma-reduction training to staff and be implementing grievance reporting systems.
5. **Strengthen the TB surveillance system** and ensure TB data is of high quality with data accuracy score from a baseline of 46% (2025) to at least 75% in annual audits so that the TB information system can sufficiently be used as a proxy for tracking the burden of TB in Liberia.

6. **Strengthen National and Subnational Stewardship of the TB response** through effective leadership and governance, sustainable financing, and functional multisectoral coordination to improve accountability, performance, and equitable access to quality TB services.

By, 2030, strengthen national and subnational stewardship of the TB response by ensuring that:

- ⇒ Functional governance and multisectoral coordination mechanisms operate at national level and in all counties, with at least 4 coordination/performance review meetings conducted annually and ≥80% of agreed action points closed within 90 days.
- ⇒ TB financing is more sustainable, with domestic co-financing of the annual TB budget at the national, county and facility levels increasing each year
- ⇒ Program accountability and equitable access improve, evidenced by ≥90% facility reporting complete data and timely, ≥90% of facilities reporting complete treatment outcomes, and all counties implementing the approved annual TB operational plan.

6.6.1 Rationale for the choice of these objectives

The challenges facing the TB response in Liberia have been highlighted in earlier sections of this NSP and are summarized here to emphasize the link between these constraints and the selected objectives.

- 1) **Inadequate case finding:** the TB program is missing an estimated 31% of incident people with TB and may also be finding people with TB late which increases both short-and long-term morbidity from TB and is associated with higher mortality from the disease.
- 2) **Sub-optimal TB treatment success rate:** From 2018 to 2024 the national TB treatment success rate has not gone beyond 79% and in 2022, it was as low as 64%. In one county the TSR was a mere 29% in 2024.
- 3) **Sub-optimal implementation of TB preventive measures:** All interventions for TB prevention are sub-optimally implemented in Liberia with, for example, an unclear TPT coverage among children under the age of 5 who are household contacts of people with TB in 2024.
- 4) **Inadequate financing of the TB response:** The TB response in Liberia is grossly underfunded. In 2024 most TB financing came from the Global Fund and was able to cover less than 20% of the required annual budget.

- 5) **Limited engagement of relevant sectors outside the health sector:** Key sectors such as agriculture and food security, mining and housing, that are critical for addressing upstream social determinants of TB are not currently engaged in the TB response.
- 6) **Inadequate patient support systems amid high levels of stigma:** even though the country has not carried out a TB cost survey or TB stigma survey, WHO estimated that 92% of people with TB suffered catastrophic costs in 2024. The general perception is that a high proportion of people with TB experience stigma.

Achieving these objectives over 2027–2031 period will substantially address these challenges and advance the NSP goal.

7. Strategic Interventions and activities of the TB-NSP-2027-2031

A detailed list of interventions and activities is provided in the operational and technical assistance plan in annex 1. Highlighted in this section, is a prioritized list of interventions and activities.

Objective 1: Strengthen TB prevention at community and health facility levels by ensuring active case finding is linked to provision of TPT to at least 90% of eligible persons and ensuring at least 90% of health care facilities are implementing facility specific IPC measures that are aligned to national IPC standards by 2030.	7.1 Expand identification of eligible persons and households for TPT. ○ Integrate systematic TB screening into HIV clinics with clear documentation. ○ Conduct routine household contact tracing and screening for all bacteriologically confirmed TB patients. ○ Support community health workers (CHWs) to screen households and high-risk groups. 7.2 Improve access to TPT Initiation & Enrollment. ○ Train health care workers and conduct onsite mentorships for healthcare workers and CHWs on TPT. ○ Decentralize and expand community based TPT initiation and follow up by trained CHWs. ○ Introduce same-day TPT initiation for identified eligible persons at TB, HIV, and high-risk clinics. ○ Conduct quarterly TPT performance reviews at all facilities implementing TPT. 7.3 Strengthen TPT Supply Chain. ○ Forecast and procure sufficient 3RH, 6H, and 3HPs regimens. ○ Establish buffer stocks at national and county levels.
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	○ Integrate TPT commodities into the LMIS system. 7.4 Strengthen TB- IPC Governance, coordination and integration with other IPC activities including pandemic preparedness. ○ Establish or revitalize TB IPC committees in all health facilities with TOR. ○ Support facilities to assign facility IPC focal persons. ○ Provide technical support to facilities to develop and implement facility specific IPC plans. 7.5 Enhance capacity of health care workers to implement IPC ○ Train and mentor health care workers. ○ Update & disseminate IPC guidelines and job aids. 7.6 Monitor IPC implementation and carry out quality improvement measures ○ Develop an IPC M&E plan that includes quality indicators ○ Track IPC implementation and outcomes including monitoring health care workers who develop TB infection and disease.
Objective 2: Increase TB case detection with early diagnosis, and notification through efficient use of screening and diagnostic tools, including new tools, to reduce the TB incidence/prevalence-	2.1 Efficiently use available tools to scale up integrated systematic TB screening in communities and health facilities. ○ Conduct systematic TB screening in OPD, IPD, ANC, HIV, diabetes, and malnutrition clinics. ○ Conduct periodic targeted community screening, with high population coverage, using the

detection gap to less than 20% by 2030 (achieve a treatment coverage of at least 80% by 2030).	most sensitive TB screening tool as far as feasible (CXR with AI interpretation) in geographical areas with high TB disease defined by case notification rates. ○ Explore use of sputum specimen pooling in TB screening programs. 2.2 Expand access to rapid molecular TB diagnostics. ○ Procure and deploy WHO endorsed near point of care molecular assays (nPOC) to increase access to assays with a higher sensitivity compared to smear microscopy. ○ Adopt use of tongue swabs for TB testing among persons who are sputum scarce (such as children and PLHIV) on appropriate WHO endorsed molecular assay platforms. ○ Examine and develop mechanisms to enhance specimen transportation to Xpert MTB/Rif ultra and Xpert XDR assay sites using the hub and spoke model. ○ Review and develop a diagnostic platform placement plan that ensures no one is left behind including people in hard-to- reach rural counties ○ Review, develop and implement a laboratory reagents and consumable procurement plan that ensures an uninterrupted supply of Xpert cartridges and consumables. ○ Train laboratory staff on molecular testing and biosafety. ○ Develop SOPs for routine equipment maintenance and calibration. 2.3 Improve TB screening and diagnosis among children. ○ Partner with the Liberian pediatric society/association to develop clinical standards for TB diagnosis and treatment in children.
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- Train clinicians on the clinical standards for TB diagnosis and management in children.
- Promote the use of easy to collect non sputum samples such as stool and tongue swabs for microbiological testing on WHO endorsed molecular platforms.
- Create mechanisms to increase access to CXR for children presumed to have pulmonary TB.
- Integrate TB screening into IMNCI and nutrition programs

2.4 Intensify implementation of TB/HIV collaborative activities

- In partnership with the HIV program, develop a TB/HIV working group or task force with specific ToRs
- Routinely screening all PLHIV for TB.
- Routinely screen all people with presumed or confirmed TB for HIV infection.

