



NATIONAL HEALTH POLICY

NATIONAL HEALTH PLAN 2007-2011



MINISTRY OF HEALTH & SOCIAL WELFARE

MONROVIA, LIBERIA

FOREWORD

For Liberia, the National Health Policy and Plan could not have come at a more promising time! After more than twenty years of civil unrest and violent conflict, peace has been restored, an elected government is in place, and Liberians are motivated and ready to move forward as a unified country with one destiny.

The confident new atmosphere in Liberia gives us the opportunity to create strategies and programs that will help our nation not only recover, but also flourish. Our mission in creating the National Health Policy and Plan has been to **reform the health care sector to effectively deliver quality health and social welfare services to the people of Liberia**. The process of formulating our national documents was carried out with passion, commitment, and professionalism.

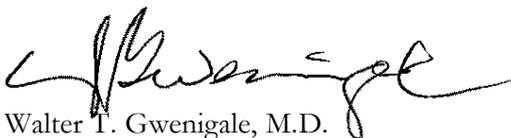
Our hope is that the National Health Policy and Plan will serve as inspirations and guiding roadmaps for the Liberian people, stakeholders, and health care workers in implementing reforms of the health care system. These documents will help us reach our vision: **a Liberia with improved health and social welfare status and equity in health; therefore becoming a model of post-conflict recovery in the health field**. Enlightened leadership, sustained efforts, coherent prioritization, and generous external support are needed to materialize this attainable vision. The Ministry of Health and Social Welfare shares this vision with our partners in the international development community, and our National Health Policy and National Health Plan were met with unparalleled support at the Liberia Partners' Forum held in February 2007. The time is now to capitalize on this momentum, using our collective knowledge, energy, and optimism to propel our dreams into reality.

The National Health Policy and Plan have been prepared with a theme of decentralization. We understand that the Liberian *people* are our most important and fundamental resource. A trained, educated, and skillful workforce must be the foundation for increasing access to quality health services. Particularly in rural and poor urban areas, building the human capacity of the health sector at the community, district, and county levels is an essential component of the national health reform process and policy implementation. This will involve the building of skills at every level in our health care system, from the floor sweeper and grass cutter to the head nurse and the senior surgeon. When we have achieved our first goal of skill- and capacity-building, the process of making difficult decisions concerning resource management and service delivery will be the logical and fully attainable next step. In this way, the health care system can move towards a healthy and immensely satisfying future.

The Basic Package of Health Services is the cornerstone of the new Liberian national health care delivery strategy. The Ministry of Health and Social Welfare is committed to ensuring equity and quality through the delivery of the Basic Package of Health Services, including essential preventive and curative care services to be provided at every level of the health system, from the village health worker to major regional referral hospitals.

As stated by President Ellen Johnson Sirleaf, for capacity building in any area of our country's recovery to be truly sustainable, it must be indigenous. It must flow from the people themselves. It must be built upon the experience of all Liberians. It must be driven by their present social conditions and by their dreams and desires for the future. We understand that the issue of sustainability is paramount, as is the need for support and assistance from our donors and partners. We all share the goal of developing our internal capacities, so that with the passage of time Liberia will thrive with diminishing dependence on outside support.

We are grateful to our donors who have provided funding for the National Health Policy and Plan and sincerely thank all those who have spent hours and days preparing these documents. We are confident that implementation of the National Health Policy and Plan is both possible and essential. We ask that you join us in our journey towards the transformation and development of our health care programs. These documents are the roadmaps that will lead the way.



Walter T. Gwenigale, M.D.
Minister

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PREPARATION OF THE NATIONAL HEALTH POLICY AND NATIONAL HEALTH PLAN

The development of the National Health Policy and Plan has been a very long and tasking process. Despite several obstacles, the Ministry of Health and Social Welfare is indeed pleased that the process remained on course; culminating in a strategic plan that will lead the health sector for the next five years.

The Ministry of Health and Social Welfare wishes to acknowledge the contribution and support of various members and institutions in the preparation of these documents. Firstly, we would like to thank our Steering Committee, including the World Health Organization (WHO), United Nations Children's Fund (UNICEF), European Union (EU), United Nations Population Fund (UNFPA), United States Agency for International Development (USAID), World Bank, Ministry of Planning and Economic Affairs, Ministry of Gender and Development, and Ministry of Education, for mobilizing resources and providing guidance in the process of developing the National Health Policy and Plan. Special acknowledgements go to the following organizations for their additional support:

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- USAID, for financial support and hosting our validation workshops, as well as technical support provided via BASICS;
- UNICEF, for providing financial support for the county consultative and national process;
- UNFPA, for technical support and underwriting the costs of secretarial support, including office equipment;
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- Johnson and Johnson, for providing technical support via DAH Consulting, Inc.

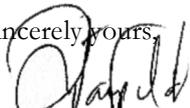
In addition, our appreciation goes to Mr. Z. Moulai Reeves, Deputy Minister, Ministry of Planning and Economic Affairs; and Ms. Doris Bedell, Ministry of Education, who helped to develop the plan's review and revision process.

We also appreciate the inputs and efforts of the following staff from the Ministry of Health and Social Welfare: Mrs. Vivian J. Cherue, Deputy Minister for Administration; Dr. Bernice T. Dahn, Chief Medical Officer and Deputy Minister for Health Services; Dr. Moses Pewu, Assistant Minister for Curative Services; Mrs. Jessie Duncan, Assistant Minister for Preventive Services; Mrs. Bendu Tulay, Assistant Minister for Social Welfare; Mr. Nmah Bropleh, Assistant Minister for Planning; Mr. C. Sanford Wesseh, Assistant Minister for Vital Statistics; Mrs. Dedeh Jones, Chief Nursing Officer; Mr. Augustine Kromah, Director of Vital Statistics, and Ms. Carolyn Reeves, Director of Health Planning. Many thanks go to the members of the County Health Teams, County Superintendents, County Development Superintendents, and NGO partners for participating in this process.

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Sincerely yours,



S. Tornorlah Varpilah

Chair, National Technical Committee for the National Health Policy and Plan Development Process
Deputy Minister for Planning, Research, and Development

EXECUTIVE SUMMARY

NATIONAL HEALTH POLICY – 2007

Introduction

This health policy has been formulated at a crucial time in Liberian history. After decades of turmoil, the country is enjoying peace and stability, under the watch of a legitimate government, recognized and supported by the international community. However, the scale of the destruction is such that it will be overcome only after decades of sustained efforts. Aware of the complexity and risks of the course ahead, the Ministry of Health and Social Welfare (MOHSW) has pressed on with the formulation of a health policy and an accompanying National Health Strategic Plan explicitly aimed at guiding decision-makers through the next five years. The health policy will evolve over time as data become more reliable, health systems are strengthened and financial and human resources become more secure. The most urgent priorities will be addressed first, and other less pressing, but equally important challenges will be addressed in the near future, once the system has acquired additional capacity. The health sector faces two huge, competing *challenges*:

- 1) *Expanding access to basic health care of acceptable quality.* This will be possible only by:
 - Attracting additional investments in infrastructure, human resource development, and management systems, and resources to fund recurrent expenditures.
 - Reducing systemic inefficiencies and improving operations management.
- 2) *Establishing the building blocks of an equitable, effective, efficient, responsive, and sustainable health care delivery system.*

A social welfare policy has not yet been developed as substantive preparatory work is still needed. Therefore, a major review of the social welfare field will be carried out in 2007. The review will start with a thorough situation analysis where issues such as poverty, violence, displacement, unemployment, gender inequality, disability, and vulnerability will be explored in detail. The new social welfare policy will build on this assessment and will aim at restructuring a sector that is now fragmented and under-resourced, and is thus unable to address the enormous needs of the Liberian population.

Mission and Vision

The mission of the MOHSW is to reform the sector to effectively deliver quality health and social welfare services to the people of Liberia. Its vision is a nation with improved health and social welfare status and equity in health. The Ministry regards health as a basic human right, and as such has devoted itself to ensuring that every Liberian will have access to health and social welfare services regardless of economic status, origin, religion, gender or geographic location. The Ministry wishes to serve as a model of post-conflict recovery, and is committed to efficient use of its resources in order to achieve maximal health outcomes at the lowest possible cost.

Policy Orientations

The health sector will be restructured to reflect the Government's commitment to decentralization. Consistent with this mandate, the National Health Policy and Strategic Plan takes a primary health care approach, focusing on the community and the county as a locus for decision-making in relation to resource management and service delivery. The MOHSW is committed to ensuring equity and quality through the delivery of a Basic Package of Health Services, including essential preventive and curative care services to be provided at each level of the health system – from the community to referral hospitals. To realize its potential, the system must be supported by adequate referral capacity.

The County Health and Social Welfare Service Administration is the operational management structure, which includes the County Health and Social Welfare Team (CH&SWT). County health authorities will manage county health facilities. They will be responsible for financial management and personnel and will be fully accountable to local constituencies, as well as to overseeing public bodies. The Ministry will focus on health legislation and law enforcement; policy formulation, revision and enforcement; resource mobilization and allocation, national and long-term planning; broad health sector programming; monitoring and evaluation; and technical oversight of service delivery, regulation, major research and development initiatives. The Ministry will work collaboratively with a diverse set of public, private and NGO health sector partners to ensure full coverage of health services to the Liberian people.

The national health system will consist of three main levels of care - primary, secondary and tertiary. Clients will directly access primary health care services and be referred to higher levels of care, except in cases of emergency.

The Government of Liberia is committed to financing health care at the highest level compatible with its revenues, taking into consideration competing priorities. As such, the Government will strive to progressively increase the share of its budget apportioned to the health sector. A mix of other financing strategies (including health insurance, and other forms of pre-payment) will be pursued. The Ministry has suspended the administration of user fees at the primary health care level. The suspension will remain in place until the socio-economic situation improves and financial management systems perform to a level that ensures the proper extraction, accounting and utilization of revenues.

The cost of revitalizing the devastated health system will be enormous, vastly surpassing internal revenues. Donors will be invited to support the recovery process by channeling their contributions in predictable, effective and efficient ways, consistent with Government policies. The present fragmentation of services will be addressed by changing the way external assistance is managed by negotiating with the Ministry of Finance and donors to introduce financial packages that are appropriate to the current Liberian context.

A Basic Package of Health Services (BPHS) is the cornerstone of the national health care delivery strategy. The BPHS lists in detail a standard set of prevention, care and treatment services that will be available at each level of the health system. BPHS components are affordable, sustainable interventions that have been chosen on the basis of their effectiveness in reducing morbidity and mortality. The MOHSW recognizes that human resources are the most valuable asset of the health sector. The Ministry will ensure that the right health workers are in the right place at the right time with the right skills to deliver the basic package of health services. A long-term comprehensive program will be launched to produce a gender-balanced health workforce with the skill mix needed by the health services at different levels of care.

The Ministry will conduct a thorough study of existing facilities (both public and privately-owned), including utilization, population distribution, access to roads and transportation, operational costs, and socio-economic factors in order to determine the number, size and types of health facilities needed to compose the future health care network. The Ministry will establish objective planning criteria with the collaboration of concerned parties. Primary, secondary and tertiary health levels shall be provided the equipment necessary to discharge the functions attributed to them by the BPHS.

The Ministry will restructure the procurement system, with the objective of achieving efficiency gains and ensuring a reliable supply of effective drugs and commodities. A flexible, decentralized, competitive internal distribution system will be established in collaboration with concerned partners, guided by the National Drugs Policy. The essential drugs list, standard treatment guidelines and formulary will be updated to ensure consistency with the BPHS.

The MOHSW will develop strong internal and external communication capacity, so that it can convey the rationale behind the National Health Policy and resource allocation decisions to concerned audiences in clear, understandable ways in order to foster trust and openness. The Ministry will develop a comprehensive monitoring and evaluation system, based on policy goals and an agreed set of indicators. The system will monitor the enforcement of the policy against the overall performance of the health sector and the health impact of development initiatives through analysis of routine health information, surveillance data and periodic survey results. The Health Management Information System (HMIS) will be strengthened in order to better collect, organize and maintain relevant data in a timely way.

The enforcement of the policy will be continuously monitored. Progress and constraints shall be regularly communicated to the public and health stakeholders. The MOHSW will invest in the establishment of adequate regulatory capacity for legislation, standards setting, inspection and operational guidance. The Ministry will seek to strengthen technical and procedural capacity of the regulatory body and provide adequate resources to ensure its operation according to objective and transparent criteria.

The Government of Liberia will take the lead and ownership in mobilizing funding and ensuring the availability of resources for the effective implementation of the policy. The Government will strive to progressively increase its health spending to meet the Abuja target of 15% of national budget, with a specific commitment to supporting the implementation of this policy. The Ministry will pay particular attention to increasing the effective absorption of funds allocated to health and ensuring long-term funding for critical health services. A Health Management Fund will be established to purposefully support policy implementation and review mechanisms.

EXECUTIVE SUMMARY NATIONAL HEALTH PLAN 2007 – 2011

Context of the National Health Plan:

The National Health Plan outlines the objectives, strategies and resources to reform the health sector to effectively deliver quality health and social welfare services to the people of Liberia. The MOHSW vision is improved health and social welfare status and equity in health; therefore becoming a model of post-conflict recovery in the health field. The five-year health plan (2007-2011) will operate within the framework of the Interim Poverty Reduction Strategy (iPRS) and also guide the transition from humanitarian to development assistance.

Components of the National Health Plan:

The National Health Policy and Plan are designed around four strategic orientations of Primary Health Care, Decentralization, Community Empowerment and Partnerships for Health. The operational and integrated framework for implementing the National Health Policy and Plan is based on four key components -- 1) Basic Package of Health Services; 2) Human Resources for Health; 3) Infrastructure Development; and 4) Support Systems.

The **Basic Package of Health Services (BPHS)** is the cornerstone of the National Health Plan. It defines an integrated minimum package of standardized prevention and treatment services. The BPHS will be adapted for each level of the health system – community, health clinic, health centre, county hospital, and tertiary hospital. The BPHS will be introduced incrementally to become functional in 70% of existing health facilities by the end of 2008.

Human Resources for Health will ensure that the right numbers of health workers are in the right place, at the right time, and with the right skills to delivery the BPHS. This component will 1) Ensure a coordinated approach to human resource planning; 2) Enhance health worker performance, productivity and retention; 3) Increase the number of trained health workers and their equitable distribution; and 4) Ensure gender equity in all aspects of employment.

Infrastructure Development will increase geographic access to the BPHS, especially for clinics and health centers, which comprise 94% of facilities. County health development plans will be prepared by County Health Teams in collaboration with districts, health facilities, communities and local partners. The National Health Plan in years one and two will consolidate health work in existing health facilities. At the same time a longer-term plans for major rehabilitation and construction will be prepared to being in year three.

Support Systems are the planning and management functions required to deliver the BPHS. This includes Policy formulation & implementation; Planning & Budgeting; Human Resources Management; Health Management Info Systems; Drugs & Medical Supplies; Facility & Equipment Maintenance; Logistics & Communication; Supervision, Monitoring & Evaluation; and Stakeholder Coordination. The NH Plan will incrementally and pragmatically decentralize decision-making, especially to the county level.

These components will be supported through health financing and implemented in collaboration with a variety of partnerships for health. The integrated strategic National Health Plan is like a child whose body is like a child whose head (the BPHS) guides its heart (its capable human resources); and whose arms (its strong support systems and partnerships) and legs (health financing and infrastructure) support the body.

Costing and Financing the National Health Plan:

Costing and financing the National Health Plan requires a balancing investment costs with anticipated funding. While Millennium Development Goals recommend a US\$34 per capita investment level, experience from other post conflict countries indicates that rebuilding health systems can begin with US\$10-\$20 per capita. The proposed four-year budget of US\$ 283 million is based on US\$12 per capita and increasing to US\$18 per capita.

National Health Plan Multi-Year Budget (2007 - 2010)

AREA	YEAR				Total
	2007	2008	2009	2010	
Human Resource for Health	15,300,000	19,149,000	19,608,000	20,079,000	74,136,000
Health Support System	6,800,000	6,963,000	7,130,000	10,952,000	31,845,000
Basic Package (PHC)	15,300,000	19,149,000	19,608,000	20,079,000	74,136,000
Infrastructure	1,700,000	1,741,000	8,913,000	12,778,000	25,132,000
Social Welfare	1,700,000	1,741,000	1,783,000	1,869,000	7,093,000
Subtotal	40,800,000	48,743,000	57,042,000	65,757,000	212,342,000
Transition Gap & Health Plan Implementation Costs	\$13,600,000	\$16,247,000	19,014,000	\$21,904,000	70,765,000
Total	\$54,400,000	\$64,990,000	\$76,057,000	\$87,617,000	283,064,000

Financing of the National Health Plan will combine funding from four sources – 1) the National Budget; 2) National Programs; 3) Humanitarian/Developmental funds; and 4) Other Sources. The financing proposal shown below is based on the following scenario:

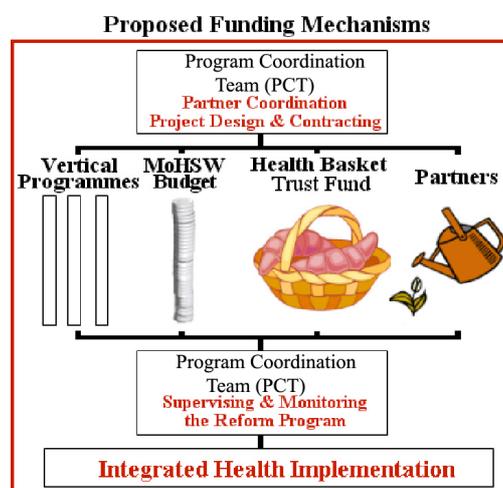
- **The National Budget:** US\$10 Million in 2007 and increasing to US\$33 million by 2010;
- **National Programs, Humanitarian and Developmental:** Maintain the current US\$40 million funding level by replacing humanitarian funding dollar per dollar with developmental funding; and
- **Other Sources:** NGO and private not-for-profit contributions (and potentially user fees).

