

GOVERNMENT OF LIBERIA

NATIONAL HEALTH POLICY

MINISTRY OF HEALTH AND SOCIAL WELFARE



MONROVIA, LIBERIA

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Ministry of Health and Social Welfare

National Health Policy

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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

FOREWORD

For Liberia, this policy could not have come at a more promising time. After over twenty years of civil unrest and violent conflict, peace has been restored, a democratically elected government is in place and Liberians are now wholeheartedly willing to move forward as a united nation.

The new atmosphere in Liberia gives us the opportunity to create strategies and devices for programs that will help our nation not only recover, but also flourish. Along with a mission of reforming the health sector to effectively deliver quality health and social welfare services to the people of Liberia, the process of formulating a policy to direct our national plans was piloted with passion, commitment, and professionalism.

Our hope is that the National Health Policy will serve as an inspiration and guiding compass to the Liberian people, stakeholders, and health care workers, in implementing our reforms of the health care system. This system will help us reach our aspirations, in an attainable and all encompassing vision: a nation with improved health and equity in health, therefore becoming a model of post-conflict recovery in the health field. The Ministry of Health and Social Welfare shares this dream with many others in the development community. Our National Health Policy and National Health Plan were met with unparalleled support at the Liberia Partners' Forum in February 2007.

The time is now to capitalize on this momentum, using our collective knowledge and optimism to make our dreams a reality. We are faced with the great challenge of development, great responsibility to our people, and great opportunity to become a model of health care in post-conflict recovery.

The National Health Policy was written with a theme of decentralization. We understand that in Liberia, our 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. With the most help needed outside of Monrovia, increasing the human capacity of the health sector at the community, district, and county levels is an essential component of policy implementation. Once capacities are developed, the health sector shall move forward with the community and county as a locus for decision-making in relation to resource management and service delivery.

A Basic Package of Health Services (BPHS) is the cornerstone of the national health care delivery strategy. The Ministry of Health and Social Welfare 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.

As stated by President Ellen Johnson Sirleaf, for capacity building to be truly sustainable, it must be indigenous, building on the experience of all Liberians and encouraged by their own social conditions, as well as their dreams and desires. 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 Liberia will thrive with diminishing dependence on outside support.

We believe this is possible, and we ask that you join us in our journey towards development. This document is the roadmap that will lead the way.

Walter T. Gwenigale
Minister of Health and Social Welfare

Chapter 1

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 adhesion 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.

Chapter 2

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

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

2.4%. 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 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

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

³ Ibid

⁴ Source National Micronutrients Survey 2000

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 Centers 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.

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.

Chapter 3

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.

Chapter 4

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 programmes.

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.
- Guidelines for the hiring of expatriate health professionals will be produced by the Ministry.
- 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.

No.	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 care		
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 of care		
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)		
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.	Stockout 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.

Chapter 6

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:

- 6.3.1. **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.
- 6.3.2. **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.
- 6.3.3. **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.
- 6.3.4. **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.

Chapter 7

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 inter-connected 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:

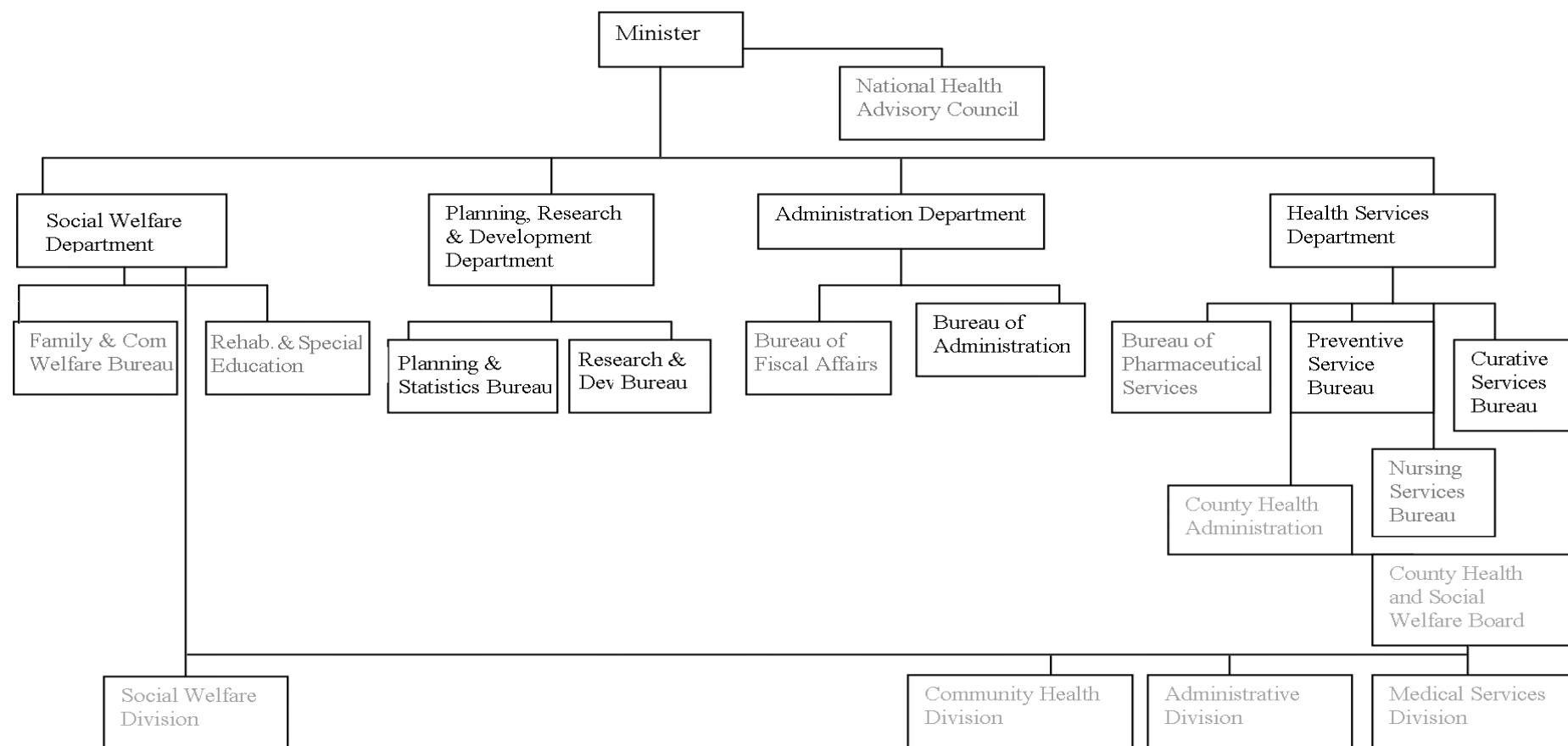
- Government will strive to progressively increase its health spending to meet the Abuja target of 15% of national budget, with a specific commitment to supporting the implementation of the policy. While the bulk of the allocation will go directly to the Ministry of Health and Social Welfare, other public 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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Annex:

ANNEX 1: MODIFIED ORGANOGRAM OF THE MINISTRY OF HEALTH & SOCIAL WELFARE



NOTE: A HUMAN RESOURCE DEVELOPMENT BUREAU WILL BE CREATED UNDER THE DEPARTMENT OF PLANNING, RESEARCH & DEVELOPMENT

NOTE: Shaded areas represent structures to be adopted [] National and [] Intermediate/County Level