2.5 Intensify implementation of integrated, bi-directional TB screening for people with diabetes, other co-morbid states

- Develop norms and standards for TB and other disease bi-directional screening (diabetes, alcohol use disorder, mental health, tobacco cessation programs, undernutrition)
- Integrate comorbidity screening, recording, and reporting into TB surveillance (MNS, diabetes, and other priorities)
- Integrate comorbidity indicators into routine analytics and data use (dashboards, monthly/quarterly review meetings, decision logs, and corrective action tracking for low screening or poor referral completion).

	○ Train health care workers on bi-directional screening and management of TB in the setting of the presence of other co-morbid states. ○ Provide tools (glucometers and glucose test strips, weight and height scales, mental health screening tools) to facilitate screening for long term co-morbid states in TB clinics and TB screening tools at clinics serving people with TB associated co-morbid states. 2.6 Strengthen private sector engagement in TB care and prevention. ○ Develop norms and standards for private health provider engagement. ○ Set up a PPM TWG or task force with specific ToRS. ○ Develop a criterion for prioritizing private providers for engagement (high, medium or low) ○ Map private providers in each TB basic management unit (district or county) and place each identified provider on the appropriate priority list for engagement. ○ Train prioritized private providers on TB norms and standards of care ○ Provide supervisory support to engaged private providers ○ Develop and implement a mutually agreed incentive and enabler scheme (preferably nonfinancial) for TB notification (such as recognition, certification).
Objective 3: Enhance quality of care including patient support systems to improve TB treatment success rate from 79% to at least 90% before 2030 and	3.1 Strengthen quality of clinical management of TB ○ Develop parameters to define quality of clinical care for TB. ○ Train clinical staff at all levels (PHC and hospital) on current national TB guidelines. ○ Conduct routine clinical mentorship and supportive supervision, bedside coaching, and case

sustain this performance for both drug susceptible and drug-resistant TB.	reviews for complicated TB patients. Develop a standardized checklist. ○ Develop, disseminate and train clinical staff on a tool for adverse event screening and management. Ensure the tools are available and in use. ○ Standardize treatment algorithms (for DSTB, DR TB, TPT and pediatric) and ensure every facility uses the adverse -event screening and management tool at each patient visit. ○ Introduce regular quality of care audits and facility performance dashboards to identify gaps early and address them, to monitor facility targets and indicators. ○ Establish quality improvement team to monitor the dashboard. 3.2 Enhance patient support systems to improve adherence & reduce loss to follow up ○ Expand treatment supporter models (DAT, family supporters, trained CHWs, TB survivors) and match every patient to a specific model, based on patient preference and profile. ○ Develop, disseminate and train clinical staff to use a lost to follow up risk assessment tool to identify persons at a high risk of interrupting treatment such as being homeless, having no family support, difficult work schedules, self-stigmatizing, substance abuse and having a mental health problem. ○ Offer socioeconomic support including nutritional packages, transport subsidies, and conditional incentives to reduce treatment interruption. ○ Develop, disseminate and train clinical staff to use an appointment register to be used to rapidly identify persons who miss appointments
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3.3 Expand and decentralize care delivery for drug susceptible and drug-resistant TB .

- Improve a clinical criterion to identify persons who need in hospital care at the time of TB diagnosis (for example RR>25, SPO₂ of <90% while breathing room air, serious co-morbid state, unable to stand unaided, temperature of >39°C, BP <90/60 mmHQ etc.)
- Upgrade and promote initiation of DS-TB treatment at the eligible primary health care level to reduce delays and travel costs.
- Establish, train and mentor clinical care teams for the treatment and care of drug -resistant TB at the district level.
- Use established, trained and mentored clinical teams to initiate and monitor treatment of DR-TB at the lowest possible level of the health care system within the district, including the primary health care level.
- Expand community-based treatment adherence models to reach rural and mobile populations.
- Improve coordination between PHC facilities, CHWs, and district hospitals for rapid referral, lab turnaround, and follow-up.

3.4 Strengthen monitoring, drug supply & treatment continuity systems.

- Maintain uninterrupted availability of DS-TB and DR-TB drugs through improved quantification and digital stock management.
- Conduct monthly cohort reviews to track outcomes, missed doses, and treatment completion.
- Provide, train and use electronic TB registers and real-time dashboards to flag at-risk patients.

	○ Introduce rapid clinical response mechanisms for drug adverse effects to prevent treatment stops.
Objective 4: Empower communities and key populations to contribute effectively to the TB response, reduce TB associated stigma and ensure TB service provision is human rights based and gender responsive. By 2030, 90% of facilities providing TB services should have undertaken stigma-reduction training to staff and be implementing grievance reporting systems.	4.1 Scale up integrated community-based active case finding (ACF) ○ Train and deploy CHPs and community volunteers for symptom screening and referral at the community level. ○ Provide CHWs with screening and referral tools. ○ Use CHPs and trained community volunteers to carry outdoor-to-door screening in high-burden districts and among populations with a high risk of TB such as miners and urban slum dwellers. ○ Undertake TB screening as an integral component of HIV community outreaches and immunization campaigns among other community level health programs and interventions. 4.2 Establish and strengthen a community specimen collection & referral system. ○ Train and monitor community health care workers on safe handling of sputum specimens. ○ Include sputum collection and transport in the terms of reference of community health care workers ○ Provide sputum collection kits (cool box) for use by community health care workers to store and transport sputum specimens from the community to facility-based TB diagnostic sites. 4.3 Formalize engagement of TB survivors as peer educators