Financing of the National Health Plan (in US\$ millions)

Source of Funding	2007	2008	2009	2010	Total
MOHSW + JFk (increasing to 15% of Nat. Budget)	10	18	28	33	89
National Programs, Humanitarian & Development Funding	40	40	40	40	160
Other Funding (NGO, FBO, User Fees)	4	7	8	15	34
TOTAL	54	65	76	88	283

Implementation and Monitoring:

The MOHSW has created a Program Coordination Team (PCT) to coordinate partners and resources for implementing the National Health Policy and Plan. The PCT consists of the four Deputy Ministers supported by technical experts, and is headed by the Chief Medical Officer/Deputy Minister of Health Services. The PCT provides the best option for institutional capacity building, both at the management and organizational levels. Contracting mechanisms with NGOs will be selectively used for both geographic and programmatic focused projects. A comprehensive system for monitoring and evaluation, as well as an Office of Financial Management, has been established within the Ministry to ensure results that will meet and exceed international and regional standards.





NATIONAL HEALTH POLICY

MINISTRY OF HEALTH AND SOCIAL WELFARE



MONROVIA, LIBERIA

2007

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LIST OF ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
BPHS	Basic Package of Health Services
CFSNS	Comprehensive Food Security and Nutrition Survey
CHSA	County Health Services Administration
CHS&WT	County Health and Social Welfare Team
CHWs	Community Health Workers
DPT-3	Diphtheria, Pertussis and Tetanus vaccine- Third dose
FBO	Faith Based Organization
GDP	Gross Domestic Product
GHI	Global Health Initiatives
GoL	Government of Liberia
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HRH	Human Resources for Health
HSCC	Health Sector Coordinating Committee
IMCI	Integrated Management of Childhood Illness
iPRS	Interim Poverty Reduction Strategy
JFK – MC	John Fitzgerald Kennedy Medical Center
MCH	Maternal and Child Health
MDGs	Millennium Development Goals
M&E	Monitoring and Evaluation
MOU	Memorandum of Understanding
MPEA	Ministry of Planning and Economic Affairs
MOH&SW	Ministry of Health and Social Welfare
MDs	Medical Doctors
NCDs	Non Communicable Diseases
NDP	National Drug Policy
NDS	National Drug Service
NGO	Non-Governmental Organization
NHP	National Health Policy
PHC	Primary Health Care
RAR	Liberia Health Sector Rapid Assessment Validation and Strategy Design Workshop (Rapid Assessment Report)
STDs	Sexually Transmitted Diseases
TB	Tuberculosis
UNDP	United Nations Development Program
UNICEF	United Nations Children Fund
WHO	World Health Organization

INTRODUCTION

1.1 Health Policy Context and Process

This health policy has been formulated at a crucial time in Liberian history. After decades of turmoil, the country is enjoying peace and stability, under the watch of a legitimate government, recognized and supported by the international community. However, the scale of the destruction is such that it will be overcome only after decades of sustained efforts. The recovery process offers a unique opportunity to build a stronger health sector—an opportunity that cannot be missed.

Aware of the complexity and risks of the course ahead, the Ministry of Health and Social Welfare (MoH&SW) has pressed on with the formulation of a health policy explicitly aimed at guiding decision-makers through the next five years. The health policy will evolve over time as data become more reliable, health systems are strengthened and financial and human resources become more secure. It will be updated and enriched by new elements, as experience in restoring health services is gained and issues are progressively clarified. The acquisition of adequate analytical capacity will be crucial to understanding the changing environment and introducing appropriate adjustments to the National Health Policy and the plans intended to enforce it.

The health policy formulation process has gone through several inter-related phases. It started with a rapid assessment of health services. The first draft policy document was discussed in four regional consultation meetings and in one national meeting. Additional meetings were held with key stakeholders. The policy document was revised many times, progressively incorporating stakeholders' input and clarifying its inspiring principles and goals, as well as the operational implications of the chosen goals and approaches. A precondition to success is the shared commitment to this National Health Policy by all partners engaged in the health sector.

This health policy draws attention to nationally agreed priorities, on which the efforts of all concerned partners shall concentrate. The Ministry knows well that capacity and resources are in very short supply, that dispersing attention on many fronts could jeopardize true progress, and that many issues cannot be properly tackled until the foundations of a functioning health sector are properly laid down. Thus, the most urgent priorities will be addressed first, and other less pressing, but equally important challenges will be addressed in the near future, once the system has acquired additional capacity.

In summary, the health sector faces two huge, competing *challenges*:

- 1) *Expanding access to basic health care of acceptable quality*. This will be possible only by:
 - Attracting additional investments in infrastructure, human resource development, and management systems, and resources to fund recurrent expenditures.
 - Reducing systemic inefficiencies and improving operations management.
- 2) *Establishing the building blocks of an equitable, effective, efficient, responsive, and sustainable health care delivery system*.

The adherence to a shared health policy by partners currently engaged in the health sector and of new entrants is a precondition for progress. Some sub-sector policies shall be presented as separate meta-policies, because of their special features and unique response requirements.

The *National Health Plan* is the instrument devoted to the implementation of this policy, and the documents should be considered together and jointly evaluated.

1.2 Social Welfare Policy

The MOH&SW believes that substantive preparatory work is still needed in order to formulate a sound social welfare policy. The new social welfare policy will aim at restructuring a sector that is now fragmented and under-resourced, and is thus unable to address the enormous needs of the Liberian population. Therefore, a major review of the social welfare field will be carried out in 2007. The review will start with a thorough situation analysis where issues such as poverty, violence, displacement, unemployment, gender inequality, disability, and vulnerability will be explored in detail.

The review will consider the following critical aspects of social welfare:

- Resource and capacity constraints in the social welfare field.
- Social welfare areas of priority based on international evidence-based best practices and lessons learned. Priorities will take into consideration existing needs, available resources and the comparative effectiveness of different interventions.
- Resources needed to carry out the chosen interventions and provide equitable, sustainable and effective social welfare services.
- Institutional implications of the proposed measures, including linkages with other sectors and stakeholders. The policy will focus on ways to encourage the integration of the actions promoted in the field, and remove operational obstacles.
- Monitoring and evaluation tools.

The review exercise will take place during the first half of 2007. It will provide the basis for the formulation of the new social welfare policy in the second half of 2007. Review and policy formulation will involve all national and international concerned stakeholders, through a transparent and participatory process.

SITUATION ANALYSIS

2.1 The Socio-Economic Situation

The Liberian economy has been in decline since the 1980s due to extreme social and political upheaval and mismanagement. The war destroyed productive capacity and physical infrastructure on a massive scale. The result has been a precipitous economic decline and the deepening of national poverty. Liberia -- a nation that had achieved food security and middle income status in the 1970s -- is today a shell of its past. Per capita Gross Domestic Product (GDP) in 2005 prices declined from US\$1,269 in 1980 to US\$163 in 2005, a decline of 87 percent. It is estimated that three fourths of the population is living below the poverty line on less than US\$1 a day (iPRS, 2007). The south-eastern region of the country, particularly Sinoe, Grand Gedeh, River Gee, Grand Kru and Maryland counties, lags behind the rest of the country in terms of socio-economic development.

During the war, agricultural production dropped precipitously as people fled their farms and markets closed. Mining and timber activity nearly ceased, rubber plantations closed, manufacturing dropped sharply and services ground to a halt. Basic infrastructure was badly damaged by the conflict. There was virtually no public source of electricity or piped water in the country for 15 years until recently, when power and water was restored to parts of Monrovia in July 2006. Schools, hospitals, and clinics were badly damaged, and most government buildings are in shambles. Many roads are still impassable, which seriously constrains peace building efforts, weakens economic activity and undermines basic health and education services.

Years of mismanagement have left Liberia with a huge external debt burden, estimated at about US\$3.7 billion as of mid-2005, equivalent to an astonishing 800 percent of GDP and 3000 percent of exports. The decimation of the economy has led to very high levels of unemployment (one estimate suggests unemployment in the formal sector is 85 percent). With the collapse of so many sectors of the economy, ex-combatants and returning refugees and internally displaced persons are struggling to find work. The majority of the population works in agriculture and subsistence farming or the informal economy in trading and small scale production. Many families and communities rely on external remittances from relatives abroad and spin offs from donor-funded investments through international NGOs. Almost without exception Liberians are far worse off today than they were twenty five years ago.

The Liberian economy is recovering, thanks to investments in physical infrastructure, donor inflows and a gradual improvement in security in rural areas. The economy finally stabilized and began to rebound in 2004. Growth reached 5.3 percent in 2005 and is expected to reach 7-8 percent in 2006.

However, total government expenditure including grants has not exceeded US\$85 million since 2000, translating into spending per capita of only about US\$25, one of the lowest levels in the world. The 2006/07 budget is projected at US\$130 million, a 60% increase over the previous year, with at least 15 percent devoted to pro-poor targeted activities. Inflation, which jumped to 15 percent in 2003, subsequently subsided to around 6 percent, although there are pressures from rising prices as the economy rebounds.

Massive population displacement in rural areas during the war has led to accelerated urbanization. Close to half of the population resides in urban communities. Monrovia currently hosts more than one million inhabitants, double its pre-war population. Poor waste and water management systems have led to high levels of pollution and the rapid spread of communicable diseases in urban areas (GOL and UNDP, 2006).

The literacy rate is less than 40%. Between 2000 and 2002, the Gross Enrolment Ratio declined from 73% to 49% for boys and from 73% to 36% for girls. As of 2004, the proportion of pupils starting grade one and reaching grade five was 35% for boys and 27% for girls. Net enrolment is targeted at 100% by 2015 from current level of 30%. Currently 30% of males and 37% of females of school age are not enrolled in schools – mainly due to not having enough money to pay for associated school costs, or not having a school in the community (UNDP, 2006).

2.2 Demography¹

The last population census of Liberia was conducted in 1984. Since then, the Ministry of Planning & Economic Affairs has updated its population projections. Its 2006 population estimate is 3.2 million, with a growth rate of 2.4%. Population density is 84 per square mile. Population distribution is very uneven, with four counties hosting 70% of the total population. The South-East is very sparsely settled. The age-group 0 – 18 years accounts for about 54% of the population. Nearly 15% are under 5 years of age while approximately 3% of the population is over the age of 65.

Average life expectancy at birth is estimated by WHO (2006) at 42 years, with 44 years for women and 39 years for men. The current fertility rate is estimated to be 6.8 (DHS, 1999). Three out of every four women age 20-24 years have had a child. The use of modern family planning methods among women is 11.3%. The average household size is 5.1.

2.3 Mortality and Morbidity

The infant mortality rate is currently estimated to be 157/1,000 live births -- well above the Sub-Saharan Africa average of 102/1000 live births and the world average of 54.² The under-five/child mortality rate is also high, at 235/1,000 live births. Liberia ranks above the Sub-Saharan Africa average of 171/1,000 live births and the world average of 79/1,000.³ In 2005, the maternal mortality ratio was estimated by UNFPA at 580/100,000 live births. The crude mortality rate was recently estimated in rural areas at the alarming level of 1.1 deaths per 10,000 persons per day (CFSNS, 2006).

Malaria, acute respiratory infections, diarrhea, tuberculosis, sexually-transmitted diseases (STDs), worms, skin diseases, malnutrition, and anemia are the most common causes of ill health. Malaria accounts for over 40% of OPD attendance and up to 18% per cent of inpatient deaths. Diarrheal diseases in Liberia are the second leading cause of morbidity and mortality HIV prevalence rate estimates vary widely, but the the Interim Poverty Reduction Strategy (iPRS) suggests a figure of 5.2%. All agree, however, that HIV/AIDS is a problem of mounting severity. Existing data are inadequate to draw firm conclusions about internal variations in HIV prevalence. It appears that Monrovia and the south-eastern region have higher HIV prevalence rates than the rest of the country.

2.4 Nutrition

Approximately 27% of children under-five years are underweight. In addition, an estimated 7% are wasted, while 39% are stunted (CFSNS, 2006). These values are remarkably similar to those registered by the National Nutrition Survey of 2000. In the same year, iron deficiency anemia was 87% in children 6-35 months, 58% in non-pregnant women 14-49 years, and 62% in pregnant

¹ UNICEF: The Official Summary of The State of the World's Children 2006; World Population Prospects: The 2004 Revision, United Nations Population Division, Department of Economic & Social Affairs, New York, 2005; WHO: 'World Health Statistics 2006' and 'The World Health Report, 2006 Edition'; MPEA 2006

² UNICEF: The Official Summary of The State of the World's Children 2006; World Development Indicators database, April 2006

³ Ibid

women aged 14-49 years.⁴ Vitamin A deficiency affects 52.9% of children 6-35 months and 12% of pregnant women. Only 35% of children below 6 months of age are exclusively breast-fed (UNICEF, 2006). Zinc supplementation for children has not yet been introduced.

2.5 Water and Sanitation

Access to safe water declined from 58% of households in 1997 to 24% in 2005, due to the destruction of piped water facilities in urban settings (UNDP, 2006). Nationwide, 26% of households have access to sanitation but significant rural/urban disparities exist – with sanitation available to 49% of urban residents and only 7% of rural residents (UNICEF, 2006). However, the problem of poor sanitation is particularly acute in cities. The collapse of waste disposal and sewage services and an increase in population have led to extremely poor sanitary conditions in urban areas - especially in Monrovia - generating serious environmental and health problems.

2.6 Access to Health Care

Liberia's health services have been severely disrupted by conflict. Health workers fled to camps for internally-displaced people (IDPs), to secure areas or to neighboring countries. Health facilities were looted and vandalized and medical supplies became unavailable. Government funding stopped and health services collapsed (UNDP, 2006). Following the end of the war, the revitalization of the health services has begun, but the health situation is still poor.

The dearth of accurate data on health service access and utilization makes most considerations in this respect only tentative. Available estimates are grossly divergent, suggesting that overall they are unreliable. The Interim Poverty Reduction Strategy (iPRS, 2006) reports that 41% of the population has access to health services. Most data suggest low service consumption and gross imbalances across Liberia. The last EPI survey carried out in 2004 found that less than one third of children received a DPT-3 shot. EPI reporting has since shown improvements with DPT-3 at 87% and Measles at 94% (WHO immunization monitoring 2005).

2.7 Health Care Delivery and Resources

Health care delivery is fragmented and uneven, heavily dependent on donor-funded vertical programs and international NGOs. Disease prevention and control programs exist for malaria, leprosy, tuberculosis, STDs/HIV/AIDS, and onchocerciasis. Humanitarian relief agencies concentrated their interventions in the most war-affected areas and where refugees and IDPs were resettling. Many health care providers including Community Health Workers are funded by emergency programs, which are being withdrawn as the country stabilizes. The gap created by the reduction in funding for emergency assistance, before development aid starts flowing, has the potential to disrupt health care provision, as witnessed in other post-conflict settings.

Health Facilities. In 1990 there were 30 Hospitals, 50 Health Canters and 330 Clinics functional. In 2006, 18 hospitals, 50 health centers and close to 286 health clinics were considered to be functional (RAR, 2006). Many of these facilities struggle to attain acceptable performance levels, and are in need of robust infrastructural interventions to become truly functional and respecting referral functions. The hospital component of the health sector is under-sized. Its technical capacity is grossly inadequate. Large investments are already under way to restore the functionality of some hospitals.

⁴ Source National Micronutrients Survey 2000

Resources

Financing. Current total annual health care expenditure is estimated at about US\$12 per head, but could be higher if private spending is included. The state budget contribution to health is increasing (Msuya and Sondorp, 2005). Most facilities supported by NGOs are providing services free of charge. Faith-based organizations (FBOs) usually raise user fees. Other facilities charge for services, often on an informal basis. No global estimate of private health expenditure is available.

Human Resources. According to the *Rapid Assessment of the Health Situation in Liberia* 2006, the workforce is composed of approximately 4,000 full-time and 1,000 part-time staff. The distribution of trained health workers is grossly imbalanced in favor urban areas and qualified professionals are scarce. Many health workers hold sub-standard qualifications, whose actual value shall be verified. Given modest service uptake, staff workloads are often low. Numerically, the workforce appears adequate for the size of the health sector and the population to be served. However, analysis indicates 36% of the total work force are made up of health aides and traditional midwives. Human resources must be strengthened in terms of skills, appropriateness and productivity.

Drugs. Drug procurement is mainly paid by emergency funds. The National Drug Service (NDS) is an autonomous, publicly-owned agency, mandated to supply the health sectors with medicines and other critical health commodities. Regulation is deficient and private dealers freely import, distribute and sell medicines. Reportedly, the circulation of counterfeit, sub-standard and expired medicines is considerable. In 2001, the Ministry has issued a National Drug Policy (NDP), whose provisions have not been fully implemented. A national Essential Drugs List exists that calls for review.