	○ Create a TB survivor champions network. ○ Train and support TB survivors to provide TB education and adherence support to people on TB treatment within their communities. 4.4 Engage Key Populations (KPs) and vulnerable groups ○ Map, estimate population size and target vulnerable groups for TB screening at the community or occupational setting (miners, prisoners, urban poor, migrants, people who have alcohol use disorder and people who use drugs). 4.5 Enhance community health worker performance. ○ Provide performance-based incentives for community referrals such as cash and recognition for verified TB referrals from the community. ○ Develop a mechanism for holding community health care workers accountable for the work they do at the community level. ○ Establish community data reporting systems. ○ Develop and standardize community TB registers and link the data to DHIS2. ○ Conduct quarterly review meetings of the community health care worker program at the facility, district, county and national levels. ○ Establish a bi-directional feedback system for use for continuous improvement and redress 4.6 Reduce TB related stigma and discrimination
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	○ Develop and institutionalize a national TB stigma-reduction curriculum with alignment with existing human rights framework and include modules on gender. ○ Partner with training institutions to integrate training on stigma into pre-service and in- service training. ○ Provide stigma-reduction training for all TB service providers (including clinicians, lab staff, CHPs, data clerks, security staff, civil Society organizations and others) using the developed training curriculum. ○ Carry out community stigma dialogues and anti-stigma TB campaigns. ○ Work with religious leaders, traditional leaders and youth groups. ○ Carry out media campaigns addressing myths and misconceptions. ○ Use drama, radio, social media for awareness among the general population, school, workplaces and hotspots ○ Develop and incorporate stigma indicators into supportive supervision tools ○ Develop and rollout stigma-related checklist items during supervision/ OSDV. ○ Carry out community-level stigma audits using Community-Led Monitoring approach ○ Conduct periodic anonymous patient experience surveys. 4.7 Institutionalize human rights & gender-responsive TB services ○ Develop and disseminate patient rights IECs (SBC materials) ○ Display patient rights IEC (SBC) materials in all TB clinics, communities, hot spot communities and workplaces
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	○ Translate patient rights IEC (SBC) materials into local languages/dialects. ○ Analyze sex-disaggregated TB data all along the care cascade from screening to treatment completion to identify gaps ○ Integrate gender-responsive TB programming ○ Address gender related barriers to access to TB services for women (caregiving burden, stigma) and men (screening where men work, socialize), and other gender driven barrier ○ Develop and implement gender specific TB screening approaches such as male -targeted screening campaigns at hotspots. Carry out legal literacy and rights awareness sessions ○ Train (in partnership with civil society organizations) community leaders, uniformed personnel, religious groups, women, youth groups on TB and the rights of people with presumed or confirmed TB to access stigma/discrimination free TB services ○ Undertake legal literacy and rights awareness sessions, in partnership with civil society organizations, targeting people at risk of TB ○ Provide information on social protection schemes and the right of people presumed or confirmed to have TB to access these schemes.
Objective 5: Strengthen the TB surveillance system and ensure TB data is of high quality with data accuracy	5.1 Strengthen surveillance standards, and accountability ○ Collaborate with NPHIL to update and disseminate TB surveillance SOPs (case definitions; reporting timelines; cohort/outcome rules; zero-reporting).

score of at least 95% in annual audits so that the TB information system can sufficiently be used as a proxy for tracking the burden of TB in Liberia.	○ Establish/refresh a TB surveillance TWG with clear TORs (MOH/NTP, lab, DHIS2/HMIS, partners, private sector). ○ Strengthen reporting pathways and responsibilities from community, facility, district/county and national levels. ○ Integrate TB surveillance responsibilities at the county (CDO), the district (DHO/DSO), facility (Lab or Clinician) and Community (CHSS) levels. And performance agreements for county/facility leadership and TB focal persons. ○ Conduct quarterly surveillance performance review meetings with TB surveillance integration. 5.2 Improve case-based reporting and system interoperability (paper-to-digital continuity) ○ Map the current data flow (registers, lab tools, electronic platforms) and eliminate duplications/parallel reporting. ○ Develop a road map with timelines for the transition from paper based to a fully digital data system. ○ Standardize unique identifiers (patient ID and/or TB registration number) to enable linkage across sources. Include unique identifiers and cross-program linkage rules for TB–NCD–MHPSS records. ○ Configure or optimize electronic case-based reporting (where available), including offline workflows for low-connectivity sites. ○ Define interoperability rules between TB databases and national HMIS (e.g., automatic aggregation, validation checks).
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- Implement routine reconciliation between facility registers, electronic systems, and DHIS2/HMIS submissions.

5.3 Strengthen laboratory surveillance and linkage to patient records

- Establish a specimen referral and results return tracking system (logbooks or electronic tracker).
- Ensure all bacteriological test results (including rapid molecular and culture/DST where available) are captured and linked to the patient record.
- Introduce routine lab–clinic line lists reconciliation (weekly) to identify missing results and un-notified positives.
- Implement quality controls for lab data entry: completeness checks, test-to-patient concordance, error correction loops.
- Strengthen reporting for drug resistance testing eligibility, coverage, and results reporting completeness.
- Integrate the TB laboratory surveillance system with existing and evolving infectious disease surveillance systems such as IDSR.

5.4 Improve data quality, completeness, and timeliness through DQA and supportive supervision

- Adopt a tiered Data Quality Assessment (DQA) approach: routine validation rules and periodic verification visits.
- Conduct bi-annual DQA focusing on missing variables, duplicates, inconsistent dates, outcome

	misclassification, and lab linkage gaps (including paper-based and digital tools with a clear plan to transition DQA to digital system when feasible). Clear mechanisms for secondary feedback should be part of this process. ○ Implement supportive supervision using standardized checklists (records review plus mentoring plus on-site fixes for both paper-based and digital tools). ○ Introduce facility-level “data huddles” (monthly) to review performance and correct errors before submission deadlines. ○ Establish escalation procedures for persistent non-reporting or chronic data quality issues at all levels. 5.5 Build surveillance workforce capacity and continuity. ○ Conduct competency-based training for TB focal persons, data clerks, lab staff, district surveillance officers and county surveillance officers (case-based reporting, cohort/outcomes, data use). ○ Implement mentorship and on-the-job coaching with clear competencies and certification/recognition. ○ Develop a turnover continuity package (job aids, SOPs, quick guides, onboarding checklist). ○ Create a surge support roster for high-burden sites and during reporting backlogs. ○ Integrate surveillance training into routine capacity-building platforms (e.g., county review meetings, mentorship visits).
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5.6 Strengthen community, private sector, and partner reporting into the national surveillance system

- Build a community of practice around data management and use.
- Build capacity for micro-planning at all levels.
- Partner with training institutions to include data management and use in the training curriculum at the pre-service level.
- Formalize notification requirements and reporting pathways for private providers (simplified reporting tools; feedback loops).
- Integrate community screening/referral data into TB facility register, facility report and ensure referral outcomes are documented.
- Produce routine county “league tables” and facility scorecards to drive targeted improvement.
- Train managers at all levels in collaboration on data interpretation and use (trend analysis, cohort analysis, triangulation with lab and pharmacy/commodity data).

Ensure enabling infrastructure and resources for surveillance (tools, connectivity, and logistics)

- Provide essential tools: updated registers, reporting forms, computers/tablets (as applicable), power backup solutions, and connectivity support.
- Ensure reliable transport/logistics for specimen referral and supervision, aligned to surveillance priorities.
- Maintain secure data storage and confidentiality controls (access rights, locked storage for paper records, password policies).

	○ Establish a simple maintenance plan for hardware/software and routine troubleshooting support. ○ Budget and plan for recurring costs (data bundles, printing, transport, supervision). ○ Update the TB M&E framework. ○ Conduct TB-NSP mid-term and end-term NSP reviews. ○ Conduct operational research with a focus on ▪ TB diagnostic delays. ▪ TB associated cost survey. ▪ TB associated stigma survey. ▪ Drivers of lost to follow up. ▪ TB prevalence surveys.
Objective 6: Strengthen national and subnational stewardship of the TB response through effective governance and leadership, sustainable financing, and functional multisectoral coordination to improve accountability, performance, and equitable access to quality TB services.	6.1 Strengthen TB stewardship, governance structures, and accountability mechanisms. ○ Update TB governance architecture (roles, decision rights, reporting lines, and accountability from national to county/facility). ○ Update TORs and operating procedures for TB committees (TWGs, task forces laboratory network, TB/HIV, DR-TB, supply oversight, community engagement). ○ Institutionalize monthly county reviews, quarterly national reviews, and annual joint reviews with action trackers and closure monitoring. ○ Introduce escalation protocols for persistent underperformance (low notification, poor outcome reporting, low lab linkage, stockouts or expiries).

	○ Standardize supportive supervision using integrated checklists (TB clinical, lab, surveillance, TB/HIV, community systems). ○ Conduct regular national and sub-national reviews to monitor policy implementation and address bottlenecks 6.2 Strengthen leadership and management capacity at all levels ○ Conduct management capacity assessment and implement targeted leadership development for TB management teams. ○ Establish mentoring and coaching systems across national–county–facility levels with peer learning exchanges. ○ Implement performance agreements for TB focal persons and county TB supervisors with measurable deliverables. ○ Strengthen continuity planning: onboarding, handover protocols, and succession planning for key TB positions. ○ Introduce routine Quality Improvement (QI) cycles for key TB performance bottlenecks. 6.3 Strengthen human resource capacity for the TB response ○ Assess HR needs for TB program management (number and skills needed) at national, county and district levels through Annual Capacity Assessment. ○ Ensure HR gaps are filled with appropriately skilled staff. ○ Provide a conducive work environment for program staff at all levels (office space, power,
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	equipment, electricity, equipment (computers, printers) and internet. ○ Provide appropriate tools and equipment to program staff to support effective program management including capacity to provide supportive supervision of the program at all levels (vehicles, motorcycles etc.) ○ Develop TB human resource development and support plan. ○ Coordinate with the Ministry of Health to develop and implement strategies for staff motivation and retention in TB care provision especially for underserved areas. ○ Strengthen performance management. ○ Create an environment that enables staff to meet their KPIs. ○ Address workload distribution. ○ Design and implement a continuous system for non-financial performance recognition of high-performing staff. ○ Conduct Work Force Management (WFM) to maximize HRH productivity and efficiency. ○ Encourage bottom-to-top approach of communication through creation of channels (including virtual) and better platforms that encourage this form of feedback. ○ Document and share county best practices through community of practice. 6.4 Strengthen TB health financing for sustainability and efficiency. Strengthen strategic planning, costing, and resource mobilization. ○ Develop and implement fully cost annual operational plans with financing gap analysis and
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	prioritization scenarios. Consider strengthening the relationship with Stop TB Partnership to support advocacy efforts for increased domestic funding for TB which is integrated into national budget processes. ○ Develop a TB resource mobilization strategy (domestic and donor plus private sector) aligned to national health financing reforms. ○ Advocate for protected TB budget lines at national and county levels with predictable disbursement schedules. ○ Align financing to reduce catastrophic costs for TB-affected households through integration of and linkages to existing social protection mechanisms/packages. ○ Improve partner harmonization around the costed plan and avoid parallel funding streams and reporting ○ Develop a TB funding landscape tool and continuously use it to review the funding landscape and carry out funding mapping 6.5 Strengthen financial management and value for money ○ Continuous update of financial SOPs (planning, disbursement, procurement planning alignment, documentation standards). ○ Strengthen fiduciary controls, audit readiness, and closure of audit findings within agreed timelines. ○ Conduct cost-effectiveness reviews of major cost drivers (case finding models, sample transport, diagnostics utilization, outreach).
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- Improve transparency in financial flows through standardized partner financial reporting templates.

6.6 Strengthen multisectoral coordination and partnerships for an integrated TB response

Institutionalize a functional multisectoral TB coordination mechanism

- Map and identify all sectors, outside the health sector, critical to the TB response.
- Establish/strengthen a multisectoral TB collaboration platform with ToR, meeting schedule, and decision authority (Health, Finance, Justice, Education, Agriculture, Housing, Labor, Social Protection, Immigration, Local Government, private sector, CSOs/FBOs, affected communities).
- Develop sector contribution plans with annual workplans and reporting arrangements.
- Institutionalize joint planning and annual multisectoral reviews of TB determinants and coordinated actions.
- Conduct quarterly inter-sectoral review meetings at national, county and district.
- Strengthen county-level multisectoral committees with standardized reporting and feedback loops to national level
- Maintain partner mapping and coordination to reduce duplication and improve geographic/thematic coverage.
- Conduct quarterly county TB coordination meetings to enable optimal performance of county level stakeholders.
- Develop sector KPIs and monitor achievements of these KPIs by each sector.

- Document sector contributions and share best practices across sectors.

6.7 Strengthen governance and coordination for TB–comorbidity integration (HIV, diabetes, MNS, and other priorities)

Establish national standards and governance for integrated TB–comorbidity care pathways

- Define and endorse a national TB comorbidity integration framework (priority conditions, service package, minimum dataset, screening points, referral completion definition).
- Collaborate with other government coordinating bodies to integrate TB into national guidelines and SoPs to embed comorbidity actions in the TB cascade (diagnosis, initiation, follow-up, end-of-treatment).
- Establish a joint technical sub-group (e.g., TB–HIV–NCD–MNS Integration) under the TB TWG with clear deliverables and reporting.
- Harmonize tools and indicators across integrated programs (TB, HIV, NCD/diabetes, MHPSS) to ensure consistency and reduce parallel reporting.
- Integrate comorbidity performance domains into supportive supervision and QI packages (including confidentiality for MNS/substance use).

6.8 Strengthen multisectoral and service-level coordination

for referral, linkage, and continuity of care

- Collaborate with other government coordinating bodies to define standardized referral pathways and linkage protocols between TB and other relevant clinics.

- Implement routine case conferencing or integrated review (where feasible) for patients with complex medical conditions (TB + DR-TB + HIV/DM/MNS) through a Consilium of experts.
- Undertake integrated community-based linkage support (peer supporters, CHWs, adherence supporters) to improve referral completion and follow-up.
- Pilot, institutionalize, and monitor (via monthly/quarterly review) comorbidity linkage indicators with action tracking at county and national levels.
- Integrate TB commitments into all relevant sector plans to ensure consistent application across government.
- Adopt or update a national accountability framework with routine multisectoral reporting and review

Strengthen TB advocacy to enhance multi- sectoral TB responses and resource mobilization

- Engage parliamentarians and policymakers to support multi-sectoral responses to TB and to advocate for domestic resource mobilization.
- Integrate TB into national development agendas.
- Engage media for sustained TB advocacy (Talk shows, World TB Day, Civil society engagement, etc.).
- Develop and monitor political commitment indicators.
- Document advocacy successes.