Management Systems. Management systems are dysfunctional or non-existent. Staff with professional and management skills is in severe shortage. The collapse of the old hierarchical state structure has given way to a variety of pragmatic arrangements. Local health authorities have been left to fend for themselves, with the help of any partners they could find. Vertical programs stand apart from mainstream services, as operated according to structured management provisions. Decentralization, adopted as policy before the war, has been chosen by the new government as a key driver of reconstruction. In the present context of management disarray, the first step towards decentralization is strengthening the capacity and the structure of the central health authority.

2.8 Health Needs and Challenges

Enabling the health sector to play a full and effective role implies addressing immediate as well as long-term challenges in a holistic and balanced way. The health needs of a distressed and impoverished population must be alleviated by urgent measures, while starting to invest in the areas that will make the future growth of the health sector possible. The post war needs include:-

- Assurance of quality equitable antenatal care and safety in obstetric practices
- Assurance of child health
- Addressing nutrition issues
- Dealing with the current burden of disease
- Addressing the high fertility rate
- Meeting demand for access to quality health services
- Development of a social welfare policy and strategy
- Meeting population requirements to access safe water and sanitation

The immediate challenge is *expanding access to basic health care of acceptable quality*, through immediate interventions such as:

- Ensuring the availability of funds at county level to support the continuous delivery of basic services;
- Improving the availability of essential medicines and other critical health commodities;
- Rehabilitating health facilities in under-served areas;
- Upgrading the skills of health workers and redeploying them to areas where they are most needed;
- Boosting management capacity at all levels to support the delivery of services. The first step in this direction is improving the information base and monitoring and evaluation capacity.
- Improving availability of safe water and sanitary facilities.

Long-term challenges include:

- Ensure the availability of adequate resources to sustain the investments called for by reconstruction, as well as the increased recurrent expenditure induced by it;
- Restructuring resource allocation patterns, so that underserved communities benefit adequately from health sector recovery;
- Reducing the present strategic and operational fragmentation, in order to ensure coherence of sector development and attain efficiency gains;
- Upgrading, streamlining and restructuring the workforce, through a long-term training program and the introduction of effective personnel management practices;
- Strengthening the supply chain and rationalizing pharmaceutical management in order to ensure the availability of affordable, safe, effective essential drugs and other critical commodities;
- Revamping the health care network, through targeted investments in health care and support facilities, in view of increasing access to primary and referral health services;
- Establishing effective management systems that are capable of operating a modern health sector and are able to evolve as the context and health needs of the Liberian population change over time;
- Introducing effective regulatory provisions and mechanisms to ensure adherence to norms, fair and productive competition and quality health services.

POLICY FOUNDATIONS

3.1 Mission

The mission of the Ministry of Health and Social Welfare is to reform the sector to effectively deliver quality health and social welfare services to the people of Liberia. The MOH&SW is dedicated to equitable, accessible and sustainable health promotion and protection and the provision of comprehensive and affordable health care and social welfare services.

3.2 Vision

Liberia's vision is improved health and social welfare status and equity in health; therefore becoming a model of post-conflict recovery in the health field,

Enlightened leadership, sustained efforts, coherent prioritization and generous external support are needed to materialize this vision by:

- taking stock of the experience earned in other countries,
- adopting realistic and sustainable approaches in order to make effective use of available resources,
- giving priority to Primary Health Care in the allocation of available resources,
- giving attention to equity, particularly concerning persons in difficult circumstances,
- tapping the potential strengths of the health sector and the opportunities for progress when they arise,
- striking productive partnerships with committed stakeholders,
- continuously studying events, so that appropriate measures can be timely taken.

3.3 Guiding Principles and Strategic Approaches

The principles guiding the policy are health as a basic human right, equity, efficiency, sustainability and accountability. The PHC approach encompassing decentralization, community empowerment and partnership shall be followed in the enforcement of the policy.

3.3.1 Health as a Universal Human Right

Access to health care is a universal human right within the means that society can sustain. Health is a precondition for individual and societal development. Recognizing the value of health care, the Government of Liberia is committed to invest adequate resources, capacity and political capital in health sector development.

3.3.2 Equity, Gender and Poverty Focus

Equity, social justice and good governance are essential for health and social improvements. Every Liberian shall have access to health services, irrespective of socio-economic status, origin, gender, and geographic location. The pro-poor commitment of the Government will be demonstrated by concrete measures, taken at all levels of health care provision. Recognition shall be given to the special needs of the most vulnerable.

User-friendly services shall be equally accessible to everyone regardless of their gender. Government will ensure that health care services are delivered on an equitable and affordable basis to all communities and persons, especially to the poor and vulnerable members of the community and to women and children.

3.3.3 Efficiency and Sustainability

Given the resource gap crippling the development of social sectors, all efforts must be made to achieve maximal health outcomes at high efficiency cost-effectively. Efficiency must remain a constant concern, particularly in relation to resource allocation. A long-term capacity building program will ensure that employees possess the capacity to discharge their health and social welfare responsibilities. Choosing appropriate options that are locally manageable and affordable over the long-term and building local and institutional capacity and confidence to ensure long-term success is critical to meeting health needs.

The recurrent cost ceilings considered affordable by Liberia in the long term will be a major factor in the development of long-term plans. As such, the MOH&SW will ensure that all investments contribute to the creation of a balanced, effective and sustainable health sector. Measures aimed at attaining quick results and gradual progress with positive impact shall be examined *inter alia* for sustainability before definitive commitments

This policy promotes a primary health care approach that emphasizes positive economic benefits and a balance between prevention, promotion and curative care . Liberia can make savings on resources that would otherwise be spent on treating preventable or avoidable diseases by promoting good health and nutrition, preventing disease and injury and restoring health to those who are ill. Given the critical link between health and productivity, high-quality, efficient and sustainable services that meet the physical and mental health needs of its population will contribute to the achievement of Liberia's development goals.

Coordination and integration:

Presently, multiple vertical and humanitarian programs account for a significant proportion of the health services provided in Liberia. Resources and capacity available in these programs support the delivery of basic health services but not within an integrated framework that maximizes potential health outcomes. To reform this systems constraint the MOH&SW shall strengthen the existing coordination mechanism and promote an incremental integration process guided by a concern for attaining systemic efficiencies without disrupting the delivery of the health services. Particular priority will be given to integrating information, planning and management systems to facilitate this process. Vertical training programs will ultimately be absorbed into the overall human resource development program.

3.3.4 Accountability

Adequate political, financial, administrative and communication instruments are needed to ensure the accountability and transparency of health sector decisions and operations. These instruments must encompass the whole sector, enabling decision-makers and the public to understand how decisions are taken, resources allocated, and results achieved. To that effect, all resources, internal and external, public and private shall be comprehensively monitored. The monitoring system will be designed to enable concerned parties to verify adherence to the PHC principles inspiring this policy

3.3.5 Decentralization

The Government of Liberia has stated its intention to proceed towards decentralization. While the overall characteristics of the future decentralized public structure are being specified, the health sector will work hard to prepare the ground for the reform. The de-concentration of management responsibilities requires the building of performing systems at county level, as well as effective support systems at central level. The Ministry will pursue de-concentration in an incremental and pragmatic way, by assigning to County Authorities responsibilities they are equipped to assume and

progressively expanding these responsibilities. Caution will be exerted in the process, to ensure that health services are delivered without major disruptions.

NGO/FBO partners will be involved in the reform, through conventions or contracts. Resources will be redistributed in favor of local communities, with the objective of improving the capacity of health services to respond to local health care needs. The county level shall be responsible for health service delivery, while the central level will focus on policies, resource mobilization and allocation, aggregate planning, standards setting and regulation. The exact boundaries of the decentralized structure will be clarified over time, through interaction of central and peripheral levels.

3.3.6 Primary Health Care

Primary Health Care shall be the foundation of the health system and a model for improving health care delivery. The PHC approach focuses on promoting good physical and mental health and preventing illness, but it also includes basic curative care at the level closest to users, where they have first contact with health services. The PHC approach means being attentive to and addressing the many factors in the social, economic and physical environments that affect health—from diet, lifestyle, relationships, income and education, to housing, workplaces, culture and environmental quality. It also includes addressing the mental health impact of the recent mass violence and displacement suffered by the Liberian people. The PHC approach places citizens and patients on an equal partnership with health professionals in decision-making about health.

The foundation of a primary health care approach is a focus on the community, district, and county as a locus for decision-making in relation to resource management and service delivery. The MOH&SW is committed to ensuring equity and quality through the delivery of a Basic Package of Health Services to be provided at each facility to the largest number of potential beneficiaries. To realize its potential, the system must be supported by adequate referral capacity. Therefore, a network of first-referral facilities shall be progressively put in place to cover the whole country.

Interventions will focus on community empowerment - seeking to enhance a community's ability to identify, mobilize, and address the issues that it faces to improve the overall health of the community. Translating community contributions into improved health requires that they have an understanding of health issues in order to make informed health decisions. Increased community capacity, in turn, is expected to enhance the health of the individuals within the community and the development of the community as a whole.

3.3.7 Partnerships

The Ministry will effectively manage the diverse set of health sector partners who are motivated by a range of different mandates, interests, resources and ways of working. Liberia needs effective partnerships that are characterized by continuous and frank consultations, information sharing, clear rules of engagement and conflict resolution, transparent transactions, and explicit incentives. Partnerships for health shall be guided by the Government, to ensure that their actions are coherent with the principles of the national health policy. The involvement of potential partners in policy formulation and planning since early stages is the first step towards strengthened collaboration.

Taking basic health services closer to an expanding number of potential users implies an overhauling of the collaboration between Liberian health authorities and private/non-profit health care providers. Relationships will gain in transparency, efficiency and effectiveness if they are formalized into mutual binding commitments.

3.4 Policy Objectives

From the preceding, the scope and rationale of the health policy may be articulated as follows:

<i>Overall goal</i>	To improve the health status of an increasing number of citizens, on an equal basis..
<i>Main strategy</i>	...through expanded access to effective basic health care, backed by adequate referral services and resources.
<i>Adopted means</i>	The overall policy goal will be attained through the improved management of expanded resources, provided by the state, donors, international agencies, non-profit health care providers, economic actors and communities. Strong, structured partnerships around shared objectives and approaches, within and outside the health sector, will be required to improve health status.

Policy objectives:

The following objectives are formulated based on limited information accruing from the situation analysis in chapter 2 which summarizes the health challenges currently facing the Liberian people.

- Improved child health
- Improved maternal health
- Increased equitable access to quality health care services
- Improved prevention, control and management of major diseases
- Improved nutrition status
- Increased access to quality social welfare services

As baseline data is currently inadequate, the MOH&SW must, for the time being, rely on estimates, projections and qualitative formulations. However, the Ministry is committed to strengthening information systems so that effective monitoring of operations through quantitative indicators will soon become possible. In formulating the National Health Plan, a set of indicators to monitor health sector progress has been developed, with particular emphasis on studying health development from a sector-wide perspective. In Chapter 5, a preliminary list of indicators is suggested.

POLICY ORIENTATIONS

4.1 Organizational Policy

The health sector reform shall reflect the Government's commitment to decentralization. The Ministry shall invest heavily in strengthening county structures and building human capacity, with the objective of enabling county health authorities to assume their expanded role.

4.1.1 Central Level

Key roles and functions of the Central level Ministry shall be:

- Proposing and monitoring of health legislation and law enforcement
- policy formulation, revision and enforcement
- resource mobilization and allocation, national and long-term planning
- broad health sector programming
- monitoring and evaluation
- technical oversight of service delivery, regulation, major research and development initiatives.

For purposes of policy guidance a multidisciplinary National Health Advisory Council (NHAC) shall be established to work directly under the Minister. Members to the Council shall be presidential appointees based on recommendations of the Minister for Health and Social Welfare. Council membership shall be fifteen with representation from relevant government agencies, major health providers, the business community, community leaders, health professional bodies, health development partners and civil society. The Council shall hold sessions to consider major policy issues and strategic directions for national health and the sector as a whole and advise the Minister accordingly.

The Ministry's responsibility for direct health care service delivery, particularly in relation to disease control programs, will be progressively devolved to county health authorities and autonomous hospitals.

The MOH&SW is headed by the Minister and contains four departments, each headed by a Deputy Minister (see MOH&SW organization chart in annex 1 which will be modified following the institutional reform):

- Health Services;
- Planning, Research, Human Resource Development and Statistics;
- Administration; and
- Social Welfare.

The departments are sub-divided into bureaus headed by Assistant Ministers. The bureaus comprise several divisions, headed by Directors.

The Ministry is reconsidering its organizational structure to make it more effective. The functions of each department and relative sub-divisions will be reviewed and clarified. The MOH&SW will assess the interface between the various components of the Ministry and progressively introduce state-of-the-art management approaches to improve its efficiency. To play its role in full, the

Ministry shall adjust its structure, size, procedures and technical capacity. The future Ministry will be small, but staffed by a competent and highly motivated staff in order to lead the decentralized health sector.

4.1.2 Operational Levels

County Level

The County Health and Social Welfare Service Administration is the operational management structure, which includes the County Health and Social Welfare Team (CH&SWT). County health authorities manage county health facilities, including county hospitals. Proper administrative structures and management tools will be introduced at county level, to make health authorities truly autonomous. They will be responsible for financial and asset management and personnel, and will be fully accountable to local constituencies, as well as to overseeing public bodies. The relationships of county health authorities with local government structures shall be clearly spelled out.

4.2 The Tier System of Health Care Delivery

The national health system shall continue to be based on three main levels of care (primary, secondary and tertiary), with each level acting as a gate-keeper for the next level. Users will directly access quality primary health care services. Access to higher levels of care shall be based upon referrals, except in cases of emergency. To function adequately, referral mechanisms shall be adequately resourced, including the acquisition and maintenance of transportation and communication equipment. Specific guidelines will be formulated by the Ministry to assist health care providers and users in referral-related decisions.

The service mix provided at each level will be specified by the Ministry, consistently with the Basic Package of Health Services (BPHS), as described below. Hospital services, in addition to those included in the basic package will also be specified by the Ministry after a thorough review of secondary and tertiary facilities and an assessment of the implied costs of delivering additional services.

The **Primary Level of Care** includes basic health care services delivered through clinics and small health centers. The *health clinic* is a small facility with not more than five beds, providing basic preventive and curative care. The package at this level includes promotional health, basic mental health services and the management of common conditions of children and adults. Facilities will also support environmental health (water and sanitation) in the surrounding community. Community health services will be supported by the appropriate Community and District Management structures.

The **Secondary level of Care** encompasses large health centers and county hospitals. The *health center* is a primary care and referral facility with up to 40 beds, providing a wide range of curative and preventive services, supported by a small laboratory. Basic emergency and inpatient care is included. The *county referral hospital* has more than 50 beds and permanent capacity to manage common surgical conditions, including basic intensive care. Health Centers will be equipped with an adequate power source, communication equipment and an ambulance.

The **Tertiary Level of Care** is represented by the John Fitzgerald Kennedy Medical Center (JFK-MC), which shall continue to be autonomous and managed by its Hospital Administration Department under the supervision of a Board of Directors. For the time being, newly established regional referral hospitals (150 beds) will be administered by the County Health and Social Welfare Administration, pending decisions about their level of autonomy.

The JFK-MC will be rehabilitated to enable it to serve as tertiary referral facility for the whole country. The Ministry will conduct a thorough feasibility study of restoring JFK-MC to full functionality, considering both the magnitude of the initial investment as well as the implications for recurrent costs. The Ministry will ensure that the rehabilitation of JFK-MC is consistent with the priorities established in this policy. This means a modest rehabilitation program that does not divert substantive resources and capacity away from the primary and secondary levels of care.

The Ministry shall review the physical and functional characteristics of the different levels of health facilities and issue detailed descriptions for each. The summary descriptions presented above are only illustrative at this point.

4.3 Health Care Financing Policy

The Government of Liberia is committed to financing health care at the highest level compatible with its revenues, taking into consideration competing priorities. The Government shall strive to progressively increase the share of its budget apportioned to the health sector. A mix of other financing strategies (user fees, health insurance, and other forms of pre-payment) will be pursued.

The Ministry will closely monitor health expenditure, resource allocation patterns, financing gaps and absorption capacity through financial information generated by the Health Management Information System and review of National Health Accounts and Public Expenditure Reviews. National and county financial management systems will be revitalized to improve efficiency, absorption capacity, accountability and transparency.

In most poor countries recovering from protracted violence, a large portion of health expenditure is covered by donor contributions in the first phase. The progressive improvement of public finances usually allows the Ministry of Finance to shoulder an increasing share of health expenditures in a second phase. This pattern is likely to emerge in Liberia. The cost of reconstruction will be certainly huge, vastly surpassing internal revenues. Donors will be invited to support the recovery process by channeling their contributions in predictable, effective and efficient ways, consistent with Government policies. However, the present fragmentation of services must be addressed by changing the way external assistance is managed. The MOH&SW will negotiate with the Ministry of Finance and donor agencies to introduce financial transfer modalities that are appropriate to the current Liberian context. The funds channeled through these modalities will be submitted to regular audits according to international standards.