6.9 Strengthen financing and supply readiness for integrated TB-comorbidity services

	Cost and finance the integrated TB–comorbidity service package ○ Cost the incremental requirements for comorbidity integration (screening tools, training, referral support, supervision, M&E). ○ Include comorbidity integration line items within TB annual operational plans and advocate for complementary allocations within HIV, NCD, and mental health budgets. ○ Mobilize partner support specifically for integration enablers (systems strengthening rather than vertical duplication). ○ Introduce efficiency measures (integrated outreach, bundled supervision, shared data systems) to reduce total delivery cost. ○ Track expenditures against integrated outputs (e.g., screening coverage, referral completion) to improve value for money. Ensure essential commodities and tools are financed and consistently available for comorbidity screening and care linkage ○ Quantify and procure essential screening commodities (e.g., glucose testing supplies) and minimum MNS screening/job aids as per national policy. ○ Align procurement plans across TB and relevant programs to prevent stockouts and duplication. ○ Strengthen last-mile distribution and stock monitoring for integrated service sites. ○ Integrate comorbidity-related commodity availability checks into supervision and routine reviews.
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	○ Establish contingency mechanisms for supply disruptions affecting integrated services
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8. Operationalization of the TB-NSP (2027–2031)

The operationalization of the TB-NSP (2027–2031) will be undertaken through the development and implementation of **costed, prioritized annual operational plans**. These plans will focus on interventions and activities with the highest potential impact, while remaining responsive to the prevailing financial context and resource availability.

The selection of interventions for implementation each year will be guided by program priorities, epidemiological needs, and available funding.

8.1 High-priority interventions

8.1.1 Integrated facility- and community-based active case finding (ACF)

- Expansion of access to **rapid molecular TB diagnostics** within a decentralized diagnostic network
- Implementation of **TB/HIV collaborative activities**
- Integration of **bi-directional TB screening** among people with diabetes, other co-morbid conditions, and pregnant women
- Strengthened **private sector engagement** in TB care and prevention
- Implementation of interventions to **reduce TB-related stigma and discrimination**
- Institutionalization of **human rights- and gender-responsive TB services**
- Strengthening of **surveillance standards and accountability mechanisms**
- Improvement of **case-based reporting systems and interoperability**, ensuring seamless paper-to-digital continuity

8.1.2 Enhancing Implementation Efficiency and Quality of Care

- To improve the efficiency of NSP implementation and enhance the quality of TB care, the program will undertake the following measures:
- **Consolidate training activities** into a unified, integrated national training plan, shifting away from fragmented, component-based approaches
- **Decentralize mentorship and supportive supervision**, with integration across disease programs
- Conduct **diagnostic network optimization** to identify gaps and guide the deployment of additional tools and technologies
- Promote **integration across all components** of the TB-NSP and with other national health and development programs

8.2 Program Integration Priorities

Integration will be strengthened across key systems and program areas, including:

- ✓ **Community health systems and implementation platforms**
- ✓ **Monitoring and evaluation (M&E) and digital health surveillance infrastructure**
- ✓ **Infection prevention and control (IPC)**
- ✓ **Supervision and mentorship systems**
- ✓ **Commodity management and pharmacovigilance**, including adverse drug reaction monitoring and reporting
- ✓ **Leadership and governance**, including human resource mapping, governance structures, and domestic resource mobilization

9. Financing the TB – NSP 2027-2031 in Liberia

9.1 Introduction

Costing of the TB - NSP is critical for the following reasons: first, it provide a rigorous, bottom-up estimate of the full resources needed to deliver each objective of the NSP, thus grounding planning in data rather than assumptions. Secondly, it establishes a credible, costed investment case to support fundraising efforts with the Government of Liberia, development partners such as the Global Fund, bilateral donors and the corporate sector. Thirdly, it supports strategic decision-making on how to deploy constrained funding envelopes, by helping to identify interventions with the highest impact and thus guiding trade-offs across objectives; and fourthly, it helps to quantify and communicate the funding gap so as to sustain advocacy efforts to attract new financing, including from bilateral donors through mechanisms such as Debt2Health.

9.2 Costing Methodology

The costing of the NSP was carried out using a rigorous bottom-up micro-costing approach, ensuring that resource requirements are realistically estimated and directly tied to planned program outputs. This methodology builds credibility for resource mobilization and accountability

The methods included activity-based costing where all activities were broken down and costed at the sub-activity level for precision and transparency. Unit cost costs were multiplied by expected service delivery volumes, linked directly to NSP targets. The QuanTB forecasting tool was used to for TB medicine quantification while the WHO GLI diagnostic planning tool was used to estimate diagnostic requirements. All costs were adjusted to reflect the current USD inflation rate of 1.32%. The results were reported in both USD and Liberian Dollars (LD) to ensure relevance for international partners and national stakeholders.

The NSP costing process followed a detailed review of national targets, strategies, and implementation activities. Costs were calculated across the full implementation period (2027–2031) and can be analyzed by objective, strategy, activity, year, geography, or cost category.

The NLTCP teams defined the inputs and sub-activities required for implementation and established standardized unit costs based on:

- Global Drug Facility negotiated pricing.
- Historical expenditure data from previous funding cycles.
- Harmonized cross-program assumptions for common costs such as fuel, travel, stationery, and trainings.

The costing process was highly participatory, taking place over several weeks and engaging government, civil society, and implementing partner representatives. It marks only the second time Liberia has estimated the full cost of achieving its TB elimination goals. By defining the true financial requirements beyond existing donor commitments, the process supports more proactive resource mobilization, stronger national ownership, and clearer prioritization. This approach improves transparency, strengthens consistency across disease programs, and links strategic priorities directly to financial requirements. It also allows the program to model different funding scenarios and prioritize investments based on available resources.

Outlined below are the approaches used to estimate the cost of essential TB products and consumables.

A: TB Medicines and Preventive Therapy (QuanTB)

Drug quantification was conducted using QuanTB, a WHO-endorsed forecasting and supply planning tool for anti-TB medicines. Forecasts incorporated:

- National population projections.
- TB incidence and notification trends.
- Estimated DR-TB burden.
- Pediatric TB proportions.
- TB/HIV co-infection rates.
- TB-NSP treatment and preventive therapy targets.

The analysis included:

- First-line DS-TB regimens.
- Short and long DR-TB regimens.
- Pediatric formulations.
- TB preventive therapy regimens, including 3HP, 1HP, and 6H.

Forecasting assumptions accounted for regimen duration, expected patient volumes, treatment scale-up, procurement lead times, safety stock requirements, and uninterrupted multi-year supply continuity.

B. TB Diagnostics and Laboratory Commodities (WHO/GLI Tool)

Diagnostic and laboratory commodities were quantified using the WHO/GLI Planning and Budgeting Tool for TB and Drug-Resistant TB Testing (2024 Calculation Tool).

Forecasts were based on:

- National population projections.
- Geographic distribution of testing sites.
- Planned diagnostic network expansion.
- National diagnostic algorithms adopted under the NSP.

The analysis included projected use of:

- The Xpert MTB/Rif ultra and Xpert /XDR assays
- Truenat
- nPOC (PlusLife -MiniDock)
- Line Probe Assay (LPA)
- Microscopy and related laboratory consumables

Quantification also incorporated planned scale-up of molecular testing, adoption of near point-of-care diagnostics, pediatric testing volumes, and expanded drug-resistance testing.

Commodity estimates were aligned directly with NSP case detection and treatment targets to

ensure consistency between program ambitions and operational requirements. Efforts were also made to optimize the diagnostic network and reduce commodity wastage.