In light of crushing levels of poverty, the Ministry has decided to suspend the administration of user fees at the primary health care level. Additional funding will be mobilized to facilitate the implementation of this measure across the spectrum of PHC providers, in order to encourage their progressive alignment with the national policy. The suspension will remain in place until the socio-economic situation improves and financial management systems perform to a level that ensures the proper extraction, accounting and utilization of revenues. Meanwhile, private health spending will be studied, to gain insights useful to the formulation of a pro-poor comprehensive health financing policy.

Major health service providers, including private voluntary agencies and faith-based organizations, will be considered by the government as potential recipients of public subsidies. Precedence will be given to privately-supported facilities that provide services in areas lacking functioning public sector facilities. Performance-based contracting will be introduced gradually.

4.4 Basic Package of Health Services

A Basic Package of Health Services (BPHS) shall be the cornerstone of the national health care delivery strategy. The BPHS lists in detail a standard set of prevention and treatment services that the MOH&SW assures will be available throughout the health system. BPHS components are affordable, sustainable interventions that have been chosen on the basis of their effectiveness in

reducing morbidity and mortality. A mental health strategy and programme will be developed as part of the BPHS in the course of the process to refine the basic package.

The entire package will be available as an integrated whole, rather than as individual programs implemented only when adequate funding is available or when a donor expresses particular interest. Services not currently included in the BPHS, as long as they are approved by the MOH&SW, can be added, but not substituted for, those included in the BPHS. In order for a health facility to be deemed fully functional, it must be able to offer the entire BPHS to the population it serves. To this end, if no other sources of funding are available, public sector health funds will be allocated, preferentially, to providing the BPHS. The BPHS will be delivered at each level of the health system, from the lowest to the highest level of technical sophistication. It will shape most aspects of health sector development, such as financing, the mix of health personnel, and allocation of medicines and equipment.

The BPHS will be tailored to each level of the Liberian health system, but all facilities at the same level will implement the same package of services. The content of the BPHS shall build on what is currently available as services and resources, and identify the most urgent priorities that can be addressed by cost-effective interventions. The BPHS will allow the Ministry to increase overall coverage, strengthen procurement and management of essential drugs and commodities, monitor performance and evaluate impact in a way that allows for direct comparisons between different providers supported by different programs and funding lines.

4.5 Human Resources for Health

The MOH&SW recognizes that human resources are the most valuable asset in the health sector. The workforce must be restructured, upgraded, streamlined and redeployed according to the priorities set by this policy. A short to medium term transitional and long-term comprehensive program will be launched to produce a gender-balanced health workforce with the skill mix needed by the health services at different levels of care. This is a huge endeavor, successful only in the long term. Several of the necessary measures encompass aspects beyond the control of health authorities. The MOH&SW will work collaboratively with other branches of government, such as the Civil Service Authority, Ministry of Finance, Ministry of Planning and Economic Affairs, and private partners as needed.

Measures related to *human resource policy* include:

- The Ministry will establish adequate capacity for planning the long-term development and management of the workforce, coherent with overall health sector development. This **will result in** an organizational upgrading of the unit presently dealing with human resource issues.
- The Ministry will revisit existing legislation related to human resources and will formulate proposals to update legislation, as necessary. The Ministry will study the impact of private health care providers on the workforce and introduce measures to effectively manage the human resource market..
- The Ministry will develop health worker recruitment, retention and deployment incentives schemes. This will require negotiation with civil service authorities on the status of health workers and their contracting conditions. Salaries and benefits will be set in accordance with education, qualification, market value, experience and performance.
- The Ministry will estimate present and future staffing needs of the health sector, in light of recovery plans, cost limits, workload, population, efficient utilization of staff, the requirements of BPHS implementation and the public/private mix. The Ministry will also consider the impact on the labor market of other programs.

Measures related to *human resource management and planning* will include:

- All existing job descriptions will be reviewed in light of the adopted policy. Existing job categories will be appraised to bring them in line with delivering the BPHS. The Ministry will assess the need for changing existing professional profiles or creating new categories of health workers. Adequate career structures and progression paths will be introduced for all categories.
- The Ministry shall formulate staffing criteria, according to the services to be delivered and staff workloads, paying adequate attention to the productivity and affordability of the proposed health teams. Succession plans shall be established.
- A human resource database linked to the core HMIS database will be developed.
- The Ministry will establish a registration body in collaboration with professional associations to review the qualifications of health professionals who are not covered by already existing boards and test their skills. Non-standard qualifications will be progressively converted into nationally-approved job categories, through dedicated training if necessary. This process will provide crucial information for the design of pre- and in-service training programs. Successful outcome on these examinations shall form the initial basis for licensure to practice by nationals and non-nationals within Liberia.
- The Ministry will produce guidelines for the hiring of expatriate health professionals.
- Standard contract conditions for NGO employees will be negotiated with concerned partners.
- The Ministry will introduce measures to improve workforce performance, such as providing tools and standards, rehabilitating facilities, programming in-service training, improving supervision, establishing open performance appraisal and improving coordination.

Measures related to *training* shall include:

- The Ministry will design and launch a rapid training program to upgrade the skills of active health workers. The module devoted to introducing the BPHS will constitute one of the first components of such a program.
- The Ministry will review training programs within two years to ensure their consistency with the National Health Policy, approved job descriptions and the BPHS.
- The Ministry will develop an accreditation and investment program to strengthen the physical and functional capacity of health worker training institutions and training programs..
- The training of skilled health workers will be expanded to cover priority health care needs.
- Ongoing in-service training activities will be progressively absorbed into a comprehensive institutionalized in-service training program under the Human Resource Bureau in order to improve the performance of active health workers on the basis of documented service needs.
-

4.6 Infrastructure

The Ministry will conduct a thorough study of existing facilities (both public and privately-owned), including utilization, population distribution, access to roads and transportation, operational costs, and socio-economic factors in order to determine the number, size and types of health facilities needed to compose the future health care network. The Ministry will establish objective planning criteria with the collaboration of concerned parties. Densely-populated areas will be served by larger health facilities, so as to deliver better services and attain economies of scale. Sparsely-settled areas will be served by many small health facilities.

The MOH&SW believes that it will not need to construct many new facilities in order to cover the health service delivery needs of Liberia's population. However, where needed, additional facilities may be built in underserved areas or redundant facilities closed or downgraded. Some existing

facilities will be upgraded according to BPHS guidelines, and many facilities will be rehabilitated. The Ministry will develop standard layouts and building specifications for health facilities and their functional components.

Existing hospitals will be carefully assessed to determine their current mandate, capacity, ideal size and technical functions. No expansion of the hospital component is anticipated. Investment in hospitals shall be directed to re-establishing their proper functions and improving operational efficiency. The impact of hospital investments on recurrent expenditure will be estimated in order to rationalize and ensure the future sustainability of the health sector. Some secondary hospitals shall be selected for expansion to serve as Regional Hospitals on the basis of their location and patient load so that they will be able to offer referral functions to clusters of counties, in areas of specialized care that are unavailable at standard county hospitals.

The health care network will be planned as a coherent whole, within financial ceilings considered affordable in the mid- and long-term. Warehouses, training outlets and offices, as well as houses for key health professionals, will be included in the plan. All stakeholders will be involved in the planning process in order to build a balanced, effective, equitable and sustainable mixed-ownership network of health facilities.

To ensure sustainability and equity, the nationwide total number of health facilities will be projected at national level and for each County. County health authorities will be responsible for planning the number and spatial distribution of health facilities and for programming the actions to support implementation of the National Health Plan. Technical support to county health authorities shall be provided by the central level

4.7 Technology

Primary, secondary and tertiary health levels shall be provided the equipment necessary to discharge the functions attributed to them by the BPHS. The Ministry will ensure that all technology used in the health sector is safe, secure and properly utilized through continuous staff training, routine maintenance and renewal, and that adequate funds will be allocated for this purpose. The Ministry will enforce the standardization of basic equipment by adapting WHO Equipment Guidelines to the Liberian context. A comprehensive donation policy will be formulated and carried out.

A network of clinical laboratories supported by a central reference laboratory will be established to enable hospitals, health centers and large health clinics to effectively provide the level of health services assigned to them in the BPHS. A training program for laboratory cadres will be established to complement the procurement of laboratory hardware. Clinical staff will be trained in the effective and efficient utilization of laboratory investigations. The Ministry will integrate laboratory activities related to disease control programs into general laboratory services, so that the whole health sector benefits from the inputs of all programs.

An integrated IT network shall be developed in the short term to enhance efficiency of keeping health data and processing within the health system multilevel. This will link various data bases including clients records, health facilities, human resources, financing, health statistics.

4.8 Pharmaceuticals and Medical Supplies

The framework to manage and coordinate the pharmaceutical sector in Liberia is contained in the National Drug Policy (2001). This **policy** will be periodically revised and institutional arrangements will be strengthened to ensure its implementation, i.e. through the Pharmacy Division (to be re-designated Bureau of Pharmaceutical Services), the Pharmacy Board of Liberia, the Drug Regulatory Authority (to be established) and other significant partners, i.e. National Drug Service, the School of Pharmacy and the School of Dispensers (to be re-vitalised). The MOHSW will strengthen **technical** support to implement the essential drug programme to contribute to the

delivery of the Liberia Basic Package of Health Services (BPHS), through dissemination and use of revised and updated National Formulary (NF) and Standard Treatment Guidelines (STG) coordinated through the establishment of Pharmacy and Therapeutic Committees at national and county levels. The MOHSW will ensure that the **quality standards** set for drugs and their use are adhered to. The MOHSW will strengthen its **regulatory** function working through the Pharmacy Division, the Pharmacy Board of Liberia, the Drug Regulatory Authority to ensure compliance with the laws and regulations pertaining to importation, prescribing, dispensing and use of pharmaceuticals in Liberia through both public and private sectors. The MOHSW will strengthen the **monitoring and evaluation** of all things relating to pharmaceuticals in Liberia through improved inspection, support supervision and reporting. Pharmaceutical support for the **delivery of health services** will be strengthened through the posting of Pharmacists to County Health Teams throughout the country.

Therefore, the overall **goal** for the pharmaceutical sector in Liberia is to “increase access to efficacious, high-quality, safe and affordable medicines for the people of Liberia”

The **immediate Objective** is to use available resources to develop pharmaceutical services to meet Liberia’s requirements in the prevention, diagnosis and treatment of diseases by using efficacious, high quality, safe and cost-effective pharmaceutical products through strengthening mechanisms for drug management, control, information systems, regulation and registration.

The **specific Objectives** for the MOHSW relating to pharmaceuticals are:

- To coordinate policy and regulation for the pharmaceutical sector in Liberia, through all GOL agencies, i.e. MOHSW and in collaboration with the Ministry of Justice;
- To ensure constant availability of safe and effective drugs and medical supplies to all segments of the population through strengthened supply chain management as part of implementing the essential drugs programme for the benefit of the majority of Liberians and in support of the delivery of a Basic Package of Health Services to all Liberians; improved logistics management information systems (LMIS) to track and account for drugs throughout the system;
- To facilitate the rational use of drugs through correct diagnosis, sound prescribing, good dispensing practices, and appropriate usage through appropriately trained prescribers, pharmacists, dispensers and other authorised health workers and effective support supervision, increased consumer education through effective health education and through the elimination of illegal drug vendors;
- To strengthen the regulation of pharmaceutical professionals and pharmaceutical institutions and ensure compliance with internationally accepted professional standards for their registration;
- To ensure that all drugs available in Liberia are registered and approved for their intended use, Good Manufacturing Practice (GMP) international standards will be required for all drugs imported into the country.

4.9 Emergency Preparedness and Response

Given the vulnerability of national structures and the Liberian population, emergencies are likely to be frequent and severe and widespread in their consequences. In the health field, particular attention will be given to acquiring an adequate capacity to respond to epidemics. Effective emergency preparedness and response will be two-pronged. The immediate response must take place at the service delivery point and at county level. Health workers and local managers must be prepared to identify epidemic threats and react in a timely and effective manner. At the central level, the capacity to support county actions and mount national responses shall be developed.

Additionally, the health sector shall be prepared to respond to sudden population movements.

A comprehensive emergency preparedness program will be developed in collaboration with concerned NGOs, many of whom have significant experience in this area. This will include the formulation of standard operational guidelines, training for field managers, drug and equipment stockpiling, and ensuring the quick mobilization of funds, staff and tools as need arises.

4.10 Partnership and Coordination

The public health sector shall work in close partnership with all stakeholders in health including private medical practitioners and complementary health care providers. The Ministry of Health and Social Welfare shall continually seek the opinion of health service users in planning, implementation and evaluation of all health programs, projects and activities at both the national and peripheral levels.

Charities, non-governmental organizations and private providers are major contributors to the health delivery system. Ways to strengthen coordination between the government and private providers will be identified at national and county levels. The Ministry and its development partners will allocate adequate resources, expertise and attention to improving coordination. Mutually-reinforcing measures to be introduced in the pursuit of effective coordination include:

- Improving information systems and making reliable data easily accessible to all interested parties, so that they are able to make informed decisions that are coherent with the national policy and plan.
- Establishing appropriate venues for discussion at the central and county levels, where participants can harmonize their activities in a regular and structured way.
- Rationalizing interventions, so that a reduced number of competent and committed organizations are active in each specific field.
- Standardizing operations, through the issuance of guidelines, norms and evaluation criteria, to be adopted across the whole health sector.
- Restructuring funding flows, so that procedures to access funds become uniform and transparent. The relationships between funding agencies and health care providers will be regulated, through the introduction of formal contracts.

Liberia's public health sector will participate actively in sub-regional, regional and global health exchange in order to further the health interests of the country. Liberia will benefit from engagement in the international public health arena, as it learns from the best practices of others and shares its own experience as appropriate.

4.11 Communication

The MOH&SW will develop strong internal and external communication capacity, so that it can convey the rationale behind policy and resource allocation decisions to concerned audiences in clear, understandable ways in order to foster trust and openness. The Ministry will regularly inform other branches of government, politicians, the media, civil society organizations and the public at large of events taking place in the health arena. The MOH&SW recognizes that good policy communication, management, assessment, and reporting are based on the timely availability of quality information. The Ministry will function in a transparent manner to disseminate all information necessary to enable members of the public to prevent disease, make the most efficient use of available health services and safeguard their own health. The Ministry will reconstitute health promotion and public relations teams for this purpose.

4.12 Complementary Medicine

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

4.13 Research and Development

The Ministry shall be consulted in all matters regarding health research. The National Health Plan shall identify major priorities for public health research. The Ministry will promote a culture of inquiry into the best methods of delivering health care. As part of that effort, the MOH&SW will encourage its staff to acquire relevant research skills and will provide funds for research, targeting National Health Plan priorities.

To achieve this objective and ensure coordination of research activities, the MOH&SW shall strengthen the existing Health Research Division. An ethics committee for research shall be established and be guided by approved ethics guidelines and internationally accepted standards. Health-related research shall be the role of the Liberia Institute of Bio-Medical Research, tertiary institutions, universities, and the MOH&SW, in an atmosphere of open and pluralistic investigation.

4.14 Law Enforcement

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

MONITORING, EVALUATION AND HEALTH POLICY REVIEW

5.1 The Basic Monitoring Framework

The Ministry will develop a comprehensive monitoring and evaluation system, based on policy goals and an agreed set of indicators. Work in this area must start in earnest, as the establishment of effective monitoring capacity takes time and effort.

The following indicators are suggested for observing progress in the application of the National Health Policy. Indicators cover a variety of aspects, including health status, resource availability and allocation, health care outputs, coverage, equity and efficiency. Baselines for most of the proposed indicators are not currently available and have been estimated below. The presented figures are mainly unsubstantiated, and need validation before they can be considered reliable. A definitive set of indicators will be chosen once the National Health Plan is finalized and capacity and features of the information system are specified.

N	Indicator	Baseline	Year
1.	Infant Mortality Rate	134/1000	2006
2.	Under-5 Mortality Rate	260/1000	2006
3.	Maternal Mortality Ratio	587/100,000	2005
4.	Birth rate	46 years	
5.	Total Fertility Rate	6.2	
6.	HV/AIDS prevalence rate	5.2%	
7.	Nutrition		
7a.	• Wasting	6.9 %	
7b.	• Stunting	39.0 %	
8	GOL Health Expenditure Per Capita	US\$4.79	2006
9.	Total health expenditure per capita, by county, rural/urban, investment/recurrent and level of care		
10.	Private health expenditure per capita		
11.	Absorption of budgeted funds (%)		
12.	Population with access to safe drinking water	24%	
13.	Population with access to sanitary excreta disposal	26%	2005
14.	Immunization Coverage	87%	2005
15.	Contraceptive prevalence rate	5%	2004
16.	Coverage of deliveries assisted by skilled staff, by county and level of		
17.	Population having access to the BPHS		
18.	Number of facilities providing the full BPHS		
20.	Number of hospitals providing emergency (24/7) surgical services		
21.	Number of outpatient contacts per head per year, by county and level		
22.	Beds per 1,000 inhabitants		
23.	Facilities with key health professionals to deliver BPHS		
	Doctors per population; nurses per population ratio		
23.	Bed Occupancy Rate, by level of care		
24.	Availability of tracer essential drugs (specify which drugs, check)		

N	Indicator	Baseline	Year
25.	Proportion of pregnant women who took IPT twice or more as req'd.		
26.	Proportion of children under five who slept under ITN		
27.	TB cure rates		
28.	Stock-out rates on essential medicines		

The system will monitor the enforcement of the policy against the overall performance of the health sector and the health impact of development initiatives through analysis of routine health information, surveillance data and periodic survey results. The unintended effects of adopted policy measures will be studied alongside the intended ones.

The Ministry must strengthen its policy analysis capability in order to make best use of available data, respond to research requests, interpret long-term trends and develop timely and appropriate policy based on evidence. Health policy and strategy planning depends on reliable data: The MOH&SW will seek the support of development partners to strengthen the information system. The Ministry has already begun discussions with partners who collect data, both within and outside government, to develop mechanisms to share data and program results and agree on areas of future collaboration.

5.2 Health Management Information System

The Health Management Information System (HMIS) will be strengthened in order to better collect, organize and maintain relevant data in a timely way. The system will have the capacity to produce reports related to health sector development, including the analysis of trends, in order to understand the evolution of the health sector over time. The integrated HMIS will cover the following areas:

- Financial information
- Human resources
- Physical assets and equipment
- Health care service delivery statistics
- Surveillance

These components will be complemented by vital statistics, such as births and deaths, whose collection will be revitalized through the creation of a network of county bureaus. Information management capacity will also be developed at the county level to assist CHTs in their planning, management and resource allocation decisions. Health workers will receive training on data collection, analysis and management.

The HMIS will be designed in a way that is consistent with the decentralized health structure. The rationale is that officials in charge of different levels of care must rely on data appropriate to their level of decision-making. At the county level, where most operational decisions will be taken, the system will generate detailed, disaggregated data. Conversely, information will be consolidated at the central level, where decisions will be mainly related to policy-making, planning, resource allocation and operational oversight.

Efforts will be made to incorporate the information generated by vertical programs into a coherent, unified HMIS. Routine information will be complemented and validated by field surveys, for which adequate capacity must be acquired. The Ministry will introduce mechanisms to feed information back to field workers.

In designing the HMIS, particular attention will be given to monitoring compliance with the health policy. Thus, the HMIS will collect data in ways that will allow stakeholders to study how resources are allocated across levels of care, between central and peripheral administrative bodies, between urban and rural areas, and across counties. This will encourage an informed policy discussion about

equity, efficiency, decentralization, and adherence to the primary health care approach.

The Ministry will regularly publish a statistical yearbook, which will present in a condensed way inputs, outputs, health status indicators, assessments of efficiency, effectiveness and equity in health care provision, and trends. Imbalances and distortions affecting the enforcement of the policy will receive special attention.

5.3 Performance Evaluation and Reviews

The enforcement of the policy will be continuously monitored. Progress and constraints shall be regularly communicated to the public and health stakeholders. Specific new components will be added if considered necessary. Updates or amendments will be introduced by the Ministry in light of the evolving environment, available new information and earned experience. The Ministry expects to conduct a major policy review in five years.

Annual Health Sector Reviews will be carried out by the Ministry of Health and Social Welfare and key stakeholders to determine new policies, review implementation of the National Health Plan, identify operational best practices and lessons learned and prepare work plans for the following year.

ENABLING ENVIRONMENT

6.1 Legislation

The Public Health Law of 1976 needs revision and updating in order to effectively govern the decentralized health sector and accommodate the massive changes that have taken place since its promulgation. The MOH&SW will start working the revision by collecting relevant information, clarifying the legal implications of the measures it intends to introduce in the post-conflict period, and promoting an open debate among stakeholders about the future legislation needed to govern the health sector. In order to play this role, the Ministry will acquire legal and legislative expertise.

6.2 Regulation of Service Provision

The MOH&SW shall invest in the establishment of adequate regulatory capacity in the fields of legislation, standards setting, inspection and operational guidance. A long-term institutional plan aimed at establishing adequate regulatory capacity will be formulated and a dedicated unit will be established within the Ministry to oversee this effort. The Ministry will seek to strengthen technical and procedural capacity of the regulatory body and provide adequate resources to ensure its operation according to objective and transparent criteria. Fast-track provisions will be formulated to accelerate operations in critical areas. Particular care will be given to separating regulatory responsibilities from service delivery duties, in order to avoid conflicts of interest. In the mid-term, efforts will focus on the following selected areas:

6.2.1 Technical Standards:

The Ministry's regulatory unit will develop procedures and requirements for establishing new health and social welfare facilities and other related services, consistent with the delivery of the BPHS. Potential elements include minimum investment, equipment requirements, staffing mix, priority services, geographic coverage areas, licensure and accreditation requirements. As private organizations will continue to provide health and social welfare services to the public for profit, the Ministry will develop appropriate regulations for the private sector and shall monitor and evaluate these services to ensure the delivery of a standardized quality of care.

6.2.2 Licensure:

All health care delivery and training institutions, both public and private, shall be periodically assessed at stipulated intervals, and will be licensed and accredited based upon set standards of operation. Institutions below par will be required to conform to standard within a specified time period to avoid being down-graded or having their licenses revoked or the institution closed. Public subsidies and contracts will be only awarded to providers upholding the required standards.

6.2.3 Ethical Standards and Research:

The MH&SW shall foster a climate of respect for ethical standards by promoting the study of ethics in professional training programs, informing the public about behavior to be expected from health professionals, and by routine inspection of health care practice, so that ethical behavior is transparently rewarded and sanctioned. Clinical trials, cohort studies, surveys and other research activities shall be carried out in the full respect of professional ethics. An Ethical Standards Committee shall be established to that effect.

6.2.4 Peer Review Boards:

The Ministry will encourage and assist county health authorities to establish and maintain peer review boards to promote quality case management, technical efficiency and professionalism, starting with the largest facilities.

POLICY IMPLEMENTATION

7.1 Assumptions

The policy has been written with the following assumptions:

- Peace, stability and continuity of government will be ensured. Ethical standards of governance will remain a national priority.
- Economic recovery will continue, coupled by the expansion of state revenues.
- The generous, sustained support of external donors and other partners will also continue.
- Progressive improvement of the national infrastructure, particularly in rural areas.

7.2 Risks

Among the many risks to be taken into account while enforcing the policy and implementing the National Health Plan, the following shall be considered:

- Liberia succumbs to another cycle of governance vacuum and perhaps of violence. Measures shift into emergency gear. Fragmentation and inefficiency prevail.
- External assistance is inadequate to fuel health sector recovery.
- Powerful external players continue to act in isolation, jeopardizing the application of the policy formulated by the Ministry.
- Inadequate monitoring and follow-up resulting in the National Health Policy and Plan becoming dead documents sometimes referred to but not used consistently to guide decisions.
- Proliferating priorities and political pressures compromise the enforcement of the policy and implementation of the National Health Plan.
- Despite political commitment, support of development partners and availability of resources, inadequate implementing capacity slows down operations.
- Inconsistent leadership and decision-making reduces the credibility of the policy and the plan.
- External shocks and events (within and outside Liberia) draw attention and resources away from the Liberian health sector.
- Archaic public-sector and civil-service provisions are reintroduced, jeopardizing health sector development.

7.3 Institutional Arrangements

The Ministry of Health and Social Welfare will establish a Policy and Plan Implementation structure with the following tasks:

- Provide guidance and interpretation on all matters regarding the application of the policy.
- Organize the dissemination of the NHP, ensuring a forum for discussion on the contents of this policy with stakeholders and the inclusion of stakeholder recommendations into planning and programming practice.
- Finalize a costed National Health Plan, in line with the NHP and the Interim Poverty Reduction Strategy formulated by the Government.

- Carry out an analysis of the institutional structure needed to enforce the adopted policy, identifying weaknesses and possible implementation bottlenecks. Suggest adequate corrective measures to be introduced in order to move forward.
- Monitor and report progress on the implementation of the policy across all involved areas and parties, particularly within the Ministry of Health and Social Welfare.
- Recommend revisions to the policy from time to time, as the need arises; and
- Collaborate with other concerned Ministries and agencies of the Government and the private and non-governmental sectors to promote enforcement of the policy.

7.4 Capacity Building

Enforcing the policy and implementing the plan implies a dramatic strengthening of existing MOH&SW capacity. Expertise in a variety of areas, such as law, public administration, financial management, health economics, public health, planning, health management, information management and health information systems, construction, logistics, human resource development, pharmacy and laboratory, health systems research, negotiations and communication must be acquired. Given the shortage of local skills, many experts will have to be procured on the international market. The Ministry, in collaboration with committed development partners, must find effective ways to identify and hire professionals with appropriate expertise and use them effectively. A trade-off between attaining the chosen goals and building capacity must be sought. Preference should be given to the hiring of a few senior long-term experts, instead of many short-term consultants, as is so often the case in transition contexts.

Meanwhile, a long-term capacity-building strategy must be conceived. It will consist of several interconnected elements, which must be promoted in a balanced and integrated way:

- Institutional provisions that promote transparency, accountability, fair competition, rewards and sanctions, flexibility, innovation and risk-taking.
- Educational and training measures that equip future managers with the knowledge, culture and skills they will need.
- Resources adequate to fuel the growth of the sector.
- A favorable administrative, political, economic and judicial environment.
- Donor agencies supportive of the efforts made in the health sector and committed to ensuring its development, respectful of mutual commitments, slow to push individual donor agendas and events in detriment of Government priorities, and patient with results, which cannot materialize quickly.

7.5 Funding and Resources

The Government of Liberia shall take the lead and ownership in mobilizing funding and ensuring the availability of resources for the effective implementation of the policy. Specifically, the following actions shall be taken:

- Government will strive to progressively increase its health spending to meet the Abuja target of 15% of national budget, with a specific commitment to supporting the implementation of the policy. While the bulk of the allocation will go directly to the Ministry of Health and Social Welfare, other public agencies whose functions have influence on health and social welfare may also be supported.
- Attention will be paid to increasing the effective absorption of funds allocated to health. Mechanisms devoted to ensuring long-term funding and elimination of funding-gaps will be introduced.

- Public and private health programs that directly support the achievement of the objectives of the NH&SWP will be prioritized.
- A Health Management Fund will be established to purposefully support policy implementation and review mechanisms.

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NATIONAL HEALTH PLAN 2007-2011



MINISTRY OF HEALTH & SOCIAL WELFARE

MONROVIA, LIBERIA

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I. Purpose of the National Health Plan

The National Health Plan provides the strategy for implementation of the National Health Policy. Impressive humanitarian efforts and resources that have helped sustain health services during recent years. It is now time, however, to shift from emergency and humanitarian to developmental and capacity building strategies to create a sustainable health system. This plan articulates the MOHSW five-year health plan (2007-2011) and a more detailed two-year transition plan (2007-2008).

II. Background and National Context

Liberia is emerging from more than 14 years of destructive war and a ‘culture’ of violence. The elections of 2005 have ushered in an era of new leadership and optimism that have already resulted in significant improvements in the health sector.

The population is estimated at 3.2 million with a growth rate of 2.4%. Land area comprises 111,370 square km. Population density is around 30 per square km, but very uneven, with four counties hosting 70% of the total population. Massive population displacement in the rural areas during the war led to artificially accelerated urbanization, resulting in severe overcrowding in towns and cities. The literacy rate is less than 40%.

Three fourths of the population lives below the poverty line on less than US\$1 a day. The economy, however, is making a modest recovery, and there is a gradual improvement in security in rural areas.

III. Current Health Situation

Liberia’s health services have been severely disrupted by years of conflict and looting. While revitalization of the health services has begun, but is still far from satisfactory or completed, as may be seen in the following descriptions of health status, infrastructure, workforce, utilization of services and challenges.

A. Health Status

The health status of Liberia may be summarized as follows:

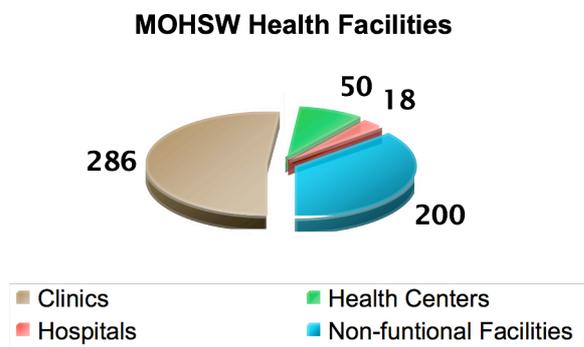


1. Infant mortality rate of 157/1,000 (compared to Sub-Saharan average of 102);
2. Under-Five/Child Mortality rate of 235/1,000 (Sub-Saharan average of 171);
3. Maternal mortality ratios of 580/100,000 (among the highest in the world);
4. HIV prevalence rate estimated at 5.2 %.
5. Exclusive breast-feeding of children less than six months of only 35%;
6. Moderate and severe underweight rates of under-fives of 27% and 7% respectively;
7. Access to safe water and sanitation estimated at 24% and 26% respectively;

B. Health Infrastructure and Utilization of Services

The MOHSW Rapid Assessment identified 354 functional health facilities, including 286 clinics, 50 health centers, and 18 hospitals. An additional 200 health facilities are currently nonfunctional. Access to health services is estimated to be 41%. The definitions of “functional” and “access” are

only rough approximations, but will be developed with precision around the Basic Package of Health Services.



The health workforce consists of approximately 4,000 full-time and 1,000 part-time staff. This includes 168 physicians, 273 physician assistants, and 453 registered nurses, more than 1,000 nurse aides and other health professionals.

The health care system is fragmented, uneven, and heavily dependent on vertical programs and NGOs still operating in a humanitarian mode. These programs have resulted in some significant achievements, e.g., 35% of health facilities have received some rehabilitation, and EPI has increased to 87%.

C. Challenges

The challenges for rebuilding the health system are many and diverse. The immediate challenge is **expanding access to basic health care of acceptable quality**, by:

- Ensuring the availability of funds at county level to support the continuous delivery of basic services;
- Improving the availability of essential medicines and other critical health commodities;
- Rehabilitating health facilities in under-served areas;
- Upgrading the skills of health workers and redeploying them to areas where they are most needed;
- Boosting management capacity at all levels to support the delivery of services. The first step in this direction is improving the information base and monitoring and evaluation capacity.
- Improving availability of safe water and sanitary facilities.

Long-term challenges include:

- Ensuring the availability of adequate resources to sustain the investments called for by reconstruction, as well as the increased recurrent expenditure induced by it;
- Restructuring resource allocation patterns, so that underserved communities benefit adequately from health sector recovery;
- Reducing the present strategic and operational fragmentation, in order to ensure coherence of sector development and attain efficiency gains;
- Upgrading, streamlining and restructuring the workforce, through a long-term training program and the introduction of effective personnel management practices;
- Strengthening the supply chain and rationalizing pharmaceutical management to ensure the availability of affordable, safe, effective essential drugs and other critical commodities;
- Revamping the health care network, through targeted investments in health care and support facilities, in view of increasing access to primary and referral health services;
- Establishing effective management systems capable of operating a modern health sector and evolving as the context and health needs of the Liberian population change over time;
- Introducing effective regulatory provisions and mechanisms to ensure adherence to norms, fair and productive competition, and quality health services.

IV. Policy Context

A. National Health Policy

A National Health Policy was drafted in 2000, but never officially approved. An update to that policy began in August 2006, and has resulted in a proposed revised policy concentrating on several overarching priorities, e.g., 1) expanding access to a basic package of health care by investments in infrastructures, human resources and decentralized management; and 2) establishing the building blocks of an equitable, effective, lean, responsive and sustainable decentralized health care delivery system.

B. Interim Poverty Reduction Strategy

An Interim Poverty Reduction Strategy (iPRS) sets out the emerging process and path of economic reform and reconstruction. It represents a bridge to a more comprehensive and longer-term national economic development framework for Liberia and full Poverty Reduction Strategy to be launched in the second half of 2007. The health sector is included within the pillar of “rehabilitating the nation’s badly conflict-devastated infrastructure and delivering basic pro-poor services and facilities” as follows:

Health and Nutrition: The provision of basic health and nutrition services is a major priority for the Government. With assistance from its development partners, GoL will continue to strive to improve the health status of the population, especially the rural and urban poor. The GOL will ensure that an equitable, affordable, and integrated Basic Package Health Services (BPHS) is provided to all communities and persons, especially to the poor, to the vulnerable, and to women and children. Health systems planning and management will be decentralized to the county level to more fully engage communities and coordinate local partners in the health development process. Major priority areas for will also include:

- Building human capacities of health workers and health managers;
- Ensuring a financially sustainable primary health care system;
- Re-establishing an efficient health referral system;
- Reducing maternal, infant, and under-5 mortality rates;
- Reducing malnutrition among infants, children and pregnant/lactating mothers;
- Fighting malaria, TB and HIV/AIDS;
- Strengthening Health Management and Information Systems; and
- Establishing Early Warning Systems for epidemic response and disease control.

C. Other Policies with Health Implications

Other sector policies that will interface with and contribute to the development of the health sector will include water, safety, information, sanitation, housing/shelter, education, infrastructure, and human rights. The health policy and plan will strive to take advantage of these synergistic opportunities.

D. Social Welfare Policy

The MOHSW believes that substantive preparatory work is still needed to formulate a sound social welfare policy. The new social welfare policy will restructure a sector that is now fragmented and under-resourced, and unable to address the enormous needs of the Liberian population. Therefore, a major review of the social welfare field will be carried out in 2007.