9.3 Financial requirements of the TB-NSP 2027- 2031.

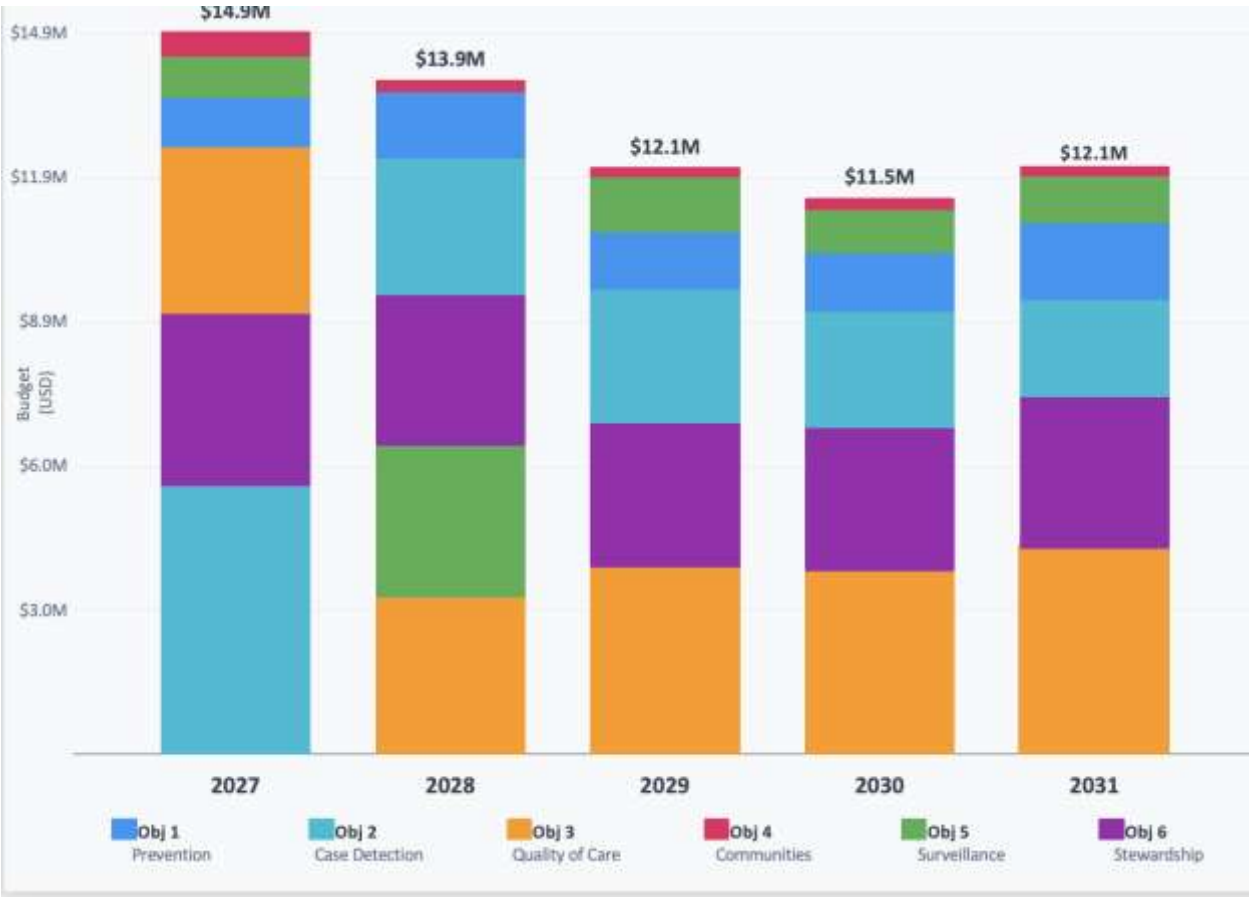


Figure 14: TB- NSP 2027-2031 summary of estimated cost

Figure 14 above shows the costs of the TB-NSP 2027-2031 by objective and year. The TB-NSP 2027–2031 is projected to cost approximately \$64.14 million USD over the five years. This represents a 9.3% increase from the previous NSP, reflecting intensification of TB care and prevention efforts in the backdrop of major shifts in the TB landscape, including adoption of newer diagnostics and shorter, more effective treatment regimens for TB prevention and treatment.

Table below shows the distribution of costs by objectives

Objective	5 year total (million USD)	% share
1. Prevention	6.39	10.0
2. Case detection	15.69	24.5
3. Quality of care	18.86	28.5
4. Community engagement rights and gender	1.24	1.9
5. TB surveillance	6.96	10.8
6. Leadership, governance and stewardship	15.56	24.3
Grand total	64.14	100

The average annual NSP costs are estimated at \$12.83, compared to an average annual Global Fund support of approximately \$5.6 million USD. This gap underscores a critical reality: current financing levels are insufficient to achieve Liberia’s ambitious, globally aligned End TB targets. Rather than scaling ambitions down to fit available funding, the National Leprosy and Tuberculosis Control Program (NLTCP) chose to present the level of investment truly required to reduce preventable illness, death, and transmission.

Of the required financial resources, objective 3 (Quality of Care) has the largest need at \$18.29M (29% of total), which reflects the ambition to increase TSR from 79% achieved in 2024 to at least 90% for both DS-TB and DR-TB by 2031. Objective 2 (Case Detection) has the second largest need at \$15.69M (24%), with spending spikes in 2026 at \$5.6M before dropping sharply, reflecting intensified upfront investment in active case finding among high-risk populations including prisons, mines, and high-priority health facilities. Objective 6 (Leadership and Governance) is the third most costly requiring \$15.69M (24% of the total). Spending on this objective is estimated to stay consistent year-on-year throughout the period of the NSP. The objective aims to strengthen national stewardship of the TB response and decentralizing

responsibilities by transitioning management to county teams. Objectives 5 & 6 together account for 34% (\$22.6M) of the total budget estimate. It is worth noting that combined, surveillance and stewardship form the backbone of a sustainable, accountable TB response. Objective 5 shows a notable spike in 2027 reflecting a planned one-off investment in surveillance infrastructure. Objective 4 (Communities & Stigma) has the smallest resource envelope requirement at only \$1.2M (1.9%) over five years. This is attributed to anticipated adoption of integration approaches during NSP execution. Overall spending is expected to peak in 2027 and then stabilize. Thus in 2026, a total of \$14.9M will be required, driven largely by investments in case detection before settling to around \$11.5–12M from 2028 onwards as the program transitions from scale-up to steady-state operations.

10. Monitoring, Evaluation and Learning Framework

10.1 Theory of Change

The MEL framework is grounded in a Theory of Change (ToC) that maps the logical pathway from programme inputs and activities through outputs and outcomes to the desired impact. The ToC posits that if the NLTCP and its partners implement high-quality, equitable, and integrated TB services—supported by adequate financing, skilled human resources, functional supply chains, robust data systems, and strong governance—and if these are delivered in an enabling environment that addresses social determinants of TB, then TB incidence, morbidity and mortality will decline, treatment success will improve, and the financial burden on TB-affected households will be reduced.