V. National Policy Mission and Vision

The mission of Ministry of Health and Social Welfare is to reform the sector to effectively deliver quality health and social welfare services to the people of Liberia. The vision of the MOHSW is improved health and social welfare status and equity in health; therefore becoming a model of post-conflict recovery in the health field. Enlightened leadership, sustained efforts, coherent prioritization, and generous external support are needed to materialize this vision.

VI. Guiding Principles and Strategic Orientations



A. Health as a Basic Human Right

Access to health care is a basic human right as enshrined in the Constitution. Health is a precondition for individual and societal development. Recognizing the value of health care, the Government of Liberia is committed to invest adequate resources, capacity, and political capital in health sector development.

B. Equity, Gender and Poverty Focus

Equity, social justice, and good governance are essential for health and social improvements. Everyone shall have access to health services, irrespective of socio-economic status, origin, gender, and geographic location. The pro-poor commitment of the Government will be demonstrated by concrete measures, taken at all levels of health care provision. Services shall be organized in such a way as to ensure that both the male and the female gender benefit equitably from the services on offer. Services shall be made user-friendly taking in account gender considerations.

C. Efficiency and Sustainability

Efficiency must remain a constant concern, particularly in relation to major allocated decisions. Long-term capacity building will build local and institutional capacity and confidence to ensure long-term success and sustainability. Quality shall be a watchword. It means promoting tools and mechanisms to provide health and social welfare services above a set of minimum standards, while ensuring the satisfaction of beneficiaries. The MOHSW shall strengthen the existing coordination mechanism and promote an incremental integration process guided by a concern for attaining systemic efficiencies without disrupting the delivery of the health services.

D. Accountability

Adequate political, administrative and communication instruments are needed to ensure that decisions and operations in the health sector are properly accounted for to decision makers and the public. The monitoring system will be designed in view of allowing concerned parties to verify the upholding of the principles inspiring this plan.

E. Decentralization

The Government of Liberia is committed to decentralization. Within the health sector, decentralization will include de-concentration of management responsibilities at the county level and effective support systems at the central level. The local level shall be responsible for primary

health services, while the central level will focus on policies, aggregate planning, and standard settings. The Ministry will assign responsibilities to County Authorities as they are equipped to assume them and progressively expand these responsibilities.

F. Primary Health Care

Primary Health Care (PHC) shall be the foundation for the entire health system based on promoting health, preventing illness and providing basic curative care. PHC places citizens and patients on an equal footing with health professionals with respect to decision-making about health issues. The ideals of PHC will be translated into the provision of a basic package of effective and affordable health services to the largest number of potential beneficiaries.

G. Community Empowerment

Community empowerment will seek to enhance the ability of communities to identify, mobilize, and address the issues that it faces to improve the overall health of the community.

H. Partnerships:

Partnerships for health shall be guided by the Government to ensure that their actions are coherent with the overall health policy. NGO/FBO partners will be involved in the reform, through conventions or contracts. Resources will be redistributed in favor of local communities, and with the objective of improving the capacity of health services to respond to local health care needs.



VII. National Health Plan Framework

During recent years, International NGOs and vertical programs have been the primary actors in Liberia providing health care in emergency mode. David Korten¹ has described this as the “Relief and Welfare” development strategy (see Table 1 on the next page), i.e., where NGOs are the primary “doers” to overcome logistics problems to deliver health care. While this approach is

necessary in the short term, it is not conducive to building sustainable health systems. Sustainable Health Systems require different developmental strategies, e.g., with NGOs working as catalysts or facilitators \with relevant public and private health institutions to create geographically defined health networks, typically called a health district.

The National Health Plan sets forward a framework for shifting from humanitarian to development and from vertical to integrated health systems development.

Table 1: NGO Development Strategies

	Relief & Welfare	Community Development	Sustainable Systems Development
Time Frame	Immediate	Project Life	10 – 20 Years
Scope	Individual & Family	Neighborhood & Village	Region & Nation
Chief Actors	NGO	NGO plus Community	Relevant Public & Private Institutions
NGO Role	Doer	Mobilizer	Catalyst
Management Orientation	Logistics Management	Project Management	Strategic (systems) Management

¹ Korten, David C. Getting to the 21st Century: voluntary action and the global agenda. Kumarian Press, 1990

This framework is based on four components and the results of four working groups:

- Basic Package of Health Services
- Human Resources for Health
- Infrastructure Development
- Support Systems

A. Basic Package of Health Services

1. Purpose

A Basic Package of Health Services (BPHS) is the cornerstone of the national health plan. It defines the services that the Ministry of Health and Social Welfare (MOHSW) assures will be available to each and every Liberian. The BPHS standardizes prevention and treatment services throughout the health system to ensure that all individuals, wealthy or poor, living in urban or in rural areas, receive the same package of care.

The BPHS is a “minimum package” to be made available as an integrated whole, rather than an assortment of vertical and parallel programs. Additional services not currently included in the BPHS will, once approved by the MOHSW, be added to, but not substituted for, those already included in the BPHS. A fully functional health facility must be able to offer the complete BPHS to the entire catchment population.

In accordance with MOHSW policy, user fees for the services included in the Basic Package will be suspended at all public facilities, at least for the current interim period. To this end, if no other sources of funding are available, public sector health funds will be allocated, preferentially, to implement the BPHS.

The Basic Package will be implemented immediately and strengthened over time with a particular emphasis placed on peripheral levels. A primary health care approach for the BPHS will be adapted for each level of the health system – community, health clinic, health center, county hospital, and tertiary hospital.

The BPHS will allow the MOHSW to manage the delivery of health services in an efficient and effective manner, one that will ensure universal access to essential health services. By ensuring standardized care with uniform treatment policies throughout Liberia, the MOHSW will be better able to achieve one of its principal policy objectives – equity in health care. In addition to being able to reach the less advantaged, effective implementation of the BPHS will also allow the MOHSW to increase overall coverage, to procure and distribute essential drugs and rationalize their use. A standardized BPHS will also allow the MOHSW to monitor, evaluate, and compare performance across health facilities that are funded and/or managed by different partners.

The implementation of a standardized BPHS can also be an excellent example of good governance – citizens will know exactly what health services they are entitled in the government-supported health system and the Government will know what services it is responsible for delivering throughout the country. An equitable BPHS will contribute to an improvement in democratic governance and help minimize the risk of future conflict.



2. Objectives and Priorities

The following objectives will be tracked in the implementation of the BPHS:

- Improved child health
- Improved maternal health
- Increased equitable access to quality health care services
- Improved prevention, control and management of major diseases
- Improved nutrition status

The services that are included in the BPHS are consistent with both national policy objectives that are aimed at making substantial progress toward achievement of the health-oriented Millennium Development Goals. The MOHSW has identified five priority areas:

- 1) Maternal and Newborn Health
 - Antenatal care
 - Labor and delivery care
 - Care of the newborn
 - Postpartum care
 - Emergency obstetric care
 - Family planning
- 2) Child Health
 - Infant and young child feeding
 - Integrated management of childhood illnesses
 - Expanded Program on Immunization
- 3) Adolescent, Sexual, and Reproductive Health
 - Sexual and reproductive health
 - Pregnancy prevention/care
 - STI/HIV/AIDS prevention
 - Family planning
 - Prevention of substance abuse
- 4) Disease Prevention, Control and Management
 - STI/HIV/AIDS
 - Malaria
 - Tuberculosis
 - Other communicable diseases
 - Non-communicable diseases, e.g., Mental Health
- 5) Essential Emergency Treatment

3. Criteria for Inclusion in the Basic Package

All elements of the BPHS fall into one of the areas listed above. The specific areas covered in the BPHS have been selected for inclusion on the basis of the following criteria:

- Epidemiological impact
- Existence of safe, effective, and affordable interventions
- Feasibility of implementing those interventions
- Potential for sustaining the activity in the medium- to long-term

While the BPHS is designed to be delivered in an integrated fashion, practical considerations with regard to limited human and financial resources may require incremental implementation. Mental Health and Control of Non-Communicable Diseases, especially diabetes and hypertension, while considered to be of high priority, require additional assessment and planning. Therefore, they will be added to the BPHS as soon as an assessment is completed and resources become available,

4. Levels of Delivery of the BPHS

The BPHS has been carefully defined by health system level and technical sophistication from clinic to hospital. An abridged compilation of key elements of the BPHS is shown in Table 2 (see Annex 1 for the detailed technical specifications). These interventions must be harmonized with the planning for human resources for health such that health personnel with the qualifications needed to deliver the specific services are present. Similarly, appropriate drugs (based on the

Essential Drug List), other health commodities, and equipment must be available to ensure the successful implementation of these interventions.

Table 2. An Abridged Summary of Key Elements of the BPHS

INTERVENTIONS and SERVICES	Community	Clinic	Health Center	County Hospital	Referral Hospital
I. MATERNAL & NEWBORN CARE					
1.1.1. ANTENATAL CARE					
Diagnosis of high-risk pregnancy	Yes	Yes	Yes	Yes	Yes
IPT with SP, Iron Supplementation, ITNs	Yes	Yes	Yes	Yes	Yes
Treatment of malaria, Tetanus toxoid immunization	-	Yes	Yes	Yes	Yes
1.1.2. LABOUR and DELIVERY CARE					
Identify fetal malpositions	Refer	Refer	Yes	Yes	Yes
Normal vaginal delivery	Yes	Yes	Yes	Yes	Yes
Emergency Obstetric Care	Refer	Refer	Yes/Refer	Yes	Yes
PMTCT Package	Yes	Yes	Yes	Yes	Yes
1.1.3. POST PARTUM CARE					
Prevention and detection of puerperal infection	Yes	Yes	Yes	Yes	Yes
Detection and treatment of anemia	Yes	Yes	Yes	Yes	Yes
Counseling on birth spacing and FP service	Yes	Yes	Yes	Yes	Yes
1.1.4. CARE OF THE NEWBORN					
Emergency neonatal care	Refer	Yes	Yes	Yes	Yes
Manage neonatal infections and sepsis	Yes & Refer	Yes & Refer	Yes	Yes	Yes
HIV care/Replacement feeding, Immunizations	-	Yes	Yes	Yes	Yes
2.0. CHILD HEALTH					
Vaccine security/cold chain	-	Yes	Yes	Yes	Yes
EPI, BF, GM, Vit. A, Deworming, ITNs, ORT	Yes	Yes	Yes	Yes	Yes
Management of pneumonia, fever and malaria	Yes	Yes	Yes	Yes	Yes
Identify & manage dehydration/ severe diarrhea	Yes & Refer	Yes & Refer	Yes	Yes	Yes
3.0 ADOLESCENT, SEXUAL, and REPRODUCTIVE HEALTH					
3.1 FAMILY PLANNING					
Distribute oral Contraceptives and condoms	Yes	Yes	Yes	Yes	Yes
DMPA injection	-	Yes	Yes	Yes	Yes
Intrauterine devices	-	-	Yes	Yes	Yes
3.2 ADOLESCENT HEALTH					
Substance abuse prevention, Family life education	Yes	Yes	Yes	Yes	Yes
Oral contraceptives and Condom distribution	Yes	Yes	Yes	Yes	Yes
4.0 DISEASE PREVENTION, CONTROL & MANAGEMENT					
4.1 HIV/AIDS					
ABC Promotion and Condom distribution	Yes	Yes	Yes	Yes	Yes
Home-based Care	Yes	-	-	-	-
Treatment of opportunistic infections	-	-	Yes	Yes	Yes
VCT, PMTCT	-	Yes	Yes	Yes	Yes
Blood Screening and Antiretroviral therapy	-	-	-	Yes	Yes
4.2 Control of Malaria					
Clinical diagnosis	Refer	Yes	Yes	Yes	Yes
RDT/Microscopy, Treating uncomplicated cases	-	Yes	Yes	Yes	Yes
Distribution of ITNs and IPT	Yes	Yes	Yes	Yes	Yes
4.2 Control of Tuberculosis					
Case detection - sputum smear	Refer	-	Yes	Yes	Yes
DOTS and Active case-finding in community/OPD	Yes	Yes	Yes	Yes	Yes
BCG vaccination	-	Yes	Yes	Yes	Yes
5.0 Essential Emergency Treatment					
Shock, Injuries, Poisoning	Yes & Refer	Yes & Refer	Yes & Refer	Yes	Yes

5. Implementation Plan

The BPHS will be implemented in at least 70% of existing functional health facilities by the end of 2008. Further expansion of the package into all existing facilities and expanded facilities will be

completed before the end of 2010. Key benchmarks for the implementation of the BPHS are shown in the following table.

Table 3: BPHS Implementation Plan & Benchmarks	2007				2008				
	Quarter	1	2	3	4	1	2	3	4
Technical content of BPHS finalized by system level	X								
Training modules for BPHS developed		X	X						
Update curriculum on BPHS and train trainers									
Training of health facility personnel in BPHS			X	X	X	X	X	X	X
70% of existing health facilities are providing BPHS									X

The presence of the BPHS will be used as the key element to define the functional status of health facilities and the accessibility of health care to the catchment population served by a health facility. The provision of the BPHS is naturally linked to the infrastructure and human resources. Some elements of the BPHS may only be provided with the presence of a specific infrastructure and/or personnel, e.g., case detection of TB by sputum smear lab exam. However, other elements of the BPHS may be provided even under less than optimal physical or personnel conditions, e.g., growth monitoring.

B. Human Resources for Health

1. Purpose

The human resource component of the National Health Plan strives to ensure that the right numbers of health workers are in the right places at the right time, and with the right skills. This workforce, with support from community partners, will ensure delivery of the BPHS to meet client and community needs.

2. Priorities and Objectives

There is a need to create a Human Resource (HR) Division with a Director to coordinate HR activities. A first priority, therefore, will be to define the functions of the HR Division with respect to central MOHSW structures and decentralized County Health Teams. The HR Division will take leadership in planning, producing, and supporting the future health workforce.

The HR Division will use accurate data to establish its priorities and ensure an adequate number, and appropriate and equitable distribution of health professionals. Practical data collection will generate information on key indicators and respond to core questions:

- What is the geographic distribution and technical composition of the current workforce nationwide?
- How many and what mix of health workers and professional staff are required by facility type to deliver the BPHS?
- What training and competencies do current health workers already have?
- What competencies and training standards are required to deliver the BPHS?

The current underproduction of health workers will be addressed through a decentralized training system, including training required for the implementation of the National Health Plan. Urgent steps should be taken by government to recruit professionals for the public sector.

The Human Resource component will include four objectives to:

1. Ensure a coordinated approach to human resource planning;
2. Enhance health worker performance, productivity and retention;
3. Increase the number of trained health workers and their equitable distribution; and

4. Ensure gender equity in all aspects of employment in health.

Objective 1 – Ensure a coordinated approach to HR planning

Establish and support a HR unit within the Ministry of Health and Social Welfare – A human resource development focal unit shall be established within Planning Bureau/HRD at the national level. The HR unit will oversee the implementation of HR policies and plans. Specifically the HR unit will take leadership to collect primary data, including a detailed HR situation analysis of staffing statistics, training statistics and other matters relevant to the development and review of the strategic plan. In addition, the HR Division will develop protocols and guidelines, prepare annual HR reports of staffing statistics, training statistics and other matters relevant to the regular review of the strategic plan.

Develop and routinely update a human resource strategic plan – In view of inevitable changes in the health field and in the wider political and economic situation, it is essential to make regular and systematic reviews of the health work force. Adjustments to the plan will be made continuously to respond to changing context, and for steady improvement.

Improve the Human Resource Information System (HRIS) – The HRIS will be developed to collect and manage HR information to support and manage the workforce. The HRIS database will be one of several databases that collectively comprise the MOHSW Health Management Information System (HMIS). The development of the HRIS will be done in two phases. The first phase will include an assessment to establish the strengths and gaps of the current system; installation of hardware and software at HQ level; data collection and training of MOHSW HQ staff on the use of the upgraded system. The second phase will concern installing and upgrading systems at the county level. Health personnel at all levels will be trained in data collection and analysis in general for the HMIS and specifically for the HRIS.

Human Resource planning and management – Human Resource management authority shall be decentralized to the county level to allow for greater degree of autonomy. County Health Team members who are assigned HR responsibilities will be responsible to manage the recruitment process, and to deploy and manage staff within the county. They will also periodically collate HR information using standard formats, for onward transfer to the national HR focal unit. The minimum recommended profile for human resources at clinic and health levels, taking account the skills and competencies required to deliver the basic package is shown in Table 4.

Table 4: Proposed Minimum Staffing for Clinics and Health Centers

	Health Clinic	Health Center
Officer in Charge (PA, N/M or nurse)	1	1
Physician Assistant		2
Nurse		1
Certified Midwife	1	4
Nurse Midwife		
Dispenser	1	1
Nurse Aide	1	
Environmental Tech.		1
Social Worker		1
Lab Technician		1
Recorder/HIS	1	1
Security/Cleaner	1	1
Total	6	14

Objective 2 – Enhance performance, productivity, and retention

Design and implement career planning for each category of health workers – The development of career paths and continuing education for all health professionals shall be endorsed. The HR unit of the MOHSW shall develop guidelines and protocols to guide career progression for every cadre. The guidelines will be disseminated to sensitize health workers about

career growth opportunities. Successful career planning will require effective coordination between the HR unit and training institutions to make sure health workers, who fulfill criteria for upgrade, are enrolled into the appropriate training institutions.

Improve performance assessments, supervision, and leadership – Job descriptions for health professional at all levels of services delivery shall be clear and specific to avoid duplication and/ or fragmentation of job tasks. Job descriptions will be used for performance appraisals, so that the results can be considered for career growth and advancement. Standard supervisory protocols will be developed and implemented to provide a supportive supervision structure that encourages positive interaction between health workers and their supervisors. This will enable them to make decisions together to improve on the delivery of the basic health care package. Capacity building activities will be organized for county management teams that perform supervisory functions, to improve on their supervision, management, and leadership skills. County teams will play a key role in the conduct of performance needs assessments and to support facilities implement improvement interventions. County advisory board members will receive orientation for role clarification, to ensure a cordial relationship between health professionals and the community.

Develop and implement motivation, incentive schemes, and compensation packages – The misdistributions of human resources shall be addressed through an incentive-driven process. Bonding schemes that require service for a maximum of three years in underserved/rural areas after completion of under graduate, graduate or post-graduate studies shall be considered. Incentive packages shall be developed for good performance and for working in hardship posts. The type of incentive package for hard ship posts shall be based on the level of adversity of the working environment. The Government shall review the salary packages of all health personnel, taking into account the recent MOHSW proposals and adopt the best salary equalizing option that is financially viable and feasible.

Strengthen professional organizations, and update definition of scopes of practice and standards – Professional associations will realign roles, to match the direction of the health policy and plan. Associations shall seek for legislation from the government, as a way to maintain standards and regulate members' practices. The MOHSW will take into consideration recommendations proposed by professional associations, when revising policies and plans and will explore opportunities to routinely orient professional bodies on the revised policies, plans and guidelines.

Objective 3 – Increase health workers trained and equitable distribution

Develop and support decentralization of the pre-service training system - An audit of training institutions and their capacities, and relevance of existing curricula will be assessed. Guidelines for future training and upgrading of personnel will be formulated based on principles of excellence. The existing number of training institution shall be increased and the intake shall reflect the demographic composition of the country. The number of admissions and graduates shall be based on an assessment of the country needs, as determined by the National Human Resource Audit, with regular review to meet the changing needs. The subsidy system for education institution shall be reactivated/ reintroducing and shall reflect priority education and training needs. The system must make provision for more equitable allocation of subsidies, especially health training institution.

Develop personnel who are competent to respond appropriately to treatment needs through efficient education and training programs – The ability of health professionals to deliver approved health service packages at various levels of health care shall be enhanced. The categories of health workers on the next page shall be regarded as a priority for training:

- Doctors
- Nurses
- Midwives
- Physician Assistants
- Environmental health officers
- Health Information Managers
- Nutrition officers
- Occupational therapists
- Health managers
- Social workers
- Psychologists
- Laboratory technicians
- Pharmacists
- Hospital Administrators
- Supply chain managers
- Physiotherapists

The health personnel education program shall be coordinated. The head of the human resource unit shall establish a coordinating education committee which shall include representative of universities, Nursing Colleges, Ministry of education, and health service providers, Non-governmental organizations and the public, to facilitate an interdisciplinary approach. The function of the health care training and education programs will include the selection of training of all professionals. The activities performed at this level shall include the planning, implementation, monitoring, evaluation, review, and co-ordination of all health personnel education programs

Develop and strengthen curricula for in-service and pre-service training – Primary Health Care curricula shall be restructured to reflect community needs more accurately, and teaching shall place greater emphases on community empowerment and intervention programs that are result driven. An understanding of, and emphasis on primary health care shall be imparted in all existing health personnel through appropriate reorientation programs with on going evaluation and monitoring components.

Promote equitable distribution of health personnel – The delivery of the basic primary health care package requires a mix of health personnel. New and vacant post shall be filled at all health service delivery levels, targeting core cadres. Counties shall have the mandate to recruit and place health workers at the appropriate facility level within the county. The MOHSW shall also reallocate budgets and personnel to under-utilized and underserved areas, to address the geographic and skill imbalance. A policy to guide mobility of personnel between positions in the district, county and national health services shall be developed and enforced.

Initiate Rapid Staffing Hire Plan (RHP) – Liberia is interested in implementing a rapid hire plan as an alternative option for improving equity in worker distribution. A rapid staffing plan is a fast-track “stop-gap” measure that seeks to mobilize and bring on board additional health workers to combat such priority diseases such as HIV/AIDS, TB, and malaria. An RHP is suitable for a country such as Liberia with unemployed health workers, which also values additional HR as an avenue to address the current health crisis. The planned audit will confirm the availability of qualified health workers that will be mobilized within the country to participate in the RHP. Liberia will also commit resources to attract qualified health workers from the Diaspora. A management structure will be put in place to oversee the rapid hiring and placement process, which will side track existing bottlenecks to the current hiring process. Interested health workers will be hired for a fixed period. The cost towards salaries and for capacity building will be initially met through external funding. MOHSW shall put in place mechanisms for a smooth transition, so that workers hired through the RHP are immediately transferred into the normal government payroll system at the end of the contractual term. MOHSW will also work towards removing current hiring bottlenecks, to drastically reduce the time when workers report at a new duty station and the time funds are available to cover their salaries.

Objective 4 – Ensure gender equity in all aspects of employment in health.

Ensure that there is gender balance in all appointments in MOHSW – Gender is one of the Millennium Development Goals. However, Gender issues are not given due consideration in

appointment of staff into positions. This is reflected in the low representation of females in top management positions and some professions in the health sector. To promote gender equity in employment MOHSW should mainstream gender in the Health sector to ensure the understanding of gender issues by all staff by 1) linking the HR Division to the gender desk in the MOHSW at central level; 2) conducting a gender needs assessment survey; and 3) developing a gender policy to guide all HRH decisions.

3. Implementation Plan

Key events and benchmarks for Human Resources implementation are shown in Table 5.

Table 5: Human Resources Implementation Plan & Benchmarks	2007				2008			
	1	2	3	4	1	2	3	4
Objective 1- Ensure a coordinated approach to HR planning								
Establish and support a HR Division within the MOHSW	X	X	X	X	X	X	X	X
Conduct a detailed HR situation analysis	X	X						
Develop and routinely update a human resource strategic plan		X	X		X	X		
Identify and train HR focal persons for HR planning/management at county levels			X	X	X	X	X	X
Improve the Human Resource Information System (HRIS)		X	X	X	X	X	X	X
Establish a multi-sector HRH observatory	X	X	X	X	X	X	X	X
Objective 2- Enhance performance, productivity and retention								
Design and implement career planning for each category of health workers			X	X	X	X	X	X
Improve performance assessments, supervision and leadership			X	X	X	X	X	X
Develop and implement motivation, incentive schemes & compensation packages			X	X	X	X	X	X
Strengthen professional organizations				X	X	X		
Objective 3 -Increase health workers trained & equitably deployed								
Decentralize the pre-service training system					X	X	X	X
Develop efficient education and training programs				X	X	X	X	X
Strengthen curricula for in-service and pre-service training			X	X	X	X	X	X
Promote equitable distribution of health personnel		X	X	X	X	X	X	X
Initiate rapid staffing hire plan (RHP)								
Objective 4 – Ensure gender equity in all aspects of employment in health								
Conduct study (with Gender Unit) on understanding and application of gender			X	X	X	X		
Develop guidelines on gender to guide all HR decisions			X	X	X			

C. Infrastructure Development

1. Purpose

The infrastructure component of the National Health Plan sets forth a proposal and estimated cost to make Primary Health Care and the Basic Package of Health Services geographically accessible to at via a decentralized system of health clinics, health centers, and hospitals.

2. Approaches to Infrastructure Development

Infrastructure planning for restoring, reforming and expanding access to PHC requires detailed or micro-leveling planning at the county level by the CHT in collaboration with districts, health facilities, communities and stakeholders. The county development plan should include proposed rehabilitation of existing facilities, upgrading of clinics to health centers, new clinic constructions in underserved areas, and closing un-needed facilities in over-served areas. This development plan will be approved and managed by the County Health Services Administration.

Ideally, the micro-planning process and the resulting county development plans should be compiled into the National Health Plan. However, we recognize that the capacity building of CHTs to complete the county development plans will need to be a key output for year one of the National Health Plan. In the meantime, a macro-planning process has been used create a best estimate of the overall development needs.

The macro-planning process included input from CHOs regarding their perspective on the current and future configuration of health infrastructure. It is also included mathematical calculations that take into account existing infrastructure, BPHS, staffing (as shown Table 4), population density and district boundaries to estimate the number of health facilities required.



3. Priorities and objectives

Liberia's Interim Poverty Reduction Strategy (iPRS) recognizes that "for many Liberians there is simply no access to primary health care." Increasing access to PHC is a key objective of iPRS and the National Health Plan. Since health clinics and health centers make up more than 90% of health facilities, they are the key to increasing access to PHC. The infrastructure plan prioritizes restoring and reforming the capacity of health clinics and health centers to provide the BPHS and increase access to PHC. However, county and referral hospitals will also not be forgotten. Table 6 summarizes the infrastructure development priorities and plans of the County Health Officers:

According to CHOs, Liberia needs between 500 and 550 health facilities to make PHC geographically accessible. As proposed, this would increase the number of functional health facilities from 354 to 550. The process would require minor or major rehabilitation of 110 existing facilities. In addition, 30 facilities would need to be reconstructed and 30 new health clinics constructed in underserved areas.

Table 6: Infrastructure Priorities and Plans of the County Health Officers

CHO Infrastructure Inventory & Plan	Bomi	Bong	Gbar-polu	Grand Bassa	Grand Cape Mt	Grand Gedeh	Grand Kru	Lofa	Mar-gibi	Mary-land	Mont-serrado	Nimba	River Gee	River cess	Sinoe	Total
	1) How many facilities exist, including func. & nonfunc, public & NFPP?	20	35	24	36	32	18	16	53	32	23	64	56	15	20	27
2) How many facilities are needed to make PHC accessible with 10kms?	24	39	23	42	37	31	16	68	35	29	66	61	22	30	32	555
3) How many health facilities are presently functional?	18	33	13	28	22	13	10	42	31	17	50	48	12	18	6	361
4) What are your facility rehabilitation and constructions plans (see below)?	14	12	5	5	11	7	6	11	8	6	7	15	9	21	26	170
Types of Rehabilitation																
Minor Rehab of Clinics or Hlth Centers		6	3		4	3	5	4	3	1	6	6	7	3	4	55
Major Rehab of Clinics or Hlth Centers	2	2	2	5	2	1		4		3		3	1	7		32
Major Rehab Health Center			1				1		2	2	1		1		2	10
Re-Construct clinic near same site	4							3								19
Construct clinic in new health area	5	4			5				3				5	10		32
Upgrade from Clinic to Health Center	2		4			2								1		9
Minor Rehab of Hospital	1						1					1			1	4
Major Rehab of Hospital			1			1										2
Summary of Health Facilities by Type																
Clinics	21	34	20	37	34	26	13	57	29	26	52	53	17	27	26	472
HC	2	3	2	2	2	4	2	7	4	2	9	4	4	2	5	54
Hospital	1	2	1	3	1	1	1	4	2	1	5	4	1	1	1	29
Total	24	39	23	42	37	31	16	68	35	29	66	61	22	30	32	555

4. Implementation Plan

It is proposed that the first two years of the National Health Plan will concentrate on the consolidation of health work in existing health facilities, and the long term assessment and planning of rehabilitation and construction needs. As such, most infrastructure development would therefore begin in year three. Key events and benchmarks for the implementation of the Human Resources are shown in the following table.

Table 7: Infrastructure Implementation Plan & Benchmarks	2007				2008			
	1	2	3	4	1	2	3	4
CHTs complete comprehensive infrastructure inventory	X	X	X					
Infrastructure database updated as part of developing HMIS		X	X	X				
CHTs develop ST and LT development plans with rehab component			X	X	X	X		
Architectural assessments completed for rehab of 15 county hospitals							X	X

D. Support Systems

1. Purpose

The support systems component outlines the strategies and means for de-concentrating the planning, management, and other key support functions to deliver the Basic Package of Health Services.

The MOHSW is very committed to the decentralization of health care as a central theme of the National Health Policy and Plan. The support systems component of the National Health Plan is a strategic program to de-concentrate power and decision-making closer to the people. It is a critical element of the Government reform agenda for building a new democratic culture and promoting a culture of accountability.

The de-concentration of management responsibilities calls for the building of performing systems at county level, as well as of effective support systems at central level. The mandates of central and county authorities, and their mutual relationships, have to be clearly spelled out. De-concentration will be pursued in an incremental and pragmatic way, by assigning to county authorities the

responsibilities they are equipped to assume, and progressively expanding these responsibilities. Caution will be exerted in the process to ensure that health services are delivered without major disruptions.

NGO/FBO partners will be involved in the reform, through conventions or contracts. Resources will be redistributed in favor of local communities, and with the objective of improving the capacity of health services to respond to local health care needs. The local level shall be responsible for primary health services, while the central level will focus on policies, aggregate planning, and standard settings. The exact boundaries of the decentralized structure will be clarified over time, by the interaction of central and peripheral levels.

2. The Proposed Support Systems

The following nine support system components will be strengthened:

- Policy Formulation and Implementation
- Planning and Budgeting
- Human Resources Management and in-service training
- Health Management Information Systems
- Drugs and Medical Supplies
- Facility and Equipment Maintenance
- Logistics and Communication
- Supervision, Monitoring and Evaluation, Research
- Stakeholder Coordination and Community Participation

Just as there are technical specifications for the BPHS for each level of the health system, there will the respective support system functions may also be assigned by system level. Table 8 provides an overview of the respective functions by system level.

Table 8: Support Systems to be Strengthened at Various Levels

Support Systems	Central	County	District	Community
Policy Formulation & Implementation	Formulate national policy with input from all levels	Develop local policies for county health planning guided by National Health Policy	Policy Implementation and problem resolution at community level	Policy Implementation for community-based activities.
Planning & Budgeting	Provide policy framework and technical guidelines for BPHS.	Prepare the county development plan and manage resources, e.g. bank account.	Plan service delivery to health facility catchment populations.	Community Development Council Plan service delivery for their communities.
Health Management Information System	Monitor and Evaluate implementation of the National Health Plan	Compile, analyze and provide data to central level and feedback to districts	Compile, analyze and provide feedback to Communities	Collect health information/data from CHWs
Supervision, M&E and Research – park rationalize M&E	Develop supervisory checklists for each system level	Regular supervision of districts and health facilities using checklists	Supervision of health facilities using checklists	Supervise community-based activities, e.g., CHWs, and TTMs.
Drugs & Medical Supplies	Implement national drug policy and strengthen procurement, storage, and distributing essential drugs and supplies	Strengthen county capacity to receive, store and distribute essential drugs and supplies	Coordinate distribution and supervise drugs and supplies in clinics and health centers	Encourage the care-seeking behavior for proper treatment at health facilities

Table 8: Support Systems to be Strengthened at Various Levels

Support Systems	Central	County	District	Community
Logistics & Communication	Formulate logistics and communication policies	Detailed logistic and communication plan and operational procedures	Organize and implement L&C activities	Maintain communication between community and health facility
Facility & Equipment Maintenance	Develop standard plans and equipment lists by health system level	Develop a facility/equipment component of county development plan	Implement facility and equipment component of county development plan	Ensure the protection of equipment at the health facility
Human Resources Management	Develop HR policy and strategy, standardize scheme of service and job descriptions for each category and level.	Develop plan and maintain HR database to staff health facilities, including deployment, training, and incentives.	Implement and supervise the HR plan for health clinic and health center personnel.	Provide feedback on service providers' behavior.
Stakeholder Coordination	MOHSW aligns counties with donors and projects that provide countywide support; develop norms and mechanisms for coordination	County Coordination Meetings coordinate county plan and resources, including NGO-managed projects	District Health Committee and/or Community Development Committee coordinate local stakeholders.	Community Health Committee coordinates local resources, e.g., CHWs, TTMS, building staff housing.

3. Priorities and Objectives

While all of these functions and system levels are necessary for proper health system functioning, it would be overly ambitious to develop them simultaneously with the same level of effort. As noted in the health policy, decentralization will be pursued in an incremental and pragmatic way, by assigning county authorities the responsibilities they are equipped to assume, and progressively expanding these responsibilities.

The priority and primary objective of the support systems component will be to develop the capacity of County Health Teams (CHT) to take charge of the planning process and resource coordination of development partners to shift from the humanitarian to development model before the end of 2008. To this end, the support systems capacity-building process will begin with Planning & Budgeting, Health Management Information System, Supervision, Drugs & Medical Supplies and Stakeholder Coordination.

A few CHTs already have an adequate level of personnel to begin this process. During year one of the health plan the MOHSW will train several CHTs in decentralized planning, management and resource coordination at the county level to initiate the transition process from humanitarian to development. Training modules for this sort of training have been developed in a number of counties, and could be updated and adapted for use in Liberia. Once this transition process has been well established in several counties, it can then be more easily expanded to all counties.