The ToC identifies the following key change pathways:

- Closing the detection gap: Systematic, integrated case finding → increased notification → higher treatment coverage.
- Improving treatment quality: Strengthened adherence support and patient-centred care → reduced loss to follow-up → improved TSR.
- Scaling TB prevention: Expanded TPT and IPC → reduced incident TB disease.
- Strengthening health systems: Adequate HRH, supply chain, diagnostics → improved service delivery.
- Empowering communities and addressing social determinants: Reduced stigma, expanded social protection → improved care-seeking and treatment adherence.
- Strengthening governance and financing: Accountable leadership, sustainable domestic financing → sustainable programme implementation.

10.2 The M&E Framework

The M&E Framework provides a visual and conceptual architecture of how TB program components relate to one another, and how inputs lead to outputs, outcomes, and impact. A detailed MEL framework will be a stand-alone document. The framework distinguishes five levels:

Level	Description	Examples
Input	Resources and preconditions enabling programme delivery	Trained staff, drugs and commodities, diagnostic equipment, and financing
Process	Activities carried out to implement the programme	Training sessions, outreach screening, supervision visits, and TWG meetings
Output	Direct, measurable products of activities	Number of people screened, number tested with WRD, number started on TPT
Outcome	Medium-term results reflecting programme performance	TB notification rate, treatment success rate, TPT coverage, data accuracy score
Impact	Long-term change in the disease burden	TB incidence, TB mortality, proportion of TB households with catastrophic costs

Indicators defined at each level feed into the program performance review cycle and are reported to WHO annually and to the Global Fund on a semi-annual basis. Data from the DHIS2 platform forms the backbone of the system, supplemented by surveys, operational research, and external evaluations.

10.3 Indicator Framework

The indicator framework encompasses impact, outcome, output, and process indicators across the six strategic objectives of the TB-NSP 2027–2031. All indicators are SMART (Specific, Measurable, Achievable, Relevant, and Time-bound) and are disaggregated by sex, age group (<15 / 15+), and county where data systems permit.

10.3.1 Impact Indicators

Impact indicators measure the long-term changes in disease burden attributable to programme implementation. These are largely estimated through WHO modelling and periodic surveys.

#	Indicator	Baseline (2024)	2031 Target	Source / Frequency
I-1	TB Incidence Rate (per 100,000 pop.)	207	≤140<	WHO Global TB Report / Annual
I-2	TB Mortality Rate (per 100,000 pop.)	18 (est.)	≤12	WHO estimates / Annual
I-3	Proportion of TB-affected households experiencing catastrophic costs (%)	92%	<20%	Catastrophic Cost Survey / Every 2 years
I-4	TB Prevalence Rate (per 100,000 pop.)	TBD (survey)	TBD	TB Prevalence Survey (planned)

10.3.2 Outcome Indicators

Outcome indicators measure medium-term program performance. They are primarily derived from routine surveillance and reporting systems.

#	Indicator	Baseline (2024) 2025	2031 Target	Frequency & Source
O-1	TB Case Notification Rate (new & relapse, per 100,000 pop.)	143 157	≥200 86	Annual / TB Register, DHIS2
O-2	Treatment Success Rate (TSR) — DS-TB (%)	79%	≥90%	Annual cohort / TB Register
O-3	Treatment Success Rate — RR/MDR-TB (%)	65% (est.) 66%	≥85% 80%	Annual cohort (24 months) / 2nd-line Register
O-4	TB Treatment Coverage (notified/estimated incidence) (%)	69%	≥80%	Annual / WHO estimates & DHIS2
O-5	% of eligible HH contacts started on TPT	<5% (est.)	≥90%	Monthly / TPT Register
O-6	% of PLHIV enrolled in care started on TPT	<20% (est.)	≥90%	Monthly / TB-HIV Register
O-7	% TB patients with documented HIV status	75%	≥95%	Monthly/ TB Register
O-8	% HIV-positive TB patients on ART	70% (est.)	≥95%	Monthly / TB-HIV Register
O-9	% new & relapse TB cases tested with WHO-recommended rapid diagnostic (WRD)	43%	≥80%	Monthly / Lab Register/GeneX
O-10	% of bacteriologically confirmed TB patients tested for rifampicin resistance	80%	≥95%	Quarterly / Lab Register
O-11	% of RR/MDR-TB cases enrolled on second-line treatment	100%	100%	Quarterly / 2nd-line Register

#	Indicator	Baseline (2024) 2025	2031 Target	Frequency & Source
O-12	TB Data Accuracy Score in annual DQA audit (%)	<85% (est.)	≥95%	Annual / DQA report
O-13	% of TB-notified children <15 years among all TB notifications	8%	≥15%	Annual / TB Register
O-14	% TB patients (and households) experiencing self-stigma	TBD	Reduce by 50%	Stigma Assessment Survey / Every 2 years

11. Annex: Budget summary

Budget Summary								
Description	No	Strategic Intervention	Grand Total	2027	2028	2029	2030	2031
Objective	1	Strengthen TB prevention at community and health facility levels by ensuring active case finding is linked to provision of TPT to at least 90% of eligible persons and ensuring at least 90% of health care facilities are implementing facility specific IPC measures that are aligned to national IPC standards by 2030						
Strategy	1.1	Expand identification of eligible persons and households for TPT	4322048.51	594122.92	939761.73	794691.22	820121.33	1173351.31
Strategy	1.2	Improve access to TPT Initiation & Enrollment	716638.28	120085.27	194897.69	129690.74	133840.84	138123.75
strategy	1.3	Strengthen and implement communication & social mobilization strategies to increase TB knowledge and awareness	65574.31	12058.92	12247.78	13667.37	13044.18	14556.07
Strategy	1.4	Strengthen TB- IPC Governance, coordination and integration with other IPC activities including pandemic preparedness.	\$-	\$-	\$-	\$-	\$-	\$-
Strategy	1.5	Update & disseminate IPC guidelines and job aids	103179.21	32509.03	16841.76	17380.69	17936.88	18510.86
Strategy	1.6	Train Health Workers on TBIPC	1181725.77	267473.45	217879.95	224852.11	232047.37	239472.89
Strategy	1.7	Implement routine, integrated IPC practices	\$-	\$-	\$-	\$-	\$-	\$-
Strategy	1.8	Monitor IPC implementation and carry out quality Improvement measures	4618.53	\$-	2236.55	\$-	2381.98	\$-
Sub-Total			6393784.619	1026249.59	1383865.46	1180282.13	1219372.58	1584014.88
Objective	2	Increase TB case detection with early diagnosis, and notification through efficient use of new tools to reduce the TB incidence-detection gap to less than 20% by 2030 (achieve a treatment coverage of at least 80% by 2030).						