3.1 Policy Formulation and Implementation

3.2 Planning and Budgeting

3.3 Human Resources Management and in-service training

3.4 Health Management Information Systems

3.5 Pharmaceuticals and Medical Supplies

The overall goal for the pharmaceutical sector in Liberia is “increased access to efficacious, high-quality, safe and affordable medicine for the people of Liberia”

The immediate objective is to use available resources to develop pharmaceutical services to meet Liberia’s requirements in the prevention, diagnosis, and treatment of diseases by using efficacious, high quality, safe and cost-effective pharmaceutical products through strengthening mechanisms for drug management, control, information systems, regulation, and registration in accordance with the National Drug Policy of Liberia (2001).

The priority areas of support necessary to achieve the specific objectives relating to pharmaceuticals and medical supplies are as follows:

3.5.1 To coordinate policy and regulation for the pharmaceutical sector in Liberia, through all GOL agencies, i.e. MOHSW in collaboration with the Ministry of Justice:

- Increased allocations to procure pharmaceutical and medical supplies for the public sector, capitalization of National Drug Service (NDS) to be able to provide drugs and supplies to support the BPHS through a sustainable revolving fund basis in accordance to its private-not-for-profit mandate, annual drug recurrent budget to purchase drugs to deliver the BPHS allocated to all counties;
- Financing options for pharmaceuticals diversified, Government financing, revolving drug funds, health insurance, community health insurance, cost-sharing;
- Terms of reference and guidelines for establishment and functioning of pharmacy and therapeutic committees developed, adopted and committees functioning at national and county levels;
- Pharmacists deployed to every county;
- National drug policy periodically revised and updated and related strategies updated and disseminated, Essential Drug List (EDL), National Formulary (NF), and Standard Treatment Guidelines (STG);
- National guideline on donation of pharmaceutical and medical supplies disseminated and complied with;

3.5.2 To ensure constant availability of safe and effective pharmaceutical and medical supplies to all segments of the population through strengthened supply chain management as part of implementing the essential drugs program for the benefit of the majority of Liberians and in support of the delivery of a Basic Package of Health Services to all Liberians; improved logistics management information systems (LMIS) to track and account for drugs throughout the system:

- Supply chain management strengthened at all levels;
- Logistic Management Information System functioning, initially for basic items and expanding to include all pharmaceutical and medical supplies;
- NDS financially autonomous through recovering cost of sales and services;
- MOHSW and NDS establish contractual relationship through MOU for supply and payment for pharmaceutical and medical supplies to the public health sector;
- NDS capitalized to supply public health needs for delivering the BPHS;
- NDS procuring pharmaceutical and medical supplies through international competitive bidding on a regular basis;

- All procurement of pharmaceutical and medical supplies planned through a medium term procurement plan (MTPP) to supply drugs for the delivery of the BPHS;
- Institutional arrangements to coordinate and monitor procurement and flows of stocks of pharmaceutical and medical supplies throughout the health system established and functioning, i.e. pharmaceutical logistics committee;

3.5.3 To facilitate the rational use of pharmaceuticals through correct diagnosis, sound prescribing, good dispensing practices, and appropriate usage through appropriately trained prescribers, pharmacists, dispensers and other authorized health workers and effective support supervision, increased consumer education through effective health education and through the elimination of illegal drug vendors:

- Increased number of pharmacists graduating from Schools of Pharmacy every year;
- School of Dispensary re-vitalized and dispensers being certified annually;
- Rational prescribing taught to all health workers in their pre-service training, through use of EDL;
- EDL disseminated and being used;
- NF and STG revised and health workers trained;
- Health promotion campaigns on rational use of drugs for the general public;
- Continuing professional development for pharmacists;

3.5.4 To strengthen the regulation of pharmaceutical professionals and pharmaceutical institutions and ensure compliance with internationally accepted professional standards for their registration:

- Pharmacy Board of Liberia (PBL) management strengthened;
- All pharmacists registering annually through professional updated re-registration;
- Code of conduct developed and adhered to by all pharmacists;
- Code of ethical practice for use of drugs and medicines for all health workers;
- Continuing Professional Development (CPD) scheme established for retention and being implemented;
- Registration and supervision of all pharmacists and dispensers being done by PBL;
- All pharmaceutical institutions licensed and operating according to their appropriate regulation and monitored by the PBL;
- Inspection of pharmacies and medicines stores to ensure compliance with relevant legislation concerning premises and proper storage of drugs and medical supplies;
- Increased awareness and compliance by pharmacists and pharmaceutical institutions of legislation, regulation and guidelines through their regular publication, advocacy and dissemination;

3.5.5 To ensure that all pharmaceuticals available in Liberia are registered and approved for their intended use, Good Manufacturing Practice (GMP) international standards will be required for all drugs imported into the country:

- Establishment of drug regulatory authority (DRA);
- All drugs imported to Liberia are pre-registered in a national drug registry, schedule of pharmaceutical and medical preparations including proprietary medicines registered published and circulated annually by DRA;
- Quality control laboratory established and functioning under DRA;
- Strengthen collaboration with regional quality assurance reference laboratories;

- Inspection of distribution channels and post marketing surveillance of pharmaceuticals carried out periodically by DRA;
- All drugs imported into Liberia meet internationally accepted quality standards of manufacturing (GMP) and are imported with an Importation Permit Declaration issued by DRA.

3.6 Facilities and Equipment Maintenance

3.7 Logistics and Communication

3.8 Supervision, Monitoring and Evaluation, and Research

3.9 Stakeholder Coordination and Community Participation

4. Implementation Plan

Key benchmarks for implementing Support Systems are shown in Table 9.

Table 9: Support System Implementation Plan	2007				2008			
	1	2	3	4	1	2	3	4
Refine and adapt training modules for support systems	X	X	X					
Orientate Central Level to Support Systems		X	X	X				
Begin Planning & Coordination training in two counties		X						
Provide necessary resources, e.g. open bank account		X	X	X				
Develop short-term and long-term county development plans			X	X				
Expand Support Systems training in first two counties								
Revise training and plans as per results of first two counties			X	X	X	X	X	X
Expand Planning & Coordination training in other counties				X	X	X	X	X
Expand Support Systems training in remaining counties					X	X	X	X

VIII. Costing and Financing the National Health Plan

The process of costing and financing the National Health Plan requires detailed budgeting for each component of the health plan. The priced health plan will enable MOHSW to justify its financial requirement to both government and other health partners for reasonable financial support for its planned activities annually.

The plan was budgeted using the per capita approach of costing. Typically, in post-conflict situations, these amounts vary from \$12 to \$18 per capita per year. This figure used depends in part on the definition of what is included in the per capita estimate. For example, some financing plans may be limited to donor investments, excluding contributions from the MOHSW budget and/or special funding for national programs (e.g. Global Fund). This costing and financing approach assumed that all resources of the national budget, special programs, and bilateral/multilateral programs are included in the calculation. The total cost of delivering the investments assistance, also includes the transitional costs of the NGO withdrawal. .

A. Costing the National Health Plan

On the next page, Table 10 shows a four-year National Health Plan budget of \$283 million that is part of the GoL multi-year planning. The total five-year budget would be \$382 million. In order to avoid service gaps as implementing partners' transition from humanitarian to developmental assistance, a special budget line is included for the Transitional Gap and Health Plan Implementation Cost.

Table 10: Proposed Budget for Health and Social Welfare: 2007-2010

AREA	INTERVENTIONS	YEAR				Total
		2007	2008	2009	2010	
Human Resources for Health	Conduct HRH Needs Assessment	0.30	-	-	-	0.30
	HRH Unit, Plan & Database Development	1.00	0.15	0.11	0.08	1.34
	Training Service Providers (scholarships & workshops)	5.00	6.00	6.25	6.25	23.50
	Support current Training Schools (6-schools)	5.00	6.00	6.25	6.25	23.50
	Strengthening County Health Teams (Capacity Building)	1.00	2.50	2.50	2.25	8.25
	Health Personal Employed	3.00	4.50	4.50	5.25	17.25
Sub-Total Human Resource for Health		15.30	19.15	19.61	20.08	74.14
Health Support System	Health Financing Assessment & Trust Fund	0.50	0.50	0.25	0.23	1.48
	Logistics (Ambulances, Motorcycles, Communications)	2.50	3.00	3.50	5.00	14.00
	HMIS Development (National & County levels)	0.80	0.25	0.13	0.13	1.31
	Community Level Support System	0.50	0.50	0.50	1.49	3.00
	County/District Support Systems (vehicles, etc.)	1.00	1.21	1.25	2.50	5.96
	Central Level Support (Admin, Plans, Policies, etc.)	1.50	1.50	1.50	1.60	6.10
Sub-Total Health Support System		6.80	6.96	7.13	10.95	31.85
Basic Package (PHC)	Reduce maternal, infant & <5 mortality rates	2.00	1.50	1.50	2.33	7.33
	Routine EPI	1.50	2.00	3.00	3.00	9.50
	Nutrition interventions	0.25	0.50	0.50	0.50	1.75
	Quality PHC Services (drugs, equipment, etc)	1.00	1.50	2.00	2.50	7.00
	Malaria treatment, IPT & ITNs (facility & home-referral)	1.00	1.15	2.00	1.00	5.15
	Referral Services & Treatment	0.50	1.00	0.50	0.50	2.50
	STIs/HIV/AIDS	2.00	3.00	3.00	4.00	12.00
	Scaling up TB & Leprosy control	1.50	1.50	1.50	2.00	6.50
	Strengthen Reproductive Health (Safe Motherhood)	0.30	1.00	1.50	2.00	4.80
	Selected social welfare services	0.25	0.50	0.71	1.00	2.46
	Emergency Preparedness Respond (EPR)	1.00	1.50	0.40	0.25	3.15
Essential Drugs and Medical Supplies	4.00	4.00	3.00	1.00	12.00	
Sub-Total Basic Package (PHC)		15.30	19.15	19.61	20.08	74.14
Infrastructure	Infrastructure Assessment & Planning	0.20	-	-	-	0.20
	Rebuilding Health Infrastructures (201- facilities)	0.50	0.50	4.50	6.00	11.50
	Rehabilitate Health Infrastructures (70% of 354)	0.50	0.50	3.50	5.00	9.50
	Logistical Support (vehicles, furniture, etc)	0.20	0.25	0.31	0.75	1.51
	Rehabilitate 3-mental health facilities	0.15	0.25	0.30	0.50	1.20
	Re-construct, equip and support 3- midwifery Schools	0.15	0.24	0.30	0.53	1.22
Sub-Total Infrastructure		1.70	1.74	8.91	12.78	25.13
Social Welfare	Rehabilitate 3-Special Rehab Facilities	0.75	0.50	0.50	0.50	2.25
	Support 150 orphanage homes	0.50	0.50	0.50	0.50	2.00
	Logistical Support	0.20	0.25	0.28	0.30	1.03
	Social Work Service, e.g., Mental Health	0.15	0.25	0.25	0.27	0.92
	Capacity Building for Social Workers	0.10	0.24	0.25	0.30	0.89
Sub-Total Social Welfare		1.70	1.74	1.78	1.87	7.08
Total Excluding transitional gap		40.80	48.74	57.04	65.76	212.34
Transitional Gap		12.00	14.25	17.00	19.00	62.25
Health Plan Implementation Cost		1.60	2.00	2.02	2.86	8.48
Grand Total		54.40	64.99	76.06	87.62	283.06

B. Financing the National Health Plan

The financing plan (see Table 11) must identify adequate sources of funds to implement the budget. It is assumed that funding will come from a number of primary sources:

- 1) The Government of Liberia budget;
- 2) Special budgets for National Vertical programs;
- 3) Bilateral/Multilateral funding for Humanitarian and Developmental Assistance; and
- 4) Other funding sources

Table 11 Financing of the National Health Plan (in US\$ millions)

Source of Funding	2007	2008	2009	2010	Total
MOHSW + JFK (increasing to 15% of Nat.	10	18	28	33	89
National Programs, Humanitarian & Development Funding	40	40	40	40	160
Other Funding (NGO, FBO, User Fees)	4	7	8	15	34
TOTAL	54	65	76	88	283

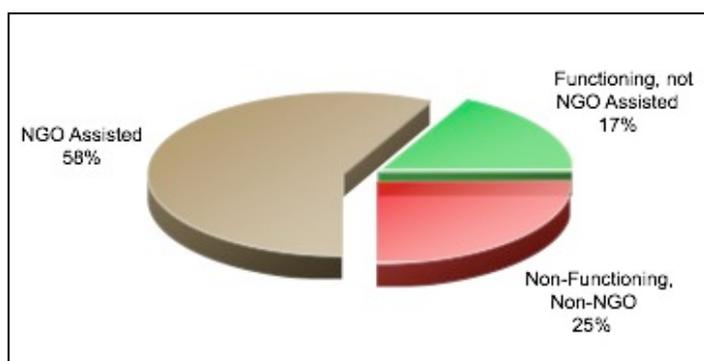
1. The Government of Liberia Budget

It is anticipated that funding for the MOHSW from the national budget will provide approximately 30% of the total funding for the four-year National Health Plan. This estimated revenue is based on the following assumptions:

- That the current budget of the MOHSW is approximately 10 Million USD (including funding for JFK hospital) and represents 8% of the total national budget of 129 million.
- That the national budget will grow yearly by a factor of 20% resulting in a budget of 245 million in 2011.
- That the MOHSW share of the national budget will increase to 12% for the 2008 budget (July 2008-June 2009) and to 15% in subsequent budgets.
- Based on those assumptions, the MOHSW contribution to the National Health Plan would be 89 Million over a four-year period.

2. National Programs, Humanitarian, and Development Funding

There are four major national programs that are already receiving significant yearly funding, i.e., EPI, Malaria, TB and HIV/AIDS. In addition, there is a more modest funding level provided annually for other programs, e.g., River Blindness and leprosy. The funding of these programs should be considered as a contribution to the National Plan, especially since some key components of the BPHS are funded by these programs, e.g., immunizations. The financing of bilateral and multilateral funding for both humanitarian and developmental programs must also be taken into consideration.



Humanitarian funding will be phased out by the end of 2008, and the developmental funding must be phased in as soon as possible. It is proposed that funding partners should maintain the current US\$40 million funding level over the next four years by replacing humanitarian funding dollar per dollar with developmental funding.

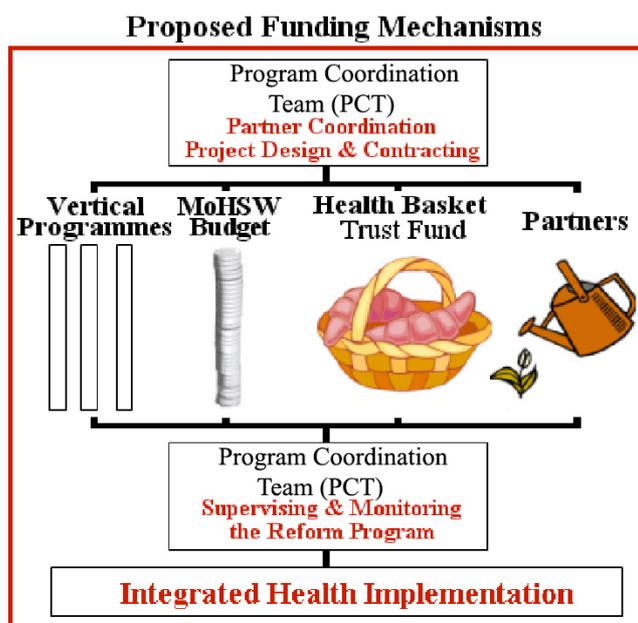
4. Other Sources of Funding

There are other sources of funding for the Liberian health sector. Faith based organizations currently manage 44 health facilities, including a number of county hospitals, under the auspices of the Christian Health Association of Liberia (CHAL). This contribution should be factored into the financing of the health sector.

IX. Monitoring Implementation and Targets

The MOHSW has created a Program Coordination Team (PCT) to coordinate partners and resources for implementing the National Health Policy and Plan. The PCT consists of the four Deputy Ministers supported by technical experts, and is headed by the Chief Medical Officer/Deputy Minister of Health Services. The PCT provides the best option for institutional capacity building, at both the management and organizational levels.

Contracting mechanisms with NGOs will be selectively used for both geographic and programmatic focused projects. An Office of Financial Management has been established within the Ministry to ensure accountability and transparency that will meet and exceed international and regional standards.



This will include a mix of funding channels as shown in the figure above. Contracting mechanisms with NGOs will be selectively used for both geographic and programmatic focused projects

For the effective implementation of the National Health Plan, a comprehensive system for monitoring and evaluation will be put in place based on the outlined policy targets and agreed set of indicators. The following progress indicators shown in Table 12 will be used to monitor progress in the implementation of the National Health Plan.

Table 12: Milestone Indicators for Health: 2006 – 2015

Parameters	2006	2008	2011	2015
% of health facilities providing the BPHS	40%	70%	90%	100%
Immunization Coverage (6 Childhood Diseases)	80%	80%	85%	90%
Counties with a LT health development Plan	0%	70%	100%	100%
Counties with Key Social Welfare Services	30%		60%	80%
GOL Health Expenditure Per Capita (USD)	\$4.79	\$7	\$11	\$28.2
% of population with access to safe drinking water	46%		76.7%	82%
Access to Sanitary excreta disposal	30%		60%	80%
Contraceptive prevalence rate	5%		15%	20%
Awareness of STIs/HIV/AIDS prevention & control 5 of pop)	70%		90%	95%
Malnutrition – Under nutrition (H/A)	39%		35%	30%