Strategy	2.1	Scale up integrated systematic TB screening in communities and health facilities using efficient use of tools.	2375981.06	580560.94	446019.86	529326.27	408348.31	411725.68
Strategy	2.2	Expand access to rapid molecular TB diagnostics	9463973.16	4601506.88	1230562.83	1376110.54	1227173.86	1028619.05
Strategy	2.3	Strengthen internal quality control, External Quality Assurance, and NTRL	2039463.13	319575.62	287177.12	619517.33	492814.5	320378.56
Strategy	2.4	Improve TB screening and diagnosis among children	749943.86	147699.53	140364.52	144856.18	149491.58	167532.05
Strategy	2.5	Intensify implementation of TB/HIV collaborative activities	314603.83	58500.98	68360.7	70548.24	72805.78	44388.13
Strategy	2.6	Intensify implementation of integrated, bi-directional TB screening for people with diabetes, other co-morbid states and among pregnant women	231985.14	27049.6	204935.54	\$-	\$-	\$-
Strategy	2.7	Strengthen private sector engagement in TB case detection	565272.66	45077.76	371510.19	48008.9	49545.18	51130.63
Sub-Total			15741222.84	5779971.31	2748930.76	2788367.46	2400179.21	2023774.1
Objective	3	Enhance quality of care including patient support systems to improve TB treatment success rate from 79% to at least 90% before 2030 and sustain this performance for both drug susceptible and drug-resistant TB.						
Strategy	3.1	Strengthen quality of clinical management of TB	8591220.18	3641404.14	1570633.9	1749649.86	790944.24	838588.04
Strategy	3.2	Enhance patient support systems to improve adherence & reduce loss to follow up	6372.6	6372.6	\$-	\$-	\$-	\$-
Strategy	3.3	Expand and decentralize care delivery for drug susceptible and drug-resistant TB	570711.98	178315.56	\$-	190020.27	\$-	202376.14
Strategy	3.4	Strengthen monitoring, drug supply & treatment continuity systems	14129432.58	2463200.4	2637858.24	3042616.77	2890398.23	3095358.94
Sub-Total			23297737.33	6289292.7	4208492.14	4982286.9	3681342.47	4136323.12

Objective	4	Empower communities and key populations to contribute effectively to the TB response, reduce TB associated stigma and ensure TB service provision is human rights based and gender responsive. By 2030, 90% of facilities providing TB services should have undertaken stigma-reduction training to staff and be implementing grievance reporting systems.						
Strategy	4.1	Scale up integrated community-based active case finding (ACF)	\$-	\$-	\$-	\$-	\$-	\$-
Strategy	4.2	Establish and strengthen a community specimen collection & referral system	270460.19	241214.77	6770.22	7120.54	7486.36	7868.3
Strategy	4.3	Formalize engagement of TB survivors as peer educators	159868.59	65751.92	22429.41	23147.15	23887.86	24652.27
Strategy	4.4	Engage Key Populations (KPs) and vulnerable groups	91839.56	44617.85	7455.17	31826.61	7939.93	\$-
Strategy	4.5	Enhance community health worker performance	\$-	\$-	\$-	\$-	\$-	\$-
Strategy	4.6	Reduce TB related stigma and discrimination	488623.6	103527.14	99651.1	92167.63	95116.99	98160.74
Strategy	4.7	Institutionalize human rights & gender-responsive TB services	135257.22	25374.66	26186.65	27024.62	27889.41	28781.87
Strategy	4.8	Screen people with TB (women in particular) for Sexual and Gender-Based Violence and refer appropriately	96423.26	\$-	46693.53	\$-	49729.73	\$-
Sub-Total			1242472.43	480486.34	209186.08	181286.55	212050.28	159463.18
Objective	5	Strengthen the TB surveillance system and ensure TB data is of high quality with data accuracy score of at least >95% in annual audits so that the TB information system can sufficiently be used as a proxy for tracking the burden of TB in Liberia.						
Strategy	5.1	Strengthen surveillance standards, and accountability	4586.46	2038.2	505.89	659.46	680.57	702.34
Strategy	5.2	Improve case-based reporting and system interoperability (paper-to-digital continuity)	1835355.92	314123.93	362424.9	377319.81	389394.04	392093.24
Strategy	5.3	Strengthen laboratory surveillance and linkage to patient records	\$-	\$-	\$-	\$-	\$-	\$-

Strategy	5.4	Improve data quality, completeness, and timeliness through DQA and supportive supervision	2214537.26	415492.49	428687.07	442427.04	456635.75	471294.91
Strategy	5.5	Build surveillance workforce capacity and continuity	2401320.93	58406.45	2276665.43	\$-	\$-	66249.04
Strategy	5.6	Strengthen community, private sector, and partner reporting into the national surveillance system	25049.91	\$-	23383.67	1099.1	567.14	\$-
Strategy	5.7	Ensure enabling infrastructure and resources for surveillance (tools, connectivity, and logistics)	472898.57	45924.1	37073.49	306339.95	48478.96	35082.07
Strategy	5.8	Integrate comorbidity screening, recording, and reporting into TB surveillance (MNS, diabetes, and other priorities)	1981.44	1981.44	\$-	\$-	\$-	\$-
Sub-Total			6955730.48	837966.61	3128740.45	1127845.36	895756.46	965421.6
Objective	6	By, 2030, strengthen national and subnational stewardship of the TB response by ensuring that: I. functional governance and multisectoral coordination mechanisms operate at national level and in all counties, with at least 4 coordination/performance review meetings conducted annually and ≥80% of agreed action points closed within 90 days. II. TB financing is more sustainable, with domestic co-financing of the annual TB budget increasing each year and annual TB budget execution ≥90%. III. program accountability and equitable access improve, evidenced by ≥95% facility reporting complete data and timely, ≥90% of facilities reporting complete treatment outcomes, and all counties implementing the approved annual TB operational plan.						
Strategy	6.1	Strengthen governance and leadership for accountable TB program performance	13388223.71	3161942.92	2411970.06	2597045.85	2582118.54	2635146.35
Strategy	6.2	Strengthen TB health financing for sustainability and efficiency	100259.34	\$-	\$-	\$-	\$-	100259.34
Strategy	6.3	Support advocacy efforts for increased domestic funding for TB which is integrated into national budget processes	364055.24	50232.5	182984.97	42246.29	43598.17	44993.31
Strategy	6.4	Strengthen multisectoral coordination and partnerships for an integrated TB response	907757.57	146859.17	300581.72	148631.94	153388.16	158296.58

Strategy	6.5	Strengthen governance and coordination for TB–comorbidity integration (HIV, diabetes, MNS, and other priorities)	404697.37	89944.48	106993.32	79306.45	63128.7	65324.41
Strategy	6.6	Strengthen TB advocacy to enhance multi-sectoral TB responses and resource mobilization	312325.84	55545.08	61194.68	63152.91	65173.8	67259.37
Strategy	6.7	Strengthen financing and supply readiness for integrated TB–comorbidity services	211796.45	39733.65	41005.13	42317.29	43671.45	45068.93
Sub-Total			15689115.52	3544257.8	3104729.88	2972700.73	2951078.82	3116348.29
Grand Total			69320063.24	17958224.35	14783944.77	13232769.13	11359779.82	11985345.17

